



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JAN 21 2011

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report is submitted in response to Section 721(e)(2) of the National Defense Authorization Act for Fiscal Year 2010 (P.L. 111-84). This report highlights progress made in the undertaking of required actions since our initial report, "Study and Plan to Improve Military Health Care," sent to Congress earlier this year. Specifically, the report includes progress on actions taken to enhance the capability of the Military Health System and improve the TRICARE program, along with an explanation of how the Department's budget submission may reflect such progress and plans.

We are dedicated to improving the health care provided to all Department of Defense beneficiaries in the United States and abroad. Thank you for your continued support of the Military Health System.

Sincerely,

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Jonathan Woodson, M.D.

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member



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JAN 21 2011

The Honorable James H. Webb
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

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The Honorable Howard P. "Buck" McKeon
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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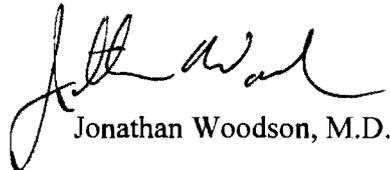
The Honorable Joe Wilson
Chairman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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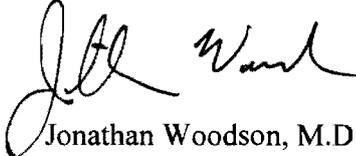
The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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The Honorable Thad Cochran
Vice Chairman



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Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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The Honorable Norman D. Dicks
Ranking Member



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JAN 21 2011

The Honorable C.W. Bill Young
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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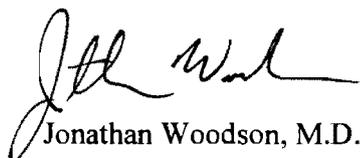
The Honorable John Boehner
Speaker of the House of Representatives
U.S. House of Representatives
Washington, DC 20515

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The Honorable Joseph R. Biden
President of the Senate
Washington, DC 20510

Dear Mr. President:

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Report to Congress



Study and Plan to Improve Military Health Care - Follow up Report

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Background

Section 721 of the National Defense Authorization Act for Fiscal Year (FY) 2010 directs that the Secretary of Defense, in consultation with the other administering Secretaries, undertake actions to enhance the capability of the Military Health System (MHS) and improve the TRICARE program. This report annotates progress made undertaking such actions since our initial report, “Study and Plan to Improve Military Health Care,” sent to Congress earlier this year.

Actions to Guarantee Care within Established Standards

We were asked to consider actions to guarantee active duty family members (ADFM)s have availability of care within established access standards. We were also asked to consider the availability and access in both the direct care and purchased care system of providers.¹

As we previously reported, the importance of enrollment to and establishing a relationship with a Primary Care Manager (“Primary Care Manager by Name” or PCM BN) has been targeted as an important MHS goal since TRICARE’s inception. The Medical Home model for providing primary care further develops this concept. The Patient-Centered Medical Home (PCMH) is an established model of primary care that improves continuity of care and enhances access through patient-centered care and effective patient-provider communication. Effective implementation of this model has been associated with better outcomes, reduced mortality, fewer hospital admissions, and reduced medical spending.

The MHS made progress over the past year and a half toward the MHS-wide adoption of the PCMH. In September 2009, the MHS held the Inaugural Tri-Service Medical Home Summit that included leadership from Health Affairs, TRICARE Management Activity (TMA), the Services, and leading civilian associations involved in the PCMH concept such as the National Committee for Quality Assurance (NCQA). Among the goals of this initial gathering was the development of recommendations for PCMH standards and measures. Also in September, the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) issued a policy memorandum directing the implementation of the PCMH as a comprehensive and coordinated primary care model to improve patient satisfaction and outcomes. With this mandate, military treatment facilities (MTFs) were encouraged to utilize innovative approaches that are patient-centered and access-focused. A cornerstone of this policy is that primary care managers (PCMs) be organized into teams to reinforce patient-provider communication and to optimize continuity. The effectiveness of implementing this policy will be evaluated through a range of metrics that include clinical effectiveness, access to care, patient satisfaction, and provider communication, all of which will form a standard set of PCMH performance measures that will be tied back to the overall MHS strategic plan and imperatives. Over the past year, the MHS has also begun work on a PCMH guide to provide consistent guidance on PCMH implementation across the Services.

¹ 32 Code of Federal Regulations, Section 199.17(p) (5). The standards include a beneficiary being seen by a health care provider for an acute issue within 24 hours, for routine care within 7 days, and for specialty and wellness care within 28 days.

