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

Naval Branch Health Clinic (NBHC) Belle Chasse
Volume I

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

Executive Summary

Site	Naval Branch Health Clinic (NBHC) Belle Chasse
Decision	Transition Naval Branch Health Clinic Belle Chasse outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). Active Duty Family Members (ADFM) will be enrolled as necessary to round out the physician panels and maintain readiness. All base support functions and pharmacy workload supporting all beneficiaries will be maintained.

Background and Context

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

Base Mission Summary

Naval Air Station (NAS) Joint Reserve Base (JRB) New Orleans is one (1) of two (2) Joint Reserve Bases in the country that serves and houses commands from various branches of the Armed Services. NAS JRB New Orleans currently supports two (2) Naval Air Reserve Squadrons, two (2) Marine Forces Reserve units, a Coast Guard Air Station, a Louisiana Air National Guard fighter wing, an Army Reserve unit, a Fleet Readiness Center, a Navy Reserve Operational Support Center, and other support units. Nearly 5,400 military, Department of Defense (DoD) civilian employees and contractors work at the base daily, and approximately 1,700 family members live in more than 900 housing units. The Public Private Venture housing complex, operated by Patrician Military Housing, is one of the most successful ventures of its type in the country. NAS JRB is also home to the first ever charter school on a military installation, Belle Chasse Academy.

Criteria Matrix

Criteria	Rating or Value[1]	Key Takeaways or Findings	Use Case Package
Mission Impact	L	• NBHC Belle Chasse provides readiness value through care for drilling/training units and Active Duty units, along with providing care at the Reserve/Guard medical drilling location • NBHC Belle Chasse is the sole MTF providing medical support for Navy/Air National Guard drill weekend. The Army National Guard is interested in using NBHC Belle Chasse which would result in 300 additional cases a year • For NAS JRB, providing AD, reserve, and training units their physicals/exams and / or acute care is a priority, with exams and follow-ups taken care of in an expedited fashion reducing impact to drilling and training time. Readiness care for AD and activated and drilling reserves (drill sheets, line of duty) are first priority and generally seen the same day (critical for drill weekends) • AD Family Member care is important to the base mission. Receiving care off base is seen as an additional stressor (especially if they live on-base). Many families are junior enlisted and may have only one (1) or no car. NBHC Belle Chasse is expanding Child/Youth Program in the population served and having easy access to that care is critical to reduce stress on already-stressed families	Section 1.0
Network Assessment	M	• Belle Chasse is near New Orleans, LA and has a robust Primary Care network with 240 Primary Care Practices, which account for 363 Primary Care Physicians (not limited to TRICARE), in the facility's 30-minute drive-time radius • Enrollment of additional beneficiaries to the network would depend on Managed Care Support Contractor (MCSC) network expansion and potentially the entry of additional physicians into the market • The independent government assessment found that the market may be challenged to service the incremental demand without new entrants • Base Leadership has expressed concerns in the network's ability to provide Primary Care service near the MTF with only two (2) Primary Care Managers (PCMs) within a 15-minute driving distance • Marine Corps Forces Reserve (MARFORRES) must address readiness gaps/Individual Medical Readiness issues for reserve component, even when they're not on-base. There is a reporting	Section 2.0

[1] See Appendix B for Criteria Ratings Definition

		burden to review records prior to deployment, especially when some network care is not captured in the record • MTF Leadership has cited issues with the TRICARE referral process where network providers are not accepting new patients, or no longer accepting TRICARE beneficiaries. For New Orleans, providers are already doing a lot of low/no-cost care for indigent population, and they may be hesitant to take on another low-rate payer (despite speed and consistency of payment)	

Risk / Concerns and Mitigating Strategies

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

	Risk/Concerns	Mitigating Strategy
1	Families with single cars (i.e., one mode of transportation) could lead to extended time away from duty for Active Duty Service Members (ADSM)	• The installation and MTF should coordinate to develop alternative modes of transportation for ADSM dependents
2	The patients' change in expectations from getting care at the MTF to getting care off the base will have to be monitored and managed	• The risk will be mitigated through the implementation and communication plan as well as care coordination
3	The pace at which the network can absorb new enrollees into Primary Care is unknown. There will be an adjustment period for the network, and it may experience challenges sustaining adequacy until new entrants enter the market	• Transition patients to the network in a measured way that is tailored to their specific needs. MCSC/THP and the MTF will monitor progress to identify access or supply issues and address any issues by slowing down the transition as necessary
4	Potential loss of unscheduled ADSM work hours due to acute healthcare needs of dependents and transportation limits (i.e. one mode of transportation)	• The installation and MTF should consider developing alternative modes of transportation for ADSM dependents. As Defense Health Program funding is not authorized currently for local non- emergent healthcare transportation innovative solutions should be explored • The DHA Market Manager should take lead on partnering with network providers to use available clinic space to provide acute care services for ADSM dependents and other healthcare services as necessary for a sustainable practice.

