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

Barquist Army Health Clinic (AHC) 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	**Barquist Army Health Clinic (AHC)**
Decision	Transition Barquist Army Health Clinic outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). Active Duty Family Members (ADFM) will be enrolled as necessary to round out the physician panels and maintain readiness. 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:
The United States (U.S.) Army Garrison, Fort Detrick, provides sustainable base operations support, quality of life programs, and environmental stewardship to facilitate the sustainment of vital national interests. The U.S. Army Garrison, Fort Detrick, supports five (5) cabinet-level agencies: The Department of Defense (DoD), Department of Veterans Affairs, Department of Agriculture, Department of Homeland Security, and Department of Health and Human Services. Within the DoD, Fort Detrick supports elements of all four (4) military services. Major Department of the Army mission partners include the U.S. Army Medical Research and Materiel Command and the 21st Signal Brigade.

Criteria Matrix

Decision Criteria	Rating or Value[1]	Key Takeaways or Findings	Use Case Package
Mission Impact	L	• The mission of U.S. Army Garrison, Fort Detrick, is to provide sustainable base operations support, quality of life programs, and environmental stewardship to facilitate the sustainment of vital national interests • Exceptional Family Member Program (EFMP) and Overseas Screening Service (OSS) mission could be compromised. There are concerns they wouldn't be able to identify potential EFMP cases since they would be going directly to the network • Concerns that restriction of medical services may cause loss of Healthcare Effectiveness Data and Information Set (HEDIS) information fidelity from network providers • Sending family members and retirees to the network could cause ADSM and Ft. Detrick Federal employees with TRICARE benefits to miss several hours of duty when ADSM accompany their dependents for network appointments or when employees who currently use services at Barquist attend medical appointments off post • There is one (1) provider for Occupational Health supporting 5,200 non-DoD civilians (family members, retirees, and retiree family members). Additionally, there are 350 members in the Biological Personnel Reliability Program (BPRP) that require 24/7/365 support based on potential exposures. The Occupational Health Clinic takes care of the civilian population and the Biosurety Clinic takes care of the BPRP of which there are additional training and requirements	Section 1.0
Network Assessment	L	• Both the TRICARE Health Plan and independent government assessments found the Primary Care market to potentially be capable of accepting the more than 5,000 current enrollees who would be sent to the network if Barquist AHC was transitioned to an AD only clinic • Moderate (more than 3%) population growth is forecasted for the next five (5) years (2019 to 2023). Based on analytic assumptions, the Managed Care Support Contractor (MCSC) network could likely meet any new demand • 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 Primary Care Providers (PCP), each PCP would have to enroll ~40 new patients to accommodate the Barquist enrollees transitioned to the network	Section 2.0

[1] See Appendix B for Criteria Ratings Definitions

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 will be used to help develop a final implementation plan.

	Risk/Concerns	Mitigating Strategy
1	The patients' change in expectations from getting care at the MTF to getting care off the installation will have to be monitored and managed	• The risk will be mitigated through the implementation and communication plan, as well as care coordination
2	The pace at which the network can absorb new enrollees 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. MCSC/THP and the MTF will monitor progress and address access issues by slowly transitioning
3	Accessing care in the network may result in the workforce spending an increased amount of time away from work, training or duty, leading to a decrease in productivity and increasing costs and the administrative burden of the MTF	• The MTF will work with the MCSC to help retiree-civilian employees receive timely care in the network • As part of the implementation plan, the MTF will develop resources, guidance and/or policy to reduce potential time away from work, training or duty, incurred through seeking healthcare services
4	The local MCSC is currently experiencing difficulty maintaining contracted Primary Care Managers (PCMs) and it could be difficult to meet the assumption that MCSC can contract an additional 50% of the existing non-network PCPs	• As MCSC increases the number contracted providers to meet the requirements of a larger population seeking care in the network, the MTF should slow the transition of beneficiaries if the network of contracted providers is not expanding at the required rate
5	The MTF is concerned that there is not enough commercial Specialty Care (Psychiatry) to meet the demand from family members and retirees being transitioned to the network due to network Psychiatry providers not accepting TRICARE Patients	• MCSC should monitor the availability of Specialty Care in the network and coordinate with the MTF to meet the demand for Behavioral Health as necessary