Each Service has also reported progress with advancing their respective PCMH efforts over the past year. Navy's pilot program at National Naval Medical Center in Bethesda has demonstrated some improvements in the areas of PCM continuity, access to care, and patient satisfaction. The Air Force has approximately ten MTFs engaged in their PCMH model. Finally, the Army has developed an implementation strategy for a Community-Based Primary Care Clinic initiative (a PCMH model) designed to provide off-post primary care to ADFMs.

The Purchased Care sector was also actively engaged in the PCMH effort. A recent survey of our networks revealed more than 700 providers use a PCMH approach. We are now considering pilots to reward/incentivize or enhance care coordination in these practices. In the TRICARE West region, TriWest provided primary care optimization consultations advocating PCMH principles. The South and North regions coordinated convenience-care clinics focusing on optimizing access, one of the central PCMH tenets. Finally, many of the designated providers have also piloted PCMH initiatives, including PacMed, Johns Hopkins, and Martin's Point.

Access to Urgent Care

In exploring how to better provide access for acute conditions, 68 percent of all MTFs have developed standing arrangements with local urgent care facilities for after hours or "pop off" relief. The South Region has already reported a decrease in emergency room utilization. In addition, we have begun developing demonstration and pilot programs for testing various alternatives for shifting care from the emergency room to an urgent care setting. A workgroup has been formed to develop implementation plans for the following demonstration and pilot projects:

1. **Demonstration.** Under consideration by the ASD (HA) is a proposal to evaluate the effectiveness of waiving authorization requirements for four urgent care visits per annum to determine impact on emergency room use and access to care.
2. **Health Care Finder Functionality.** The Managed Care Support Contractors (MCSCs) in each region will provide a limited health care finder functionality for authorizing urgent care after normal business hours of a PCM at three MTFs in each region. This functionality will be provided in the evenings and on weekends when urgent care centers are open. An evaluation will be accomplished one year following implementation.

These initiatives will be evaluated on the basis of satisfaction, and shifts in care settings from emergency departments to urgent care centers when PCMs are not available to treat their TRICARE Prime enrollees. Potential MTF revenue implications will also be examined as PCMH policy is codified. It is our hope that these urgent care pilot programs will both enhance the use of a health care finder for after-hours and out-of-area care and facilitate network development of urgent care options to enhance access to care. Currently, TRICARE is affiliated with 2,000 urgent care clinics and 530 convenience clinics, it is our goal to optimize and grow these relationships to improve overall access to care.

Sharing of Health Care Resources among Federal Health Care Programs

We were asked to consider actions to expand and enhance sharing of health care resources among Federal health care programs, including designated providers (as that term is defined in section 721(5) of the National Defense Authorization Act for FY 1997 (Public Law 104-201; 110 Stat. 2593; 10 U.S.C. 1073 note)).

As we previously reported, the Department of Defense (DoD) and Department of Veterans Affairs (VA) have a highly developed partnership under the oversight of the joint Health Executive Council (HEC). The HEC mandates resource sharing to promote cost effective use of Federal health care resources, improve access, and maintain high levels of clinical capability. Each year, the Departments submit a joint report to Congress on the activities and accomplishments of DoD/VA health care resource sharing over the past fiscal year, as mandated by Title 38, § 8111, Sharing of Department of Veterans Affairs and Department of Defense Health Care Resources. Ongoing programs are captured in the VA/DoD Joint Executive Council FY 2009 Annual Report, Joint Strategic Plan FY 2010-2012. The key joint programs therein are symbolic of the nature of the current activities.

Medical Technology to Speed and Simplify Referrals

We were asked to consider actions using medical technology to speed and simplify referrals for specialty care. The health care industry has long been aware and made use of electronic data transactions for administering referrals from an organization's internal care system and out into the purchased care networks. This practice enables the controlling organization (i.e., the one that serves as the patient's PCM) to make best use of its internal resources in the overall care provided to the patient.

We previously reported that in the next generation of TRICARE contracts, the MHS will use the Air Force's Integrated Clinical Database on an interim basis to streamline referral processing operations using the Referral Management System (RMS). RMS is a software application that supports an electronic fax capability from all CONUS, Alaska, and Hawaii MTFs to the three MCSCs for all MTF "Defer to Network" referrals and all incoming Right of First Refusal (ROFR) determinations. It creates a referral request document with information from CHCS/AHLTA of sufficient clinical, administrative, and authorization detail to allow a consulting provider to appropriately evaluate the patient, contact the referring provider, and complete the appropriate claims/billing paperwork. A companion software application, Referral Management System Tracking and Reports (RMSTR) allows tracking and accounting for referrals and referral results. Additionally, via the AudioCARE system, all beneficiaries whose referrals were deferred to the network will receive a follow up phone message reminding them to make the appointment with the civilian provider. The MCSC's phone number for assistance will be provided. Together, we believe these systems will both speed and simplify our referral management.