Next Step

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

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

Naval Air Station (NAS) Joint Reserve Base (JRB) New Orleans is one (1) of two (2) Joint Reserve Bases in the country that serve and house commands from various branches of the Armed Services. NAS JRB New Orleans currently supports two Naval Air Reserve Squadrons, two Marine Forces Reserve units, a Coast Guard Air Station, a Louisiana Air National Guard fighter wing, an Army Reserve unit, a Fleet Readiness Center, a Navy Reserve Operational Support Center, and other support units. Nearly 5,400 military, Department of Defense civilian employees and contractors work at the base daily, and approximately 1,700 family members live in more than 900 housing units. The Public-Private Venture housing complex, operated by Patrician Military Housing, is one of the most successful ventures of its type in the country. NAS JRB is also home to the first ever charter school on a military installation, Belle Chasse Academy.

1.1. Installation Description

Name	Naval Air Station (NAS) Joint Reserve Base (JRB) New Orleans
Location	Belle Chasse, Louisiana; Plaquemines Parish, approximately 13 miles from New Orleans, Louisiana
Tenants	159th Louisiana Air National Guard, Coast Guard Air Station, Marine Air Group-49, Fleet Readiness Center Mid- Atlantic Det. New Orleans, Regional Legal Service, Navy Operational Support Center, 377th Theater Sustainment Command, Strike Fighter Squadron-204, Fleet Support Squadron-54, Navy Munitions Command (NMCLANT) Det. New Orleans, Navy Reserve Professional Development Center, Navy Talent Acquisition Group (NTAG) New Orleans, Marine Transport Squadron (VMR) Belle Chasse, Military Entrance Processing Station, Joint Reserve Intelligence Center New Orleans, Navy Air Logistics Office
Mission Description	NAS JRB New Orleans provides a high-quality operational environment for AD and reserve components of all branches of the armed Services; to reduce redundancy and overhead by developing joint doctrine and operating procedures that create seamless functionality among host and tenant commands in base support and community service programs.
Regional Readiness / Emergency Management	NAS JRB New Orleans is the premiere training detachment facility in the Central Gulf Coast Region. Its proximity to both over-water and over-land training areas is unsurpassed. NAS JRB provides newly renovated hangar space for all squadron personnel; large ramp areas; tenant aircraft support (F/A-18 and F-15); TACTS auditorium (coming soon); Moral, Welfare, and Recreation facilities, equipment and events; and of course, those world- renowned New Orleans attractions.
Base Active or Proposed Facility Projects	Unknown
Medical Capabilities and Base Mission Requirements	Required Capabilities: • Behavioral Health • Primary Care • Laboratory • Immunizations • Dental Procedures • Physical Therapy • Optometry • Audiograms NBHC supports 44 units associated with the installation. It is the sole MTF locally for Navy and Air Guard drill weekend support.

1.1. MTF Description

Name	Naval Branch Health Clinic (NBHC) Belle Chasse
Location	Belle Chasse, Louisiana; Plaquemines Parish County approximately 13 miles from New Orleans, Louisiana
Market[2]	Small Market and Stand Alone
Mission Description	Deliver high-quality health care to ensure a medically ready force and a ready medical force through strategic partnerships and innovation
Vision Description	To be the health system of readiness and excellence for America's heroes, past and present, and their families

[2] Defined by FY17 NDAA Section 702 Transition

Facility Type	Outpatient facility
Square Footage	43,700 Square Feet (1,200 Square Feet Marine Corps Security Force Regiment Annex)
Deployable Medical Teams	Unknown
Operating Target Fund[3]	$12M
MTF Active or Proposed Facility Projects	Unknown
Performance Metrics	See Volume II Part E for Partnership 4 Improvement (P4I) measures and Part F for Joint Outpatient Experience Survey data.

