The seal of the Defense Health Board is a circular emblem. It features a central figure of a person in a white lab coat, possibly a nurse or doctor, holding a stethoscope. The figure is set against a light blue background with a globe. The word "DEFENSE" is written in a blue arc at the top, and "HEALTH BOARD" is written in a blue arc at the bottom. Two yellow stars are positioned on the left and right sides of the inner circle.

Decision Brief:

Pediatric Health Care Services Tasking

Chair, Health Care Delivery Subcommittee

Chair, Neurological/Behavioral Health Subcommittee

**August 10, 2017
Defense Health Board**

PREDECISIONAL



Overview

- Membership
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- Importance of Pediatric Care in the Military Health System
- National Defense Authorization Act 2017: Opportunities for Transformation
- History of TRICARE
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Membership

Health Care Delivery (HCD) Subcommittee

- Membership consists of 9 members, including the chairperson. Two of the nine members were fully appointed through June 26, 2017.

*Members until 6/26/2017



Membership

Neurological/Behavioral Health (NBH) Subcommittee

- Membership consists of 8 members, including the chairperson. Four of the eight members were fully appointed through June 26, 2017.

*Members until 6/26/2017



Tasking

(1 of 3)

On October 21, 2015, the Acting Under Secretary of Defense for Personnel and Readiness requested the Defense Health Board provide recommendations to **improve the monitoring and provision of pediatric clinical preventive services in military dependents**. Specifically:

- Policies, practices, and capabilities the Department of Defense (DoD) should implement to improve monitoring of compliance with pediatric clinical preventive services and immunizations in military dependents; and
- Approaches DoD should take to increase compliance with recommended pediatric clinical preventive services and immunizations in military dependents.



Tasking

(2 of 3)

On July 26, 2016, the request to the Board was updated and expanded to include examination of **opportunities to improve the overall provision of health care and related services for children of members of the Armed Forces**, in addition to the original request.

Specifically:

- Identify the extent to which children receive developmentally appropriate and age appropriate health care services, including clinical preventive services, in both the direct care and purchased care components.
- Identify the degree to which the MHS delivers clinical preventive services that align with standards, guidelines, and recommendations established by the Patient Protection and Affordable Care Act; the Early and Periodic Screening, Diagnosis, and Treatment program; and organizations that specialize in pediatrics, such as the American Academy of Pediatrics and the American Pediatric Surgical Association.



Tasking

(3 of 3)

- Evaluate whether children have ready access to primary and specialty pediatric care.
- Address any issues associated with the TRICARE definition of "medical necessity" as it might specifically pertain to children and determine if the requirement for TRICARE to comply with Medicare standards disadvantages children from receiving needed health care.
- Measure the impact of permanent changes of station and other service-related relocations on the continuity of health care services received by children who have special medical or behavioral health needs.
- Assess certification requirements for residential treatment centers of the Department to expand the access of children of members of the Armed Forces to services at such centers.
- Evaluate the quality of and access to behavioral health care under the TRICARE program for children, including intensive outpatient and partial hospitalization services.
- Assess other issues related to the evaluation and general improvement of health care for children within the MHS, including:
 - Data collection, data utilization, and data analysis that could improve pediatric care and related services, including the availability and maturity of pediatric specific outcome measures.
 - Best practices for coordination of pediatric care.



Meetings Since Last Board Meeting

The HCD and NBH subcommittees have worked to gather information and review the draft report through the following in-person briefings and teleconferences since the June 26 Board meeting:

• July 13-14, 2017	HCD and NBH meetings to review report sections
• July 25, 2017	HCD and NBH teleconferences to review report sections



Board Definition of “Pediatric”

- For the purposes of this report, the pediatric population included:
 - Individuals from birth to 21 years of age.
 - Dependents of members of the Armed Forces (Army, Navy, Marine Corps, Air Force, and Coast Guard), including dependents of active duty, guard/reserve on active duty, retirees (including medical retirees), and inactive guard/reserve, as well as dependent survivors.
 - From the contiguous United States and outside the contiguous United States.
 - Excluding active duty Service members and active duty spouses.
- By definition of this tasking, Public Health Service and National Oceanic and Atmospheric Administration beneficiaries were excluded, as they are not members of the Armed Forces.
- The Board included individuals from birth to 21 years of age in its definition due to the need for consistency in the data requests, but members acknowledge that there are cases in which individuals over the age of 21 would be considered pediatric patients.