Next Steps:

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

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

United States (U.S.) Army Garrison Fort Detrick and Barquist AHC, Frederick, MD approximately 50 miles from Washington D.C. U.S. Army Garrison, Fort Detrick, provides sustainable base operations support, quality of life programs, and environmental stewardship to facilitate the sustainment of vital national interests. Approximately 5,200[2] current enrollees would be sent to the network if Barquist AHC was transitioned to an AD only clinic.

1.1. Installation Description

Name	USAG Fort Detrick
Location	Frederick, MD; approximately 50 miles from Washington D.C.
Mission Elements	US Army Medical Research and Materiel Command and the 21st Signal Brigade
Mission Description	Fort Detrick is a leader in transformation. As the host of partnerships from five (5) Cabinet level agencies, Fort Detrick is the largest employer in Frederick County and the genesis of innovative thought, educational opportunities, and business. The U.S. Army Medical Research and Materiel Command (USAMRMC) is the Army's medical materiel developer, with responsibility for medical research, development, and acquisition and medical logistics management. The USAMRMC's expertise in these critical areas helps establish and maintain the capabilities the Army needs to fight and win on the battlefield. **Mission**: The U.S. Army Garrison, Fort Detrick, provides sustainable base operations support, quality of life programs, and environmental stewardship to facilitate the sustainment of vital national interests. The US Army Garrison, Fort Detrick, supports five cabinet-level agencies: The Department of Defense, Department of Veterans Affairs, Department of Agriculture, Department of Homeland Security and Department of Health and Human Services. Within the DoD, Fort Detrick supports elements of all four military services. Major Department of the Army mission partners include the US Army Medical Research and Materiel Command and the 21st Signal Brigade. **Vision**: Relevant, Respectful, Responsible, and Ready. Providing a safe, sustainable, and high quality of service to our families, workforce, and Mission Partners. Empowering our workforce to transform our processes to be more integrated and effective to set the conditions for a sustainable future.
Base Active or Proposed Facility Projects	No Information
Medical Capabilities and Base Mission Requirements	There is one (1) provider for Occupational Health supporting 5200 non-DoD civilians (family members, retirees, and retiree FMs). Additionally, there are 350 members in the Biological Personnel Reliability Program (BPRP) that require 24/7- 365 support based on potential exposures. The Occupational Health Clinic takes care of the civilian population and Biosurety Clinic takes care of the BPRP.

1.2. MTF Description

Name	Barquist AHC
Location	Frederick, MD; approximately 50 miles from Washington D.C.
Market[3]	National Capital Region (NCR) (Large Market)
Mission Description	To promote health and build resilience for Warriors, Military Families, and all those entrusted to their care
Vision Description	To be a premier Patient Centered Medical Home. Their legendary customer service, delivered by a well-developed workforce, makes them the first choice for care
Facility Type	Outpatient facility, no ambulatory surgery

[2] Source: Non-AD MTF Prime and Plus
[3] Defined by FY17 NDAA Section 702 Transition

Square Footage[4]	28,523 Net Square Feet
Deployable Medical Teams	N/A
MTF Active or Proposed Facility Projects	No Information
Performance Metrics	See Volume II Part D for Partnership for Improvement (P4I) measures

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

	Active Duty	Civilian	Contractor	Total
Medical	6.7	84.1	0.0	**90.8**

Healthcare Services[6]

Medical

- Primary Care (all ages)
  - Force Health Protection
  - Exceptional Family Member Program
- Executive Medicine
- Physical Therapy
- Biosurety
- Occupational Health
- Behavioral Health / Substance Use Disorder Clinical Care (SUDCC)
- Family Advocacy
- Industrial Hygiene / Environmental Health

Ancillary

- Pharmacy
- Immunizations
- Laboratory
- Digital Radiology / Electrocardiogram (EKG)
- Medical Records

