OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

MAR 13 2017

Dear Mr. Chairman:

The enclosed report is in response to section 730 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114–92). This section requires a comprehensive report on the current and future plans of the Department to improve the healthcare experience of beneficiaries across the Military Health System (MHS).

The MHS remains committed to the core performance measures of readiness, better health, better care, and lower cost in support of the Quadruple Aim. I am pleased to report the MHS continues to make impressive strides in all areas requested for this Congressional report, including the development of an enterprise-wide performance management system enabling improvement and reducing variance in several key measures across the direct and purchased care systems, particularly in access to care. Finally, the MHS deployed or is getting ready to deploy some exciting, cutting-edge initiatives such as mobile applications, telehealth modalities, joint surveys, streamlined specialty appointing and referral practices, and the development of enterprise-wide, standardized guidance.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter is being sent to the House Armed Services Committee.

Sincerely,

A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Sincerely,

AM Kurta

A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Response to Section 730 of the National Defense Authorization Act

for

Fiscal Year 2016 (Public Law 114-92)

Report on Plans to Improve Experience with and Eliminate Performance Variability of Health Care Provided by the Department of Defense

The estimated cost of this report or study for the Department of Defense is approximately $16,000 for the 2016 Fiscal Year. This includes $25 in expenses and $16,000 in DoD labor.

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Executive Summary

Section 730 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2016 required the Department of Defense (DoD) to submit its current and future plans, with estimated dates of completion, to improve the experience of beneficiaries with health care provided in Military Treatment Facilities (MTFs) and purchased care and to eliminate performance variability with respect to the provision of such health care.

More specifically, the NDAA required that the report include DoD plans to: (a) align performance measures for health care provided in MTFs with performance measures for health care provided through purchased care; (b) improve performance in the provision of health care by the DoD by eliminating performance variability with respect to the provision of health care in MTFs and through purchased care; (c) use innovative, high-technology services to improve access to care, coordination of care, and the experience of care in MTFs and through purchased care; (d) collect and analyze data throughout the Department with respect to health care provided in MTFs and through purchased care to improve the quality of such care, patient safety, and patient satisfaction; (e) develop a performance management system, including by adoption of common measures for access to care, quality of care, safety, and patient satisfaction, that holds medical leadership throughout the Department accountable for sustained improvement of performance; and (f) use such other methods as the Secretary considers appropriate to improve the experience of beneficiaries with and eliminate performance variability with respect to health care received from the Department.

This report to the House and Senate Armed Services Committees is organized along these major categories of performance measurement and improvement described above and demonstrates efforts to date as well as future plans in both the direct and purchased care systems.

The Military Health System (MHS) has established a comprehensive set of enterprise-wide performance measures and has aligned measures across the direct and purchased care systems, where possible. Performance has improved overall across the major domains of readiness, access, safety, quality, and cost and has made strong progress in reducing variance, particularly in primary care. Also, this effort has identified further opportunities to reduce variance within and across each system.

The MHS has deployed innovative technology to improve access, care coordination, and the experience of care for its patient population in both the direct and purchased care systems. Innovative technology currently in use includes secure messaging, the Nurse Advice Line (NAL), the TRICARE OnLine (TOL) patient portal, mobile applications, virtual primary care visits, and other telehealth capabilities such as TeleCritical Care to monitor patients in remote areas.

The MHS has a robust data collection, validation, and analysis capability, especially in the areas of quality, access, and satisfaction. The MHS also has established accountability for performance improvement at every level of the organization and has identified those areas where continued improvements are needed. Finally, the MHS has taken a number of additional steps to reduce variance and further improve the patient experience. These steps include optimizing primary care to enhance access and maximize the value of each visit, identifying and addressing patient literacy challenges, and increasing patient engagement.

The following pages describe the plans we put into practice over the last two years, as well as our future plans, to continuously improve the beneficiary experience and quality of care in the MHS. The Department will include additional requirements identified in the NDAA for FY 2017 into future plans identified in this report. An overall summary of the Department's future plans to improve performance and reduce variability in access, care coordination, and patient experience is provided in Appendix A.

I. Align Performance Measures

The MHS' overarching strategic framework is the Quadruple Aim – Improved Readiness, Better Health, Better Care, and Lower Cost. In support of this strategic framework, the MHS developed 34 core performance measures. Figure 1 identifies the MHS' performance measures and depicts whether the measures currently are used in the direct and/or purchased care systems as well as those that are still in development. A comprehensive description of each of these measures is provided in Appendix B.

Of note, eleven measures have common definitions and data collection processes across both the direct and purchased care systems. For several reasons, the MHS does not include performance data for civilian institutions and primary care practices for the remaining 23 measures. First, aligning the performance measures in all aspects of the direct and purchased care systems is challenging given the variance in clinical practices and technical capabilities in addition to the vast number of healthcare facilities in the United States. For instance, Prime enrollees to the purchased care system may receive inpatient care at the 5,627 registered hospitals in the United States and are enrolled to many individual providers and healthcare practices. Second, these civilian providers/hospitals do not share a common electronic appointing system and secure messaging system, which is the source of access to care performance data in the direct care system. Finally, some of the MHS measures were specifically developed to focus on direct care system performance and are not applicable to the purchased care sector.

Future Plans

We are closely coordinating with the Centers for Medicare and Medicaid Services (CMS) to add DoD MTFs to the CMS Hospital Compare website that will provide MHS staff and beneficiaries with the ability to compare institutional performance between DoD and civilian hospitals at a local level. With CMS support, we plan to introduce this capability in FY 2017.

Efforts will continue in FY 2017 and FY 2018 to align direct and purchased care data as well as to align with standard industry measures.

Figure 1: MHS Performance Measures

AIM	OBJECTIVE	PERFORMANCE MEASURE	DIRECT CARE	PURCHASED CARE
Readiness	Improve Medical Readiness & Ensure a Ready Medical Force	Individual Medical Readiness (IMR)	**Yes**	No (****)
		Medical Ready Force	In Development	No (****)
Better Health	Improve the Overall Health of the Population	Healthcare Related Quality of Life Index (HRQOL)	In Development	In Development
Better Care	Improve Safety	Hospital Acquired Infection - Central Line-Associated Bloodstream Infection (CLABSI)	**Yes**	No (*)
		Unintended Retained Foreign Objects (URFOs)	**Yes**	No (*)
		National Surgical Quality Improvement Program (NSQIP) 30-Day All Case Morbidity Index	**Yes**	No (*)
		Catheter Associated Urinary Tract Infection (CAUTI)	**Yes**	No (*)
		Wrong Site Surgery (Non-Dental Sentinel Events)	**Yes**	No (*)
	Improve Clinical Outcomes & Consistent Patient Experience	Risk Adjusted Mortality	**Yes**	No (*)
		Inpatient Satisfaction - Recommend Hospital	**Yes**	**Yes**
		Outpatient Overall Satisfaction with Care	**Yes**	**Yes**
	Improve Condition - Based Quality Care	Diabetes Care Index	**Yes**	**Yes; 1 of 2 index measures**
		Acute Conditions Composite	**Yes**	**Yes**
		Cancer Screening Index	**Yes**	**Yes**
		National Perinatal Information Center (NPIC) Postpartum Hemorrhage	**Yes**	No (**)
		NPIC Vaginal Deliveries with Coded Shoulder Dystocia Linked to a Newborn ≥2,500 grams with Birth Trauma	**Yes**	No (**)
		HEDIS Follow Up after 30 Days of Hospitalization for Mental Illness	**Yes**	**Yes**
		HEDIS All Cause Readmissions	**Yes**	No (*)
		ORYX Index	**Yes**	No (*)
		PQI Index	**Yes**	No (*)
	Improve Comprehensive Primary Care	PCM Continuity	**Yes**	No (****)
		Primary Care Leakage	**Yes**	No (****)
		Days to Third Next Available 24-Hour Appointments in Primary Care	**Yes**	No (***)
		Days to Third Next Available Future Appointments in Primary Care	**Yes**	No (***)
	Optimize & Standardize Access & Other are Support Processes	Percent of Direct Care Enrollees in Secure Messaging	**Yes**	No (***)
		Outpatient - Satisfaction with Care When Needed	**Yes**	**Yes**
Lower Cost	Improve Stewardship	PMPM	**Yes**	**Yes**
		Total Purchased Care Cost	**Yes**	No (****)
		Private Sector Care Cost per Prime Enrollee	**Yes**	**Yes**
		Total Enrollment	**Yes**	**Yes**
		Enrollment per PCM	In Development	No (****)
		Pharmacy Percent Retail Spend	**Yes**	No (****)
		Productivity Targets	**Yes**	No (****)
		OR Utilization	In Development	No (****)

Key	Explanation
(No*)	The CMS Hospital Compare website includes performance data for participating hospitals in the purchased are system. Approximately 75 percent of hospitals in the United States report data on the CMS Hospital Compare website.
(No**)	The NSQIP and NPIC measures are used by a subset of leading health care delivery systems in the United States. The performance data is proprietary to participating institutions. DoD participation in these Collaboratives allows the direct care system to compare its performance against high-volume, industry leaders in surgical/perinatal quality and safety.
(No***)	Prime enrollees to the purchased care system are enrolled to many individual providers and healthcare practices. These civilian providers/practices do not share a common electronic appointing system, which is the source of access to care performance data in the direct care system. In addition, not all civilian providers offer secure messaging capabilities. Therefore, primary care access performance measurement is only applicable to the direct care system. Primary Care access performance in the purchased care system currently is measured by proxy on satisfaction surveys.
(No****)	These measures were developed specifically to focus on direct care system performance; therefore, these measures are not applicable to the purchased care sector.

II. Eliminating Performance Variability

This section describes the MHS' plan to improve healthcare performance by eliminating performance variability in direct and purchased care. The section provides examples where the direct care system has reduced variance in core performance measures and provides DoD plans to further reduce variance in performance among Military Services and between MTFs through process changes and other initiatives to improve patient experience. This section will also discuss the MHS' efforts to reduce performance variance in the purchased care system.

Direct Care System Patient Experience and Access Performance Data Results

In 2014, the MHS completed a comprehensive 90-day review (MHS Review) demonstrating the Department's commitment to continuous improvement in key areas including access to care, safety, and the quality of care. The following measures describe performance captured at the time of the MHS Review compared to the most recent data available at the time this report was written.

Inpatient Satisfaction - Recommend Hospital. One TRICARE Inpatient Satisfaction Survey (TRISS) survey question is included as a MHS core performance measure: Would you recommend this hospital to a family member or friend? Figure 2 below demonstrates mean performance across the direct care system improved from 70.9 percent in the third quarter FY 2014 to 73.3 percent in the first quarter FY 2016 and currently exceeds the national benchmark of 71 percent. Variance among individual MTFs decreased 17.5 percent during this same period. Increased patient satisfaction with inpatient care is an important component of measuring improved patient experience. Current direct care system performance is above the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) benchmark.

Figure 2: TRISS
Would you recommend this hospital?

	FY14Qtr3	FY16Qtr1	Change
Mean	70.9%	73.3%	3.4%
Median	70.8%	73.8%	4.2%
Variance	8.9%	7.3%	-17.5%
HCAHPS Benchmark	71.0%	71.0%	
Mean Above/ Below Benchmark	**0.1% Below**	**2.3% Above**	

Primary Care Manager (PCM) Continuity. Beneficiaries report PCM Continuity and having a personal relationship with a primary care provider as very important to them. As demonstrated by direct care performance, the percent of time enrollees had an appointment with their own PCM has improved. By April 2016, performance had increased to 59.1 percent; median performance was up 6.2 percent. During this same comparison period, variance among MTFs

reduced almost six percentage points. Figure 3 summarizes PCM Continuity performance results in August 2014 and April 2016.

Figure 3: PCM Continuity

	August 2014	April 2016	Change
Mean	57.4%	59.1%	3.0%
Median	58.6%	62.2%	6.2%
Variance	17.2%	16.3%	-5.6%

Average Number of Days to Third Next 24-Hour Appointments in Primary Care. The direct care system made reducing the wait times for primary care appointments within 24 hours a priority. The "third next available" appointment measure provides a good indicator of the timeliness of appointing. Figure 4 shows that the Average Days to Third Next 24-Hour Appointment (i.e., available for urgent or same-day appointments) improved by over 30 percent, and variation was reduced by nearly 50 percent.

