MHS Section 703 Workgroup Use Case Decision Package

Branch Health Clinic (BHC) Indian Head
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	**Branch Health Clinic (BHC) Indian Head**
Decision	Transition Branch Health Clinic Indian Head 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.

Base Mission Summary:
Naval Support Facility (NSF) Indian Head and BHC Indian Head is in Indian Head, MD, approximately 20 miles from Washington, D.C. Installation management of the Navy base at Indian Head transferred to Commander Navy Installation Command (CNIC) in 2003 with the standup of this new Echelon II command, charged with providing shore installation management services to all Navy activities. All naval installations within the National Capital Region aligned to Naval District Washington (NDW), and on Nov. 3, 2005, the Indian Head base was renamed as Naval Support Facility Indian Head with the commissioning of Naval Support Activity South Potomac (NSASP) as the installation's host command. Current supported commands on board NSF Indian Head includes the Naval Surface Warfare Center Indian Head Explosive Ordnance Disposal Technology Division, Naval Ordnance Safety and Security Activity, Naval Sea Logistics Center Indian Head, Joint Interoperability Test Command, and Marine Corps Chemical Biological Incident Response Force.

Criteria Matrix

Criteria	Rating or Value[1]	Key Takeaways or Findings	Use Case Package
Mission Impact	L	• According to MTF leadership there are approximately 3,000 civilians who receive Occupational Health and Industrial Hygiene care at NSF Indian Head along with the AD population. Service include hearing testing, exploded ordnance care and screening chest x-rays. Leadership feels capability to provide this care does not exist in the network • Where care is available, seeking care off base would result in a significant reduction in manhours for both military and civilians • 23% Mission Growth expected by 2021 (1,700 to 2,100 employees)[2] • The Chemical Biological Incident Response Force (CBIRF) Commanding Officer (CO) stated that CBIRF believes the degradation in services at the branch clinic aboard NSF Indian Head would have an overall negative impact on unit readiness and quality of life for the Marines and Sailors if the clinic closed • All Specialty Care is already referred out to the network or to another MTF. Specialty referrals to MTFs in the National Capital Area generated from Indian Head Primary Care of FMs and Retirees may be lost to the network	Section 1.0
Network Assessment	M	• The potential addition of new MHS Beneficiaries on the total population, within the 30-minute drive-time boundary for Primary Care and 60-minute drive-time boundary for Specialty Care, is well below the 10% threshold for both population groups and thus will not materially impact supply of and demand for services in the Indian Head market • NSF Indian Head is near a metropolitan area with a currently adequate Primary Care network indicated by an alignment of supply and demand of Primary Care services. Enrollment of additional beneficiaries to the network would depend on the MCSC network expansion and potentially the entry of additional physicians into the market. If the MCSC contracts 50% of the non-network PCPs, they would have a total of 181 PCPs who could potentially accept new	Section 2.0

[1] See Appendix B For Criteria Ratings Definitions
[2] Per 1 April 2019 e-mail from CDR Scott Coon, Officer-in-Charge of Branch Health Clinic Indian Head

		patients. Each PCP would have to enroll eight new patients to accommodate the 1,460 Indian Head enrollees. Based on the assumptions above, the MCSC network could easily expand to meet the new demand of services in the Indian Head market • Population growth over the last five years (2014 to 2018) has been strong at more than 6%, which is projected to level out around 4% over the next five years. However, projected shortages in Primary Care providers in Charles county, where the MTF is located and where 99% of the impacted beneficiaries reside, may result in difficulty absorbing the incremental demand without new provider entrants. Additionally, the supply of Primary Care physicians is concentrated in Prince George's county, which is adjacent to Charles county • There is a more-than-adequate supply, or a projected surplus in supply, of psychiatric providers to cover the increased demand for the impacted TRICARE beneficiaries within the 60-minute drive-time radius	

