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

AF-C-66th MEDSQ-
Hanscom 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	**66th Medical Squadron Hanscom**
Decision	Transition the 66th Medical Squadron-Hanscom outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). 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.

Wing Mission Summary:
Hanscom Air Force Base (AFB) and the 66th Medical Squadron is in Hanscom AFB, MA, in Middlesex County, approximately 20 miles from Boston. Hanscom AFB's key mission elements are the Air Force Life Cycle Management Center and Air Force Program Executive Offices (PEOs). The Hanscom mission includes acquiring critical warfighting systems for the Air Force and the other services. These systems provide the connectivity for and between warfighters with items such as radar, communication and intelligence systems, command operations centers, and network infrastructure and cyber security.

Criteria Matrix

Decision Criteria	Rating or Value[1]	Key Takeaways or Findings	Use Case Package
Mission Impact Risk	L	• Proximity of the local network to the base mitigates travel times for Primary Care appointments. 94% of non-active duty MTF Prime and Plus beneficiaries are living within the 30-minute drive- time boundary for Primary Care, concentrated around the MTF with an adequate network • The 66th Medical Squadron functions as a regional deployment hub for 220+ Geographically Separated Units (GSU) for all Services, spread over 99,000 square miles. Moving forward with the transition may not impact this mission of Hanscom, but should take this into consideration • Wing support services provided by the 66th Medical Squadron (e.g., Bioenvironmental Engineering, Public Health) will need to be resourced as per Air Force guidance	Section 1.0
Network Assessment	L	• Hanscom AFB is near a metropolitan area with a robust Primary Care network. The total impacted population represents <1% of the total regional population located within a 30-minute drive-time radius of the MTF. This is well below the 10% threshold, and thus will not materially impact the supply and demand of Primary Care services • The Managed Care Support Contractor (MCSC) network could likely expand rapidly to meet the new demand, even as the local population is expected to grow by 4.5% over the next five years (2019 to 2023). If MCSC contracts 50% of the non-network Primary Care Providers (PCP), they would have a total of 434 PCPs. Each PCP would have to enroll 8 new patients to accommodate the 3,696 66th Medical Squadron enrollees. Beneficiaries rate network health care 21% higher than 66th Medical Squadron healthcare, so beneficiary satisfaction is not likely to suffer with network enrollment • The civilian provider market potentially has capacity to absorb the incremental demand of MTF Prime, Reliant, and Medicare Eligible Tricare beneficiaries for Psychiatry, which is currently provided at the MTF. There are projected surpluses of Psychiatry providers across the market area. The commercial network will potentially be able to sustain the increased demand over time (2019 to 2023) • There are established military-civilian partnerships with many Boston health systems	Section 2.0

[1] See Appendix B for Criteria Matrix Definitions

Risk/Concerns and Mitigating Strategies

The Risk/Concerns and Mitigation table below, represents a high-level summary of the risks identified throughout the process as well as the main concerns of the Base and MTF Commanders identified during the site visit. Though not exhaustive, the mitigation strategies / potential courses of action were established by the 703 Workgroup and will be used to help develop a final implementation plan.

	Risk/Concerns	Mitigating Strategy
1	Impact of the GSU workload on the remaining MTF employees if there is a reduction in staff	• Adequate clinical, support and administrative staff will need to be sustained to cover the GSU workload or have it realigned to other MTFs
2	Maintaining adequate network capacity to support access for active duty family members at the minimum	• MTF and MCSC will need to continue to monitor access and enforce compliance with the requirements of the contract to maintain an adequate network
3	Impact of work supporting Family Advocacy and Medical Evaluation Boards (MEB)	• Adequate Administrative support must be maintained to support the requirement
4	The pace at which the network can absorb new enrollees into Primary Care is unknown. There will be an adjustment period for the network	• The MTF should conduct the transition in a measured way that is tailored to their specific needs and addressed in the implementation plan. The MTF and DHA will monitor progress and address access issues by slowing down the transition
5	The patients' change in expectations from getting care on the base to getting care off the base will have to be monitored and managed	• This risk will be mitigated through the implementation and communications plan as well as care coordination