Importance of Pediatric Care in the Military Health System

"We've asked a lot of our men and women in uniform and they've never failed to answer the call. Their commitment to the mission and willingness to put themselves in harm's way is based, in large part, on how well the Nation cares for them and their families."

General Joseph F. Dunford
Chairman of the Joint Chiefs of Staff, July 24, 2017

- Pediatric care in the MHS is a readiness issue. When the quality of life, including physical and mental health, of families of Service members is compromised, DoD's military mission is compromised.
- The MHS must deliver quality health care to ensure a military ready force in the context of its global military presence, frequent deployments, and permanent changes of station. This includes ensuring as smooth a transition as possible for families, particularly for those with children with complex or special needs.
- Many children of Service members go on to join the military themselves.



National Defense Authorization Act (NDAA) 2017: Opportunity for Transformation

- Through the Fiscal Year 2017 NDAA, Congress mandated transformational reorganizations in the administration of the Defense Health Agency and military treatment facilities, TRICARE reform, and an increased focus on standardization, cost-controlling measures, and value metrics.
 - In January 2018, the TRICARE regions will be reorganized, reducing the number of Managed Care Support Contractors in the contiguous United States from three to two, and the health benefit will transition from TRICARE Standard to TRICARE Select.
 - The Board's recommendations strongly align with several sections of the Fiscal Year 2017 NDAA.
- Another area of transformation is the implementation of MHS GENESIS, the commercial off-the-shelf electronic health record, which will replace various legacy outpatient and inpatient systems.



History of TRICARE

- TRICARE was established in 1995 from the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
- As stipulated by Congress, CHAMPUS payment structures and reimbursement policy followed Medicare guidelines, as does TRICARE today. This makes it difficult for the system to adapt to the nuances of pediatric care, and it is not designed to account for the role that the family plays in pediatric care.
- TRICARE is a framework that is decidedly clinical and very much civilian health plan oriented, without the foundation needed to comprehensively track and integrate the social determinants of health into medical care.



Complexity of the System

- With approximately 9.4 million total beneficiaries, including 2.3 million pediatric beneficiaries, and 150,000 military and civilian providers disbursed across the globe, the MHS is arguably the Nation's largest and most complex health care system.
- Care is provided through the direct care component, which is the collective health care resources of the Uniformed Services organized into clinics or military treatment facilities, and is supplemented by TRICARE services in the purchased care component.
- Processes to modify, update, or expand the TRICARE benefit are complex due to statutory and regulatory constraints.
- Organizational change is slow, and, within the MHS, it is made even more complex due to distinct cultures across the Services and the Defense Health Agency.



Variability of Care Experience

- The health needs of children are wide-ranging, and much of how families and children experience care within the MHS depends on their specific needs from the system (Routine, Urgent, Chronic, Complex).
- Through public commentary and advocate testimony, the Board concluded that variability in the MHS is a source of dissatisfaction that often promulgates a sense of frustration and unfairness among families, all of which is exacerbated for families with children with special needs.



Variability of Care Experience

Differences in care experience may stem from the following:

- Provider shortages
- Definition of medical necessity
- Differences between direct and purchased care
- Challenges navigating the system for families of children with special needs
- Long waitlists to reestablish care following a permanent change of station
- Variation in the interpretation of the TRICARE manuals by Managed Care Support Contractors
- TRICARE benefit level
- Duty status of the sponsor