Figure 4: Third Next 24-Hour Appointment Performance

	August 2014	April 2016	Change
Mean in days	2.00	1.32	-34%
Median in days	1.78	1.05	-41%
Variance	1.42	0.74	-48%

Average Number of Days to Third Next Future Appointments in Primary Care. Figure 5 shows that the Average Days to Third Next Future Appointment (i.e., available for routine and follow-up needs) improved by 20 percent, and variation was reduced by 23 percent.

Figure 5: Third Next Future Appointment Performance

	August 2014	April 2016	Change
Mean in days	7.7	6.4	-17%
Median in days	6.7	5.3	-22%
Variance	3.5	2.7	-23%

Percent of Direct Care Enrollees Registered For Secure Messaging. Part of improving access is providing our enrollees with the means to communicate with their providers by secure email. Variance remained the same; however, more than half of the MTFs have registered at least 45 percent of its patient population in secure messaging. The direct care system continues efforts to increase registration in secure messaging.

Figure 6: Secure Messaging Registration Performance

	May 2015	April 2016	Change
Mean	36%	42%	17%
Median	39%	45%	15%
Variance	14%	14%	0%

Outpatient Satisfaction with Getting Needed Care. Variance between MTFs can be analyzed using TRICARE Outpatient Satisfaction Survey (TROSS) data. As shown in Figure 7 below, TROSS variance decreased seven percentage points. Between FY 2014 and FY 2016, satisfaction as reported on the TROSS increased eight percentage points to 84 percent.

Figure 7: TROSS Median and Variance

TROSS Satisfaction	FY 2013 Overall	FY2016 Qtr 1	Change
Mean	71%	84%	18%
Median	72%	86%	19%
Variance among MTFs	8.2%	7.6%	-7%

Direct Care System Initiatives

This section of the Report will demonstrate initiatives the direct care system has implemented in order to reduce performance variability. These initiatives range from establishing Tri-Service standards for staffing, performance, and clinical processes to increasing transparency at the Senior Leadership level to better inform strategic decision making regarding the MHS enterprise.

Governance and Performance Monitoring. Military Service and Defense Health Agency (DHA) collaboration is essential to reducing variability. Senior Leadership is also needed to provide direction and hold responsible parties accountable for complying with Tri-Service standards. Therefore, the DoD monitors performance at several levels of governance. The Assistant Secretary of Defense for Health Affairs, the Service Surgeons General, and the Director, DHA monitor direct care performance quarterly. The Deputy Surgeons General and Deputy Director, DHA provide monthly oversight. Tri-Service and DHA subject matter experts monitor overall performance and variability across the direct care system on a monthly basis and identify both opportunities for improvement and outliers. Subject matter expert boards, such as the Tri-Service Patient Centered Medical Home (PCMH) Advisory Board, also monitor driver measures, which impact MHS core performance measures, and explore opportunities for performance improvement.

National Committee for Quality Assurance (NCQA) PCMH Recognition. One of the first major PCMH initiatives was to support implementation of common industry standards supporting patient experience, care coordination, quality, safety, and access through the NCQA PCMH Recognition program. NCQA is the industry leader in recognizing PMCHs, with over 70 percent of the healthcare industry market share. NCQA recognition provides the mechanism for MHS PCMHs to hold themselves to the same standards applied to the civilian healthcare system. As of FY 2016, over 92 percent of the 440 direct care PCMHs are recognized by NCQA as level 3 PCMHs. Level 3 is the highest level awarded by NCQA. By FY 2013, the MHS PCMHs had achieved the highest average score of any health system seeking NCQA PCMH Recognition in the United States.

Tri-Service Workflow (TSWF) Forms in the Electronic Health Record (EHR). In FY 2012, the direct care system began implementing core TSWF forms for use in the direct care system's Armed Forces Longitudinal Health Application (AHLTA) EHR. TSWF forms ensure standard screening and documentation in the medical record, support team-based work to maximize provider time and allow data analysis of encounter and outcome data. TSWF forms are developed by a team of Tri-Service physicians and are based on recommendations from the United States Preventive Task Force, the Centers for Disease Control and Prevention (CDC), and other professional organizations, such as the American Academy of Pediatrics. The use of TSWF forms is associated with an increase in annual screening for depression for all direct care system enrollees from 29 percent to over 90 percent. In addition, DoD/VA Clinical Practice Guidelines (CPGs) developed to provide evidence-based medicine clinical pathways and recommendations for care in the direct care and Veterans Affairs' systems are included in TSWF for providers' use. In FY 2016, the TSWF team developed a methodology to measure compliance with CPGs, secondary to the MHS Review follow-on action plan. CPGs selected for measurement first included those dealing with conditions prevalent in the patient population, including Low Back Pain, Type 2 Diabetes, Smoking, Hypertension, Hyperlipidemia, and Obesity. The results will be used to improve performance across the direct care system.

Embedded Specialists in Primary Care. The most common conditions in the direct care enrollee population, excluding pregnancy, are behavioral-health related, musculoskeletal issues and miscellaneous conditions such as hypertension, hyperlipidemia, obesity, and diabetes. As a result, the direct care system began embedding some specialty providers to treat these most common conditions directly into PCMHs to provide more continuous, comprehensive care in the primary care setting and to facilitate coordinated care. Currently, over 80 percent of PCMHs serving adult enrollees have embedded behavioral health specialists, who provide treatment for mental health and behavioral health issues. Directly embedding behavioral health providers ensures the embedded specialists are able to work closely in partnership with the patient, PCM and PCMH team; moreover, because the specialties are co-located, it helps destigmatize the care received. Studies conducted by the Uniformed Services University of the Health Sciences determined that being seen by a behavioral health specialist embedded in PCMH results in a statistically significant improvement in mental health status. The MHS also is implementing embedded clinical pharmacists in PCMH. A recent independent analysis demonstrated that the use of embedded clinical pharmacists resulted in a statistically significant improvement in diabetes, hypertension, and hyperlipidemia outcomes. Finally, the MHS is implementing physical therapists in PCMH to address highly prevalent musculoskeletal issues, such as low back pain. Where implemented, embedded physical therapists have resulted in improved outcomes and reduced MTF enrollee purchased care costs.

Simplified Appointing in Primary Care. The direct care system completed implementation of simplified appointing in PCMHs by October 1, 2016, four months earlier than originally planned. Simplified Appointing was based on MTF leading practices and Institute of Medicine

recommendations. Reducing the complexity of PCMH templates through the implementation of simplified appointing has resulted in over 24 percent more appointments being available per duty day.

First Call Resolution. The direct care system implemented first call resolution policies, secondary to the MHS Review. Policies outline standard processes to ensure Prime enrollees' needs are met the first time they call for an appointment. The goal is to ensure enrollees are not asked to call back another day because no appointments are available. Standard Tri-Service first call resolution processes include the patient receiving an appointment or having the MTF meet the patient's needs in other ways, such as calling in a prescription renewal to the pharmacy or setting up a telephone visit with the provider, usually within two hours. If the patient's need for an appointment cannot be met and there is no MTF Urgent Care (UC) or Emergency Room (ER) fast track available, the patient is referred to an UC in the network. MTF staff members assist the Prime enrollee with locator service and/or directions. Enrollees may also be offered virtual care via a telephone call with the provider or PCMH team.

Specialty Referral Guidelines. The direct care system recently implemented specialty consult guidelines in TSWF to drive standardization and reduce variance on when it is clinically appropriate to refer beneficiaries for specialty care. The specialty referral guidelines' goal is to reduce clinically unnecessary specialty care utilization. The guidelines also include what information and diagnostic tests should be accomplished prior to the beneficiary seeing a specialty provider, to maximize the value of the first appointment by providing the specialty provider with needed information to make a diagnosis.

Direct Care System Future Plans

The direct care system plans to implement additional processes in FY 2017 and FY 2018 to further reduce variability in performance and improve the overall experience of care. The Department will incorporate requirements identified in section 709 of the NDAA for FY 2017, to establish and ensure a reliable, standardized, single medical appointing system within all MTFs, which ensures patient-friendly access to high quality primary, specialty, and behavioral health care. In order to fully meet the intent of section 709, the MHS is aligning and synchronizing its efforts with the requirements in section 703 of the NDAA for FY 2017 on MTF capabilities; section 704 on access to urgent care and expanded primary care hours; section 706 on development of integrated healthcare delivery systems; and section 718 on the deployment of telehealth capabilities in primary and specialty care.

PCMH Optimization and Access. The Tri-Service PCMH Advisory Board identified leading practices to further reduce variance and improve access, patient experience and quality. These leading practices are being codified as standard, direct care system-wide processes in Tri-Service guidance.

- The Tri-Service Work Flow 2.0 (TSWF 2.0) is being implemented to make CPGs easier for providers to use. TSWF 2.0 also includes new "quick visit" forms to expedite encounters for common acute conditions.
- The direct care system is developing plans for and monitoring extended hours of PCMH and MTF UC fast track clinics in ERs to provide convenient after hours care for enrollees, where feasible.
- The direct care system has initiated an access to care learning collaborative with the Institute for Healthcare Improvement (IHI). The IHI collaborative will also work with the direct care system's surgical quality program.
- The direct care system is developing standard training curricula in access to care for all direct care system personnel, based on role or duty.
- Finally, the MHS Guide to Access Success is being codified in standard DoD guidance to identify mandatory Tri-Service access processes, reduce variance, and improve performance across the direct care system.

Inpatient Patient Experience Optimization. The direct care system has identified key initiatives to improve the inpatient experience of care, especially in obstetrics, where feasible. The initiatives include: wireless internet in waiting areas and inpatient rooms; unlimited or expanded visiting hours; and meal delivery for inpatients 24 hours a day, seven days a week. Standard processes to optimize inpatient patient experience in MTFs will be developed by the Patient Experience Working Group (PEWG) in FY 2017 for governance approval and implementation across the direct care system in FY 2018.

Specialty Appointing, Referral Management and Optimization. A new Tri-Service policy to improve and expedite the specialty care appointing and referral processes in the direct care system will be implemented in FY 2017. The policy was informed by patient feedback and based on industry leading practices. The goal is to provide the enrollee with a specialty care appointment date and time in the MTF at the time the consult is written or within 24 hours. If the MTF does not determine whether the enrollee can be seen in the direct care system within 24 hours, the referral will be sent immediately to the purchased care network.

Purchased Care System

The MHS has implemented a Congressionally-directed UC demonstration to allow direct and purchased care system enrollees up to two visits in network care UC clinics without authorization. A plan for expanded opportunities for UC in MTFs and in the purchased care network are in development to support section 704 of the NDAA for FY 2017 requirements. The MHS also introduced key changes to the current Managed Care Support Contracts (MCSC) to reduce variability between the three regions. The MCSCs are now allowed to establish beneficiary-centric data warehouses and industry analytic tools/systems (including predictive analytics) in order to meet the requirements of the upcoming TRICARE 2017 (T-17) contracts. The MHS has established clear guidelines for each MCSC on the transfer of complex pediatric

cases across regions. The MHS has instituted consistent reporting requirements and definitions for Medical Management (MM) in both the direct and purchased care systems, in addition to implementing evidence-based and outcome-oriented programs in the MM process. MM/Utilization Management (UM) Plan reporting is also standardized in format and process requirements. The MHS recently modified the current TRICARE Third Generation MCSC contracts that enhance and standardize clinical quality and patient safety reporting.

Purchased Care System Future Plans

The MHS has brought forward changes discussed to be included in future T-17 MCSC contracts to reduce variability between regions. These changes include quality and patient safety metrics and standardized reporting. Purchased care is also implementing multiple value-based care efforts, which will seek to improve patient outcomes and experience of care.

III. Use of High Technology Services

The MHS has deployed numerous technology-based applications to enhance the beneficiary experience and is developing plans to further optimize the use of innovative technology to improve the experience of care for its patient population in both the direct and purchased care systems.

Direct Care System

Over the last several years, the direct care system has introduced a suite of tools and services to provide beneficiaries with more contemporary options for accessing health care. In addition to traditional patient appointments, these services include:

NAL. Available 24 hours a day, every day of the year, the NAL provides beneficiaries with access to after-hours health care expertise from Registered Nurses (RNs) along with integrated appointing services for direct care enrollees when follow-on care is required. Since implementation in FY 2014, the NAL has provided triage services, self-care advice, and general health information to more than 1.3 million callers. Over ninety-four percent of calls are from direct care system enrollees and almost 30 percent of all calls concern patients aged 2 and under. The daily call volume in Calendar Year 2016 averaged over 1,700 calls per day. In June 2016, average daily call volume showed a 5.3 percent increase compared to June 2015.