FY18 Assigned Full-time Equivalents (FTEs)[4]

	Active Duty	Civilian	Contractor	Total
Medical	79.1	17.6	2.8	**99.5**

Healthcare Services

- Primary Care
- Dental (Active Duty (AD) Only)
- Optometry
- Physical Therapy
- Mental Health
- Aviation Medicine
- Occupational Health (for 3,196 personnel & site visits*)
- Audio Booth
- Health Promotion
- Health Benefits
- Registered Nurse Case Manager
- Immunizations
- Lab (Waived Testing & Mail Out)
- Plain Film X-ray
- Medical Records
- Physical Evaluation Boards Limited Duty Coordination

Network Considerations

- Base Leadership has expressed concerns in the networks ability to provide Primary Care service near the MTF with only two (2) PCMs within a 15-minute driving distance
- Marine Corps Forces Reserve (MARFORRES) must address readiness gaps/Individual Medical Readiness issues for reserve component, even when they're not on-base. There is a reporting burden to review records prior to deployment, especially when some network care is not captured in the record
- MTF Leadership has cited issues with the TRICARE referral process where network providers are not accepting new patients, or no longer accepting TRICARE beneficiaries. In New Orleans providers are already doing a lot of low/no-cost care for indigent population, and they may be hesitant to take on another low-rate payer (despite speed and consistency of payment)

Projected Workforce Impact

Active Duty	Civilian	Total
15	7	**22**

[3] Volume II Part I: MTF Mission Brief
[4] MTF Portfolio

2.0. Healthcare Market Surrounding the MTF

Description	The Primary Care market analysis for NBHC Belle Chasse, located in Belle Chasse, Louisiana includes 98 zip codes, two (2) complete counties (Orleans, St. Bernard), and four (4) partial counties (Jefferson, Lafourche, Plaquemines, St. Charles). Within NBHC Belle Chasse Johnson drive-time standard, there are currently 240 Primary Care Practices, which account for 363 Primary Care Physicians (not limited to TRICARE).
Top Hospital Alignment	• East Jefferson General Hospital (Metairie, Louisiana) • Ochsner Medical Center Jefferson Highway (Jefferson, Louisiana) • Children's Hospital (New Orleans, Louisiana) • Touro Infirmary (New Orleans, Louisiana) • West Jefferson Medical Center (Marrero, Louisiana)
Likelihood of Offering Primary Care Services to TRICARE Members[5]	

	Number of Practices	Number of Physicians
Contracted with TRICARE	108	149
High Likelihood	22	11
Medium Likelihood	82	173
Low Likelihood	28	30
Total	**240**	**363**

2.1. TRICARE Health Plan Network Assessment Summary

Facts:

- Belle Chasse, Louisiana (New Orleans) has a market area population of approximately 1.4M[6]
- NBHC Belle Chasse offers Primary Care, Mental Health, Optometry, and Physical Therapy
- NBHC Belle Chasse HC has 2,910[7] non-AD enrollees who could enroll to the network
- Managed Care Support Contractor (MCSC) has contracted 190[8] of 363[9] (52%) PCPs within a 15-mile radius of the MTF. Only 188 of the 190 are accepting new patients
- Rolling 12-month JOES-C scores ending October 2018 with a "health care rating" scored as a nine (9) or 10 on a scale of 0-10:
  - NBHC Belle Chasse patients: 61.4% (21 respondents)
  - Network patients: 69.0% (216 respondents)
- TRICARE Prime Out-of-Pocket Costs for Retirees and their family members[10]
  - Preventive Care Visit: $0
  - Primary Care Outpatient Visit: $20
  - Specialty Care Outpatient or Urgent Care Center Visit: $30
  - Emergency Room Visit: $61
- TRICARE Prime enrollees should expect to drive no more than:
  - 30 minutes to a PCM for Primary Care
  - 60 minutes for Specialty Care

Assumptions:

- MCSC could contract an additional 50% of the existing non-network PCPs
- The average PCP panel is approximately 2000[11]
- PCPs generally have relatively full panels, able to immediately enroll:
  - Up to 2.5% more enrollees (49) easily
  - 2.5% - 5% (50-99) with moderate difficulty

[5] Contracted with TRICARE: Providers are currently contracted to provide services to TRICARE beneficiaries; High Likelihood: Providers are connected to organizations currently providing services to TRICARE beneficiaries; Medium Likelihood: Providers are accepting Medicare and/or Medicaid; Low Likelihood: Providers are neither providing Medicare nor Medicaid
[6] Network Insight Assessment Summary (Independent Government Assessment)
[7] M2
[8] MCSC
[9] Network Insight Assessment Summary (Independent Government Assessment)
[10] http://www.TRICARE.mil/costs
[11] MGMA

    - > 5% (100+) with great difficulty
- Rural networks will grow more slowly than metropolitan networks to accommodate demand

Analysis:

- Belle Chasse is near New Orleans, LA and has a currently robust Primary Care network
- Enrollment of additional beneficiaries to the network would depend on MCSC network expansion and potentially the entry of additional physicians into the market
- If MCSC contracts 50% of the non-network PCPs, they would have a total of 275 PCPs accepting new patients
- Each PCP would have to enroll 11 new patients to accommodate the 2,910 NBHC Belle Chasse enrollees
- Based on the assumptions above, the MCSC network could easily expand to meet the new demand
- There are 11 network facilities within drive time of NBHC Belle Chasse that offer like services (Specialty Care) currently provided by the MTF with more than adequate access to care
- Beneficiaries rate network health care 8% higher than NBHC Belle Chasse healthcare, so beneficiary satisfaction is not likely to suffer with network enrollment
- Network enrolled Retirees and their family members will have higher out-of-pocket costs than MTF enrollees
- On base non-AD residents will have to travel farther for Primary Care if enrolled to the network

