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

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436th Medical Group (MEDGRP), Dover Air Force Base (AFB) Volume I

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

Executive Summary

Site	436th Medical Group (MEDGRP) Dover
Decision	Transition the 436th Medical Group-Dover outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.

Background and Context

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

Wing Mission Summary

Dover Air Force Base (AFB) and the 436th Medical Squadron is in Dover, DE, in Kent County, approximately 50 miles from Wilmington, DE. Dover AFB is home to the Department of Defense's (DoD) largest aerial port and nearly 9,000 Airmen and joint service members, civilians, and families. Its personnel are responsible for global airlift aboard assigned C-5M Super Galaxy and C-17 Globemaster III aircraft. Additionally, the 436th Airlift Wing serves as host for key partners such as the Air Force Reserve's 512th Airlift Wing, the Air Force Mortuary Affairs Operations (AFMAO), the Armed Forces Medical Examiner System (AFMES), and the Joint Personal Effects Depot (JPED), jointly responsible for the dignified return of fallen American service members.

Criteria Matrix

Criteria	Rating or Value[1]	Key Takeaways or Findings	Use Case Package
Mission Impact	L	• The 436th MEDGRP is one (1) of the four (4) MTFs within the Air Mobility Command (AMC) that will experience cuts in personnel • Dover AFB would be unable to operate the three ambulances critical to the base, AFMES, and AFMAO missions if the MTF was restructured. Defense Health Agency (DHA) and Air Force Medical Service (AFMS) will need to determine if Emergency Medical Services (EMS) capabilities will be supported by the base Fire Department or contracted to a local EMS/Ambulance service to support coverage to the installation • Dover AFB is home to the AFMES and the Air Force Mortuary Affairs Operations (AFMAO). To process remains, no fewer than three (3) radiology technicians are required to be staffed/available for 24/7/365 on-call roles and responsibilities in support of AFMES. All of the radiology technicians must be Computed tomography (CT) trained/certified and encouraged to have a current American Registry of Radiologic Technologist (ARRT) certification. The 436 MEDGRP must also have a radiologist on staff to perform CT studies, read films, and provide medical inputs to the AFMES team. Additionally, the mission requires dentists and dental technicians to assist in the identification process for some remains. Given the sensitive nature of this mission, Dover radiology technicians, Diagnostic Imaging Technicians, dentists, and dental technicians require pre/post exposure briefings conducted by mental health • Proximity of the local network to the base indicates excessive time away from duty or job for Primary Care visits as there are a limited number of Primary Care physicians within the 30-minute drive-time radius	Section 1.0

[1] See Appendix B for Criteria Ratings Definitions

Network Assessment	M	- Dover AFB is located in a rural area, in which the impacted population represents 3.7% of the total Dover population - Enrollment of additional beneficiaries to the network would depend on the Managed Care Support Contractor (MCSC) network expansion and potentially the entry of additional physicians into the market. If the MCSC contracts 50% of the non-network Primary Care Providers (PCPs), they would have a total of 46 PCPs accepting new patients. Each PCP would have to enroll 164 new patients to accommodate the approximately 7,500 436th MEDGRP enrollees. Based on the assumptions above, the MCSC network would expand slowly and experience great difficulty enrolling the MTF non-Active Duty beneficiaries - Dover is projected to grow 3.4% over the next five (5) years. Based on analytic assumptions, the MCSC network could likely meet new demand. However, the network would be challenged, both for primary and Specialty Care, over time without new entrants - The MTF conducted phone calls and informal interviews of the local network. MTF assesses that the local network could absorb 1,200 patients today. Local network providers told MTF leadership that if they had it in writing that the MTF would be moving to AD only, they could plan to absorb the MTF patient population most likely within three (3) years and certainly within five (5) years	Section 2.0