The NAL is fully integrated with direct care system PCMH primary care clinics to schedule MTF appointments if the RN determines the caller needs to be seen within 24 hours; transfer the caller directly to his or her MTF via telephone; or provide information about MTF UC and ER Fast Track options. If care is not available in the MTF, the NAL will assist callers in seeking UC in the network. PCMH teams have access to caller encounter information in a live NAL portal. Teams use portal data to follow-up with the patient and coordinate care, if clinically indicated. The NAL portal also includes performance data, which allows PCMH teams to monitor demand surges in real-time and adjust future appointing templates to accommodate changes in demand.

The NAL meets The Joint Commission and NCQA requirements for PCMH recognition by offering a means for direct care system enrollees to obtain clinical advice on urgent care needs.

Secure Messaging. Secure Messaging uses advanced technology to improve the patient experience, enhance access, and facilitate care coordination in the direct care system. Enrollees registered to use secure messaging are able to send a question to their PCM on new or on-going medical issues, arrange appointments directly with the PCMH team, request prescription renewals, discuss lab and other test results, and coordinate specialty referrals. In addition, colleague-to-colleague secure messaging is increasingly used for communication and care communication between primary and specialty care providers and the extended care team including case and disease managers. In FY 2015, the required response time to a patient's

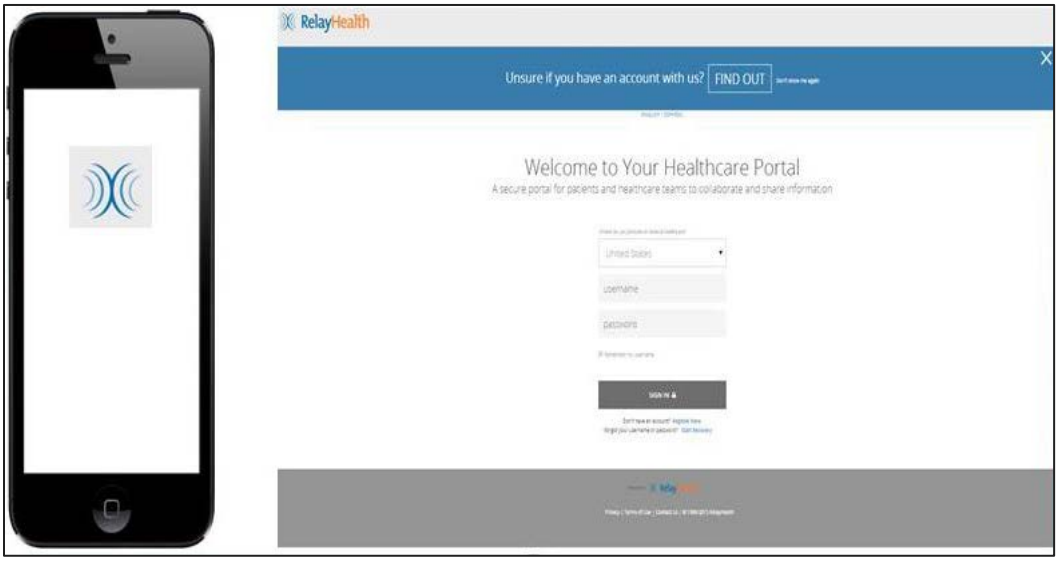
message was decreased from 72 hours to within 8 hours. Secure messaging is fully implemented in all direct care system PCMHs and implementation is underway in specialty care.

Secure messaging also is used by the PCMH teams to send preventive care messages to all patients or select groups of direct care enrollees with certain chronic diseases, such as hypertension and diabetes. Finally, secure messaging can be used to communicate directly to all registered enrollees to quickly provide patient education on emerging public health threats. For example, the direct care system has developed a standard Tri-Service message on the Zika virus threat for all enrollees registered in secure messaging.

The percent of MTF enrollees registered for Secure Messaging is a MHS core performance measure. As of May 2016, 43 percent of MTF enrollees were registered for secure messaging. Satisfaction with secure messaging is over 95 percent.

Secure Messaging recently reformatted their software to allow enrollees to use secure messaging as a smart phone application (app) at (URL: https://app.relayhealth.com). Figure 8 below depicts the secure messaging front page when the app is accessed.

Figure 8: Secure Messaging App



TOL Patient Portal. TOL is a secure patient portal available to all eligible direct care system enrollees. TOL offers convenient access to health care information and services. Direct care enrollees can use TOL to make or cancel MTF appointments by selecting preferred date and time parameters, set prescription reminders for themselves or family members, refill prescriptions, check prescription status, and through the DoD Blue Button feature, download their historical personal health information from the military EHR. Enrollees also can select a feature to turn on reminders of upcoming appointments by email and/or text.

The DoD Blue Button feature allows patients to share important data with their family as well as with providers in the purchased care system. Access to this information is especially important for those transitioning out of the military.

Targeted Mobile Apps. The MHS' National Center for Telehealth and Technology has developed mobile apps such as a Mental Health Professional face-to-face coaching tool, a Mindfulness coaching app and a Traumatic Brain Injury Coaching guide. All of these apps are available through Apple and Android app stores.

Virtual PCMH Telephone Visits. PCMHs now offer virtual telephone visits scheduled with a PCM for established patients. Virtual telephone visits are used to address new or on-going medical issues and to coordinate care. In FY 2016, 20 percent of all direct care system PCMH encounters were accomplished virtually using the telephone.

Telehealth. Numerous pilots have been implemented across the direct care system to increase providers' abilities to provide quality healthcare remotely. For example, TeleCritical Care in the Navy utilizes dedicated technology to remotely monitor critical care patients in remote areas, and is being expanded for Neonatal Intensive Care Unit (ICU) use. Telehealth Cart technology for the Army enables providers to diagnose and treat patients using electronic peripherals that transmit real-time vital signs. The Army's Mobile Care will provide the ability to do remote health monitoring on patient's personal electronic devices in a bi-directional, secure manner as is available from some commercial providers

The direct care system is also planning to use telehealth to enhance access to care, quality, and medical readiness by leveraging existing and emerging technologies. The three Military Services and the DHA have jointly aligned Tri-Service Telehealth initiatives to focus current efforts on Telehealth to the Patient Location, Teleconsultations, Remote Health Monitoring, and Extension for Community Healthcare Outcomes® (ECHO). Each are deployed at varying levels, but are centered on the goal of providing access to quality care to direct care system enrollees. Telehealth, in many cases, is also a covered benefit in purchased care and a pilot project is underway to provide telehealth care to the patient's site, including the patient's home, when appropriate.

> **Teleconsultation:** Teleconsultation is an asynchronous transmission of electronic medical information to allow a provider to obtain an expert specialty opinion regarding the care of a patient. Teleconsultation is already in use in the direct care system. Examples of teleconsultation initiatives include the Navy's Health Experts onLine Program, which provides rapid consultation to remote areas; Tele-radiology in the Air Force, allowing diagnostic imaging procedures to be done in theatre with the clinical expertise of a specialist; orthopedics and amputee consultation in partnership with the Department of Veterans Affairs in the National Capital Region; and, a web-based, asynchronous teleconsultation program in the Pacific for Army soldiers.

Project ECHO®: In May 2014, MHS leadership approved Project ECHO® as a direct care telehealth initiative. Project ECHO® is an industry leading practice developed by the University of New Mexico. Project ECHO® uses a hub and spoke model to link a team of expert clinicians with multiple PCMH teams to consult on care for direct care system enrollees. A recent focus for this initiative is Pain Management. Currently, the Army hosts four Pain ECHO® clinics with 48 spoke sites; the Navy, two Pain ECHO® clinics with 22 spoke sites and the Air Force hosts one monthly chronic pain webinar with their hub at Walter Reed National Military Medical Center. Other efforts include an Air Force webinar-based clinic on topics such as Diabetes, Behavioral Health, Dental, Sports Medicine, Acupuncture, Neurology, and Addictions. Tele-Behavioral Health is an emerging focus area to ensure routine and surge support care is readily available to readiness forces. Project ECHO® Tri-Service champions are working towards identifying other clinical focus areas and performance measurements of success.

Remote Health Monitoring: Remote Health Monitoring in the direct care system is intended for use in the management of chronically ill patients with specific conditions (e.g., Type 2 Diabetics). Remote Health Monitoring utilizes patient monitoring devices to collect biometric data, which is then transmitted to PCMH providers and case managers for use in assessing the direct care system enrollees' health status and care plan effectiveness. Remote health monitoring also is used to monitor health and coordinate care for wounded warriors or other direct care system enrollees at remote locations, and is also offered by some purchased care providers.

Provisional Coverage for Emerging Treatments and Technologies and Provisional Coverage. Section 704 of the NDAA for FY 2015 provided the DoD with the authority to extend provisional TRICARE coverage for an emerging healthcare service or supply. The Assistant Secretary of Defense for Health Affairs may authorize provisional coverage if the service or supply is widely recognized in the United States as being safe and effective but it does not yet meet the TRICARE standard for proven effectiveness. Prior to expiration of provisional coverage a decision will be made on whether to convert the healthcare service or supply to a covered benefit under the TRICARE Basic program. Surgical treatment for Femoroacetabular Impingement Syndrome was the first emerging treatment to be given provisional coverage under the authority in section 704. The DHA is working with the Service Medical Departments to review and prioritize these emerging technologies and treatments for potential provisional coverage assessment.

Direct Care System Future Plans

NAL. In FY 2017, the NAL began piloting virtual visits with primary care providers at select MTFs. Virtual telephone visits are offered to enrollees who require an appointment within 24 hours if no MTF appointments are available or if the MTF is closed. Following assessment of the "PCM On Call" pilot, the Department will determine how the program may be adjusted and/

or expanded in FY 2018. In addition, the direct care system is working to maintain NAL capabilities including MTF appointment scheduling during the transition to MHS Genesis, the Departments new EHR. The first MTFs will transition to the new system in February 2017. In FY 2018, the NAL will be expanded globally to provide services to direct care system enrollees and other patients served by overseas MTFs, which will result in a more consistent patient experience across the direct care system.

Secure Messaging. In FY 2017, the direct care system will continue to deploy secure messaging in specialty care and expand the use of colleague-to-colleague messaging to facilitate care coordination and consultations between PCMH team members and specialty care. Full implementation in specialty care is expected in FY 2018.

The direct care system also plans to increase registration and utilization of secure messaging in FY 2017. In December 2017, the direct care system will supplement enrollment in secure messaging with a CMS Meaningful Use measure of secure messaging utilization, the percent of registered enrollees who have sent a message in the last 30 days, as well as the CMS goal of 5 percent or more. The direct care system will evaluate other secure messaging utilization measures in FY 2017.

Finally, the DHA and White House Social and Behavioral Sciences Team have partnered with Naval Hospital (NH) Camp Lejeune to conduct a process improvement study on secure messaging to enhance patient experience and increase utilization of secure messaging. The study will measure the effectiveness of different communication techniques for when and how PCMs encourage enrollees to use secure messaging. NH Camp Lejeune enrollee utilization will be measured monthly through FY 2017 to determine which PCMs' methods were the most efficient. The results of the study will be briefed to MHS governance and if effective, will be applied across the direct care system through Tri-Service standard guidance.

Patient Portals. In November 2016, the DHA completed Phase 1 of the TOL Patient Portal redesign. The simplified redesign was informed by patient feedback and now provides easy access and links to current TOL capabilities, the NAL and secure messaging. The TOL Portal redesign goal was to mimic the new MHS Genesis portal so MTF enrollees may become familiar with the look and feel prior to full EHR transition. TOL Patient Portal Phase 2 enhancements will be implemented in FY 2017 and include a streamlined appointing module, wellness reminders, links to health information websites, and a mobile app for smart phones. Phase 2 enhancements also will include "Open Notes" of MTF outpatient encounters and inpatient admissions to improve care coordination and patient engagement. Finally, the MHS Genesis patient portal will be implemented in phases, starting in the Pacific Northwest in FY 2017.

Health Information Exchange (HIE). The MHS is implementing HIE or Electronic Health (eHealth) initiatives in locations where the states make health information sharing among government and civilian healthcare institutions available. HIE supports a safe, high quality

patient experience, and facilitates clinical decision-making and care coordination by ensuring both purchased care and direct care providers have access to important medical information on direct care enrollees. Direct care enrollees at locations where HIE is available are offered the opportunity to "opt out" of information sharing. The Colorado Springs enhanced Multi-Service Market (eMSM) is one example of successful partnership with private-public HIEs. The Colorado Springs eMSM MTFs participate in the Colorado Regional Health Information Organization (CORHIO) HIE. MTF clinical teams and providers are able to quickly access clinical information from CORHIO on their enrollees' inpatient or outpatient encounters delivered in the purchased care system in Colorado including any test results. The direct care system will continue expanding HIE capabilities between MTFs and private sector health care organizations in FY 2017 and beyond.