Current Initiatives

- Pharmacy Redesign and Automation Project
- Resource Sharing Agreement with the Department of Veterans Affairs (VA) Community Based Outpatient Clinics (CBOC) for Radiology services
- Expansion of Behavioral Health services to include family members and retirees
- Logistics Modernization project to improve efficiency and decrease cost
- Telehealth Nutrition
- Prenatal care to enhance Women's Health Services and improve female Soldier readiness

Projected Workforce Impact

Active Duty	Civilian	Total
13	23	**36**

[4] Source: 703 WG requested net SF data TSG-4-15-19.xlsx
[5] Source: Kimbrough ACC MTF Portfolio
[6] Barquist Army Health Clinic Brief

2.0. Healthcare Market Surrounding the MTF

Description	In the Barquist AHC drive-time standard, there are currently 103 Primary Care Practices, which account for 204 Primary Care Physicians (not limited to TRICARE). Additionally, there are 342 psychiatric care practices, which account for 651 psychiatric care physicians (not limited to TRICARE).
Top Hospital Alignment	• Frederick Memorial Hospital (Frederick, MD) • Meritus Medical Center (Robinwood, MD)
Likelihood of Offering Primary Care Services to TRICARE Members[7]	

	Number of Practices	Number of Physicians
Contracted with TRICARE	39	113
High Likelihood	0	0
Medium Likelihood	43	82
Low Likelihood	21	9
Total	**103**	**204**

2.1. TRICARE Health Plan Network Assessment Summary

Facts:

- Fort Detrick, Maryland (Frederick) has a market area population of approximately 3.7M[8]
- Barquist Army Health Clinic has 5,049[9] non-AD enrollees who could enroll to the network
- Barquist offers Primary Care, physical therapy and behavioral health
- MCSC has contracted 54[10] of 204[11] (26%) Primary Care providers (PCP) within a 15-mile radius of the MTF. Only 47 of the 54 TRICARE providers are accepting new patients
- Rolling 12-month JOES-C scores ending December 2018 with a "health care rating" scored as a 9 or 10 on a scale of 0-10:
    - Barquist patients: 86.3% (22 respondents)
    - Network patients: 72.7% (329 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

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

[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 (Independent Government Assessment)

[9] M2

[10] MCSC

[11] Network Insight Assessment (Independent Government Assessment)

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

[13] MGMA

- Metropolitan networks will grow more rapidly than rural networks to accommodate demand

Analysis:

- Fort Detrick is in a metropolitan 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 122 PCPs accepting new patients
- Each PCP would have to enroll 41 new patients to accommodate the 5,049 Barquist enrollees
- Based on the assumptions above, the MCSC network could likely expand easily to meet the new demand
- There are 16 network facilities within drive time of Barquist AHC that offer like services currently provided by the MTF with more than adequate access to care
- Beneficiaries rate network health care 13% lower than Barquist healthcare, so beneficiary satisfaction could 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 Barquist
- 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 approximately 5,500, which represents 1.2% 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 of, and demand for, care. High population growth over the last five (5) years (2014 to 2018) of nearly 6.7% 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 12,000, which represents 0.3% 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 4.6% over the next five (5) years (2019 to 2023) which will sustain the current surplus of psychiatric providers

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 are capable of accepting the specific demand from the more than 5,000 impacted beneficiaries who are being transitioned out of the MTF

- **Specialty Care:** Commercial Specialty Care (Psychiatry) providers within the 60-minute drive-time standard should be capable of accepting the specific demand from the more than 12,000 impacted beneficiaries
    - **Psychiatry:** There is an overall surplus of Psychiatry providers in the market service which are covering current demand. There is capacity to accept the incremental MHS population with the current supply of providers

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 F	Supplemental Materials

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.[15]

[15] 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

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Part B	DHA TRICARE Health Plan Network Review
Part C	Network Insight Assessment Summary (Independent Government Assessment) P4I
Part D	Measures
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Part F	MTF Mission Brief
Part G	Network Primary Care Providers
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Appendix E: MTF Trip Report