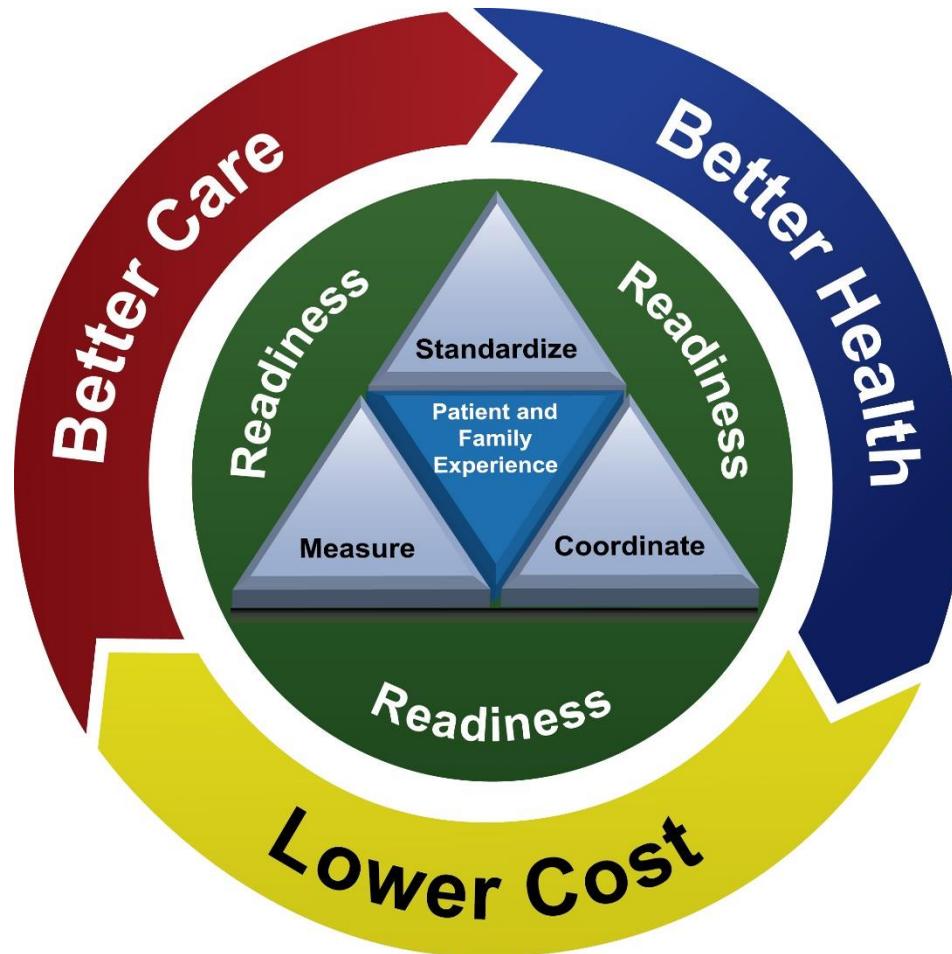


Findings and Recommendations

- Within the MHS, passionate providers and staff are working to improve children’s health and are making some positive steps forward with pilot programs and localized initiatives. Despite these intentions and efforts, the Board received numerous public comments from families expressing frustration due to barriers to accessing care, dissatisfaction with the care they received, or both.
- Four foundational themes were used to organize the Board’s findings and recommendations:
 - Patient and family experience;
 - Measurement, collection, and reporting of data;
 - Standardization of care, and;
 - Care coordination.
- Because pediatric health care services affect readiness, pursuing improvements according to these four foundational themes is essential to the MHS achieving the MHS Quadruple Aim.



Findings and Recommendations





Patient and Family Experience

- Families and patients served by the MHS expect the delivery of health care as a benefit, earned through service to and sacrifice for the country.
- Families face many challenges navigating the MHS, which they characterize as a difficult system in which there are differences between direct care and purchased care and across military treatment facilities.
- The process of scheduling appointments, obtaining referrals, and navigating the complexities of the system frustrates parents and proves detrimental to the care experience for many families, especially for those with children with complex needs.



Patient and Family Experience

The MHS is working on a number of initiatives to improve patient experience. Examples include:

- The Walter Reed National Military Medical Center is developing a Directorate for Quality and Experience, and will include patient and family representatives on policy and experience boards and committees.
- The DHA and its Tri-Service Patient Experience Working group are also developing a standardized approach to improve patient engagement across the direct care component, in accordance with Section 731 of NDAA 2017.