Risk/Concerns and Mitigating Strategies

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

	Risk/Concerns	Mitigating Strategy
1	The pace at which the network can absorb new enrollees into Primary Care is unknown. There will be an adjustment period for the network	The MTF should conduct the transition in a measured way that is tailored to their specific needs and addressed in the implementation plan. The MCSC / TRICARE Health Plan (THP) and MTF will monitor progress and address access issues by slowing down the transition, including maintaining necessary MTF staffing levels as the transition progresses
2	The impact of the 436th MEDGRP wing support, such as radiology, dental, and ambulance services	- DHA and Air Force Medical Service (AFMS) will need to determine if Emergency Medical Services (EMS) capabilities will be supported by the base Fire Department or contracted to a local EMS/Ambulance service to support coverage to the installation - AFMS will need to explore options such as additional staffing or rotational taskings to adequately resource radiological and dental support to AFMES/AFMAO
3	The network's ability to provide adequate Behavioral Health services in the future	Access standards for Behavioral Health will be closely monitored and the MTF should work with MCSC/THP to identify additional providers if necessary
4	Impact of work supporting Family Advocacy as the decision is implemented	The MTF should interact with the enrolled population to provide services to meets its statutory requirements and assist with the referral process to the network if necessary
5	Frustrations with the MCSC could drive some current network providers to drop from the network	MCSC provider relations representatives will continue regular network provider education and engagement
6	The patients' change in expectations from getting care on the base to getting care off the base will have to be monitored and measured	This risk will be mitigated through the implementation and communications plan, as well as case management and care coordination
7	The TRICARE network may need to be expanded to cover impacted beneficiaries. Providers' willingness to accept TRICARE patients must be confirmed	- Maintain Primary Care for the AD population - Shift beneficiaries to the network slowly, and continuously monitor the network to ensure access standards are being met

Next Steps:

Develop the implementation plan for the above decision, with a focus on deliberately shifting enrollees to an expanded civilian network one (1) panel at a time. DHA & AFMS must determine if EMS capabilities will to be supported by the base Fire Department or contracted to a local EMS/Ambulance service to support coverage to the installation (excluding flight line response) post 4,684 and NDAA Section 703 decisions.

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

Dover Air Force Base (AFB) and the 436th MEDGRP is in Dover, DE, in Kent County, approximately 50 miles from Wilmington, DE. The 436th Airlift Wing serves as host for key partners such as the Air Force Reserve's 512th Airlift Wing, the Air Force Mortuary Affairs Operations (AFMAO), the Armed Forces Medical Examiner System (AFMES), and the Joint Personal Effects Depot (JPED), jointly responsible for the dignified return of fallen American service members. The total Military Treatment Facility (MTF) enrolled population affected by the decision is approximately 7,000[2] non- active duty (AD) beneficiaries that will need to find a new Primary Care Manager (PCM). Of note, Dover has unique population attributes, supporting approximately 490 Exceptional Family Member Program (EFMP) beneficiaries.

1.1. Installation Description

Name	Dover Air Force Base (AFB)
Location	Dover, DE; Kent County; approximately 50 miles from Wilmington, DE
Mission Elements	436th Airlift Wing; 512th Airlift Wing, AFMAO; AFMES; JPED
Mission Description	Provide rapid global Airlift, combat-ready Airmen, and Unrivaled Installation Support
Regional Readiness/ Emergency Management	No information
Base Active or Proposed Facility Projects	(1) Fiscal Year (FY) 2018 On Base School in solicitation phase (2) FY21-25 Dormitory Air Mobility Command's (AMC's) #5 Military Construction (MILCON)
Medical Capabilities and Base Mission Requirements	Current medical capabilities at Dover AFB are meeting the base mission requirements. However, Dover is one (1) of the four (4) MTFs within the AMC that are projected to experience personnel reductions due to the 4,684 redux (pre-decisional) directive

1.2. MTF Description

Name	436th MEDGRP Dover
Location	Dover, DE; Kent County; approximately 50 miles from Wilmington, DE
Market[3]	Market Development Office (MDO) – Stand-Alone MTF
Mission Description	Ensure medically fit forces, provide expeditionary medics, and deliver Trusted Care to all we serve.
Vision Description	Air Force Warrior Medics...Mission Focused, Excellence Driven.
Goals	No Information
Facility Type	Outpatient clinic, no ambulatory surgery
Square Footage	107,859 Net Square Feet
Deployable Medical Teams	FFGRL, FFRM1, FFPM2, FPPS, FFPS3, FFPS4, FFGR1, 9AFS2, FFLGE, FFPME, FFLG1, FFZZZ-1, FFZZZ-2, FFZZZ-3
FY17 Annual Budget[4]	$13.2M
MTF Active or Proposed Facility Projects	No Information