Telehealth Mobile Apps. Navy Medicine East (NAVMED-E) directed each of its MTFs to develop a mobile app for Apple and Android smart phones. These mobile apps provide easily accessible information on appointing and other patient experience features. For example, NH Camp Lejeune and NH Jacksonville mobile apps include event calendars, clinic phone numbers, daily appointment availability, pharmacy wait times, refill information, a feedback module, links to the NAL, Secure Messaging and TOL, and maps with directions. NH Camp Lejeune's mobile app also includes a way to contact a medical campus golf cart to obtain transportation between the MTF and the parking lots. The direct care system is developing plans to extend this capability to make mobile apps for all MTFs available through Apple and Android app stores in FY 2017.

Telehealth to Patients' Location. In addition to further expanding the use of PCMH virtual telephone visits discussed above, the direct care system is developing or has implemented pilots on Telehealth to Patients' Location at several MTFs. Blanchfield Army Community Hospital (Fort Campbell, Kentucky) offers virtual visits to enrollees presenting to the MTF ER. Enrollees are triaged by the ER RN and if the patient's problem is of low acuity, the patient is offered a virtual visit via camera with available providers at another Army MTF. A one-year pilot program is planned for launch in FY 2017 at NH Jacksonville. This pilot involves using an "Uber" like process to schedule virtual visits, using the software provided by contract physicians. Eligible beneficiaries will be offered a virtual visit with a PCM through a web app. In FY 2017, the NAL also began piloting virtual telephone visits with a primary care provider through the NAL. The MHS is working through the technical, cyber security and information assurance requirements required to implement this initiative across the direct care system. In addition, telehealth into a patient's home will be piloted in the purchased care system in FY 2017 or FY 2018.

Purchased Care System Future Plans

The MHS is adding new requirements to the future T-17 MCSC contracts to increase the use of innovative, high technology capabilities to improve access to care and care coordination. The

MCSCs will be required to operate a fully electronic data system for the MM/ UM program that will offer reporting and information to the MHS at the beneficiary and MTF level. The electronic data system for the MM/UM program will be made accessible to users on a twenty-four hours a day, 7 days a week basis. The MCSCs also will be required to establish a beneficiary-centric data warehouse and industry analytic tools/system, including predictive analytics, provide the MHS with access to view all data for a Prime beneficiary enrolled to a civilian PCM and exhibit a sophisticated data analysis technique with evidence-based algorithms. The MCSC will utilize its analytic tools, to include predictive analytics, to promote health, identify at-risk individuals and populations, treat chronic diseases and will describe and report to the MHS its methods to engage all TRICARE-eligible beneficiaries and their providers in appropriate care and treatment.

The MCSCs will be required to utilize leading industry best practice automation in processing referrals and authorizations, episodes of care, procedures, and diagnosis coding. The MCSCs will make referrals and authorization letters available electronically and printable to the beneficiary. The MCSCs also will also implement a computer-based referral management system which interfaces with the Government's referral management system interface. The MHS expects to implement these changes in FY 2017 (contingent upon timely resolution of the current contract appeals).

IV. Collecting and Analyzing Data

In this section, we describe MHS activities and plans to collect and analyze data for both the direct and purchased care systems.

Direct Care System

The direct care system has a robust data collection, validation and analysis capability, especially in the areas of quality, access and satisfaction. Since the MHS Review, the MHS has developed Tri-Service consensus on obtaining key data (i.e., safety, performance, cost, satisfaction, and readiness) by standardizing reporting requirements and measurement for performance analysis. Measures where data are still being validated are in an exploratory phase. MHS core performance measures are provided in Figure 1 of this report.

Data sources. Data is collected from reliable, accurate, and standard reporting systems. Data sources include the Composite Healthcare System, AHLTA, the MHS Mart for direct and purchased care encounter and claims information, the Medical Data Repository, the Referral Management System, the Defense Medical Human Resources System, and patient satisfaction surveys including the TRISS and the Joint Outpatient Experience Survey (JOES). Data are extracted from these sources directly or through applications including the TRICARE Operations Center and the MHS CarePoint Population Health Portal. In cases of specific patient safety events, the data are uploaded by and obtained from the Services through the Patient Safety Reporting System.

Performance Measures. Performance measures are proposed by Military Service and DHA subject matter experts. Data sources, methodology, goals and thresholds are approved through the Tri-Service Governance process and ultimately by the Medical Deputies Action Group, consisting of the Service Deputy Surgeons General and DHA. The performance measure process is managed by the Partnership for Improvement (P4I) Steering Committee, which consists of DHA and Service representation. The P4I Steering Committee drives stakeholder consensus and support for the process and ensures rigor, accuracy, reliability, and timeliness in the performance measurement process by providing oversight over measure development, data availability, goals, thresholds, and measurement. Oversight and performance analysis are conducted throughout the MHS from MTFs, Tri-Service subject matter expert working groups and at senior MHS leadership meetings held at least quarterly. The MHS' rigor in the identification, measurement, reporting and analysis of key metrics supports continuous process improvement.

Direct Care System Future Plans

The MHS has established a process to review core measures annually to ensure measures align with strategy. The process also includes the ability to propose new goals and measures for governance approval in support of continuous process improvement. In FY 2017, the direct care

system plans to add specialty care access and satisfaction with provider communication to the MHS core measures.

The direct care system is transitioning to MHS Genesis, a new, commercially procured EHR to replace AHLTA. The MHS Genesis deployment is phased, starting in the Pacific Northwest in FY 2017 and continuing through FY 2022. Future plans include ensuring accurate, reliable, timely and relevant historical data are maintained and integrated into MHS Genesis, and that MHS Genesis is effectively used to provide more real-time information to clinical staff on readiness, health, quality and safety.

Purchased Care System

During the MHS Review, MHS leaders identified the lack of data standardization on access, quality and safety data reporting and availability from the purchased care system as a gap. Subsequently, the DHA developed a plan of action to close the gap.

Changes to the TRICARE Operations Manual and Contracts. The DHA introduced changes to the TRICARE Operations Manual and future TRICARE contracts in the areas of clinical quality and purchased care reporting. These changes increase consistency between the direct and purchased care systems' quality reporting and definitions. In addition, contractor UM plans now have standardized format and process requirements consistent with those in the direct care system.

Updated MCSC Reporting Requirements. The DHA updated MCSC reporting requirements, and standardized the format and frequency for analysis and reporting of focused reviews and clinical quality and safety data. These updates included increasing reporting of the Agency for Healthcare Research and Quality Patient Safety Indicators from annual to biannual and clarified requirements for reporting and tracking sentinel events, serious reportable events, potential and confirmed quality issues. The MHS also included requirements for reporting health plan measures, best quality outcomes in the network, and inter-rater reliability in the quality review process. A review and analysis of the CMS Hospital Compare measures for network facilities is required to help improve visibility of performance. New language was also added to establish timeliness standards for processing potential quality issues and to define expectations for peer review and peer review committees to determine deviations from standards of care and appropriate interventions for patient safety.

Purchased Care System Future Plans

Future TRICARE contracts will also include reporting changes to ensure MHS leaders have greater visibility into the quality and safety of network providers. At the current time, the transition to the T-2017 contracts is underway. With contract transition periods of at least nine months before the start of health care delivery, this new reporting will not be operational until late FY 2017 or early FY 2018.

V. Performance Management System

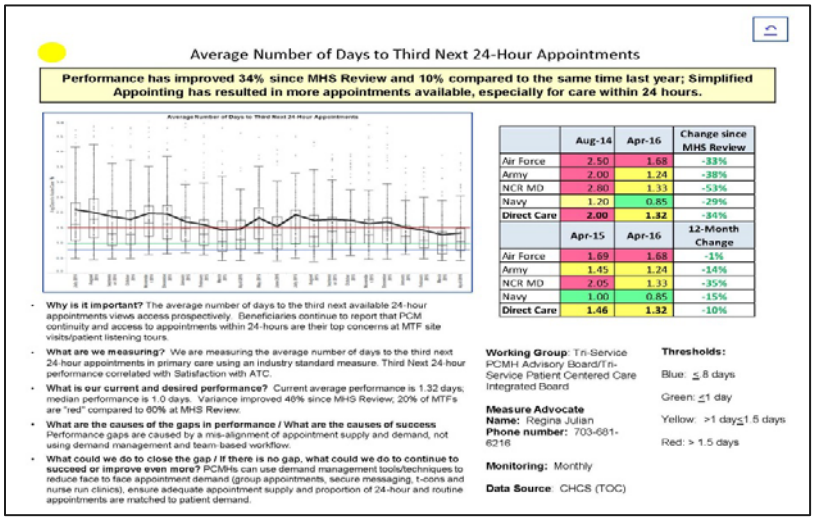
Direct Care System

Performance Monitoring. Performance data for direct care are presented to and monitored quarterly by the Assistant Secretary of Defense for Health Affairs, the Service Surgeons General and Director, DHA. If specific corrective action plans are recommended, subject matter experts must report back to leadership. On a monthly basis, the Medical Deputies Action Group, comprised of the Principal Deputy Assistant Secretary of Defense for Health Affairs, the Service Deputy Surgeons General, and Deputy Director, DHA, review detailed performance data in the three Process Improvement Priority areas: access, quality, and safety. The subject matter expert advisory boards, such as the Tri-Service PCMH Advisory Board, analyze performance management system data on a monthly basis and identify performance outliers for Service action. The Tri-Service subject matter expert boards further explore reasons for challenges and opportunities for improvement by analyzing core measure driver metrics affecting core measure performance.

The Services subsequently monitor performance of subordinate MTFs and identify reasons for and opportunities to resolve some MTFs' low performance on core measures. MTFs are expected to monitor and address core performance as well as supporting driver measure performance on an on-going basis.

MHS leaders have approved a data source, a calculation methodology, a subject matter expert and performance goals for each of the MHS core performance measures discussed in Section I of this report. MHS Leadership reviews performance of core measures individually in order to monitor performance and drive discussion about challenges and opportunities. An example of the detailed information reviewed by leadership is displayed below in Figure 9 for the "Average Number of Days to Third Next 24-Hour Appointments."

Figure 9: Detailed Core MHS Performance Measure Information for Leadership



The MHS Performance Dashboard. The MHS Performance Dashboard is available to all Common Access Card (CAC) holders on the DHA CarePoint Platform. Overall MHS data are presented for each measure compared to the goals and thresholds. Data can be further selected for each Service or purchased care (for the measures available and in common with direct care) and the eMSMs. Figure 10 depicts a screenshot of the dashboard visible after log-in.