Currently, the interim MHS enterprise-wide RMS is the Integrated Clinical Database (ICDB) with associated tracking and reporting software. MHS enterprise-wide, standardized referral management business rules are in final staffing.

Future plans for improvement of the MHS include deploying the Electronic Health Record (EHR) Way Ahead. It will be the ultimate enterprise-wide system. The architecture is being designed now. The goal remains to simplify, integrate, and standardize the referral and authorizations functions to better support MHS operations.

Plan to Improve Regional or National Staffing Capabilities

The primary objectives of the MHS Human Capital Office (HCO) are focused on helping DoD attract and retain an increased number of health care professionals needed to care for its wounded warriors. This report provides an update to the human capital solutions described in the original report.

Civilian Staffing:

As a method of succession planning, and to answer the Deputy Secretary of Defense's challenge to "grow our own," the Department proposed legislation for the development of a scholarship program, with a focus initially on mental health professionals. This proposal is designed to provide tuition for graduate education in a medical profession in exchange for a period of service. This program provides a direct link to civilian succession planning for our civilian workforce by recruiting young talent, paying for their education in exchange for commitment to serve in areas where there are DoD beneficiaries, and developing loyalty to DoD as they "grow" in our workforce. This proposal would require legislative approval prior to implementation.

Appointing Authorities:

Congress has provided many authorities to assist in DoD healthcare recruitment efforts and improve market competitiveness. The components utilize a variety of existing incentives to recruit at the entry level, to include Student Career Experience Program (SCEP) and Student Temporary Employment Program (STEP), intern programs, recruitment, retention and relocation incentives, special salary rates, targeted recruiting and direct and expedited hiring authorities. The Expedited Hiring Authority (EHA) and Direct Hiring Authority (DHA) enable the Department and the Services to recruit and retain critical shortage mental health providers. Additionally, the Department also extensively utilizes non-competitive appointments such as VRA and disabled veterans appointments, handicapped appointments, military spouse appointments, etc.

As we originally reported, the EHA was authorized under the NDAA for FY09; however, this authority required a "highly" qualified determination for applicants and included an

expiration date of September 30, 2012. In 2010, the Department proposed legislation to amend the current EHA authority in order to improve recruiting effectiveness of civilian healthcare workers. The Ike Skelton National Defense Authorization Act for Fiscal Year 2011 included legislation to extend and expand EHA.

Given the immediate need for increased numbers of mental health providers, a request has been initiated to establish a permanent direct hire authority for Clinical Psychologists and Social Workers. A permanent direct hire authority currently exists for several other healthcare occupations and is used extensively. This authority would provide the required tool to meet the need to hire quickly and efficiently and will ensure DoD has the means to meet its ongoing and critical mental health mission requirements. This proposal will require approval by the Office of Personnel Management.

Compensation Authorities:

As previously reported, the Department has instituted a number of compensation flexibilities to facilitate recruitment and retention of health care practitioners. An updated status regarding a new compensation system for physicians and dentists and the health care positions exempt from National Security Personnel System (NSPS) transition is provided below.

The Department projects implementation of a new compensation system for physicians and dentists in early 2011. Policy for the new hybrid Title 38 pay system has been approved with the issuance of a Department of Defense Instruction, 1400.25, Volume 543, dated August 18, 2010. This authority will provide the pay comparability needed to recruit and retain civilian physicians and dentists in DoD.

On May 27, 2010, the director of the NSPS Transition Office published a final decision memorandum on the health care positions that are exempt from conversion during the NSPS transition. Physicians, dentists, therapists, and many healthcare occupations did not convert to the General Schedule on September 26 during TRICARE Management Activity's NSPS transition. The NSPS Transition Office was supportive of the medical community and agreed to this delay in order to provide time to explore some of the human resource flexibilities granted to DoD by Congress. As a result of this review, the identified medical positions will convert back to the GS system in late FY11 or early FY 12 and will include additional flexibilities such as special salary rates and new qualification standards.

The Department remains committed to improving staffing capabilities across the medical specialties and shares Congress's concern for a quality medical force by providing the necessary recruiting and retention tools.

Plan to Improve Access to Health Care for Reservists

We were asked to improve health care access for members of the Reserve Components (RC) and their families, including access with respect to mental health care, and consideration of access issues for members and their families located in rural areas. As stated in our previous report, the Department has taken many steps to improve access to health care for all eligible beneficiaries in rural areas. While many of the RC members and their families live in rural areas, our approach is to continue to improve or enhance access to care for all eligible MHS beneficiaries living in rural areas.