MHS Section 703 Workgroup Site Visit Trip Report

Barquist Army Health Clinic (BAHC) – Fort Detrick, Frederick, MD

29 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

Base/Mission Impact:

- The mission of US Army Garrison, Fort Detrick, provides sustainable base operations support, quality of life programs, and environmental stewardship to facilitate the sustainment of vital national interests
- The Signal Brigade's primary function is to support the president and White House and Pentagon communications
- Federal organizations performing biological security mission
- There is one (1) provider for Occupational Health supporting 5200 non-DoD civilians (family members, retirees, and retiree FMs). Additionally, there are 350 members in the Biological Personnel Reliability Program (BPRP) that require 24/7- 365 support based on potential exposures. The Occ Health Clinic takes care of the civilian population and Biosurety Clinic takes care of the BPRP of which there are additional training and requirements
- Fort Detrick and BAHC are concerned that the civilian network will not be able to handle sending the 5,200 family members, retiree, and retiree family members to the network
- Loss of Healthcare Effectiveness Data and Information Set (HEDIS) information readiness and fidelity is a concern to Fort Detrick

MTF Impact:

- BAHC is the only MTF in the beneficiary catchment area, which covers West Virginia, Virginia, Maryland and Pennsylvania
- Many specialty care cases, including family members, are already referred to Fort Meade, Fort Belvoir, and Walter Reed
- The lack of full service care among primary care providers in the network leading to an increase in referrals is a concern to Fort Detrick
- Due to already low staffing, BAHC is concerned with the increase in case management that would come with sending family members to the network
- BAHC is concerned with the lack of quality assurance that would be presented when enrollees are sent to the network

Network Impact:

- 108 of 169 care providers would accept new patients but they are not clear as to how many they could accommodate. Source of data is the Humana representative who called all 169 care providers
- Approximately 5,200 current enrollees would be sent to the network if BAHC was converted to an AD only clinic

Summary of MTF Leadership Discussion

List of Attendees

The following were in attendance during the MTF Leadership discussion:

Name	Title	Affiliation
COL James D. Burk	Commander, USAMEDDAC and Kimbrough ACC	Fort Meade
LTC Birgit Lister	Commander, Barquist Army Health Clinic	BAHC
SFC Wilson	SEL, Barquist Army Health Clinic	BAHC
Mr. Logan	Chief Nurse, Primary Care	BAHC
Dr. Mary-Elizabeth Delmonte	Chief Medical Officer	BAHC
CAPT Angela Hawkins	--	BAHC
Ms. Anna Walsh	Deputy to the Commander for Administration	BAHC
Dr. David Smith	Reform Leader for Health Care Management for the Department	703 Workgroup
LTC Brent Clark	Director of Clinical Operations	DHC-A
Mr. Ricky Allen	Business Operations Specialist, TRICARE Health Plan	TRICARE Health Plan (THP)
Mr. Asasi Francois-Ashbrook	Contract Support	703 Workgroup

Summary of MTF Leadership Discussion Agenda

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

Voice of the Customer Summary:

- If Barquist is downsized to an "Active Duty Only" Clinic:
    - EFMP and Oversees Screening Service (OSS) mission could be compromised. There is a safety issue in not identifying EFMP families due to not properly being screened where they're coming from. Then BAHC has to scramble to find them the proper healthcare at Walter Reed. There are concerns they wouldn't be able to identify potential EFMP cases coming in since they'd be going to the network
    - The civilian network would be inundated: 5,200 patients would have to be pushed to the network
    - Decreased "health" of the population—loss of primary care manager (PCM) continuity as well as Healthcare Effectiveness Data and Information Set (HEDIS) and Clinical Practice Guideline (CPG) programs. Concerned about who would oversee the access to care (ATC) standards
    - Primary care providers (PCPs) in network do not provide full-service care which leads to increased referrals to specialists and overall increase in cost of healthcare
    - Concerns over health records continuity – how do you ensure medical documents are being transferred, scanned and monitored properly? This would require a lot of office support to make sure medical records go out to new PCMs, which raises quality and safety concerns.
    - Loss of Family Readiness that cannot be quantified. Right now, families see the same providers
    - Inability to support Garrison missions due to decreased staffing
- If Barquist is downsized to an "Active Duty & AD Family Member Only" Clinic:
    - Maintain Family and Soldier Readiness