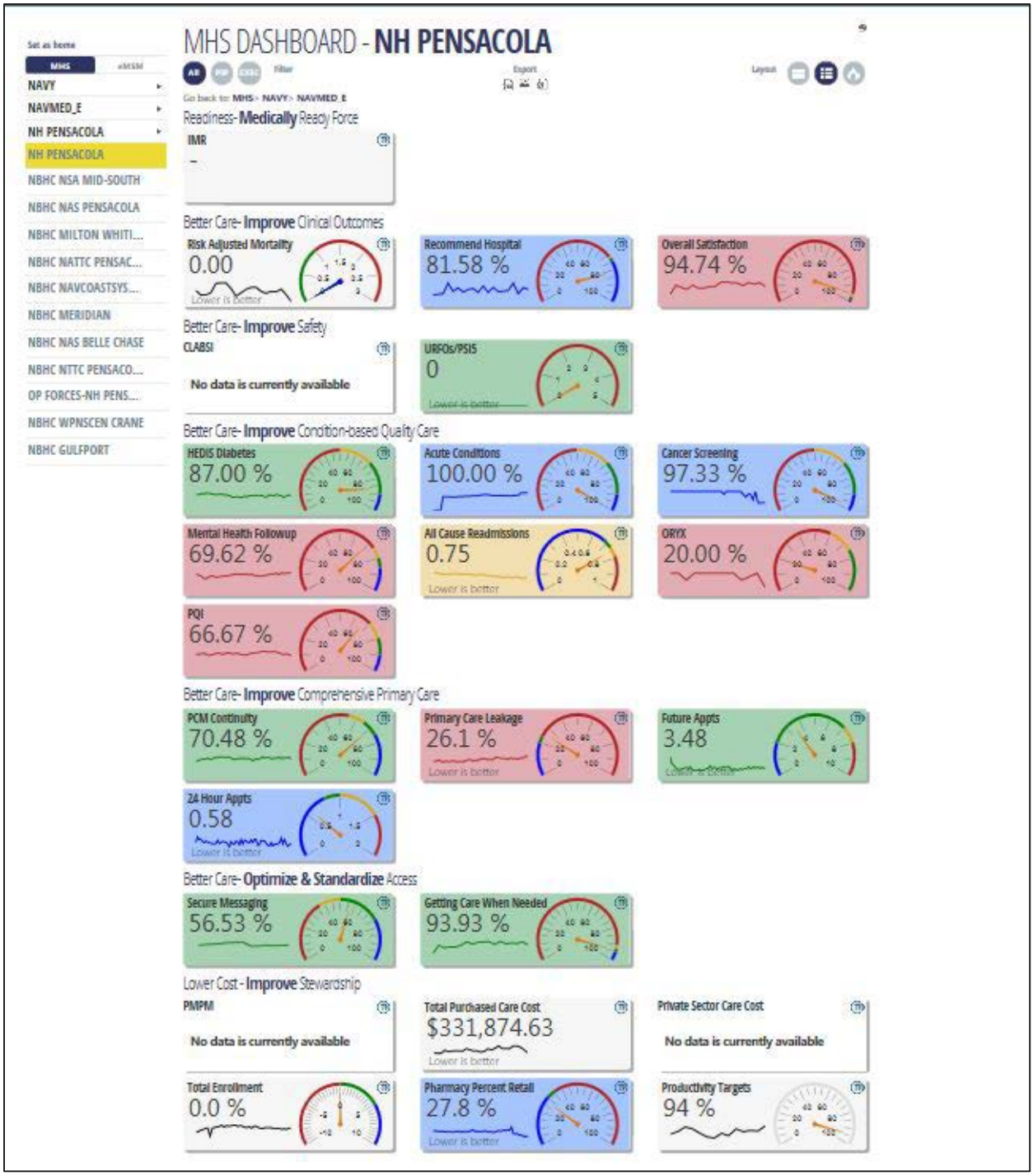
Figure 10: MHS Dashboard Front Page

<u>Service Level Performance</u>. Service data can be stratified by regional commands. Overall regional command performance is depicted and includes an average performance of each subordinate MTF in the command. Specific MTFs in the command are aligned in the menu on the right. Figure 11 depicts the MHS Dashboard for NAVMED-E, a Navy regional command.

Figure 11: MHS Dashboard for NAVMED-E

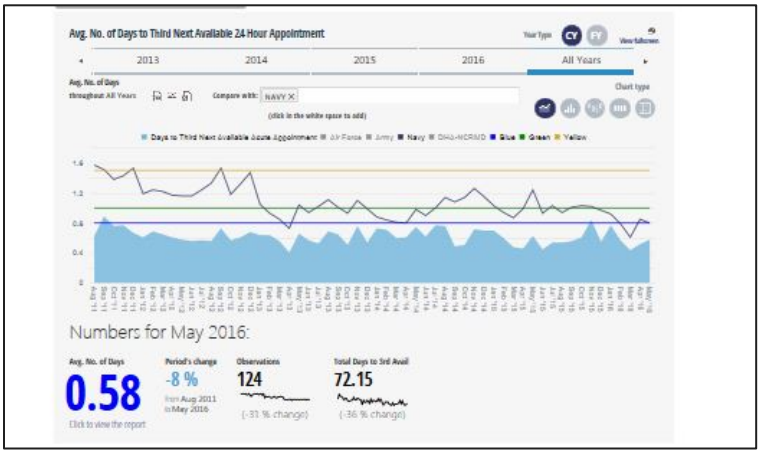
MTF Level Performance. Specific MTFs may be selected to view performance on core measures. Figure 12 below depicts performance data for NH Pensacola.

Figure 12: MHS Dashboard for NH Pensacola



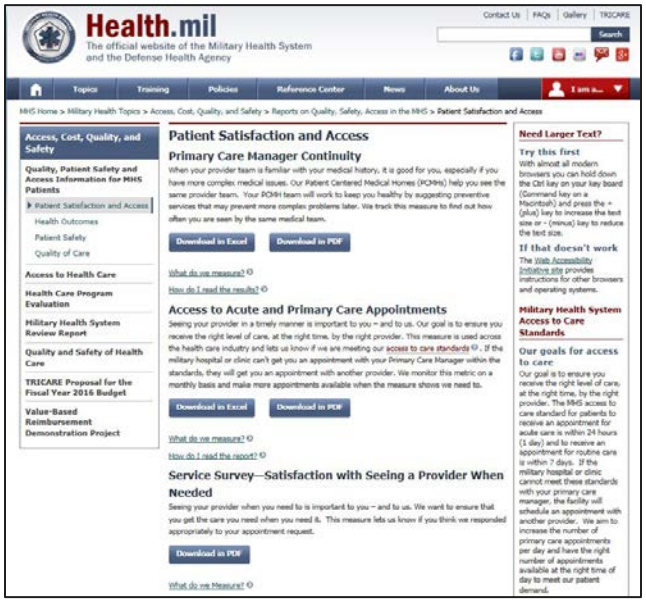
Specific Core Performance Measures. If a core measure is selected on any level of the dashboard, detailed information on the core measure is presented including current performance trended over time compared to goals and thresholds. As an example, Figure 13 depicts NH Pensacola performance on Average Number of Days to Third Next 24-Hour Appointments over time and against the performance goal. In this case, NH Pensacola has achieved the MHS' highest blue threshold for performance of 0.8 days or less.

Figure 13: NH Pensacola Average Number of Days to Third Next 24-Hour Appointment



Transparency. The MHS makes Core Measure performance data on Quality, Safety, and Access available to the public and beneficiaries on the Health.Mil website (URL: http://www.health.mil/transparency). Figure 14 displays the access and satisfaction transparency website page, which provides detailed information about each relevant measure. The access and satisfaction transparency webpage also meets requirements established by sections 712 and 713 of the NDAA for FY 2016. A link to this page is available on each MTF's website.

Figure 14: Access and Satisfaction Data Transparency Page



Direct Care System Future Plans

The direct care system plans to further refine the MHS Performance Management Dashboard and add additional details to support Service and MTF performance improvement efforts. In FY 2017, the direct care system will include discussions, knowledge sharing on leading practices, and Tri-Service guidance on how to resolve challenges and other resources on its Carepoint website, as shown in Figure 15 below.

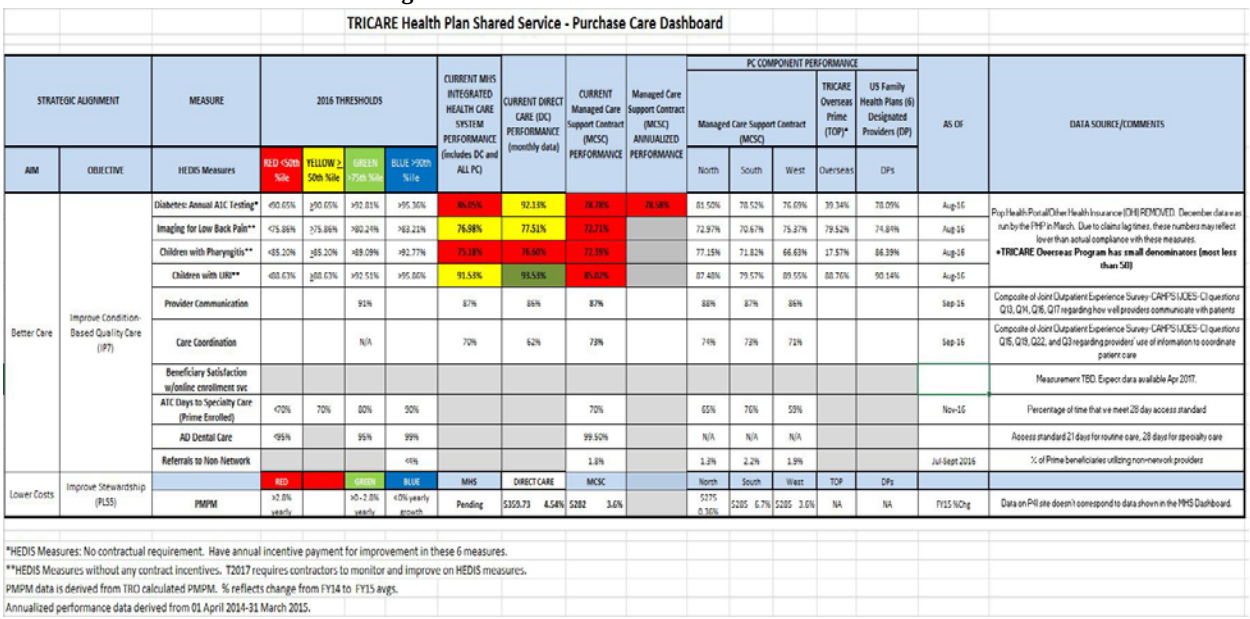
Figure 15: MHS Dashboard Continuous Improvement Support

The direct care system also will evaluate core performance measures for alignment with strategy and priorities annually. Performance goals and thresholds will be re-validated and adjusted each year to drive continuous process improvement. The Department will revisit and enhance the MHS Quality, Safety, and Access performance data on the Health.Mil website at least annually with the goal to maximize the information available to the public and beneficiaries.

Purchased Care System

Since purchased care data for MHS core performance measures is, in many cases, currently unavailable, the MHS is working to develop additional purchased care measures in support of the Quadruple Aim. To accomplish this, the MHS approved and implemented a Purchased Care Dashboard in FY 2016.

Figure 16: FY 2016 Purchased Care Dashboard



TRICARE Health Plan Shared Service - Purchase Care Dashboard

STRATEGIC ALIGNMENT		MEASURE	2016 THRESHOLDS				CURRENT MHS INTEGRATED HEALTH CARE SYSTEM PERFORMANCE (includes DC and ALL PC)	CURRENT DIRECT CARE (DC) PERFORMANCE (monthly data)	CURRENT Managed Care Support Contract (MCSC) PERFORMANCE	Managed Care Support Contract (MCSC) ANNUALIZED PERFORMANCE	PC COMPONENT PERFORMANCE					AS OF	DATA SOURCE/COMMENTS
											Managed Care Support Contract (MCSC)			TRICARE Overseas Prime (TOP)*	US Family Health Plans (6) Designated Providers (DP)		
AIM	OBJECTIVE	HEDIS Measures	RED <50th %ile	YELLOW ≥ 50th %ile	GREEN ≥75th %ile	BLUE >90th %ile					North	South	West	Overseas	DPs		
Better Care	Improve Condition-Based Quality Care (IP7)	Diabetes: Annual A1C Testing*	<50.05%	≥50.05%	≥92.81%	>95.36%	86.05%	92.18%	78.78%	78.58%	81.50%	78.52%	76.69%	39.34%	78.09%	Aug-16	Pop Health Portal/Other Health Insurance (OHI) REMOVED. December data was run by the PHP in March. Due to claims lag times, these numbers may reflect lower than actual compliance with these measures. •TRICARE Overseas Program has small denominators (most less than 50)
		Imaging for Low Back Pain**	<75.86%	≥75.86%	≥80.24%	>83.21%	76.98%	77.51%	72.71%		72.97%	70.67%	75.37%	79.52%	74.84%	Aug-16	
		Children with Pharyngitis**	<85.20%	≥85.20%	≥89.09%	>92.77%	75.18%	76.60%	72.39%		77.15%	71.82%	66.63%	17.57%	86.39%	Aug-16	
		Children with URI**	<88.63%	≥88.63%	≥92.51%	>95.86%	91.58%	93.58%	85.02%		87.48%	79.57%	89.55%	88.76%	90.14%	Aug-16	
		Provider Communication			91%		87%	86%	87%		88%	87%	86%			Sep-16	Composite of Joint Outpatient Experience Survey-CAHPS MDES-CI questions Q13, Q14, Q16, Q17 regarding how well providers communicate with patients
		Care Coordination			N/A		70%	62%	78%		74%	72%	71%			Sep-16	Composite of Joint Outpatient Experience Survey-CAHPS MDES-CI questions Q15, Q19, Q22, and Q3 regarding providers' use of information to coordinate patient care
		Beneficiary Satisfaction w/online enrollment svc															Measurement TBD. Expect data available Apr 2017.
		ATC Days to Specialty Care (Prime Enrolled)	<70%	70%	80%	90%			70%		65%	76%	59%			Nov-16	Percentage of time that we meet 28 day access standard
		AD Dental Care	<95%		95%	99%			99.50%		N/A	N/A	N/A				Access standard 21 days for routine care, 28 days for specialty care
		Referrals to Non Network				<6%			1.8%		1.8%	2.2%	1.9%			Jul-Sept 2016	% of Prime beneficiaries utilizing non-network providers
Lower Costs	Improve Stewardship (PLS5)		RED		GREEN	BLUE	MHS	DIRECT CARE	MCSC		North	South	West	TOP	DPs		
		PMPM	>2.0% yearly		>0-2.0% yearly	<0% yearly growth	Pending	$359.73 4.54%	$282 3.6%		$275 0.36%	$285 6.7%	$285 3.6%	NA	NA	FY15 %Chg	Data on P4I site doesn't correspond to data shown in the MHS Dashboard.