[1] Source: Non-AD MTF Prime and Plus
[3] Defined by FY17 NDAA Section 702 Transition
[4] Source: Source: 436 MEDGRP Mission Brief-Mar19.pptx

Performance Metrics	See Volume II, Part C and D for Partnership for Improvement (P4I) measures and Joint Outpatient Experience Survey –Consumer Assessment of Health Providers and Systems (JOES-C) data

Projected Workforce Impact

Active Duty	Civilian	Total
53	13	**65**

FY18 Assigned Full-time Equivalents (FTEs)[5]

	Active Duty	Civilian	Contractor	Total
Medical	159.6	39.8	0.0	**199.4**

Healthcare Services

(1) Medical
- Family Health
- Pediatrics
- Women's Health
- Disease Management
- Case Management
- Behavioral Health
- Physical Therapy

(2) Aerospace Medical
- Public health
- Flight medicine
- Optometry
- Occupational medicine
- Bioenvironmental engineering

(3) Dental
- General dentistry
- Preventive dentistry
- Dental laboratory

(4) Ancillary
- Pharmacy
- Laboratory
- Radiology
- Immunizations

(5) Mental Health
- Clinical counseling
- Domestic Abuse Victim Advocate (DAVA)
- Family advocacy
- Alcohol & Drug Abuse Prevention & Treatment (ADAPT)

(6) Other Services
- Wounded Warrior
- Referral Management
- Resource Management Office
- Exceptional Family Member Program

Weekly Average Workload

- Primary Care Appointments: 423
- Primary Care Walk-Ins: 46
- Primary Care Telephone Consults: 953
- Primary Care Referrals: 15
- Specialty Care Appointments: 356
- Specialty Care Walk-Ins: 38
- Specialty Care Telephone Consults: 109
- Specialty Care Referrals: 341

[5] Source: 436th MEDGRP- Dover MTF Portfolio

2.0. Healthcare Market Surrounding the MTF

Description	In the Dover drive-time standard, there are currently 63 Primary Care Practices, which account for 90 Primary Care Physicians.
Top Hospital Alignment	▪ Bayhealth Medical Center, Kent Campus (Dover, DE) ▪ Christiana Hospital (Newark, DE) ▪ Bayhealth Hospital, Sussex Campus (Milford, DE) ▪ Alfred I Dupont Hospital for Children (Wilmington, DE)
Likelihood of Offering Primary Care Services to TRICARE Members[6]	

	Number of Practices	Number of Physicians
Contracted with TRICARE	44	76
High Likelihood	4	3
Medium Likelihood	14	10
Low Likelihood	1	1
Total	**63**	**90**

2.1. TRICARE Health Plan (THP) Network Assessment

Summary Facts:

- Dover AFB, Delaware (50 miles south of Wilmington) has a market area population of approximately 1.3M[7]
- 436th MEDGRP has 7,556[8] non-AD enrollees who could enroll to the network
- 2,328 of the non-AD enrollees live on post (zip code 19901[9])
- Managed Care Support Contractor (MCSC) has contracted 66[10] of 90[11] (73%) Primacy Care Providers (PCPs) within a 15-mile radius of the MTF. Only 34 of the 66 TRICARE providers are accepting new patients
- Rolling 12-month JOES-C scores ending October 2018 with a "health care rating" scored as a nine (9) or 10 on a scale of 0-10:
  - 436th MEDGRP patients: 30.1% (141 respondents)
  - Network patients: 73.7% (243 respondents)
- TRICARE Prime Out-of-Pocket Costs for Retirees and their family members[12]:
  - Preventive Care Visit: $0
  - Primary Care Outpatient Visit: $20
  - Specialty Care Outpatient or Urgent Care Center Visit: $30
  - Emergency Room Visit: $61
- TRICARE Prime enrollees should expect to drive no more than:
  - 30 minutes to a PCM for Primary Care
  - 60 minutes for Specialty Care

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

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

[8] M2

[9] M2

[10] MCSC

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

[12] http://www.TRICARE.mil/costs

Assumptions:

- MCSC could contract an additional 50% of the existing non-network PCPs
- The average PCP panel is approximately 2000[13]
- PCPs generally have relatively full panels, able to immediately enroll:
  - Up to 2.5% more enrollees (49) easily
  - 2.5% - 5% (50-99) with moderate difficulty
  - > 5% (100+) with great difficulty
- Beneficiaries are reluctant to waive the 30-minute drive time for Primary Care
- Metropolitan networks will grow more rapidly than rural networks to accommodate demand