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	BHC Indian Head and BHC Dahlgren share a number of staff (e.g., Occupational Health physician, Behavioral Health providers, including a dual-hatted department head). Changes at one MTF will impact the other. Clinic staff feel stretched due to shared responsibilities across Indian Head, Dahlgren, and Patuxent River, as well as the demand from retiree population; leadership feels that this limits capacity to care for AD	• 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/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	Care management is more difficult to coordinate with the network, and leadership perceives network care management capabilities to be limited	• Work with the MCSC, as well as local health systems to put additional case management resources and processes in place using the QPP business and performance planning process
3	The patients' change in expectations from getting care at the MTF to getting care off the base will have to be monitored and managed	• The risk will be mitigated through the implementation and communication plan as well as care coordination
4	Families with single cars (i.e., one mode of transportation) could lead to extended time away from duty for Active Duty Service Members (ADSM)	• The installation and MTF should consider developing alternative modes of transportation for ADSM dependents. As Defense Health Program funding is not authorized currently for local non- emergent healthcare transportation innovative solutions should be explored
5	The pace at which the network can absorb new enrollees into Primary Care is unknown. There will be an adjustment period for the network, and it may experience challenges sustaining adequacy until new entrants enter the market	• Transition patients to the network in a measured way that is tailored to their specific needs. MCSC/THP and the MTF will monitor progress to identify access or supply issues and address any issues by slowing down the transition as necessary
6	This effort will need to take into consideration the population growth of the area as well as future readiness end strength requirements	• This risk will be mitigated through the implementation and communications plan as well as working closely with the MCSC as they implement their network development plan and strategy
7	Potential loss of Specialty referrals to National Capital Region (NCR) MTFs sponsored graduate medical education	• MCSC shall work with NCR Market manager to identify care best suited to support medical force generation and sustainment requirements

Next Step:

Develop the implementation plan for the above decision, with a focus on deliberately shifting enrollees to an expanded civilian network one (1) panel at a time.

Table of Contents

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

NSF Indian Head and BHC Indian Head is in Indian Head, MD, approximately 20 miles from Washington, DC. Installation management of the Navy base at Indian Head transferred to Commander Navy Installation Command (CNIC) in 2003 with the standup of this new Echelon II command, charged with providing shore installation management services to all Navy activities. All naval installations within the National Capital Region aligned with Naval District Washington (NDW), and on 3 November 2005, the Indian Head base was renamed as Naval Support Facility Indian Head with the commissioning of Naval Support Activity South Potomac (NSASP) as the installation's host command.

Current supported commands on board NSF Indian Head include the Naval Surface Warfare Center Indian Head Explosive Ordnance Disposal Technology Division, Naval Ordnance Safety and Security Activity, Naval Sea Logistics Center Indian Head, Joint Interoperability Test Command, and Marine Corps Chemical Biological Incident Response Force.