*HEDIS Measures: No contractual requirement. Have annual incentive payment for improvement in these 6 measures.
**HEDIS Measures without any contract incentives. T2017 requires contractors to monitor and improve on HEDIS measures.
PMPM data is derived from TRO calculated PMPM. % reflects change from FY14 to FY15 avgs.
Annualized performance data derived from 01 April 2014-31 March 2015.

The Purchased Care Dashboard was developed by the TRICARE Health Plan (THP) Enterprise Support Activity Workgroup (WG) to provide a method for determining the value of the services provided by THP to the Services and to our beneficiaries and other stakeholders. The goal was to identify and track important, actionable measures that directly impact on each component of the quadruple aim. Thus the first four measures focus primarily on quality, the next four on beneficiary experience, Active Duty Dental Care on readiness, and the last two on cost of care/efficiency.

To the degree possible, measures were also selected to be benchmarked against civilian data, show performance in both adult and pediatric populations, and allow comparison with the direct care system. Several are also included on the P4I dashboard. The total number of measures was based on ensuring a sufficiently broad approach to allow evaluation of all aspects of the quadruple aim while also limiting the number to that which could be reasonably managed. All of the measures were agreed upon by the Services and DHA.

The Purchased Care Dashboard is used by the WG to monitor the performance of the THP with the goal of continuous improvement. The WG reviews the entire dashboard on a quarterly basis and recommends actions for improvement as needed. Data is updated constantly and can also be discussed as it is received. The dashboard will be shared internally within THP and DHA to guide improvement efforts and to improve transparency. In addition, the dashboard is a "living" tool. The WG may add or remove measures based on sustained high performance or areas of concern that are identified in the future.

The MHS benefits from the dashboard as it is an easily understood tool used to measure purchased care performance in light of the quadruple aim and will drive improvement in areas important to the Services and beneficiaries.

Purchased Care System Future Plans

The MHS has initiated a process to evaluate and execute Value-Based Purchasing (VBP) Health Care Initiatives in purchased care to improve the quality of care and beneficiary experience while reducing cost. TRICARE MCSC contracts have historically been structured to provide purchased care on a fee-for-service reimbursement basis using Diagnosis Related Groups for inpatient stays and a Maximum Allowable Charge rate schedule for outpatient care. By law, purchased care reimbursement must, in most cases, follow Medicare rates.

Recent changes in industry reimbursement methodologies, coupled with the pioneering of VBP initiatives by CMS, prompted the development of section 726 of the NDAA for FY 2016 - Pilot Program on Incentive Programs to Improve Health Care Provided under the TRICARE Program. Section 726 of the NDAA for FY 2016 requires the Department to initiate one or more demonstration projects to determine whether value-based incentives can be used to improve health care quality, enhance beneficiary satisfaction, and reduce the rate of increase in health care spending across the MHS. Successful demonstrations, expected to be implemented in 2017 to meet sections 701, 705 and 729 of the NDAA for FY 2017 requirements, will lead a transition from volume-based to value-based reimbursement with appropriate incentives for clinical quality outcomes, cost efficiency, and patient engagement.

The VBP Health Care Initiative will not be limited to a single pilot or demonstration. Instead, it will incorporate a variety of value-based approaches in multiple markets to gain in-depth knowledge and insight to guide future policy decisions. The VBP Initiative will be divided into a series of near term, midterm, and long term pilot and demonstration projects, which will focus on direct care, purchased care, and integrated care modalities. The current Lower Extremity Joint Replacement Demonstration will incentivize excellence in provider performance since hospitals that are able to reduce costs while maintaining an acceptable level of quality will be eligible for gain-sharing payments. Hospitals not achieving and maintaining an acceptable level of quality will not receive any incentive payments, regardless of whether they achieve cost savings, which maintains the primary emphasis on performance quality. Value-based efforts currently in development will focus on improving outcomes in a number of chronic diseases as well as preserving and improving health.

VI. Other Methods to Improve Patient Experience and Eliminate Variability

This section of the report provides additional examples of how the MHS is improving patient experience in the direct and purchased care systems and will provide information on future plans with projected dates of completion.

Direct Care System

The direct care system has taken a number of additional steps to increase performance consistency and further improve the patient experience.

PCMH Primary Care. The direct care system's PCMH program is consistent with the CMS Comprehensive Primary Care Plus (CPC+) efforts to transform primary care across the United States. Like CPC+, the direct care system's long-standing PCMH strategies include: supporting patients with serious or chronic diseases to achieve their health goals; giving patients 24-hour access to care and health information through secure messaging; delivering preventive care facilitated with embedded national screening guidelines; engaging patients and their families in their own care; and working together with hospitals and other clinicians, including traditional and PCMH-embedded specialists, to provide better coordinated care. Direct care PCMHs also work to maximize the value of each patient visit. For example, if a patient is seen for an acute medical need, the PCMH also addresses needed preventive services, renews medications and meets as many of the patient's other medical needs as possible during the same visit.

In order to further explore what aspects of primary care are associated with high patient satisfaction, the Tri-Service PCMH Advisory Board conducted correlation analysis between MHS core performance measures and patient satisfaction. The results demonstrate there is a strong statistical correlation in the direct care system between high patient satisfaction on all surveys and a high rate of PCM Continuity, a low Average Number of Days to Third Next 24-hour and Future Appointments in primary care and the presence of an MTF ER or UC clinic to provide after-hours care when the PCMH clinics are closed.

The direct care system has introduced a new screening tool which will be used to evaluate each enrollee's health literacy annually. The Single Item Literacy Screener (SILS) is an industry standard method of evaluating a patient's ability to understand medical information and instructions. If the SILS screening demonstrates low health literacy, the PCMH team is alerted to provide additional instructions to the patient in order to improve patient engagement and health outcomes.

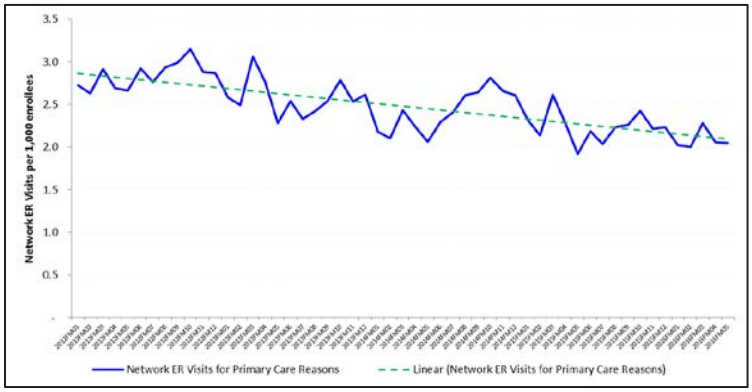
Direct Care Future Plans

Enhanced Access Education. In FY 2017, the direct care system will continue refining stakeholder publicity materials to educate beneficiaries on all enhanced access options such as the NAL, use of virtual phone visits, secure messaging and the many features of the TOL Patient

Portal, including appointment scheduling, email/text appointment reminders and the ability to view test results and prescriptions 24 hours a day.

Further Optimization of Enhanced Access Options in Primary Care. In FY 2017, the direct care system will continue exploring ways to enhance access to care beyond face-to-face visits with a provider by optimizing the use of nurse-run protocols for common acute conditions on a walk-in basis, secure messaging, the NAL, resilience education, and telephone visits. To date, PCMH efforts to enhance access to primary care and reinforce enrollees' relationship with their MTFs have resulted in reduced network ER visits for primary care reasons. Figure 17 depicts the decrease in network ER visits over the last several years as a result of these efforts.

Figure 17: Network ER Visits per 1,000 Enrollees for Primary Care Reasons



Patient Engagement. In order to increase patient convenience, the direct care system plans to leverage MTF leading practices in reducing unnecessary primary care utilization in FY 2017 and FY 2018. Currently, primary care utilization by direct care system non-active duty enrollees is several hundred percent higher than the national average in an insured population. The Tri-Service PCMH Advisory Board is developing standard guidance for patient education on conveniently and safely self-treating minor illness at home with free over the counter medications available from the MTF.

In FY 2017, the Air Force is piloting a number of patient engagement initiatives as part of their "Trusted Care" strategy. A Patient and Family Engagement (PFE) Coordinator Demonstration will be conducted at eight Air Force MTFs. The PFE coordinators will implement standardized and innovative methods to increase patient and family engagement among the MTF enrollee population. Patient safety and patient experience are improved through activated, engaged patients working in partnership with the healthcare team. The Air Force also is developing a publicly accessible Patient and Family Engagement Toolkit, built as a sub-page from the Air Force Medical Service Public website (URL: www.airforcemedicine.af.mil). The toolkit is designed to determine what behaviors and attitudes to promote in the beneficiary population and how to encourage beneficiaries to effectively partner with their healthcare teams. The toolkit will have resources (videos, patient education materials, articles) on how and why to become more engaged in care. If the results of these pilots prove successful, the process will be

considered for expansion across the MHS. The Air Force also has developed an action plan for Patient and Family Partnership Councils to provide MTFs with a formal process to assess and incorporate patient and family values into MTF decision making.

In FY 2017, PEWG will analyze and leverage lessons learned from the Air Force and other Service leading practices and in FY 2018 develop standard processes to ensure MTFs incorporate patient feedback and preferences into the patient experience.

Customer Service Training. The direct care system will finalize development of standard customer service training curricula for all direct care system staff members in FY 2017 and FY 2018. The PEWG will monitor and evaluate patient satisfaction with MTF customer service based on data from the JOES. The MHS also is considering using secret shoppers to provide additional feedback on the patient experience in the direct and purchased care systems.

Virtual Health/Telehealth. In FY 2017, the direct care system will explore plans and funding requirements for three virtual health options to increase convenient care options for the patient: remote health monitoring for select numbers of direct care system enrollees who have Type 2 diabetes; specialty teleconsultations from large, multi-specialty medical centers to more remote locations without direct care specialty care options; and virtual visits using face-to-face video technology.

Direct Access Reporting Tool (DART). In FY 2017, the direct care system will implement the Air Force's DART throughout the direct care system. The DART is a CAC-enabled system within Carepoint, which provides MTF staff members near real-time information on appointment supply and demand. The DART system data will facilitate MTF staff tactical decision making to better meet beneficiary demand for appointments.

Determinants of Patient Satisfaction. The direct care system will continue studying the determinants of high patient satisfaction with the experience of care in FY 2017 and FY 2018 by using the result of the TROSS and the new JOES. All Services and the National Capital Region Medical Directorate will have transitioned to the JOES survey by the beginning of FY 2017. Detailed filters based on patient age, health status and beneficiary category will allow the direct care system to use data from the JOES to identify targeted opportunities for improvement in patient satisfaction and experience.

Purchased Care System

The MCSCs support the patient experience by providing user-friendly state of the art web-sites that are easy to navigate and which include information regarding benefits and programs. To further improve patient experience, some of the MCSCs are now offering a "Chat" feature to their web-site along with a TRICARE app for use by beneficiaries on their smart phones.

Purchased Care System Future Plans

The MHS is making additional changes to the T-17 contracts, which will improve the experience of beneficiaries and eliminate performance variability. A care management liaison will be on-site at each eMSM to facilitate and resolve referral process issues between eMSM MTFs and the MCSC.

Electronic access to case management information will provide information and transparency to MTFs on beneficiaries who are case managed by the MCSC. The dashboard will eliminate confusion or uncertainty on the part of the MTFs and facilitate a faster response to those beneficiaries in need to increased medical oversight and assistance. These changes are expected to be completed in FY 2017 and 2018 as the new MCSCs are implemented across the purchased care system in the 50 United States and the District of Columbia.