Analysis:

- Dover AFB is in a rural area with a currently adequate Primary Care network
- Enrollment of additional beneficiaries to the network would depend on MCSC network expansion and potentially the entry of additional physicians into the market
- If MCSC contracts 50% of the non-network PCPs, they would have a total of 46 PCPs accepting new patients
- After the MCSC expansion to 46 PCPs accepting new patients, each PCP would have to enroll 164 new patients to accommodate the 7,556 436th MEDGRP enrollees
- A call-out by the MTF suggested the network could immediately accommodate 1,200 patients
- Based on the assumptions above, the MCSC network would expand slowly and experience great difficulty enrolling the MTF non-AD beneficiaries
- Beneficiaries rate network health care 43% higher than 436th MEDGRP healthcare, so beneficiary satisfaction is not likely to suffer with network enrollment
- Network enrolled Retirees and their family members will have higher out-of-pocket costs than MTF enrollees
- On-base non-AD residents will have to travel farther for Primary Care if enrolled to the network

Implementation Risks:

- MCSC network may not grow fast enough to accommodate beneficiaries shifted from 436th MEDGRP
- Retirees and their family members may seek less Primary Care due to out-of-pocket costs (+/-)

2.2. Network Insight Assessment Summary (Independent Government Assessment)

Facts:

- **Primary Care:** The Military Health System (MHS) impacted population for Primary Care is greater than 7,000, which represents 3.7% of the population within a 30-minute drive-time radius. This is well below the 10% threshold, and thus will not materially impact the supply

[13] MGMA

of, and demand for, care. High population growth over the last five (5) years (2014 to 2018) of nearly 10% has increased the demand for Pediatric and Primary Care specialties; however, moderate (more than 3%) growth is forecasted for the next five (5) years (2019 to 2023).

- **Specialty Care:** The MHS impacted population for Specialty Care is greater than 16,000, which represents 1.3% of the population within a 60-minute drive-time radius. This is well below the 10% threshold, and thus will not materially impact the supply of, and demand for, care. Projected population growth for this area is approximately 3% over the next five (5) years (2019 to 2023) and will lead to increased demand for specialty services.

Assumptions:

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

Analysis:

- **Primary Care:** Commercial Primary Care providers within the 30-minute drive-time would be challenged to absorb the more than 7,000 beneficiaries within the drive time who are being transitioned out of the MTF. Even though there is a high supply in New Castle County, it sits adjacent to majority of impacted beneficiaries
- **Specialty Care:** Commercial Specialty Care (Obstetrics and Gynecology (OB/GYN) and Psychiatry) providers within the 60-minute drive- time standard would be challenged to accept the specific demand from the more than 16,000 impacted beneficiaries
  - **OB/GYN:** Current OB/GYN providers in the market service area can potentially meet the incremental demand. There is limited capacity to accept the incremental MHS population with the current supply of providers
  - **Psychiatry:** Current Psychiatry providers in the market service area are covering current demand. There is capacity to accept the incremental MHS population with the current supply of providers. However, it may not be able to support this population over time

3.0. Appendices

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Appendix A: Use Case

Assumptions General Use Case

Assumptions

1. Population impact that is greater than 10% of total population will impact the supply and demand of the provider network market
2. There will be no change in the TRICARE benefit to accommodate decisions
3. Readiness requirements for the final decision will be addressed in the Service Quadruple Aim Performance Plan (QPP)
4. There will be no changes to the existing Managed Care Support Contract (MCSC)
5. The MCSC could contract an additional 50% of the existing non-network Primary Care Providers (PCPs).
6. The average PCP panel is approximately 2000[14]