Patient and Family Experience

DoD programs for families with children with chronic or complex health needs include:

- **Extended Care Health Option (ECHO)** provides financial assistance for assistive services, durable medical equipment, and respite care, among other support, to active duty families with children with a qualifying condition. Services closely align with state Medicaid Home and Community-based Services waivers.
 - The amount of respite care available to families differs from the hours that would be available under a state Medicaid waiver program. This difference between the ECHO respite benefit and a given state's Medicaid waiver program benefits further promulgates the sense of unfairness and confusion experienced by families.
- **Exceptional Family Member Program (EFMP)** provides support to military families with special needs to ensure that special medical or educational needs are considered during a relocation and that families have information about the available services, support, and assistance in their next duty station. It is administered by the Office of Special Needs and the individual Services. Service members must be enrolled in EFMP for their families to be eligible for ECHO.
 - The Board learned that some families experience an absence of case managers and find it difficult to identify the resources pertinent to their needs and to initiate care for their children.
- There are currently attempts to standardize Service variability.



Finding and Recommendation 1

Finding 1:

- A. There is a conceptual disconnect between families and those providing care to or purchasing care on behalf of DoD beneficiaries, which stems from a fundamental difference in understanding health care delivery as an "entitled benefit" versus "health insurance coverage."
- B. The MHS can be extremely difficult for beneficiaries to navigate. This is exacerbated in certain geographic locations and by differences in the direct and purchased care components.
- C. Although the Board has been unable to quantify the magnitude of the problem, there are families of children with complex and chronic needs who report that DoD does not assure access to high-quality, coordinated care for their children.

Recommendation 1:

The MHS should commit to assuring a positive patient and family experience and high-quality, coordinated care for all pediatric beneficiaries, irrespective of geographic location, age, sex, sexual orientation, gender identity, race, health status, socioeconomic status, or Service status of the sponsor.



Recommendation 1 (Continued)

Recommendation 1: Specifically, the MHS should:

- A. Create a mutually accountable partnership model between families and MHS providers to assure the optimal health of DoD pediatric beneficiaries. Proof of adherence to recommended pediatric clinical preventive services would be early evidence of such a partnership.
- B. Create new methods of communication with pediatric patients and families, including notifying them of changes in health benefits and alerting them to opportunities to provide input into the system.
- C. Enhance opportunities for patient and family feedback with the goal of improving response rates, providing the feedback to health care providers, and, in the spirit of trust and partnership, increasing the transparency of that feedback data for the broader community of patients and families to be able to access.
- D. Require inclusion of parents in working and policy groups at all levels. These groups are empowered to guide TRICARE implementation in ways that are meaningful to pediatric patients and their families.



Recommendation 1 (Continued)

Recommendation 1: Specifically, the MHS should:

- E. Establish an enterprise-wide Patient Experience Office within the Defense Health Agency. This office would have linkages to military treatment facilities to align the MHS with industry best practices for patient-centered care. This office should promote activities that allow insight into how pediatric patients and families navigate the system. This could include shadowing activities, or “a day in the life.”
- F. Ensure that MHS GENESIS provides the pediatric patient or their family access to their personal health information, as has come to be expected by patients in the civilian health care system.
- G. Analyze manpower requirements for pediatric primary care practitioners and subspecialists. In the context of providing health care and assuring readiness, the MHS should support training programs and other innovative solutions that would meet those requirements.



Measure

The lack of outcome data and quality and cost measures for both direct and purchased care has hindered the Board's ability to systematically assess access to and quality of pediatric care throughout the MHS.

- There is no single reporting system across the DoD for health data that captures clinical services for pediatrics.
- A lack of system-wide measures for both access to and quality of care received within the MHS makes it difficult to determine if ready access to the four types of care (routine, urgent, chronic, and complex) is being delivered successfully to pediatric patients.
- Of the current survey tools used within the MHS to track patient satisfaction, only one (the Joint Outpatient Experience Survey) tracks the pediatric population, and that tool only captures patients up to age 10. It is vital to include the adolescent and young adult population in this tracking (ages 11-21).