The TRICARE Regional Offices (TROs) and their contractor partners perform outreach services to RC units, members, and families. Two Army RC Units were recently selected for a TRICARE outreach pilot, 307 MP CO (307th Military Police Company, Fort Bliss-El Paso, TX) and 0941 TC CO (941st Transportation Company, Camp Atterbury-Edinburgh, Indiana). The units contain approximately 170 soldiers each, and will deploy within the next six months. The detailed outreach pilot will work to ensure soldiers and families fully understand how to use their TRICARE benefit to meet their health care needs before, during, and after deployment. We will emphasize options that preserve continuity of care, while offering the full range of choices (MTF, TRICARE network provider, or non-network authorized provider) depending on family location and circumstances.

Representatives from the Army MEDCOM and TMA will co-sponsor this effort. Metrics will include survey data to assess Service member and family satisfaction with using TRICARE effectively. This pilot will involve reaching out to activating units so that their families will know how to find TRICARE providers in their localities and, in particular, TRICARE Standard providers outside of our network. An assessment will be performed approximately three months after activation to identify problems experienced by the families in finding providers. TRICARE education will be an integral component to ensuring family readiness of these activating units.

Since our initial report, we have been working to provide further assistance to these beneficiaries by drafting a policy change which directs the MCSCs to provide an online provider search tool to help these beneficiaries find TRICARE authorized providers. Until this change is implemented, the MCSCs offer online listings of only network providers. We believe the expanded list will be especially useful to RC members and their families and our Standard beneficiaries living in rural areas.

Access to Mental Health Care

In addition to the mental health initiatives addressed in our initial report, we continue to champion the TRICARE Assistance Program (TRIAP), which provides video chat-based, short-term professional, non-clinical counseling, similar to employee assistance counseling, 24 hours a day, seven days a week. It provides unlimited access for Active Duty Service Members (ADSMs), their families, those enrolled in TRICARE Reserve Select, and those in the Transitional Assistance Management Program in the continental United States. Since our last report, this demonstration has been extended until March 2011. We will use the continued

outcomes and satisfaction levels to help determine if it will eventually become a permanent program.

In the West region, the Marine Corps has provided a Marine “Semper Fi” link directly to TRIAP counselors. They have also provided Marine-specific training highlighting Marine-unique mental health care needs to provide better service to Marines who access TRIAP.

In assessing our progress with ensuring access to mental health care, we can report an increase in mental health purchased care providers. The number has jumped from 39,587 in 2007 to 53,080 in 2010. We will continue to survey providers and beneficiaries to assess access to care and patient satisfaction issues. We will use the results to identify geographical areas that may not have sufficient numbers of TRICARE-authorized providers to satisfy the demand for health care in a particular area. If access to care is severely impaired and additional providers cannot be persuaded to accept the prevailing TRICARE reimbursement rates, the Department will evaluate the need for locality-based reimbursement waivers.

Actions to Ensure Access to Care Standards

We were asked to consider actions to ensure consistency throughout the TRICARE program to comply with access standards which are applicable to both the commanders of MTFs and our MCSCs.

As we initially stated, access to care standards have been in place since the beginning of TRICARE in 1995, and the standards have always applied to both the direct care and purchased care systems. Throughout these past 15 years of TRICARE operations, numerous policies have consistently sent this message. This year, to further highlight our access to care standards, we have consolidated eight access to care policy memoranda and are reissuing a consolidated memorandum to the Services for their further dissemination to the field.

The consolidated access to care policy is currently undergoing a second round of review by the Services and the TROs to ensure the end product addresses all stakeholders’ areas of concern. In addition, each Service continues to review their access to care metrics on a regular basis.

Furthermore, because one of the MHS’s strategic imperatives is to optimize access to care, a quarterly strategy review and analysis is done for three access to care performance metrics (see below):

1. Primary Care Third Available Appointment (Routine/Acute): We are making progress to eliminate variation in appointing templates and processes across the Services. Our ability to offer patients three available appointments has declined in the last six months. However, as more MTFs implement the PCMH we expect this to fuel improvement across the enterprise.

2. Getting Timely Care Rate: Satisfaction with access appears to be improving. However, those seeking care from the Health Care Support Contractors report a higher satisfaction with getting timely care.
3. Percentage of Visits Where MTF Enrollees See Their PCM: PCM continuity has seen a notable increase in the third quarter 2010.

New Budgeting and Resource Allocation Methodologies for MTFs

We were asked to consider actions to create new budgeting and resource allocation methodologies to support and incentivize care provided by MTFs. The MHS Prospective Payment System (PPS) for adjusting funding levels for patient care workload on a fee-for-service (FFS) basis was revised to include two new approaches which will provide funding based more specifically on resources used for the services provided.