Implementation Risks:

-
- Retirees and their family members may seek less Primary Care due to out-of-pocket costs (+/-)

2.2. Network Insight Assessment Summary (Independent Government Assessment)

Facts

- **Primary Care:** The MHS impacted population for Primary Care is more than 2,800; 99% are represented within the 30-minute drive- time radius for Primary Care, concentrated around the MTF location. The population growth was 9.1% over the last five (5) years (2014 to 2018) and is projected to level out at 3.0% over the next five (5) years (2019-2023). This level of growth coupled with the influx of MHS beneficiaries will result in increased demands for PCPs in NBHC Belle Chasse's market area
- **Specialty Care:** The MHS impacted population for Specialty Care is more than 10,000; 100% are represented within the 60-minute drive-time radius for Specialty Care, concentrated around the MTF location. The population growth in the 60-minute drive-time boundary was 7.4% over the last five (5) years (2014 to 2018) and is projected to level out at a moderate 3.0% growth for the next five (5) years (2019-2023). The supply of Psychiatry providers is expected to surge to meet demand and may allow the commercial network to sustain the ability to service incremental demand over time
- The potential impact of new MHS Beneficiaries on the total population is well below the 10% threshold for both population groups and thus will not materially impact supply and demand of services in the market

Assumptions

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

Analysis:

- **Primary Care:** The area is expecting a significant increase in demand for General / Family Practice services over the next five (5) years attributable to a combination of population growth and shift to value-based care. There are expected shortage of General/Family practices that can be offset by observed surpluses in Internal Medicine and Primary care, however, the commercial Primary Care network may be challenged to sustain adequacy over time when faced with an incremental demand from impacted MHS beneficiaries. This is particularly given the projected market shifts to value-based care and increased Primary Care provider usage
- **Specialty Care:** Commercial Psychiatry providers could potentially absorb the incremental demand from beneficiaries who are being transitioned out of the MTF. With projected surpluses of providers, the network should maintain this level of adequacy over time

3.0. Appendices

Appendix A	Use Case Assumptions
Appendix B	Criteria Ratings Definition
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Appendix E	MTF Trip Report

Appendix A: Use Case Assumptions

General Use Case Assumptions

1. Population impact that is greater than 10% of total population will impact the supply and demand of the provider network market
2. There will be no change in the TRICARE benefit to accommodate decisions
3. Readiness requirements for the final decision will be addressed in the Service Quadruple Aim Performance Plan (QPP)
4. There will be no changes to the existing Managed Care Support Contract (MCSC)
5. The MCSC could contract an additional 50% of the existing non-network Primary Care Providers (PCPs)
6. The average PCP panel is approximately 2000[12]

[12] MGMA

Appendix B: Criteria Ratings Definition

Criteria Ratings Definition

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

Appendix C: Glossary

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

Appendix D: Volume II Contents

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Part C	TRICARE Health Plan Network Review
Part D	Network Insight Assessment Summary (Independent Government Assessment) P4I
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Part F	JOES-C 12-month Rolling Data
Part G	Base Mission Brief
Part H	MTF Mission Brief
Part I	MTF Portfolio (Full)

Appendix E: MTF Trip Report

MHS Section 703 Workgroup Site Visit Trip Report

Naval Branch Health Clinic (NBHC) Belle Chasse – Naval Air Station (NAS) Joint Reserve Base (JRB) New Orleans, Belle Chasse, Louisiana

11 April 2019

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Purpose of the Visit:

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

Summary of Site Visit

Overall:

- NHBC Belle Chasse provides readiness value through care for drilling/training units and active duty, along with providing Reserve/Guard medical drilling location
- The MCSF Annex provides care 3 days/week to the ~1,000 uniforms at that facility, saving man-hours due to decreased travel time (resulting in a 19% increase in IMR since opening in 2016)

Base/Mission Impact:

- For NAS JRB, getting AD, reserve and training units their physicals/exams or and acute care and follow-up taken care of ASAP to get them back to duty (critical for drill weekends)
- For MCSF New Orleans, maintaining or expanding 3 days of clinic operation to meet readiness needs while avoiding lost man-hours due to travel to Belle Chasse

MTF Impact:

- Readiness care for AD and activated and drilling reserves (drill sheets, line of duty) are first priority and generally seen the same day
- A decrease in service to a troop-only clinic may adversely impact case management currently handled by the MTF

Network Impact:

- Network care, especially Specialty care in New Orleans, seen as high-quality overall
- Distance concerns differ significantly for on-base families at NAS JRB New Orleans compared to those around MCSF New Orleans
- Primary care for ADFM and Retirees, seen as a required benefit, will be difficult to push across the Belle Chasse drawbridge for those on or near the base (only two network PCMs in Belle Chasse)

Summary of MTF Leadership Discussion

List of Attendees

The following were in attendance during the MTF Leadership discussion:

Name	Title	Affiliation
CAPT Amy Branstetter	NHP, Commander	USN
CDR Phillip Boyer	NBHC Belle Chasse, OIC	USN
CDR Matthew Chang	NHP, Director, Branch Clinics	USN
HMCS Michell Hopson	NBHC Belle Chasse, SEL	USN
HMCM Omar Azmitia	NHP, SEL, Branch Clinics	USN
CAPT Christine Dorr	BUMED M3	703 Workgroup
CDR Tim Barnes	Deputy Chief of Staff, M3 Navy Medicine East	703 Workgroup
Dr. Mark Hamilton	Program Analyst, DOD Medical Reform Team	703 Workgroup
Dr. Kimberlyn Ard	Business Operations Specialist, TRICARE Health Plan	THP
Mr. Michael Mathias	Contract Support	703 Workgroup

Summary of MTF Leadership Discussion Agenda

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

MTF Medical Mission Overview:

- MTF Mission: Deliver high quality health care to ensure a medically ready force and a ready medical force through strategic partnerships and innovation
- MTF Vision: To be the health system of readiness and excellence for America's heroes, past and present, and their families
- Naval Branch Health Clinic (NBHC) Belle Chasse is an outpatient facility with 52,372 outpatient encounters in FY2018 (including the Annex), across primary care, behavioral health, dental, physical therapy, optometry, immunizations, and audiology. The staff include 68 enlisted, 12 officers, 20 GS Civilians, and 4 Contract FTEs

Voice of the Customer Summary:

- Facilities: three former facilities collapsed into Naval Air Station (NAS) in 2010, with a $16.9M renovation from 2007-2010
    - Main Clinic – 42,500 sq ft
    - Veterinary Clinic (NBHC staff supports facilities/IT) -1,995 sq ft
    - Marine Corps Support Facility (MCSF) Annex is a Class 500 building (1,200 sq. ft hallway in building) for garrison care with 3 exam rooms, dental exams, immunization (no shot storage), lab draw station and audio booth. It opened in January 2016 and sees patients 3 days/week. The clinic is estimated to return 2500 man-hours / year by having medical care at Marines'/Sailors' worksite
- Medical Care/Product Lines:
        - Active Duty and drilling/activated reserve (drill sheet/line of duty) patient care is the top priority, and are seen same-day, Aerospace Medicine workload is included in Medical Homeport metrics.
    - Retiree vs ADFM Care (seen as two different missions – ADFM seen as part of readiness for sailor/marine)
    - Behavioral/Mental Health – losing psychiatrist, looking to set up tele-behavioral health with NME

        - 3rd Next Available for initial Mental Health is 18 days (vs 45.3 days in network)
        - Losing this capability could impact Force Mental Health
    - Occupational Health – no occupational health doctor/LIP, but Primary Care providers cover the Occupational Health Clinic examinations with the help of the Certified Occ Health RN
    - Women's Health
        - Focus Group research (pending IRB) – access to care barriers are different for women, personal space barriers mean in-unit care can be problematic. Having access to separate Women's Health can lead to better utilization of care and improved IMR for the female population
    - Case Management – Service Asset (GS/AD) committed to the culture
        - Case management used on hospital ships/humanitarian mission
- Mission Care: Prioritizing drill weekends for medical care for reservists, line of duty care, and other unit- required care
    - NBHC Belle Chasse is the sole MTF locally for Navy/Air National Guard drill weekend medical support. The Army National Guard interested in using NBHC Belle Chasse (300 cases/year), which will add another mission requirement. The MTF saw 5,626 must-see visits (non-enrolled) in FY18 – 3,986 specialty cases (a lot of PT), 1,640 primary care cases
        - Skills Sustainment – 2 MOUs in works, support agreement with Air Guard, TAD to NHP, and the MTF also hosts TCCC Instructor training site for all NBHC personnel as well as 40 local requestors
- Impacts of moving to Troop only clinic:
    - Primary Care – there's a need to determine what a rounded panel looks like to maintain skills, which are currently being balanced by Individual Burden of Illness (IBI) score. Business rules around panels for the new Troop clinic paradigm need to be determined, with some flexibility for provider preference (some may want to see OB/GYN, some not)
        - On-base families – dependents on base with only one car, only two primary care PCMs in Belle Chasse – will increase in drive time for Primary Care
    - Pharmacy – heavy usage by retirees/TFL to account for
    - Care coordination/case management has been more difficult when the network is involved
        - Clear and Legible Report system is broken/not functioning properly and effectively
    - Urgent Care Center Pilot (off-base)
        - Issues with continuity, and people will wait in the NBHC lobby to be seen, even with urgent cases
- Network Adequacy:
    - Network issues following Katrina were significant, but capacity has been building back up. Anecdotally, some quality issues persist despite the resurgence of New Orleans and the surrounding areas
    - Network distance is reasonable for specialty care – people are willing to drive for the best care (Tulane, LSU, Ochsner). However, there is expected to be some difficulty for beneficiaries to accept driving across the bridge for primary care, where the drawbridge can unexpectedly add 15-20 minutes to travel