Measure: TRICARE Comprehensive Autism Care Demonstration

- To ensure a consistent benefit for autism care for all beneficiaries, the MHS consolidated three autism programs into the five-year TRICARE Comprehensive Autism Care Demonstration, which ends December 31, 2018.
 - The demonstration was also established to analyze, evaluate, and compare the quality, efficiency, convenience, and cost effectiveness of autism-related services, particularly Applied Behavioral Analysis (ABA) services.
- ABA services are available to all beneficiaries through the Autism Care Demonstration and are obtained through the purchased care component.
- Research on the effectiveness of ABA has been mixed; however, a few well-established ABA interventions may be beneficial in the short-term. Additionally, the Board found that these services are highly valued by families.
- The MHS has only recently begun to collect data to assess progress and outcomes of the demonstration and, as a result, is unable to determine the scope and effectiveness of the demonstration since its inception.
- Section 716 of the FY 2017 NDAA requires an analysis of the program to determine whether the use of Applied Behavior Analysis therapy improves outcomes for beneficiaries with Autism Spectrum Disorder.



Finding and Recommendation 2

Finding 2:

The MHS does not have an enterprise-wide system to accurately and consistently track and measure **pediatric** outcomes and other metrics related to quality, cost, and experience of care. ~~for all pediatric beneficiaries.~~

Recommendation 2:

The MHS should commit to accurate and consistent tracking and reporting of metrics across the system to ensure delivery of cost effective, quality care to all pediatric beneficiaries. Specifically, the MHS should:

- A. Prioritize the collection of outcome and quality measures using the proposed pediatric quality dashboard as a foundation.
- B. Utilize these data and metrics to optimize system cost effectiveness and efficiency.
- C. Establish a mechanism to accurately monitor compliance with pediatric immunizations and other clinical preventive services, at an individual and population level, for services received in both the direct and purchased care components.



Recommendation 2 (Continued)

Recommendation 2: Specifically, the MHS should:

- D. Ensure that the new electronic health record has the capability to merge its data with purchased care and legacy systems.
- E. Require all TRICARE beneficiaries to be enrolled (Prime and Select), as noted in Section 701 of Fiscal Year 2017 National Defense Authorization Act, in order to accurately track and report on services delivered to pediatric beneficiaries.
- F. Improve pediatric metrics data by including a representative sample of the entire pediatric population from birth to age 21. Updating and simplifying the Joint Outpatient Experience Survey tool would be part of this endeavor.



Recommendation 2 (Continued)

Recommendation 2: Specifically, the MHS should:

- G. Collect and utilize pediatric health equity information, such as race, ethnicity, sexual orientation, gender identity, and other socioeconomic factors, in order to identify and address any health disparities that may exist within the MHS.
- H. Conduct an analysis of the TRICARE Comprehensive Autism Care Demonstration to assess its effectiveness, whether outcomes improved with the provision of Applied Behavior Analysis, and the appropriate duration of treatment for patients. This analysis would comply with Section 716 of the Fiscal Year 2017 National Defense Authorization Act and may help refine the optimal delivery of the service.



Standardize

A lack of standardization affects the care experience for patients and families, as well as the services that pediatric patients receive. There are multiple sources of variation and differences in care.

- Services received in the purchased care component may differ from services in the direct care component, due to the MHS definition of medical necessity and the hierarchy of reliable evidence, which only applies to purchased care.
- The availability of pediatric services depends on geographic location due to differences in the availability of providers in different regions.
 - Between Fiscal Year 2014 and 2016, approximately 30 percent of the pediatric population in the MHS lived in a zip code designated as a mental health professional shortage area.
- Section 709 of 2017 NDAA instructs the Secretary of Defense to implement a standardized appointing system across all MTFs that includes telephone, online, and in-person options. The MHS has submitted a plan to Congress to complete implementation by Jan 2018.



Finding and Recommendation 3

Finding 3:

MHS care for pediatric beneficiaries, whether delivered in the direct care or purchased care components, is variable and not always aligned with accepted best practices. The system is not designed to optimally provide patient- and family-centered, timely, efficient, and equitable care to all of its pediatric beneficiaries.

Recommendation 3:

The MHS should commit to standardizing care and adopting accepted best practices to provide patient- and family- centered, timely, efficient, and equitable care to all of its pediatric beneficiaries, whether in the direct or purchased care components.

Specifically, the MHS should:

- A. Develop an enterprise-wide solution to identify, test, and continuously assess the effectiveness of the implementation of models of care, designed around best practices.
- B. Identify military treatment facilities that are not achieving access standards and concentrate efforts to improve compliance.