Payment for outpatient services was previously provided based on the intensity of work by the individual providing the health care service, combined with an average per specialty of the estimated costs for running the type of practice (nurses, technicians, equipment, supplies, etc.). The MHS has evolved from using the work expense as previously determined to now using a practice expense which is a more accurate accounting of the resources used for the services provided. Implemented in FY 2010, this has allowed for funding of the MTFs to target what they invested in providing the services. It additionally more closely mirrors reimbursement models used in the Medicare system.

The second change was adoption this year of a revised system for determining resources used with inpatient services based on a “severity of illness” stratification. The Centers for Medicare & Medicaid Services (CMS) developed the “Medicare severity-adjusted diagnosis-related groups (MS-DRGs)” for the hospital PPS system which provides different levels of funding based on complications occurring during hospitalization. This will allow for greater accuracy in analyses and in payments aligned with more patient-specific granularity.

In FY 2010, the MHS adjusted funding to the Services based on increases in specific quality metrics of the Healthcare Effectiveness Data and Information Set (HEDIS) at their MTFs. These incentives recognize improvements in the prevention of illness and in clinical improvements in the experience of care.

The MHS’s Performance Plan pilot, which was targeted for implementation with the beginning of FY 2011 (October 1, 2010), is in its final stage of development. Seven MTFs have developed initiatives targeting improved performance in readiness, population health, the experience of care, and per capita cost. They will be funded for improved performance in these areas, including such things as attaining improved levels of prevention, outcomes in diabetes care, satisfaction, access, appropriate emergency room utilization, and “per member per year” cost of care. Another important component of this pilot is the inclusion of a capitated payment for primary care services in the MTFs’ Medical Homes. The Medical Home is a patient-centered model of providing services targeting patient-specific, versus volume-driven, activities. A capitated payment provides support and incentives to the MTFs to pursue innovation in the

provision of primary care services. The MHS will monitor these pilot sites closely after the pilot begins, addressing early indicators of possible complications as well as acknowledging success for best practice dissemination.

Financing Options for Civilian Providers

We were asked to consider actions regarding additional financing options for health care provided by civilian providers.

In considering possible new financing options for care provided by civilian providers, the Department is mindful of two key points. First, TRICARE's payment methods and rates generally follow Medicare's payment methods and rates when this is feasible. Second, TRICARE generally is not a dominant payer in most markets or for most providers. For both of these reasons, the Department continues to carefully monitor Medicare's various demonstrations and other research initiatives related to new financing options to assess which options might be feasible and appropriate for implementation in TRICARE.

In addition, in our Third Generation of TRICARE Contracts (T-3) we have established clinical quality monetary incentives for our MCSC's. The monetary incentive will be based on improvement (expressed as a percentage) in each measure over each one-year option period. The measures are cervical cancer screening, breast cancer screening, asthma use of medication, colorectal screening, diabetes management A1c testing, diabetes management lipid testing and diabetes management retinal screening.

Lastly, alternative financing options are under consideration for our in network PCMH pilots to test payment mechanisms other than fee for service.

Actions to Reduce Administrative Costs

We were asked to consider actions to reduce administrative costs. The Department makes great effort to reduce administrative costs wherever possible.

In our initial report, we discussed T-3 improvements and the consolidation of pharmacy and overseas contracts. T-3 requirements are included in the TRICARE Overseas contract which began on September 1, 2010, and are included in the North region's new health care support contract, scheduled to begin health care delivery on April 1, 2011.

Additionally, in the T-3 contracts, we have changed our electronic claims processing requirements from requiring only network providers to submit claims electronically to requiring a percentage of all claims to be processed electronically. Another example is our T-3 requirement for the contractors to use TRICARE's entire suite of educational materials rather than just requiring it for provider educational materials.

We also expect to obtain reduced administrative costs from our new overseas contract which consolidates the requirements of six previous individual contracts, thereby streamlining contract administration.

Plan to Control the Cost of Health Care and Pharmaceuticals

We were asked to consider and take actions to control the cost of health care and pharmaceuticals. In addition to actions taken by the Department to control the cost of health care and pharmaceuticals described in the initial report, the Department is proposing payment reform for sole community hospitals, which are currently paid based on billed charges. In addition, as recommended by multiple studies and commissions (including the congressionally mandated Task Force on the Future of Military Health Care), the Department continues to believe that an overall update of the TRICARE fee structure is an important element to control the costs of health care and pharmaceuticals. The Department will continue to work with Congress and other stakeholders to develop the way ahead on this important issue.

We are using a “Pharmacy Home Delivery Communications Plan” to encourage behavioral change among TRICARE Pharmacy beneficiaries to reduce retail pharmacy use and increase Home Delivery use in the next year through education, training and direct outreach. The plan uses tactics such as beneficiary mail outs, beneficiary newsletters/bulletins, provider newsletters & publications, media, web outreach/social media, and briefings to promote the use of Home Delivery. The Home Delivery growth trend continues to rise and to date over 20 percent of all prescriptions are dispensed via Home Delivery. The growth in Home Delivery usage equals cost control because Home Delivery represents significant savings to DoD compared to retail pharmacy usage. The average retail cost for 90 days of a brand medication is \$294 but only \$169 through Home Delivery, a 43 percent decrease.