1.1. Installation Description

Name	NSF Indian Head
Location	Indian Head, MD; approximately 20 miles from Washington, D.C.
Mission Description	USMC Chemical Biological Incident Response Force (CBIRF); Naval Surface Warfare Explosive Ordnance Disposal Technology Division
Support Commands	**Naval Surface Warfare Center Indian Head Explosive Ordnance Disposal Technology Division (NSWC IHEODTD**) is the principal Energetics Center for the Department of Defense. The command's mission is to provide research, development, test and evaluation and in-service support of energetics and energetic materials for warheads, propulsion systems, ordnance and pyrotechnic devices and fusing for Navy, joint forces, and the nation, to include research, test, and engineering of chemicals, propellants, explosives, related electronic devices, associated ordnance equipment and special weapons support. **Naval Ordnance Safety and Security Activity (NOSSA)** manages and administers U.S. Navy explosives safety programs to include ammunition and explosives safety and security; weapons, platforms and combat systems; ordnance environmental support; insensitive munitions; ordnance quality evaluation; and arms, ammunition and explosives (AA&E) physical security. **Naval Sea Logistics Center, Indian Head** (NAVSEALOGCEN Indian Head) provides information technology (IT) products and services and integrated logistics support (ILS) for Naval Sea Systems Command (NAVSEA) and its program executive offices, and ultimately in support of the Fleet. The unit combines thorough knowledge of Navy business practices integrated with information technology and project management expertise to support and deliver products that strengthen fleet logistics, maintenance and modernization, as well as products that improve the financial and industrial operations of the Naval shipyards. Additionally, NAVSEALOGCEN Indian Head provides automated information systems security, testing and accreditation. **U.S. Marine Corps Chemical Biological Incident Response Force (CBIRF)** responds to terrorist incidents involving the use of chemical, biological, radiological, or nuclear explosive (CBRNE) weapons of mass destruction in order to assist local, state, or federal agencies and designated commanders in the conduct of post-incident mitigation actions by providing capabilities for agent detection and identification; casualty extraction, extrication, and decontamination; and emergency medical care and stabilization of contaminated personnel.
Medical Capabilities and Base Mission Requirements	According to MTF leadership there are approximately 3,000 civilians who receive Occupational Health and Industrial Hygiene care at NSF Indian Head along with the AD population. Service include hearing testing, exploded ordnance care and screening chest x-rays. Leadership feels that the capability to provide this care does not exist in the network, and if it did, seeking care off base would result in a significant reduction in manhours for both military and civilians. The clinic is currently short an Occupational Health provider, and it has presented challenges in effectively delivering that care would be difficult to deliver Occupational Health care if the clinic were to close.

1.2. MTF Description

Name	BHC Indian Head
Location	Indian Head, MD; approximately 20 miles from Washington, DC
Market[3]	Large Market – National Capital Region
Mission Description	Mission is to ensure Operational Force readiness and a healthy community. Our Vision is be a highly reliable mission-ready healthcare team. Our Philosophy is to relentlessly maintain a climate of clinical excellence and safety.
Vision Description	A highly reliable, mission-ready healthcare team
Facility Type	Outpatient clinic
Square Footage	11,636 Net Square Feet (Including Lab)
Deployable Medical Teams	None
Healthcare Services	• Primary Care • Military Medicine • Pharmacy • Dental care • Laboratory • Health promotion • Radiology • Mental Health (Two technicians. The providers loaned from NHC Patuxent River) Dental Care for Active Duty: • General dentistry • Dental examinations • Cleanings • Dental restorations Immunizations • All ages from pediatrics through geriatrics Serving all Employees with Occupational Medicine • Medical Surveillance • Certification exams • Treatment, referral, and case management of acute & chronic occupational injuries & illnesses • Occupational audiology services in support of the hearing conservation program • Preventive services such as immunizations to prevent disease due to occupational exposure Health Promotion • Tobacco cessation • Healthy eating • Diabetes monitoring • Cholesterol monitoring • Women's health • Back injury prevention • Stress management • Men's health Pharmacy Military Sick Call / Overseas Screener
FY18 Annual Budget[4]	$1,818,023

[3] Defined by FY17 NDAA Section 702 Transition
[4] CAPT Chad E. McKenzie

MTF Active or Proposed Facility Projects	Ongoing facility renovation/update with anticipated completion July 2019
Performance Metrics	See Volume II, Part D for P4I Measures

Projected Workforce Impact

Active Duty	Civilian	Total
7	2	**9**

FY18 Assigned Full Time Equivalents (FTEs)[5]

	Active Duty	Civilian	Contractor	Total
Medical	29.1	13.2	3.0	**45.3**

[5] Parent 0068 NHC Patuxent River MTF Portfolio

2.0. Healthcare Market Surrounding the MTF

Description

BHC Indian Head, Maryland (20 miles south of DC) has a market area population of approximately 5.4M[6], which is inclusive of the 60-minute radius population total. The Primary Care analysis includes Charles and Prince George's Counties (30-minute drive time) and includes approximately 90 Primary Care physicians. The Psychiatric Care analysis includes Charles, Prince George's, D.C. Anne Arundel, Calvert, Montgomery, Westmoreland, Alexandria, Manassas, Fairfax, King George, Prince William, Richmond, Spotsylvania Stratford, Essex, St. Mary's and Arlington counties (60-minute drive time)