[14] MGMA

Appendix B: Criteria Ratings Definition

Criteria Ratings Definition

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

Appendix C: Glossary

Term (alphabetical)	*Definition*
Ambulatory Care	**Ambulatory care** or outpatient **care** is medical **care** provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services (Source: Wikipedia)
Beneficiary	Individuals who have been determined to be entitled to or eligible for medical benefits and therefore authorized treatment in a military treatment facility or under Department of Defense auspices (Source: health.mil)
Critical Access Designation	**Critical Access** Hospital is a **designation** given to eligible rural hospitals by the Centers for Medicare and Medicaid Services (CMS). ... The CAH **designation** is designed to reduce the financial vulnerability of rural hospitals and improve **access** to healthcare by keeping essential services in rural communities (Source: Ruralhealthinfo.org)
Direct Care	Hospitals and clinics that are operated by military medical personnel (Source: health.mil)
Eligible	To use TRICARE, you must be listed in DEERS as being eligible for military health care benefits. TRICARE-eligible persons include the following: Military members and their families, National Guard/Reserve members and their families, Survivors, Some former spouses, Medal of Honor recipients and their families (Source: Military.com)
Enrollee	An eligible MHS beneficiary that is currently participating in one of the TRICARE plans
JOES	Joint Outpatient Experience Survey
JOES-C	Joint Outpatient Experience Survey – Consumer Assessment of Health Providers and Systems
Managed Care Support Contractor	Managed Care Support Contractors. Each TRICARE region has its own managed care support contractor (MCSC) who is responsible for administering the TRICARE program in each region. The MCSCs establish the provider networks and conduct provider education. Humana is the MCSC in the East, and HealthNet is the MCSC in the West (Source: health.mil)
Network	A provider network is a list of the doctors, other health care providers, and hospitals that a plan has contracted with to provide medical care to its members. These providers are called "network providers" or "in-network providers." (Source: cms.org)
Occupational Therapy	Occupational therapy is the use of assessment and intervention to develop, recover, or maintain the meaningful activities, or occupations, of individuals, groups, or communities. It is an allied health profession performed by occupational therapists and Occupational Therapy Assistants
Overseas Remote	TRICARE Prime Remote Overseas is a managed care option in designated remote overseas locations: Eurasia-Africa, Latin America and Canada, Pacific
P4I	A set of MHS clinical, quality, safety and readiness performance measures (Partnership for Improvement)
Panel	"Provider panel" means the participating providers (Primary Care physician) or referral providers who have a contract, agreement or arrangement with a health maintenance organization or other carrier, either directly or through an intermediary, and who have agreed to provide items or services to enrollees of the health plan (Source: Definedterm.com)
Physical Medicine	The branch of medicine concerned with the treatment of disease by physical means such as manipulation, heat, electricity, or radiation, rather than by medication or surgery. the branch of medicine that treats biomechanical disorders and injuries (Source: Dictionary.com)
Plus	With TRICARE Plus, you get free Primary Care at your military hospital or clinic. The beneficiary does not pay nothing out-of- pocket. TRICARE Plus doesn't cover Specialty Care (Source: health.mil)
Prime	TRICARE Prime is a health insurance program offered to active duty members, retirees, activated guard & reserve members, and families. If you're on active duty, you have to enroll in TRICARE Prime, all others can choose to enroll or use TRICARE Select. TRICARE Prime offers fewer out-of-pocket costs than TRICARE Select, but less freedom of choice for providers (Source: health.mil)
Purchased Care	Supplementing the direct care component, the purchased care component of TRICARE is composed of TRICARE-authorized civilian health care professionals, institutions, pharmacies, and suppliers who have generally entered into a network participation agreement with a TRICARE regional contractor.
Reliant	Active Duty Service Members who are not enrolled to TRICARE Prime (e.g. students and recruits) (Source. MHS Modernization Study, Feb 2016)
Value Based Payment	**Value Based Payment** (VBP) is a concept by which purchasers of health care (government, employers, and consumers) and payers (public and private) hold the health care delivery system at large (physicians and other providers, hospitals, etc.) accountable for both quality and cost of care (Source: AAFP)