Audit DEERS to Improve Eligibility Determinations

We were asked to consider actions to audit the Defense Enrollment Eligibility Reporting System (DEERS) to improve system checks on the eligibility of TRICARE beneficiaries. The Defense Manpower Data Center (DMDC) is the agency that operates DEERS. DEERS is the central system responsible for determining and reporting the eligibility of all persons for TRICARE medical benefits.

As we previously reported, the TMA arranges through the DoD Inspector General (IG) for an annual audit of the Medicare Eligible Retiree Healthcare Fund (MERHCF) and Contract Resource Management (CRM). The MERHCF/CRM audit team visits the Defense Finance and Accounting Service (DFAS), the Defense Information Systems Agency (DISA), the DoD Office of the Actuary, TMA offices, and the DMDC.

Since our last report, the DoD IG visited DMDC September 7 – 17, 2010, to conduct a DEERS audit. They reviewed over 200 sample cases to verify accuracy of data in DEERS. We believe this annual audit and internal Data Quality Initiative (DQI) we described in our previous report will provide the Department thorough controls over the quality of beneficiary eligibility data in DEERS.

Plan to Enhance Availability of Prevention and Wellness Care

We were asked to consider actions, including a comprehensive plan, for the enhanced availability of prevention and wellness care. In our initial report, we provided our entire preventive health plan. All initially reported activities are ongoing; however, this follow-up report includes only those sections with significant changes.

PREVENTIVE HEALTH PLAN--CURRENT INITIATIVES

Smoking Cessation

In June 2010, 24/7 smoking quitlines were established, with a separate toll-free line available in each of the three TROs. The quitlines are currently run by the health care support contractors for the specific regions and provide triage and referral services. Individual provider and group cessation counseling is also now covered. The Department is currently engaged in drafting the necessary changes to the Code of Federal Regulations to allow for the coverage of no-cost smoking cessation pharmaceuticals and to expand the services of the toll-free quitlines to include cessation counseling.

Cancer Screening

On August 6, 2010, the Department published the final rule in the Federal Register to implement Section 703 of the NDAA for FY07, Public Law 109-364. The rule allows coverage for “breast cancer screening” and “cervical cancer screening” for female beneficiaries of the MHS, instead of constraining such testing to mammograms and Papanicolaou tests. This rule ensures new breast and cervical cancer screening procedures can be added to the TRICARE benefit, as such procedures are proven to be safe, effective, and in line with nationally accepted medical practice, based on Department of Health and Human Services guidelines.

Demonstrations

Our initial report described in detail two different preventive health related demonstration projects, the Military Health Risk Management demonstration project, required by Section 712 of the NDAA for FY 2009 and the Preventive Health Allowance demonstration project, authorized by Section 714 of the NDAA for FY 2009. Today, we can report that these demonstrations are progressing in line with the originally described plans.

Tobacco Cessation and Alcohol Education Campaigns

Two social marketing campaigns to counter tobacco use and alcohol misuse/abuse are proving to be very successful. These projects are ongoing and are targeted toward young enlisted active duty members, who are the most likely Service members to use tobacco products and drink alcohol. As we initially reported, the campaigns are directed by TMA with assistance from the Services.

The “Quit Tobacco - Make Everyone Proud” campaign is dependent on local program managers to get their message to the target audience. The campaign’s award-winning Web site, www.ucanquit2.org, had 285,000 visitors in 2009 (70 percent were unique visits (individuals), a 23 percent increase in unique visits compared to 2008). The Web site provides interactive information, games and videos, a message board for peer-to-peer support, and a savings calculator, as well as access to real-time, live-chat help available 18 hours per day with a trained tobacco cessation coach. Results of the recently released 2008 DoD Health Related Behaviors (HRB) survey found that 26 percent of respondents on installations with high campaign visibility reported seriously thinking of quitting smoking in the next 30 days compared to 6 percent from other installations.

The “Don’t Be That Guy” campaign is now actively deployed by 1,500 local points of contact at 228 military installations and units in 42 States and 11 countries. Half-a-million promotional items have been distributed, and www.thatguy.com has been viewed by 800,000 users at a current rate of 27,000 per month. Results of the 2008 HRB survey showed a decrease in binge drinking among junior enlisted men of ages 17–20 (45 percent in 2005, 39 percent in 2008). Findings also show a statistically significant lower incidence of binge drinking at installations implementing the campaign: 38 percent among all treated installations versus 49 percent at control (untreated) installations.