Appendix A: Future Plans to Improve Performance and Reduce Variability

Section	Plan/Initiative	Estimated Date of Completion
I. Align performance measures	ADD DoD MTFs inpatient performance data to the CMS Hospital Compare website.	FY 2017
	Continue efforts to align measures between the direct and purchased care systems.	FY 2017 to FY 2018
II. Use of High Technology Services	NAL - Evaluate results of PCM On-Call Pilot for feasibility across direct care.	FY 2017
	NAL - Transition to NAL appointing in MHS Genesis.	FY 2017 to FY 2022
	NAL - Implement Global NAL.	FY 2018
	Secure Messaging - Continue deployment in specialty care.	FY 2017
	Secure Messaging - Add a utilization measure to the MHS Dashboard.	FY 2017
	Secure Messaging - Evaluate pilot results to develop Tri-Service standard processes.	FY 2017
	Patient Portal - Complete Phase 2 redesign of TOL Patient Portal.	FY 2017
	Patient Portal - Transition to MHS Genesis Patient Portal.	FY 2017 to FY 2022
	Expand HIE capabilities between MTFs and purchased care.	FY 2017
	Develop and implement standard MTF smart phone mobile applications.	FY 2017
	Expand use of virtual telephone visits in PCMH and other standard appointing processes in direct care to meet 2017 NDAA Section 709 requirements.	FY 2017
	Pilot telehealth into a patient's home in the purchased care system.	FY 2017 to FY 2018
	Add T-17 contracts requirements for innovative, high technology access and care coordination capabilities in purchased care.	FY 2017
III. Eliminating Performance Variability	Develop and implement additional Tri-Service standard processes based on leading practices to further improve performance and reduce variance and to meet 2017 NDAA Section 709 requirements.	FY 2017 to FY 2018
	Implement TSWF 2.0.	FY 2017
	Develop plans for extended hours PCMH and additional MTF UC fast track clinics to provide after hours care for enrollees, where economically feasible to meet patient demand and 2017 NDAA Section 704 requirements.	FY 2017
	Continue access to care and surgical quality learning Collaboratives with the Institute for Healthcare Improvement (IHI).	FY 2018
	Develop standard access to care training curricula for all direct care system personnel, based on role or duty.	FY 2017
	Codify Tri-Service required access to care processes in standard DoD guidance.	FY 2018
	Optimize specialty care in the direct care system.	FY 2017 to FY 2018
	Develop standard processes to optimize direct care inpatient experience.	FY 2017 to FY 2018
	Expedite the specialty care appointing and referral processes in the direct care system.	FY 2017
	Add quality/safety metrics and standardized reporting requirements to T-17 contracts and purchased care systems.	FY 2017
IV. Collecting and Analyzing Data	Begin transition to MHS Genesis EHR in the direct care system.	FY 2017 to FY 2022
	Implement new T-17 reporting requirements to provide greater visibility network provider quality and safety.	FY 2017
V. Performance Management System	Develop Performance Management Dashboard process improvement capabilities.	FY 2017
	Develop additional purchased care measures and a Purchased Care Dashboard.	FY 2017
	Initiate one or more purchased care value-based demonstration projects as required in 2016 NDAA, Section 726 and 2017 NDAA Sections 701, 705 and 729.	FY 2017

Appendix A: Future Plans to Improve Performance and Reduce Variability (Continued)

Section	Plan/Initiative	Estimated Date of Completion
VI: Other Methods to Improve Patient Experience and Eliminate Variability	Implement stakeholder publicity materials to educate direct care enrollees on all enhanced access options.	FY 2017
	Develop standard Tri-Service processes to reduce unnecessary primary care utilization through patient self-care and resilience education.	FY 2017 to FY 2018
	Optimize Tri-Service standard PCMH processes to enhance access to care beyond face-to-face visits why using nurse-run protocols for common acute conditions on a walk-in basis, secure messaging, the NAL, resilience education and telephone visits.	FY 2017
	Develop standard processes to improve direct care enrollee patient engagement.	FY 2017 to FY 2018
	Develop standard processes to ensure MTFs incorporate patient feedback and preferences into the patient experience	FY 2017 to FY 2018
	Develop standard customer service training curricula for all direct care system personnel, based on role or duty.	FY 2017 to FY 2018
	Explore direct care system telehealth plans and funding requirements.	FY 2017
	Implement the DART supply/demand reporting system across the direct care system.	FY 2017
	Study the determinants of high patient satisfaction with the experience of care in MTFs and identify standard process to improve performance.	FY 2017 to FY 2018
	Implement an on-site care management liaison at each eMSM using T-17 contracts.	FY 2017 to FY 2018
	Implement an electronic dashboard with T-17 contracts to provide MTFs with transparent information on enrollees case managed by the MCSC.	FY 2017 to FY 2018

Appendix B: Direct and Purchased Care Performance Measures

IMR: IMR is the current indicator of the Medical Readiness status of the Force. IMR measures all Service members, officer and enlisted of the Active Component and Selected Reserve in the Army, Navy, Air Force, Marines, and Coast Guard.

Hospital Acquired Infection/ CLABSI: CLABSIs are associated with increased morbidity, mortality, and health care costs. These infections are largely preventable when evidence-based guidelines are followed. The direct care system measures the number of infections per 1,000 device days by quarter in MTF ICUs. ICUs included are Medical, Medical/Surgical, Medical/Surgical Pediatric, and Trauma. The CLABSI data for purchased care hospitals are available on the CMS Hospital Compare website.

URFOs: URFOs are preventable sentinel events (SEs).

NSQIP 30-Day All Case Morbidity Index: This index includes eleven surgical complications. The NSQIP morbidity outcomes are determined for each participating MTF using the American College of Surgeons NSQIP-derived 30-day all case morbidity odds ratio based on patient-level, risk-adjusted observed outcomes compared to expected outcomes.

CAUTI: CAUTIs are associated with increased morbidity, mortality, hospital cost, and length of stay. Many CAUTIs may be prevented with recommended infection control measures. A Standardized Infection Ratio (SIR) is used to measure CAUTIs, allowing DoD and all hospitals to compare the experience among one or more groups of patients to that of a standard population rate. CAUTI SIRs are measured in MTF ICUs; ICUs included are Medical, Medical/Surgical, Medical/Surgical Pediatric, and Trauma. CAUTI data for purchased care hospitals are available on the CMS Hospital Compare website.

Wrong Site Surgery Non-Dental SEs: Wrong Site Surgeries are considered "never events." In other words, they should not occur. The measure is simply the number of surgeries on the wrong site, wrong person or wrong procedure.

All Cause Risk Adjusted Mortality: All Cause Risk Adjusted Mortality measures the inpatient mortality rate to determine if performance is higher, lower or consistent with the expected rate for specific diagnoses and procedures given the risk factors of the patient population. Lapses in quality commonly increase the risk of mortality. Similar data on purchased care hospitals are available on the CMS Hospital Compare website.

Inpatient Satisfaction - Recommend Hospital: Inpatient Satisfaction is measured using TRISS. The TRISS survey uses 11 of the industry-standard HCAHPS questions. A copy of the TRISS survey is in Appendix C. One of the 11 questions asks respondents whether they would recommend this hospital to family and friends and is monitored at the MHS enterprise level. The measure applies to both the direct and purchased care systems and allows meaningful comparisons between military hospitals and across civilian hospitals locally, regionally, or nationally.

Outpatient Overall Satisfaction with Care: The MHS evaluates overall satisfaction with care using Service patient satisfaction surveys and the TROSS. While Service surveys are sent only to beneficiaries who receive care in the direct care system, the TROSS is sent to beneficiaries seen in both the direct care and purchased care systems. The TROSS is a Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAPHS)-based survey. Service surveys have been combined into the JOES for care received in the direct care system and the JOES-Consumer Assessment of Health Providers and Systems for care received in the purchased care system. The JOES tool is provided in Appendix D.

Diabetes Care Index: The Diabetes Care Index consists of two Healthcare Effectiveness Data and Information Set (HEDIS®) measures that indicate appropriate care for diabetic patients ages 18-75. Of these two measures, only one (appropriate screening of long-term blood sugar control) is available from purchased care providers. To address this, the MHS will consider additional performance incentives for indicators of quality as part of a value-based purchasing strategy.

MHS Acute Conditions Composite: The MHS Acute Conditions Composite includes three HEDIS® measures: appropriate use of imaging studies for low back pain; use of antibiotics for upper respiratory infection (URI); and treatment of pharyngitis with antibiotics and use of testing for Streptococcus infection (Strep Test). These three common acute care services have established evidence-based guidelines. This measure indicates MHS adherence to the clinical guidelines which have been shown to improve outcomes and lower costs by eliminating unnecessary treatment or testing. The rate of compliance with the measures is converted to index points based on the HEDIS® national benchmarks. Conditions such as low back pain and acute conditions including URI and pharyngitis are prevalent in the MHS beneficiary population. Measurement of appropriate care for these conditions is important to the MHS because the over use of antibiotics for conditions such as URI and pharyngitis has been directly linked to the prevalence of antibiotic resistance while the overuse of imaging studies unnecessarily exposes patients to radiation.

Cancer Screening Index: The Cancer Screening Index measures direct and purchased care performance on three HEDIS® preventive screening measures: breast cancer; cervical cancer; and colorectal cancer. Improved scores indicate higher rates of appropriate screening that can result in early detection of cancer, reduced healthcare needs, and lower rates of death from cancer. Performance data are a combination of points for performance on each measure, based on HEDIS® national benchmarks. Purchased care system performance data is affected by significant problems in accurate measurement, the potential for care provided at sites we cannot measure or obtain, some beneficiaries with other health insurance receiving screening not paid for by TRICARE and finally, possibly lower documented performance for patients enrolled to a private sector PCM. Thus this data should be considered unreliable for purchased care.

Postpartum Hemorrhage: Postpartum Hemorrhage measures the amount of maternal blood loss at or after delivery. Excessive blood loss can result in harm, suffering, or even death and is therefore an indicator of safe and appropriate care during childbirth.

Vaginal Deliveries with Coded Shoulder Dystocia Linked to Newborns Greater than or Equal to 2500g with Birth Trauma: This measure reflects the proportion of vaginal deliveries with a shoulder dystocia as well as with a coded birth trauma. This measure is one indicator of safe and effective management of maternal and infant care.

HEDIS® Follow-Up after 30 Days of Hospitalization for Mental Illness: HEDIS® Follow-Up of Hospitalization for Mental Illness is an index, which measures both the percent of direct care and purchased care Prime enrollees six years of age and older who were hospitalized for selected mental health disorders and who were subsequently seen on an outpatient basis by a mental health provider within 30 days after their discharge. Follow-up after hospitalization can help ensure gains made during hospitalization are not lost resulting in the need for readmission. The follow-up helps health care providers assess the patient's transition to the home or work environment as well as detect early post-hospitalization reactions or medication problems.

HEDIS® All Cause Readmission: HEDIS® All Cause Readmission measures the number of acute inpatient stays during the year, which were followed by an unplanned acute readmission for any diagnosis within 30 days for members 18 years of age or older. This measure currently applies to the direct care system only and measures a MTF's transition of care performance in hospital discharges. This measure excludes maternal and perinatal care. The direct care system data includes mental health readmissions and military-related social readmissions. A social readmission includes those readmissions where a single, active duty member is living in the barracks without a caregiver and who therefore requires inpatient monitoring.

ORYX Transition of Care Index: The ORYX Transition of Care Index includes four Joint Commission measures: Children's Asthma Home Management Plan Given to Patient/Caregiver; Post Discharge Continuing Care Plan Created for Behavior Health Unit Patients; Post Discharge Continuing Care Plan for Behavior Health Unit Patients Transmitted to Next Level of Care; and Venous Thromboembolism Discharge Instructions Completed. The index currently applies to the direct care system only due to contract limitations on obtaining data; however, the CMS' Hospital Compare website includes measures on timely and effective care for purchased care facilities.

Agency for Healthcare Research and Quality Prevention Quality Indicator Index: The Prevention Quality Indicator Index is a set of measures developed by the Agency for Healthcare Research Quality, which can be used with hospital inpatient discharge data to identify quality of care issues for ambulatory care sensitive conditions. This indicator reflects the rate at which patients with selected chronic illnesses require inpatient hospitalization; better performance is one indicator of success at keeping people with chronic illness from requiring hospitalization.

PCM Continuity: PCM Continuity is measured as the percent of primary care appointments for which a direct care system enrollee is seen by his or her PCM. PCM Continuity is a critical component of the PCMH model of primary care because a continuous relationship between an enrollee and his or her PCM leads to higher quality, more integrated, coordinated and comprehensive care, a more proactive, preventive focus on health, and lower unnecessary

healthcare utilization and reduced healthcare costs. In the direct care system, high PCM continuity is statistically correlated with higher patient satisfaction with access to care, better access to care performance and reduced unnecessary inpatient utilization by enrollees.