Recommendation 3 (Continued)

Recommendation 3: Specifically, the MHS should:

- C. Modify the *administrative interpretation* of the regulatory language in 32 Code of Federal Regulations 199.2 to broaden the use of the “hierarchy of reliable evidence” for the benefit of pediatric beneficiaries. Exclusions to the hierarchy described under “reliable evidence” in 32 Code of Federal Regulations 199.2 should not preclude pediatric services (a) meeting definitions of medical necessity used broadly in civilian practice, or (b) recommended by recognized medical organizations.
- D. Continue to ensure that DoD supports the principles of mental health parity as part of the TRICARE benefit to maintain coverage for mental health and substance use services.



Coordinate

- Families of children with special health care needs, such as chronic or complex conditions, require access to high-quality care coordination and integration.
- Care coordination is a system in which primary care providers, case managers, and behavioral health professionals work together to provide care. Many care coordination models have been shown to lower long-term costs and yield cost savings by decreasing hospital utilization.
- A permanent change of station can prove to be a challenge for military families of children with complex health needs. There is little uniformity in the hand-off process for complex cases during a permanent change of station, which may disrupt continuity of care that is vital for children and youth with chronic and/or complex medical and behavioral health needs.



Finding and Recommendation 4

Finding 4:

The MHS does not consistently provide high-quality, coordinated care for pediatric patients with chronic and complex health care needs who require integrated health care services. Disruption of care is often reported during times of permanent changes in station, deployments, or other geographic relocations.

Recommendation 4:

The MHS should commit to tracking and consistently providing patient- and family-centered care coordination that ensures delivery of integrated and continuous care for all pediatric beneficiaries. Specifically, the MHS should:

A. Further integrate behavioral health care and primary care to ensure improved care coordination. This is particularly important for children with complex needs and their families.



Recommendation 4 (Continued)

Recommendation 4: Specifically, the MHS should:

- B. Establish a pediatric strategic initiative aimed at complying with Section 718 of the Fiscal Year 2017 National Defense Authorization Act to incorporate the use of telehealth technologies and services uniformly across the MHS to: 1) improve access and health outcomes; 2) diminish the disruption of care that can occur during PCS or other geographic relocations through health assessments; and 3) provide diagnoses, treatments, interventions, and supervision that can address potential gaps in care coordination.
- C. Utilize telehealth technologies and strategies to mitigate the shortage of some pediatric specialists within the MHS by facilitating provider-to-provider consultations. This would allow children to continue care with a trusted primary care provider, especially while receiving needed services from behavioral health or other specialists in another geographic area.



Additional Observations and Emerging Factors

■ Pediatric Obesity

Children who are overweight or obese are at increased risk for a host of chronic diseases. Even though the rate of childhood obesity among children of military families is generally less than the national average, it is still an important concern that the Board would like to see be continually monitored.

■ Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are related to both the development and prevalence of a wide range of health problems that can emerge in adolescence and adulthood. Both prevention and early identification of ACEs can have a tremendous positive impact on health issues that children and youth may face later in life.

■ Transgender Youth Health

The understanding and treatment of gender dysphoria, including gender reassignment surgery, is an emerging area within pediatrics. Many major health insurance carriers have worked to eliminate transgender and transsexual exclusions from their policies in order to provide accessible and affordable coverage for all patients.



Additional Observations and Emerging Factors

■ Substance Use Disorders

While the Board did not examine the issue of substance use in pediatric populations, it acknowledges that these disorders can significantly affect children and youth, in both civilian and military populations. In Fiscal Years 2014-2016, among females ages 13-17, the top Medicare Severity Diagnosis-Related Group for inpatient admissions was “poisoning & toxic effects of drugs age 0-17.” The Board feels substance use disorders are an important area that warrants further research and assessment.

■ Care Delivery Across the Military Health System

The scope of the analysis presented in this report is limited to MHS pediatric beneficiaries. However, the Board believes that the four foundational themes highlighted in the report (patient and family experience; measurement, collection, and reporting of data; standardization of care; and care coordination) may apply to care delivery in the MHS as a whole. Pediatric care, as presented in this report, can serve as a microcosm for challenges faced broadly across the system, and many of the Board’s specific recommendations highlight opportunities to improve care for beneficiaries of all ages.



Questions?