Health Assessment Review Tool (HART)

The HART is an automated self-reported health information survey that was developed specifically for MHS beneficiary health assessments. In addition to the three versions of the HART form that we mentioned in our original report, work is under way to develop a comprehensive HART, or CHART, which will be a “smart questionnaire” with the ability to guide a beneficiary to the correct HART form based on a short set of introductory questions. The CHART will eventually eliminate the need for beneficiaries to select the appropriate HART tool to fill out based on their status, thus simplifying the overall personal health assessment process for the beneficiary.

Behavioral Health

In the initial report, we described multiple DoD prevention and wellness approaches for our behavioral health practices. This follow-up report includes some new information, as well as information about significant changes to some behavioral health initiatives previously reported.

Military Pathways, at <https://www.militarymentalhealth.org>, is a voluntary, anonymous mental health and alcohol screening, referral, and education program offered free of charge to Service members and their families. Screening and referral services are offered online and by phone 24/7, as well as through in-person events. Educational materials such as family resiliency kits are available to readiness groups, family assistance centers, and chaplains. Included in the list are materials on coping with the stress of deployment, building resiliency, recognizing signs and symptoms of mental health problems, reconnecting with children, and how and when to access DoD and VA behavioral health services. The kits contain a 25 minute DVD, “A Different Kind of Courage,” also available on the Web site. The DVD depicts how Service members and

their families may be affected by combat and deployment stress and includes messages from military leadership encouraging mental health help-seeking.

The Signs of Suicide Program (SOS), another mental health screening and education project offered through Military Pathways, is the only school-based program proven to reduce suicide attempts in a randomized controlled study. The project includes an educational video, discussion, and screening. It is offered in the DoD and Impact Aide Schools (20 percent DoD students). Military Pathways is funded by the DoD Office of the ASD(HA)/TMA, Force Health Protection and Readiness Programs.

Resilience is generally thought of as the ability to effectively cope with, adapt to, and overcome adversity, stress, and challenging experiences. Our initial report included resilience training opportunities. The Army's Battlemind Training we described in our original report has undergone some changes. It is now the Army's Resilience Training (<https://www.resilience.army.mil>).

In conclusion, while resilience programs remain largely unproven, there is considerable activity in their evaluation both within and outside of DoD. Most importantly, efforts are underway to determine how to best:

- Implement to the most effective and efficient state practicable the measures that are already in place, ensuring that implementation adheres to the evidence base existing for those activities.
- Fully implement integrated behavioral health in primary care to the extent supported by available evidence.
- Focus resilience program implementation and evaluation efforts on a few initiatives rather than diluting resources over a large number of activities.
- Educate and engage enlisted and officer line leaders at all levels on prevention and wellness in behavioral health, provide targeted education in the Services' formal schools, and provide targeted education in prescribed unit training.
- Integrate prevention and wellness in behavioral health into Employee Wellness Programs for our Service members and the civilians who support our active and reserve units and commands.

Technology to Improve Health and Preventive Care Communications

We were asked to consider actions using technology to improve direct communication with beneficiaries regarding health and preventive care. The DMDC is working with the Uniformed Services, the TMA, and the VA to capture permission-based e-mail data for use in benefits correspondence and notification to the beneficiary.

As we previously reported, the permission-based e-mail is being implemented in several business areas with DMDC and TMA to reduce the cost of benefit change correspondence and to provide more timely notification of benefit changes. Currently, DMDC is working with TMA's Communications & Customer Service Division to pave the way to shift from print notifications to electronic communications. The process for collecting e-mail addresses is a main focus at this time. The desired outcome is more effective electronic communications.

A new feature, called the Blue Button, is now available on the TRICARE Online Personal Health Record site at www.tricareonline.com. It allows users to save their personal health data such as medication and allergy profiles, demographic information and a personal health summary to a Portable Document Format (PDF) file on their computer. It was implemented June 9, 2010. We believe the Blue Button will empower our patients and improve patient to provider communication.

Performance Metrics

We were asked to consider performance metrics to better evaluate access to care. In addition to the performance metrics captured by the TRICARE Operations Center and used by the Services which we addressed in our original report, we have developed metrics to analyze the effectiveness of the patient centered medical home. To date, these metrics mark improvement in clinical effectiveness, access to care, patient satisfaction, and provider communication.

Quality Assurance — Ensuring No Adverse Impact to Cost, Access, or Care

On May 28, 2010, the TRICARE Quality Monitoring Contract (TQMC), as a follow-on to the National Quality Monitoring Contract, was awarded to Keystone Peer Review Organization (KePRO). The contract is due to start delivery of services on April 1, 2011.