Appendix D: Volume II Contents

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

MHS Section 703 Workgroup
Site Visit Trip Report

MTF: Air Force Clinic 436th Medical Group - Dover

18 March 2019

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

Summary of Site Visit

Key Findings	Description
Base/Mission Impact	• Currently, the medical capabilities at Dover AFB are meeting the base mission requirements. However, Dover is one of the four MTFs within the AMC that are projected to experience personnel reductions due to the 4,684 redux (pre-decisional) directive. Base leadership is concerned that these cuts will negatively impact the base mission. • Dover AFB is home to the Armed Forces Medical Examiner System (AFMES) and the Air Force Mortuary Affairs Operations (AFMAO). To process remains, no less than three radiology technicians are required to be staffed/available for 24/7/365 on-call roles and responsibilities in support of AFMES. All of the radiology technicians must be CT trained/certified and encouraged to have a current American Registry of Radiologic Technologist (ARRT) certification. 436 MDG must also have a radiologist on staff to perform CT studies, read films and provide medical inputs to the AFMES team. Additionally, the mission requires dentists and dental technicians to assist in the identification process for some remains. Given the sensitive nature of this mission, Dover radiology technicians, Diagnostic Imaging Technicians, dentists and dental technicians require pre/post exposure briefings conducted by mental health.
MTF Impact	• The MTF expects that the network can absorb the non-AD population within five years. When the discussions about FY17 NDAA Section 703 began, they reached out to primary care and specialty care physicians and physician groups in the local market to assess their ability to accept patients and found that they could immediately accept about 1,200 patients. If they were given something in writing about the number of expected patients and the proposed timeline, then leadership says they would be willing to accept all 7,000 enrollees within a three-to-five-year period. • The 436th Medical Group (436 MDG) does not anticipate any significant impacts to their mission as a result of the transition to an AD only clinic.
Network	• The network surrounding Dover AFB is capable of absorbing beneficiaries for Primary Care (Family Medicine, Pediatrics, and Internal Medicine) as long as a phased approach is taken. From a historical perspective, the 436 MDG previously attempted to utilize the network during a provider shortage with approximately 2,000 patients being seen downtown. Some beneficiaries were unsuccessful in getting empaneled/enrolled with a MCSC network primary care physician or group. While other beneficiaries were accepted by a network provider they were unable to gain access to care for 24 hour and/or Future (72-hour and/or follow-up appts) appointment types, within TRICARE access standards, which caused delays in care for our valued beneficiaries.

- Specialty Care, many beneficiaries and Active Duty personnel are already using the existing MCSC network directory to obtain care.

Summary of Base Leadership Discussion

List of Attendees

The following were in attendance during the Base Leadership discussion:

Name	Title	Affiliation
Col Joel Safranek	Commander, 436th Airlift Wing	Dover AFB
Col Patricia Fowler	Commander, 436th Medical Group	Dover AFB
CMSgt Anthony Green	Command Chief Master Sergeant, 436th Airlift Wing	Dover AFB
CMSgt Erica Hammond	Superintendent, 436th Medical Group	Dover AFB
Lt Col Christopher Gonzales	Commander, 436th Medical Support Squadron	Dover AFB
Lt Col Christopher Segura	Chief of Medical Staff, 436th Medical Group	Dover AFB
Maj Alexander Ford	MDG / SGB	Dover AFB
Dr. Mark Hamilton	Program Analyst, Office of the Assistant Secretary of Defense (Health Affairs)	703 Workgroup
Col James Mullins	Director, Biomedical Sciences Corps (BSC) Operations	703 Workgroup
Col Ron Merchant	AMC/SG Division Chief, Med Spt	USAF Delegation
Mr. Ricky Allen	Business Operations Specialist	TRICARE Health Plan (THP) Lead

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

Topic	Key Discussion Points
Voice of the Customer Summary	• **Concern:** Currently, the medical capabilities at Dover AFB are meeting the base mission requirements. However, Dover is one of the four MTFs within the AMC that will experience cuts in personnel due to the 4684 directive. Base leadership is very concerned that these cuts will impact the base mission. • **Concern:** Having the medical clinic on base ensures that AD personnel and their families are able to obtain care without having to travel long distances for appointments with providers. If they do have to travel, it takes hours out of their day which will ultimately impact the mission. • **Concern:** Dover AFB leadership is concerned about the surrounding network's ability to serve the increased population. Dover AFB is located in a rural part of Delaware so there are limited Primary Care physicians available. • Approximately 75% of providers in the area already accept THP so leadership feels there is limited capacity for THP expansion.