Note: Indian Head radiuses adjusted to account for Potomac river crossings as follows:

- No VA zip codes included in 15-mile radius
- VA zip codes within 25 miles of I-495 crossing included in 40-mile radius
- VA zip codes within 20 miles of US-301 crossing included in 40-mile radius
- This could cause discrepancies with the MCSC count of contracted providers within a given radius of the MTF

Top Hospital Alignment

- Medstar Southern Maryland Hospital Center, Clinton, MD
- University of Maryland Charles Regional, LaPlata, MD
- Fort Washington Medical Center, Fort Washington, MD

Likelihood of Offering Primary Care Services to TRICARE Members[7]

	Number of Practices	Number of Physicians
Contracted with TRICARE	14	15
High Likelihood	24	23
Medium Likelihood	19	33
Low Likelihood	1	2
Total	**58**	**73**

2.1. TRICARE Health Plan Network Assessment Summary

Facts:

- BHC Indian Head, Maryland (20 miles south of DC) has a market area population of approximately 5.6M[8]
- According to MTF leadership, Occupational Health / Industrial Hygiene providers deliver care to ~3,000 civilians who work on base
- BHC Indian Head provides Primary Care and behavioral health
- BHC Indian Head has 195 AD enrollees in addition to the 1,396[9] non-AD enrollees who could enroll to the network
- BHC Indian Head typically also treats ~300 reliant active duty. (M2 shows 547 AD eligible in the PRISM area)
- Managed Care Support Contractor (MCSC) has contracted 141[10] (61%) Primary Care providers (PCP) within a 15-mile radius of the MTF. There are no additional providers in this location to contract. Only 135 of the 141 TRICARE providers are accepting new patients.
- Even though there are an adequate number of BH providers contracted, access to care is over 28 days
- Rolling 12-month JOES-C scores ending October 2018 with a "health care rating" scored as a 9 or 10 on a scale of 0-10:
  - NSF Indian Head patients: 74.9% (11 respondents)
  - Network patients (NHC Pax River): 65.2% (108 respondents)
- TRICARE Prime Out-of-Pocket Costs for Retirees and their family members[11]
  - 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] Network Insight Assessment Summary (Independent Government Assessment)

[7] 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

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

[9] M2

[10] MCSC

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

Assumptions:

- The average PCP panel is approximately 2000[12]
- 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:

- NSF Indian Head is near a metropolitan area with a currently adequate Primary Care network
- Enrollment of additional beneficiaries to the network would depend on the MCSC network expansion and potentially the entry of additional physicians into the market
- If the MCSC contracts 50% of the non-network PCPs, they would have a total of 181 PCPs who could potentially accept new patients
- Each PCP would have to enroll 16 new patients to accommodate the 1,460 Indian Head enrollees
- Based on the assumptions above, the MCSC network could easily expand to meet the new demand
- Beneficiaries rate network health care 10% lower than NSF Indian Head healthcare, so beneficiary satisfaction may suffer with network enrollment
- Network enrolled Retirees and their family members will have higher out-of-pocket costs than MTF enrollees
- On base residents will have to travel farther for Primary Care if enrolled to the network. This could compound the transportation issue for households with a single vehicle

Implementation Risks:

- Retirees and their family members may seek less Primary Care due to out-of-pocket costs (+/-)
- Access to care for behavioral health may worsen

[12] MGMA

2.2. Network Insight Assessment Summary (Independent Government Assessment)

Facts:

- **Primary Care:** The MHS impacted population for Primary Care represents approximately 1% of the total population within a 30-minute drive-time radius. This is well below the 10% threshold, and thus will not materially impact the supply of, and demand for, care. Projected population growth for this area is nearly 4% over the next five years (2019 to 2023)
- **Specialty Care (Psychiatry):** The MHS impacted population for Specialty Care represents just over 0% of the total 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 5.1% over the next five years (2019 to 2023)
- **Geographical Considerations:** Indian Head radiuses adjusted to account for Potomac river crossings as follows:
    - No Virginia zip codes were included within the 30-minute, 15-mile radius
    - Virginia zip codes within 25 miles of the I-495 crossing are included in the 60-minute, 40-mile radius
    - Virginia zip codes within 20 miles of the I-301 crossing are included in the 60-minute, 40-mile radius

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 may not be capable of absorbing the specific demand from the more than 2,300 beneficiaries (MTF Prime, Reliant and Plus population) who would be impacted by a full closure
    - Supply of Primary Care physicians are concentrated in Prince George's county, which sits adjacent to Charles county where the MTF is located and over 99% of beneficiaries reside
    - Population growth over the last five years (2014 to 2018) has been strong at 6.3%, which is projected to level out at 3.9% over the next five years. This growth will result in an increased demand for Primary Care services. Major shortages of General / Family Practice physicians are projected in the market area, along with minor shortages of Internal Medicine and Pediatrics physicians. Without new provider care market entrants, the market may be incapable of accepting the incremental demand of impacted TRICARE beneficiaries

- **Specialty Care (Psychiatry):** The psychiatry providers within the 60-minute drive-time are capable of accepting the specific demand from the more than 2,500 beneficiaries (MTF Prime, Reliant and Medicare Eligible population) who would be impacted by a full closure
    - There is a more-than-adequate supply of psychiatric providers to cover the increased demand for the impacted TRICARE beneficiaries, concentrated in Fairfax county and Washington D.C.
    - Population growth over the last five years (2014 to 2018) in the 60-minute radius has been strong at 10.5%, which is projected to level out at 5.1% over the next five years
    - We expect a large surplus of psychiatry providers in Fairfax county and Washington D.C. This excess supply is well equipped to handle increased demand from impacted TRICARE beneficiaries

3.0. Appendices

Appendix A	Use Case Assumptions
Appendix B	Criteria Ratings Definition
Appendix C	Glossary
Appendix D	Volume II Contents
Appendix E	MTF Trip Report

Appendix A: Use Case Assumptions

General Use Case Assumptions

1. Population impact that is greater than 10% of total population will impact the supply and demand of the provider network market
2. There will be no change in the TRICARE benefit to accommodate decisions
3. Readiness requirements for the final decision will be addressed in the Service QPP
4. There will be no changes to the existing Managed Care Support Contract (MCSC)
5. The MCSC could contract an additional 50% of the existing non-network Primary Care Providers (PCPs)
6. The average PCP panel is approximately 2000[13]

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

Appendix D: Volume II Contents

Part A	Data Call
Part B	DHA TRICARE Health Plan Network Review
Part C	Network Insight Assessment Summary (Independent Government Assessment) P4I Measures
Part D	
Part E	MTF Mission Brief
Part F	BHC 703 Decision Impact
Part G	MTF Portfolio (Full)

Appendix E: MTF Trip Report

MHS Section 703 Workgroup Site Visit Trip Report

MTF: Naval Branch Health Clinic Indian Head (NBHC Indian Head)

14 March 2019

Table of Contents

Purpose of the Visit

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

Summary of Site Visit

Base/Mission Impact:

- Base leadership feels that maintaining primary care and behavioral health care, as well as occupational health care on the base is critical to providing needed care in a timely manner to Service Members
    - **Active Duty (AD) Primary Care and Behavior Health:** NBHC Indian Head provides care to ~800 AD, many of whom live on the base, and many of whom do not have cars and/or driver's licenses. Further, 25% mission growth has been projected over the next three years. Leadership feels that pushing the AD population out to the network would result in unnecessary lost manhours and decreased readiness. Behavioral Health care, particularly short-order care, is also critical to serving the base population
    - **Occupational Health:** The installation serves as a key ordnance facility for manufacturing, research and development; it is also a strategic location for the USMC Chemical Biological Incident Response Force (CBIRF), and Naval Surface Warfare Explosive Ordnance Disposal Technology Division, EXU-1. In addition to the AD Military on base, Occupational Health providers deliver care (including hearing testing, explosive ordnance care, and screening chest x-rays) to ~3,000 civilians who work on base