Summary of NAS JRB New Orleans Leadership Discussion

List of Attendees

The following were in attendance during the NAS JRB Leadership discussion:

Name	Title	Affiliation
CAPT Anthony Scarpino	NAS JRB NOLA CO	USN
CDR Robert Barbee	NAS JRB NOLA XO	USN
CMDCM Billy Mason	NAS JRB NOLA CMC	USN
CPO Kody Krystynak	NMCLANT DET NOLA	USN
LCDR Anthony Freeman	NMCLANT DET NOLA	USN
CMDCM Darryl Williams	NRPDC CMC	USN
CDR Ryan Mudd	NRPDC CO	USN
LCDR Jason Barrett	NOSC NOLA XO	USN
CDR Arturo Perez	USCG Sector NOLA	USCG
CPT Noel Fernando	HHC, 377 TSC	USA
MAJ Craig Battle	STB, 377 TSC	USA
SCPO Alan Carmona	NTAG NO CMC	USN
CDR Roger Phelps	NTAG NO PXO	USN
MCPO Forrest Stroman	NALO CMC	USN
SCPO Ryan Martin	NAS JRB Security LCPO	USN
LtCol Andrew M. Turner	MAG-49 Det C CO	USMC
Major Patrick Richardson	MAG-49 Det C	USMC
Col Matt Rippen	159 FW	USAF
CMSgt Moira Ortiz	159 Medical Group	USAF
Col Daniel Harlow	159 FW	USAF
CMSgt Gerald Raynal Jr	159 FW	USAF
LT Cassandra M. Kovac	NIWC NOLA	USN
CDR Daniel Nieves	Tulane University NROTC, XO	USN
Steve Azzinari	NAVFAC/Public Works	USN
CDR Patrick Dill	Coast Guard Air Station NOLA	USCG
LCDR Benjamin Simon	VR-54	USN
CPO Shane Mitchell	NAVSUP FLCJ NOLA	USN
Pierre Janvier	NAVSUP FLCJ NOLA	USN
LCDR Bonnie Ellington	NAVSUP FLCJ NOLA	USN
HMCS Michell Hopson	NBHC Belle Chasse, SEL	USN
CAPT Amy Branstetter	NHP, Commander	USN
CDR Phillip Boyer	NBHC Belle Chasse, OIC	USN
CDR Matthew Chang	NHP, Director, Branch Clinics	USN
HMCM Omar Azmitia	NHP, SEL, Branch Clinics	USN
CAPT Christine Dorr	BUMED M3	703 Workgroup

CDR Tim Barnes	Deputy Chief of Staff, M3 Navy Medicine East	703 Workgroup
Dr. Mark Hamilton	Program Analyst, DOD Medical Reform Team	703 Workgroup
Dr. Kimberlyn Ard	Business Operations Specialist, TRICARE Health Plan	THP
Mr. Michael Mathias	Contract Support	703 Workgroup

Summary of NAS JRB New Orleans Leadership Discussion

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

Base / Mission Overview:

- Mission: To provide a high-quality training environment for active duty and reserve components of all branches of the armed services; to reduce redundancy and overhead by developing joint doctrine and operating procedures that create seamless functionality among host and tenant commands in base support and community service programs
- NAS JRB New Orleans has 33 tenant commands, with 275 facilities including Active, Guard, and Reserve components

Voice of the Customer Summary:

- Readiness: The key requirement is the medical readiness of the force, both those working at the base and the reservists (who need to be in training for as much of the time as possible while at NAS JRB New Orleans). In addition, based on the variety of missions of the tenant units, every kind of specialty Occ Health exam required is dealt with (hazmat, ammo, security forces, aviation)
    - *Key Requirement*: Fit airman/sailor/marine physicals and testing during drill weekend needs to be 36 hours or less. Physicals and testing that take more than that could impact the limited training time already available
    - *Expanding Mission*: in 2 years, there will be a F-18 Superhornet international training center expansion, with 40-50 uniform coalition partners coming to the facility, potentially bringing their families and support staff. What does medical look like for this population? What is the Status of Forces Agreement (SOFA)?
    - *159th MG*:
        - 200 AGR empaneled, picking up another 150 AGRs
        - Tied to services received from NBHC - Flight physicals, optometry, audiograms
            - Utilizing Navy space on drill weekends for their own medical training and readiness care
    - *Coast Guard*:
        - Flight surgeon would attend mishap boards, but fewer USCG FS now available
        - Mitigation strategies for lack of USCG flight surgeons – aviation PAs, mailing data/report – but this loses the personal interaction seen as beneficial for aviation safety
    - *Reservists*:
        - Marine Reservists are effectively operational units
            - Marine Transport Squadron (VMR) deploys to Germany with regularity
            - Hurricane/disaster support
    - *ROTC*:
        - See NBHC as a one-stop shop for getting all required physicals/care prior to orders
    - *SPAWAR*:
        - Located at University of New Orleans campus on Lakeshore Drive (north side of New Orleans)
        - 298 civilian, 9 AD (60-70% of the civilians are veterans, and 50-65% come to base for medical care). Clinic is sole source of Occ Health Exams.

- Resilience:
    - Behavioral Health issues are becoming more prevalent and are certainly more visible in both the Active Duty and Reserve forces. On the 18 bases in Southeast Region, seeing 2-12 suicidal ideations per day
    - Substance Abuse – nothing available on base, sending AD to Gulfport, MS
    - Every kind of specialty exam required is dealt with (hazmat, ammo, security forces, aviation)
- ADFM Quality of Life: additional stressor for families if they have to seek care off-base (especially if they live on-base). Many families are junior enlisted and may have one (or possibly no) car.
    - Child/Youth Program is expanding in the population served and having easy access to that care is critical to reduce stress on already-stressed families. Clinic provides health education to childcare workers at CDC/CYP as well as medical expertise to Family Advocacy/intervention cases/boards.
- Network Adequacy:
    - Reservists must obtain TRICARE Reserve Select, not Prime
        - If ADFM cannot be seen at NBHC anymore, would co-pays be required? This will depend on the structure of the new contract
    - US FHP with Ochsner as an option?
        - Looking at options for larger choice overall, as MTFs re-scope

Summary of MCSF New Orleans Leadership Discussion

List of Attendees

The following were in attendance during the Marine Corps Support Facility (MCSF) New Orleans Leadership discussion:

Name	Title	Affiliation
MajGen Bradley S. James	Commander, MARFORRES; and Commander, MARFORNORTH	USMC
Col Torrens G. Miller	MCSF NOLA CO	USMC
SgtMa Benny R. Benton	MCSF NOLA SM	USMC
Col Gerry W. Leonard	Chief of Staff, MARFORRES	USMC
CAPT William C. Brunner	MFR Force Surgeon	USMC
Col William Johnson	MCIRSA	USMC
Col Walker Field	Chief of Staff, 4 MARDIV	USMC
Col John Kelliher	4th MAW	USMC
Col Alison Thompson	MAG-49	USMC
LtCol Jason Burkett	MFR G-1	USMC
LtCol Thomas Boggs	Div	USMC
HMCS Lann Begnaud	Div	USMC
Col Aaron Craig	MLG	USMC
Col Shawn Wonderlich	FHG	USMC
Col Gerard Graham	4th MAW	USMC
CDR Margaret Moore	4th MAW	USMC
Capt George Hurley III	MFR Staff Secretary	USMC
HMC Jim Mclellan	Force HQ Group	USMC
HMC David Juarez	MLG	USMC
LCDR Anna Keller	4 MARDIV	USMC
HMCS Tiffany Williams	HSS MFR	USMC
HMCM Jeff Pritchett	4th MAW	USMC
LtCol Andrew M. Turner	MAG-49 Det C CO	USMC
CAPT Henry Holcombe	MFR Force Chaplain	USMC
LtCol Roger Thomas	MFR G-2	USMC
PO1 Brian Riordan	HGBN MFR	USMC
CAPT Amy Branstetter	NHP, Commander	USN
CDR Phillip Boyer	NBHC Belle Chasse, OIC	USN
CDR Matthew Chang	NHP, Director, Branch Clinics	USN
HMCM Omar Azmitia	NHP, SEL, Branch Clinics	USN
HMCS Michell Hopson	NBHC Belle Chasse, SEL	USN
CAPT Christine Dorr	BUMED M3	703 Workgroup
CDR Tim Barnes	Deputy Chief of Staff, M3 Navy Medicine East	703 Workgroup