Summary of MTF Leadership Discussion

List of Attendees

The following were in attendance during the MTF Leadership discussion:

Name	Title	Affiliation
Col Patricia Fowler	Commander, 436th Medical Group	Dover AFB
CMSgt Erica Hammond	Superintendent, 436th Medical Group	Dover AFB
Lt Col Christopher Gonzales	Commander, 436th Medical Support Squadron	Dover AFB
Lt Col Christopher Segura	Chief of Medical Staff (SGH), 436th Medical Group	Dover AFB
Maj Alexander Ford	MDG /GB	Dover AFB
Maj Chunil Paeng	BE Flight Commander, 436th Aerospace Medicine Squadron	Dover AFB
Maj Pamela L. Blueford		Dover AFB
Maj Alidan Bangura	Chief Education and Training	Dover AFB
TSgt Charitee Pinnace	SLP, MDOS	Dover AFB
SMSgt Clarence Franklin	Superintendent, 436 AMDS	Dover AFB
SMSgt Kenn Kilmin	Superintendent, 436 MDSS	Dover AFB
SSgt Stephanie Libid	Executive Officer, 436th Medical Group	Dover AFB
Capt Marisa Romeo	Chief Nurse, 436th Medical Group (Acting)	Dover AFB
Dr. Mark Hamilton	Program Analyst, Office of the Assistant Secretary of Defense (Health Affairs)	703 Workgroup
Col James Mullins	Director, Biomedical Sciences Corps (BSC) Operations	703 Workgroup
Col Ron Merchant	AMC/SG Division Chief, Med Spt	USAF Delegation
Mr. Ricky Allen	Business Operations Specialist	THP

Summary of MTF Commander Discussion Agenda

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

Topic	Key Discussion Points
MTF Medical Mission Overview	• The MTF provides primary care for the Air Mobility Command airlift mission and the base population. • All OCONUS and some CONUS casualties, support to other federal agencies and local/state requested examiner/mortuary support requirements are returned to Dover where the MTF provides medical staff support in in radiology, dental, ambulance, mental health pre-and post-exposure briefings and bioenvironmental engineering. • The MTF provides mental health services for families of the fallen, bus drivers, EOD, etc. involved in dignified transfers (DTs). When high level DVs are on site (e.g. Presidential/administration motorcades), the MTF

	may require additional medical teams and ambulance services on standby.
Voice of the Customer	• Overall, Dover AFB leadership believes that the network will be able to absorb the non-AD members within five years. They voiced concerns surrounding the willingness of the market to accept beneficiaries as well as retirees as there is a shortage of Primary Care (family medicine, pediatrics, and internal medicine) providers. • **Concern:** However, there is currently a shortage of Primary Care assets in the MCSC/network directory. This is particularly alarming for those members that reside on Dover AFB and are required to travel into the community to seek care. Based on market analysis, most on-base beneficiaries disenrolled to the MSCS network will have to drive greater than 30 minutes for their primary care requirements. This drive time falls outside of the congressionally mandated 30-minute travel time standards. Additionally, Dover leadership team and our beneficiaries are concerned that the market will become saturated with an influx of THP patients and the timeliness of care will be impacted. The civilian partners in the area, primarily BayHealth, has stated that they are able to fully absorb the 7,000+ non-AD within five years. • The MTF conducted some phone calls and informal interviews of the local network. MTF assesses that the local network could absorb 1,200 patients today. Local network providers told MTF that if they had it in writing that the MTF would be moving to Active Duty only, they could plan to absorb the MTF patient population most likely within three years and certainly within five years. • MTF is currently undermanned with Primary Care Providers and just starting to get healthy—it would not make sense to bring more in just to ask them to leave soon. • **Concern:** MTF would be unable to operate the three ambulances critical to the base, AFMES, and AFMAO missions if the MTF was restructured. Ambulance operation required for Presidential motorcades, dignified transfers (DTs), and Fisher House support would not be adequately available in the network. • The 436th Medical Group provides Occupational Health exams annually for civilians, contractors and AD. They are not enrolled patients, so they do not receive care on a regular basis. • Bay Health is growing and is confident they will be able to handle the increase in workload in three to five years. Significant challenge is the recruitment of the primary care health professionals to support the new patient demand signal presented by Dover AFB due to new healthcare care delivery strategy for our non-active duty beneficiaries. Bay Health just began building a Family Medicine GME program with the hopes of obtaining more providers in the area. Upon successful implementation of the Family Medicine Residency, Bay Health's future plans are to also introduce an Internal Medicine Residency program. The program will be in Sussex County, about a 30-minute drive from Dover AFB.

	• **Concern**: Because the Air Force is not on the same IT systems as the local providers, it is an intensely laborious process to follow up with appointments. The MTF does not necessarily know if they didn't receive the CLR from the service provider or if the member never scheduled an appointment