MTF Impact:

- Clinic staff feel stretched due to shared responsibilities across Indian Head, Dahlgren, and Patuxent River, as well as demand from retiree population; leadership feels that this limits capacity to care for AD
    - The clinic received an influx of higher-utilization, higher-acuity patients when Malcolm Grow reduced its Internal Medicine capabilities. Leadership feels that this has been especially challenging since NBHC Indian Head is often staffed with recently trained, less experienced providers (e.g., first-year Physician's Assistant)
    - The clinic currently has 84% of patients enrolled in Secure Messaging, and has also adopted telepsychology; this workload might not be captured in central data systems

Network Impact:

- Leadership is concerned that pushing AD and, to some extent, their family members, out into the network would result in time away from mission requirements
    - Leadership is uncertain about how many providers in the market will be willing to take TRICARE, and concerned about expanding the network if needed, as Indian Head is somewhat geographically remote
- Care management is more difficult in the network, and leadership perceives network care management capabilities to be limited

Summary of MTF Leadership Discussion

List of Attendees

The following were in attendance during the MTF Leadership discussion:

Name	Title	Affiliation
CAPT Scott Kraft	Commanding Officer	Naval Surface Warfare Center Indian Head Explosive Ordnance Disposal Technology Division, Expeditionary Exploitation Unit ONE (EXU-1)
CAPT Kathleen Hinz	Commanding Officer	NHC Patuxent River
CDR Travis Davis		
CDR Robert Lusk		
CDR Scott Coon	Director for Branch Health Clinics	NHC Patuxent River
CMC CJ Eison	Command Master Chief	NHC Patuxent River
CMDCM Chris Borkenheim	Command Master Chief	Expeditionary Exploitation Unit ONE (EXU-1)
RADM Gayle Shaffer	Director, Health Services	Headquarters Marine Corps
CAPT Gordon Smith	Chief of Staff	Navy Medicine East
CDR Debra Manning	Director of Clinical Programs	Headquarters Marine Corps
Mr. Ricky Allen	Business Operations Specialist	TRICARE Health Plan
Dr. Mark Hamilton	Program Analyst	Office of the Assistant Secretary of Defense (Health Affairs)

Summary of MTF Commander Discussion

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

MTF Medical Mission Overview:

- Provides primary care (including behavioral health and dental care) in a geographically constrained location to ~800 AD, including 480 Marines, as well as their family members and retirees
- The installation serves as a key ordnance facility for manufacturing, research and development; it is also a strategic location for the USMC Chemical Biological Incident Response Force (CBIRF), and Naval Surface Warfare Explosive Ordnance Disposal Technology Division, EXU-1
    - In addition to the AD on base, Occupational Health / Industrial Hygiene providers deliver care (including hearing testing, explosive ordnance care, and screening chest x-rays) to ~3,000 civilians who work on base

Voice of the Customer Summary:

- Clinic staff feel stretched due to shared responsibilities across Indian Head, Dahlgren, and Patuxent River, as well as demand from retiree population; leadership feels that this limits capacity to care for AD
    - The clinic received an influx of higher-utilization, higher-acuity patients when Malcolm Grow reduced its Internal Medicine capabilities. Leadership feels that this has been especially challenging since NBHC