Primary Care Leakage: Primary care leakage is the percentage of recapturable primary care workload measured in relative value units (RVUs) delivered outside of the direct care enrollee's MTF. The current methodology includes primary care, UC, and ER care delivered in direct and purchased care. The leakage measure is intended to help assess whether patients have access to timely and convenient care within the direct care system.

Average Number of Days to Third Next 24-Hour Appointments in Primary Care: The average number of days to the third next available 24-hour appointment measure views access prospectively. This industry-standard measure reflects the ability of a clinic to maintain a supply of appointments available within 24 hours for urgent health issues. The direct care system wants to ensure that patients will have at least three appointment options within the MHS Access to Care Standard of 24 hours or less for an urgent issue. In direct care, a low average number of days to third next 24-hour appointments is statistically correlated with higher patient satisfaction, higher PCM continuity, lower leakage to the purchased care system and reduced unnecessary inpatient utilization by enrollees.

Average Number of Days to Third Next Future Appointments in Primary Care: The average number of days to the third next available future appointment measure views access prospectively. This industry-standard measure reflects the ability of a PCMH to maintain availability of appointments for routine, non-urgent health issues. The direct care system wants to ensure that patients will have at least three appointment options within the MHS Access to Care Standard of seven days or less for a routine for follow-up medical issue. In direct care, a low average number of days to third next future appointments is statistically correlated with higher patient satisfaction, higher PCM continuity, lower leakage to the purchased care system and reduced unnecessary inpatient utilization by enrollees.

Percent of Direct Care Enrollees Registered For Secure Messaging: The direct care system has fully implemented secure messaging in approximately 440 PCMH primary care clinics; implementation currently is underway in specialty care. Secure messaging allows registered direct care system enrollees to email their healthcare teams 24 hours a day, 7 days a week. The direct care response time goal is one business day. Secure messaging provides enhanced, virtual access to care and medical advice.

Outpatient Satisfaction with Getting Needed Care: The MHS evaluates satisfaction with access to care or "getting care when needed" from Service patient satisfaction surveys and the TROSS. While Service surveys are sent only to beneficiaries who receive care in the direct care system, the TROSS is sent to beneficiaries seen in both the direct care and purchased care systems. The TROSS is a CG-CAHPS-based survey. The survey questions evaluated measure the percent of patients who respond favorably to "In general, I am able to see my provider when needed." Service surveys have been combined into the JOES.

PMPM: PMPM costs measure the total health care cost for Prime enrollees in both the direct and purchased care systems. The measure directly links costs to patients, providing an actionable measure to allow the MHS to identify cost drivers and reduce costs. Enrollee costs are a combination of unit of care costs multiplied by utilization. Prime enrollees, especially those enrolled to the direct care system, have utilization rates several hundred percent higher than the national average in an insured population, despite relatively low acuity. The primary cost diver in the direct care system is high utilization by enrollees. As discussed in Chapter 6 of this report, average primary and specialty care utilization by non-active duty enrollees in the direct care system is several hundred percent higher than the national average in an insured population as reported by the CDC.

Total Purchased Care Cost: Total Purchased Care Cost measures claims paid to the purchased care sector that could potentially be reduced through recapture to the direct care system. The total purchased care cost measure does not include pharmacy costs, which are captured in another measure. Total purchased care costs utilize FY 2012 expenditures as a baseline for targeted cost reduction efforts.

Private Sector Care Cost per Prime Enrollee: Total Private Sector Care Cost per Prime Enrollee is a sub-set of the PMPM performance measure discussed above. The measure links the claims costs paid for Prime patients in the purchased care network and provides a means to measure and reduce purchased care cost expenses. It includes both purchased care costs for direct care enrollees seen in the network and costs for all network enrolled Prime. Total costs are a combination of healthcare utilization by enrollees multiplied by the cost for each episode of care paid by the government.

Total Enrollment: Total Enrollment measures the number of Prime enrollees in both the direct and purchased care systems and includes Prime, Active Duty Reliant in the Navy and TRICARE Plus beneficiaries. The goal is to grow Prime enrollment in the direct care system when appropriate; however, based on specific patient needs, at times, it may be more clinically appropriate to enroll patients to the purchased care system. Enrollment growth is balanced against the ability to provide quality, safe care within MHS access standards.

Pharmacy Percent Retail Spent: Pharmacy Percent Retail Spend measures the percent of total pharmacy costs that are spent in the retail sector. This rate is measured to provide actionable information to direct care MTFs in their efforts to recapturable pharmacy workload to MTF pharmacies or to the Mail Order Pharmacy program. The measure is calculated by dividing the percent of pharmacy costs spent in the retail sector by total pharmacy expenditures.

Productivity Targets: The MHS Productivity Target measures specialty workload targets measured in RVUs. The targets were set using benchmarks established by the Medical Group Management Association (MGMA). The MHS has set a goal of achieving 40 percent of the MGMA median by FY 2018. The targets are Service and specialty specific.

Measures Under Development

The following measures are under development. Each measure is briefly described below. In addition, the current status and expected implementation dates are provided.

Ready Medical Force: Two Ready Medical Force performance measures are in development. These measures will address the readiness of the military medical force and will address clinical competency. These measures will apply to the direct care system only. Once agreement is reached, the MHS will identify a data source and calculate a baseline level of performance. Performance goals and thresholds will be determined and approved through governance. The final measures are expected to be available in FY 2018.

HRQOL: The HRQOL measures patient-reported outcomes based on answers to questions developed by the CDC to measure physical, mental, emotional, and social functioning. Because patient responses to these questions are affected not only by health risks and conditions but by the respondents' functional status, social support and especially by their socioeconomic status, the data will require the MHS to partner with the Line, military installations and other communities to address HRQOL issues. The HRQOL includes four questions depicted in Figure 18. The MHS approved this measure in FY 2016. Responses to the four questions will be combined into the HRQOL Index. The questions were added in mid-FY 2016 to the Healthcare Related Survey of DoD Beneficiaries, which is sent out randomly to beneficiaries and achieves an average 14 percent response rate. The first data are expected to be available in early FY 2017. Once a baseline is established, the MHS will approve a performance goal and thresholds. This measure is expected to be complete in FY 2017.

Figure 18: HROQL Questions

1. Would you say that in general your health is excellent, very good, good, fair or poor?
2. Now thinking about your physical health, which includes physical illness and injury, how many days during the past 30 days was your physical health not good?
3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your mental health not good?
4. During the past 30 days, approximately how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

Enrollment per PCM: The Enrollment per PCM measure currently is under development. The goal is to measure how many enrollees are empaneled to each PCM; the goal is 1,100 enrollees per PCM, which is based on the number of duty days per year and 21 encounters per PCM per day divided by the average utilization rate of 4.1 primary care visits per enrollee per year. The MHS also has identified 10 major challenges, which must be resolved before data can be accurately calculated across the direct care system. Since TRICARE beneficiaries usually make

up a relatively small percentage of most civilian provider's patients, this measure is not applicable to purchased care.

Operating Room (OR) Utilization: A measure is under development to identify and subsequently maximize OR utilization. Efficient use of ORs is associated with the increased ability to reduce private sector care costs by recapturing surgical workload from the private sector, thereby reducing private sector deferrals from the direct care system. The OR Utilization measure has been approved by MHS governance and will have three components: Caseload (the number of surgical cases performed per staffed OR at an MTF); Performance (the percentage that compares the number of minutes a patient is in the OR in a 24-hour period to the number of staffed minutes of OR time available in an 8-hour workday); and Turnover Time (time interval between the previous patient leaving the OR to the next patient entering the OR). This measure is expected to be complete in FY 2017.

Future Direct and Purchased Care Performance Measure Alignment

Eleven of the 34 approved MHS core performance measures discussed above apply to both the direct and purchased care systems. The MHS currently incentivizes performance in the purchased care system on MHS Core HEDIS® measures: Breast Cancer Screening, Colon Cancer Screening, Cervical Cancer Screening, Blood Sugar (HbA1c) Screening, Behavioral Health Follow-Up after 30 Days of Hospitalization for Mental Illness and Well Child Visits in the first 15 months. All MHS core measures are not able to be applied to the purchased care system because performance data cannot be obtained; examples include blood sugar lab values, discussed in the Diabetes Index section of this chapter. To supplement the 11 measures in common between the direct and purchased care system, the MHS is identifying additional purchased care system measures; these measures will align with MHS core measures when appropriate in support to the Quadruple Aim. These purchased care system measures will be reported on a purchased care system dashboard, once approved by MHS governance. Efforts will continue in FY 2017 to align direct and purchased care data as well as to align with standard industry measures.

Appendix C: SECTION 730 – REPORT ON PLANS TO IMPROVE EXPERIENCE WITH AND ELIMINATE PERFORMANCE VARIABILITY OF HEALTH CARE PROVIDED BY THE DOD

(a) COMPREHENSIVE REPORT.—
(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives a comprehensive report setting forth the current and future plans of the Secretary, with estimated dates of completion, to carry out the following:
(A) To improve the experience of beneficiaries with health care provided in military medical treatment facilities and through purchased care.
(B) To eliminate performance variability with respect to the provision of such health care.
(2) ELEMENTS.—The comprehensive report under paragraph (1) shall include the plans of the Secretary of Defense, in consultation with the Secretaries of the military departments, as follows:
(A) To align performance measures for health care provided in military medical treatment facilities with performance measures for health care provided through purchased care.
(B) To improve performance in the provision of health care by the Department of Defense by eliminating performance variability with respect to the provision of health care in military medical treatment facilities and through purchased care.
(C) To use innovative, high-technology services to improve access to care, coordination of care, and the experience of care in military medical treatment facilities and through purchased care.
(D) To collect and analyze data throughout the Department with respect to health care provided in military medical treatment facilities and through purchased care to improve the quality of such care, patient safety, and patient satisfaction.
(E) To develop a performance management system, including by adoption of common measures for access to care, quality of care, safety, and patient satisfaction that holds medical leadership throughout the Department accountable for sustained improvement of performance.
(F) To use such other methods as the Secretary considers appropriate to improve the experience of beneficiaries with and eliminate performance variability with respect to health care received from the Department.

Appendix D: Glossary

Acronym	Term
AHLTA	Armed Forces Longitudinal Health Application
App(s)	Application(s)
CAC	Common Access Card
CAUTI	Catheter Associated Urinary Tract Infection
CDC	Centers for Disease Control
CG-CAHPS	Clinician and Consumer Group Assessment of Healthcare Providers and Systems
CLABSI	Central Line-Acquired Bloodstream Infection
CMS	Center for Medicare and Medicaid
CORHIO	Colorado Regional Health Information Organization
CPC+	Comprehensive Primary Care Plus
CPG	Clinical Practice Guideline
DART	Direct Access Reporting Tool
DHA	Defense Health Agency
DoD	Department of Defense
ECHO®	Extension for Community Healthcare Options
EHR	Electronic Health Record
eMSM	Enhanced Multi-Service Market
ER	Emergency Room
FY	Fiscal Year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HEDIS®	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HRQOL	Healthcare Related Quality of Life
ICU	Intensive Care Unit
IHI	Institute for Healthcare Improvement
IMR	Individual Medical Readiness
JOES	Joint Outpatient Experience Survey
MCSC	Managed Care Support Contractor
MGMA	Medical Group Management Association
MHS	Military Health System
MM	Medical Management
MTF	Medical Treatment Facility
NAL	Nurse Advice Line
NAVMED-E	Navy Medicine East
NCQA	National Committee for Quality Assurance
NDAA	National Defense Authorization Act

Acronym	Term
NH	Naval Hospital
NSQIP	National Surgical Quality Improvement Program
OR	Operating Room
P4I	Partnership for Improvement
PCM	Primary Care Manager
PCMH	Patient Centered Medical Home
PEWG	Patient Experience Working Group
PFE	Patient and Family Engagement
PMPM	Per Member Per Month
RN	Registered Nurse
RVUs	Relative Value Units
SE	Sentinel Event
SILS	Single Item Literacy Screener
SIR	Standardized Infection Ratio
T-17	TRICARE 2017
THP	TRICARE Health Plan
TOL	TRICARE On-Line
TRISS	TRICARE Inpatient Satisfaction Survey
TROSS	TRICARE Outpatient Satisfaction Survey
TSWF	Tri-Service Workflow
UC	Urgent Care
UM	Utilization Management
URFOs	Unintended Retained Foreign Objects
URI	Upper Respiratory Infection
VBP	Value-Based Purchasing
WG	Workgroup