The purpose of this contract is to assist Health Affairs, TMA, the TROs, the Uniformed Services Family Health Plan (USFHP), the TRICARE Overseas (TAO) Europe, Pacific and Latin America/Canada Program Offices, the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC), and the Pharmacy and Dental Program Offices by providing the Government with an independent, impartial evaluation of the care provided to MHS beneficiaries.

The objectives under this contract are:

- To provide an independent, impartial evaluation of the health care provided to MHS beneficiaries.
- To evaluate “best value health care” as defined in the TRICARE Operations Manual.
- To measure, evaluate, and identify superior quality health care services and recommend means to transfer successes.
- To provide comprehensive and timely reviews that are consistent with all TRICARE requirements, and to ensure receipt of appropriate levels of health care for all beneficiaries.

Quality Assurance

We were asked to continue or enhance the current level of quality health care provided by the DoD and the Military Departments. We use Healthcare Effectiveness Data and Information Set (HEDIS) as a quality index for preventive health care. HEDIS measures on seven treatment protocols (three diabetes measures are combined into one index). The selected HEDIS measures

indicate the pervasiveness of routine screening or treatment in an enrolled population for five chronic or common diseases. The selected measures support an evidence-based approach to population health and quality assessment. It also provides a direct comparison with civilian health plans and a means of tracking improvements in disease screening and treatment.

The Department recognizes the value of organizational assessments by external professionals and participates in The Joint Commission accreditation process as one method to assess and continually improve the quality of care provided to beneficiaries. Accredited hospitals serving patient populations with conditions covered under core quality measures must report results in three of five available core measure sets. Core measure sets include acute myocardial infarction, heart failure, pregnancy, pneumonia and surgical infection prevention. Core Measures are a method of tracking and measuring a variety of evidence-based, scientifically researched standards of care in medicine which have been shown to result in improved clinical outcomes for patients. In particular, we have been working to improve our orthopedic surgical care and we are pleased to report that our “Prophylactic Antibiotic Received within One Hour Prior to Surgical Incision” measure is steadily showing improvement and is closing our gap to the national average.

The new TQMC also includes provisions for the performance of focused clinical studies of interest to the MHS. Study concepts may be identified by the contractor, by TMA, or other interested sources and will be presented to a Purchased Care Quality Advisory Panel (PCQAP) which, once fully implemented in early 2011, will review these concepts for formulation into and acceptance as specific focus study topics. While TMA has the ability to conduct studies utilizing administrative and claims data through a variety of venues, it currently has very limited ability to conduct studies based upon medical records abstraction. This effort will be undertaken in collaboration with our health care and other clinical support contractors, since they have the contractual relationships with the network providers who render care to our beneficiaries. The committee will have representatives from TMA, the TROs, Designated Provider Program Office, TRICARE Overseas Program Office, the Dental Program Office, Pharmacy Program Office and representatives from our contracted partners who are already experienced in doing quality studies involving the beneficiaries for whom they are responsible.

Through this study mechanism, TMA and the Services will be empowered to identify issues in the quality of care delivered to beneficiaries across the entire MHS and to perform medical records abstractions to evaluate the care provided in the purchased care networks. At least one study annually will also evaluate the interface of care between the direct care system and the purchased care network. Examples of topics for these types of studies include stabilization and transfer of trauma patients, acute myocardial infarction patients, and maternal-fetal units or neonates who are at risk. Results of studies will be available through a Web-based portal in order to fully disseminate the results and any lessons learned or best practices identified.

In situations where the Services have reviewed a case in which a malpractice claim has been paid and have made a determination that the standard of care was met, the TQMC will continue to provide board certified specialty matched physicians and other providers to conduct peer review on these MTF standard-of-care cases. There is also a provision for this level of peer review for cases involving active duty Service members (whose compensation remedies are not

through the malpractice claim system). In addition, cases of Command interest can also be sent for review. Similar peer review processes are utilized in making determinations of medical necessity in support of TMA Appeals and Hearings.

The TQMC contract will also provide for reviews of evolving technologies from the national and international commercial health care sectors. The contractor will review literature and studies to determine the level of evidence available and make recommendations to TMA as to whether an emerging technology is moving from unproven to proven status. This activity will support the TMA Office of the Chief Medical Officer and the Medical Benefits and Reimbursement Branch in their determinations as to whether emerging technologies are appropriate for inclusion in the TRICARE benefit. Another function of this review process will be assessment of the Centers for Medicare and Medicaid National Coverage Determinations for consideration under the TRICARE benefit as well.

Conclusion

In conclusion, we are undertaking a wide array of actions to enhance the capability of the MHS and improve the TRICARE program. The actions highlighted here have been done with no adverse impact to cost, access, or care. The status of these actions will be reported on a periodic basis to keep Congress abreast of our continued efforts for improvement.