Indian Head is often staffed with recently trained, less experienced providers (e.g., first-year Physician's Assistant)
    - Clinic enrollment has increased from 1,400 to 2,550 in recent years; clinic leadership feels it's had significant pressure to enroll more patients, and maintain provider readiness by enrolling high-acuity patients
    - Independent Duty Corpsmen (IDCs) who are at the clinic to serve AD can no longer enroll due to capped enrollment
    - Clinic currently does not have the authority to disenroll retirees to generate capacity to care for all AD and their family members (DHA must approve); leadership sees 703 efforts as an opportunity to change this policy
- Clinic leadership is concerned about the overlapping impacts of the planned billet reductions and 703 capability re-scoping, and encourage the 703 workgroup to assess this to the extent possible
- Clinic Leadership emphasized that pharmacy capabilities should not be reduced; the pharmacy fills 45 scripts per day

Summary of Installation Leadership Discussion

List of Attendees

The following were in attendance during the Installation Leadership discussion:

Name	Title	Affiliation
CAPT Kathleen Hinz	Commanding Officer	NHC Patuxent River
CDR Scott Coon	Director for Branch Health Clinics	NHC Patuxent River
CMC CJ Eison	Command Master Chief	NHC Patuxent River
RADM Gayle Shaffer	Director, Health Services	Headquarters Marine Corps
CAPT Gordon Smith	Chief of Staff	Navy Medicine East
CDR Debra Manning	Director of Clinical Programs	Headquarters Marine Corps
Mr. Ricky Allen	Business Operations Specialist	TRICARE Health Plan
Dr. Mark Hamilton	Program Analyst	Office of the Assistant Secretary of Defense (Health Affairs)

Summary of Installation Leadership Discussion

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

Voice of the Customer Summary:

- Occupational Health is critical to the base's mission
  - Along with AD, there are 3,000 civilians who receive Occupational Health / Industrial Hygiene care at NBHC Indian Head. Services include hearing testing, exploded ordnance care, and screening chest x- rays
  - Leadership feels that the capability to provide this care does not exist in the network, and if it did, seeking care off base would result in a significant reduction in manhours for both military and civilians
  - The clinic is currently short an Occupational Health provider, and it has presented challenges in effectively delivering that care
  - Would be difficult to deliver Occupational Health care if the clinic were to close
- The clinic and its provision of primary care not only to AD, but also to their family members, is seen as critical to achieving the base's mission. Leadership is concerned that readiness and significant manhours would be lost to:
  - Marines and Sailors being forced to drive long distances in heavy traffic to their own appointments, and not being able to receive services in a timely manner on base (i.e., immunizations, sick call, Behavioral Health). Leadership feels that full days will be lost for network appointments as there are few providers nearby
  - Marines and Sailors feeling obligated to drive their family members to appointments in the network
  - Leadership is also not confident that network providers will consistently accept family members, and that care coordination will suffer when beneficiaries are pushed into the network; additionally, they worry that projections of care that the network would have to deliver are underestimated, as the clinic is a top adopter of Secure Messaging (84% enrolled), and encounter volume in the clinic is artificially low due to limited space in the temporary trailer location. Enrollment is currently capped at 2,550, and the clinic serves ~500 reliants (The clinic received an influx of higher-utilization, higher-acuity patients when Malcolm Grow reduced its Internal Medicine capabilities)
- Behavioral Health is a significant need on base and in the region:

  - Young Marines frequently utilize this type of care
  - Indian Head and Dahlgren have a very robust telepsychology program; leadership estimates that the volume of consults between the two likely exceeds that of very large clinics
- Leadership feels that these issues would only be aggravated by an estimated ~25% growth in mission requirements at the base over the next three years
  - Growth projected to occur among AD, civilians (e.g., AEGIS Training and Readiness Center, staff from Great Lakes coming to Indian Head)
  - The base has grown by 100 people per year over the last three years (funded via a Working Capital Fund (WCF))
  - Projections have driven investments in clinic renovations, which have cost ~$7M
- Care management is more difficult in the network, and leadership perceives network care management capabilities to be limited
- NBHC Indian Head and NBHC Dahlgren share a number of staff (e.g., Occupational Health physician, Behavioral Health providers, including a dual-hatted department head). Changes at one MTF will impact the other