    - Maintain EFMP / OSS mission
    - Maintain HEDIS program integrity

- <u>If Barquist continues current operations:</u>
    - Reduce long term healthcare costs — BAHC would be able to maintain highly qualified PCMs providing exceptional, full-service care with top rated patient satisfaction scores
    - Able to support the Garrison mission

- Concern is that going to AD only would push 5,200 members to the network and the network would not be able accommodate that, and risk not meeting ATC standards. Any new patient appointments could take one (1) week or it could take two (2) months
- BAHC is already relatively small and efficient. They are one person deep in most of areas and have additional duties. There are only six (6) primary care providers. BAHC does not believe they'd be able to reduce the staff and administrative support meaningfully and continue to keep the clinic running. There is the sunk cost of the buildings and do not see much of a gain in seeing fewer patients
- There are lots of programs including clinical champions for all CPGs and the requirement to have one provider assigned to each program. Downsizing staff would give staff even more responsibilities when they are already at capacity
- Fort Detrick providers have a lot of specialized training and sending family members and retirees out to network might not actually be cheaper
- Behavioral Health (BH) capacity in general is an issue in the network. BH care out in town is difficult to get and there is not a high-level of understanding of military-specific issues or report back to PCMs. Additionally, there are no child psychiatrists in the network and beneficiaries must go to Baltimore
- Retiree copays would be cost prohibitive for some of them. There are lots of medically retired E4s and E5s in the area – overall health would decrease. Many retirees use the lab services at the clinics
- HEDIS readiness is a concern. BAHC meets all the time to make sure ADFM and AD populations are covered. The nursing staff collaborates a lot to make sure they're coordinating care for the families
- BAHC thinks the impact would be decreased if the decision was changed from AD-only to AD and ADFM only. Fort Detrick has young families with one car and the AD members accompany their spouse and children to every appointment, resulting in about half a day away from work.
- While there is an experienced workforce there are also young lab techs and troops who require additional support navigating the commercial healthcare system
- Soldier Readiness and ADFM readiness is tied together. There are concerns with what is gained from an efficiency standpoint of pushing people to the network is coming at the expense of culture

Summary of Base Leadership Discussion

List of Attendees

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

Name	Title	Affiliation
MG Barbara Holcomb	Commanding General, U.S. Army Medical Research and Materiel Command and Fort Detrick, Maryland	Fort Detrick
COL James D. Burk	Commander, USAMEDDAC and Kimbrough ACC	Fort Meade
LTC Birgit Lister	Commander, Barquist Army Health Clinic	Fort Detrick
SFC Wilson	SEL, Barquist Army Health Clinic	Fort Detrick
Dr. David Smith	Reform Leader for Health Care Management for the Department	703 Workgroup
Col Gary Hughes	Program Manager Officer of the Army Surgeon General	703 Workgroup
Mr. Ricky Allen	Business Operations Specialist, TRICARE Health Plan	TRICARE Health Plan (THP)
Mr. Asasi Francois-Ashbrook	Contract Support	703 Workgroup

Summary of Fort Detrick Leadership Discussion

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

Voice of the Customer Summary:

- Fort Detrick already makes referrals to Fort Meade, Fort Belvoir, and Walter Reed. Many family members go as well, but there is something about going to an MTF, which has a different environment than going into the commercial world where they don't understand readiness
- Impacts to downsizing the clinic to AD only include:
    - Time you put people on the road to go somewhere else: traffic, distance, etc.
    - A total of 10 soldiers work at the clinic, losing further clinic staff could put a strain on the clinic's ability to support the mission
    - The military health system should not mirror civilian healthcare organizations because the mission is different and in the long run the government ends up spending more money
    - Losing HEDIS measures is a major concern
    - Is the clinic as efficient as it's going to be? Are you just creating capacity and not running it efficiently? Are there significant cost savings – only be able to cut a provider or two. Will the change be too small to have an impact?
    - Many young soldiers want to go with their spouses. When Fort Detrick refers them to the network, it takes time away from the mission
- Frederick Memorial is the main hospital in the area and while the data may show lots of facilities between here and DC, the Base wants to make sure they're accepting new patients and enough to meet the demand
- The missions include signal, space, medical research, medical logistics, and biosecurity. Detrick works with all the labs – installation fire and emergency response and coordinates with Frederick County teaching courses at Frederick Memorial to learn how to respond appropriately
- There is a significant retiree population in Pennsylvania, and they come down to BAHC for care because Fort Detrick is the centralized location between WV, PA, MD and VA

- Fort Detrick has many federal organizations and all four services. Base housing uses a waterfall concept because there are more houses than AD members. Filled with DoD civilians and other civilians who just need to pass a background check. There are 500 units of housing on the installation filled with 60% AD
- NCI has a federal enclave on the installation. DHS, HHS all performing biological research which adds to the biosurety mission requirements

Appendix F: Supplemental Materials

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JOES Verbatim Comments

“Dr. Hwang heard and 'listened' to my concerns. He gave me options to choose from to use the choice with less side effects. Very caring, thoughtful, thorough and very knowledgeable!!!”

“Dr. Hwang provided me with one of the best medical visits I have had. He was very knowledgeable and easily explained the information. He did not rush the appointment. I left the appointment feeling very confident that my medical needs were taken care of. He also performed a procedure with precision. He is very professional and you can tell he loves his job. Any patient to have Dr. Hwang as a PCM is very lucky.”

“Awesome. Top 1% of physicians within MHS.”

“Dr. Bavari is fantastic! I had her as my primary care manager in the past- moved away- and now I've moved back and thrilled she is still here for me.”

“She is outstanding and her expertise, level of understanding and compassion is worth emanating by all that share her profession. She is a valuable part of Barquist’s operation concerning patient treatment.”

“Dr. Bavari is the consummate care provider. She is thorough and is prepared for every visit. I have had complements from specialists with regard to her thoroughness as my PCM. I don't know how an experience with another provider could be any better than that with Dr. Bavari.”

“Dr. Silver is amazing. Extremely happy with my care by her and Barquist Clinic. The people who work there are gems in the Tricare system. The past year has been my best experience at a clinic over the past 25 years.”

“Ms. Vickers consistently exceeds my expectations for a PCM. She is professional, personable, and an excellent communicator. She is never rushed or distracted and I always feel as if she is 100% focused on my personal health and well-being. I was especially impressed that she personally ensured I was notified that my pre-op lab and EKG results were sent and received by the surgical center. I rate her as the best PCM I have had in 27+ years.”

“Mrs. Vickers always takes such great care of me. She is the reason that I always choose to have my health care needs taken care of at Barquist even after retiring. She is amazing in that she remembers what was discussed during every previous encounter and follows up to ensure that my needs are adequately addressed. I appreciate how she encourages rather than admonishes. Her care and compassion are obvious and genuine.”

“Ms. Offutt is our entire family’s doctor and we really enjoy her and her nurses. She is smart, kind, patient, and respectful and we all feel comfortable with her. She went above and beyond for a medication I needed and I am glad she is our family doctor. She is a great asset to the clinic!”

“My husband (Colonel Retired) and I have been using Ft. Detrick's Barquist Army Clinic for more than 25 years. Dr. Delmonte is the best physician my husband and I have ever been fortunate enough to have, as our Primary Care doctor, during the past several years! Dr. Delmonte is both professional and personable. She goes out of her way to make sure all her patients are properly cared for. Dr. Delmonte cares about the welfare of every patient and provides clear and complete information to all! Ft. Detrick is lucky to have such an outstanding Primary Care doctor who's knowledgeable in absolutely everything a General Practitioner should be and more! I've seen a lot of physicians over the years---she's the best!
E.R.”