Dr. Mark Hamilton	Program Analyst, DOD Medical Reform Team	703 Workgroup
Dr. Kimberlyn Ard	Business Operations Specialist, TRICARE Health Plan	THP
Mr. Michael Mathias	Contract Support	703 Workgroup

Summary of MCSF Leadership Discussion

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

Base / Mission Overview:

- Marine Forces Reserve (MARFORRES) and Marine Forces North (MARFORNORTH) are tenant commands aboard the Facility, as are the headquarters elements of 4th Marine Division, 4th Marine Aircraft Wing, 4th Marine Logistics Group and the Force Headquarters Group
- MARFORRES consists of AD and selected Marine Corps Reserve (reserve units drilling 1 weekend/month and 2 weeks/year) and the Individual Ready Reserve (participating in annual musters, but only on record to be called up in case of war or other emergency)

Voice of the Customer Summary:

- Requirements:
    - *Force Readiness*: overall, good medical readiness numbers, but need them to continue improving
        - Difficulty in maintaining IMR for reserve forces not located close to MCSF
            - Garrison care will remain a part of the Navy mission, with Occupational Health, Preventive Medicine, All-Hazards (including for GS) all part of that commitment
            - Mental/Behavioral Health and Resilience are a critical part of force readiness, with identified gaps in mental health providers (especially at the reserve sites). Specifically, additional Oscar Techs (Mental Health enlisted) are desired to help decentralize care to the various reserve sites. MCSF has seen 2 suicides in the last 9 months, and suicidal ideations are a major concern. Substance Abuse access is limited in the area, so they are sending eligible patients to Gulfport, MS – 1.5 hours away
        - *Clinic in Building*: Given the difficulty in getting to NBHC Belle Chasse and the specific nature of the MCSF, critical to maintain the 3 clinic days at the Annex. With 5-6 General Officers and 900-1000 uniforms in the building, there is an established need for it. It can take half a day to get to Belle Chasse, receive care, and return to duty. This is especially critical for the reserve component, who have few man-hours to spare already
    - *Medical Readiness*:
        - Veterans Affairs (VA) Corridor – growing, opportunity for partnerships/agreements
        - Important to track medical readiness of reservist providers and there is an opportunity to utilize Knowledge, Skills, and Abilities (KSAs) to assess readiness based on private sector workload of reservist providers
- Unique Medical Needs: Marine Corps Forces Reserve (MARFORRES) must address readiness gaps/IMR issues for reserve component, even when they're not on-base
    - It's a burden to review records prior to deployment, especially when some network care is not captured in the record. MARFORRES is at upper 70s (%) for medical readiness, which is ~19% improvement since opening the Annex clinic
        - For Reserve sites, the Senior Corpsman is medical readiness manager, but they're dealing with tyranny of distance – interested in getting more medical capability out to the sites. With the 1300 TACFOR screening, they're identifying what's happened since last active status, but that can be hard to confirm depending on the medical records situation
    - Deployment Processing Center (DPC) – where reservists get care not available at reserve site
        - Located at Pendleton and Lejeune can become a chokepoint (certainly during a major deployment requirement). There are issues with AHLTA access/infrastructure for large- scale medical screening – relying on Reserve Health Readiness Program (RHRP) process, but

they don't have AHLTA either. Desire to know if DPC mission can be decentralized to allow other MTFs to help with getting deploying personnel medically ready and eliminate chokepoint.

- MARFORRES is not a credentialing authority
  - Issues with Service IT systems at joint bases when trying to enter readiness exam information

- TRICARE/Network:
  - 1700 dependents – most are satisfied with Prime Network, and network specialty care generally seen as high quality (Tulane, LSU, Ochsner)
  - In some cases, reservists not choosing TRICARE due to accessibility and continuity of care (dental especially can take a long time to get appointment) – McGuire-Dix-Lakehurst POC explained how some will utilize civilian insurance instead. Reservist dependents whose sponsors have elected it, are on TRICARE Reserve Select, until activation, then full TRICARE Prime. There's interest in servicemembers being able to opt in to TRICARE Standard – especially for those far from Belle Chasse. This may make the most sense for junior enlisted, one-car families who do not live on-base
  - Issues with TRICARE referral process – referred to providers not accepting new patients, or no longer accepting TRICARE beneficiaries, then the process has to start over. For New Orleans, in particular, providers are already doing a lot of low/no-cost care for indigent population, and they may be hesitant to take on another low-rate payer (despite speed and consistency of payment)