Next Steps:

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

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

Hanscom Air Force Base (AFB) and the 66th Medical Squadron is in Hanscom AFB, MA, in Middlesex County, approximately 20 miles from Boston. Hanscom AFB's key mission elements are the Air Force Life Cycle Management Center and Air Force Program Executive Offices (PEOs)[2]. The total Military Medical Treatment Facility (MTF) enrolled population affected by the transition is approximately 3,800[3] empaneled beneficiaries that will need to find a new Primary Care Manager (PCM). Of note, Hanscom has unique population attributes, supporting approximately 250 Exceptional Family Member Program (EFMP) beneficiaries and it supports 220+ Geographically Separated Units (GSUs) across New England.

1.1. Installation Description

Name	Hanscom Air Force Base
Location	Hanscom AFB, MA; Middlesex County; approximately 20 miles from Boston
Mission Elements	66th Air Base Squadron; Air Force Life Cycle Management Center
Mission Description	Acquires critical warfighting systems for the Air Force and sister services. These systems provide the connectivity for and between warfighters with items such as radar, communication and intelligence systems, command and operations centers and network infrastructure and cyber defense. This work helps men and women in uniform prevail in battle and return home safely. Home to three (3) Air Force Program Executive Offices (PEOs): (1) PEO for Command, Control, Communications, Intelligence, and Networks (C3I&N) (2) PEO Battle Management (3) Nuclear Command, Control, and Communications (NC3) PEO
Regional Readiness / Emergency Management	18 Agreements with Federal, State, and Local agencies: • Mutual Aid and Military Working Dog support with Police Departments • Explosive ordinance mitigation and disposal • Installation action to epidemic / pandemic outbreaks • Staging facility for federal quick reaction force to acts of terrorism • Aircraft rescue-firefighting, confined space rescue, Hazmat response • Mass casualty, medical disaster, care and overflow • Firefighting response and support (Forth Cliff reservation) • Investigation / cataloging of firearms used in the commission of crimes Base bed down and logistics support to FEMA, USNORTHCOM, ICE, and sister service units in Northeast United States for exercises and real-world disaster response and contingencies
Base Active or Proposed Facility Projects	(1) FY18 Vandenberg Gate Complex ($11.4M) (2) FY19 MIT-LL Compound Semiconductor Laboratory/Microelectronics Integration Facility (CSL-MIF) ($225M) (3) FY22 MIT-LL Fabrication Engineering and Rapid Prototyping Facility (EPF) ($220.5M)
Medical Capabilities and Base Mission Requirements	Current medical capabilities are critical to overall success of base and New England region mission requirements Medical components to 44 Federal, State, and Local agency readiness/emergency preparedness agreements • Health Services • Logistics Support • FAP • SAFE/SANE (SAPR) • Dental Sterilization • Med Support for Inmates/Detainees • Blood Collection

[2] (1) PEO for Command, Control, Communications, Intelligence, and Networks (C3I&N), (2) PEO Battle Management and (3) Nuclear Command, Control, and Communications (NC3) PEO

[3] Source: Non-AD MTF Prime and Plus

- TRICARE
- Flu Immunization of Civilian Personnel
- Mortuary Affairs
- Volunteer Services

*IT Support at Hanscom Clinic provided to eight (8) Space Warning Squadrons at Cape Cod for AHLTA support as well as the Flight Doctor at the ANG base in New Hampshire. AFMOA/DHA contractors also come to the MTF for IT support to avoid sending laptops back to JBSA. Hanscom is also the host site for GSU access to DMLSS

1.2. Military Medical Treatment Facility (MTF) Description

Name	AF-C-66th MEDSQ-HANSCOM
Location	Hanscom AFB, MA; Middlesex County; approximately 20 miles from Boston
Market[4]	New England (small market)
Mission Description	Support past, present, and future war fighters and their families through innovation, training, and sustained quality care
Vision Description	Best care – every patient, every time
Goals	(1) Promote Healthy and Resilient Population Objective - Maximize evidence-based practices (2) Foster Innovation Objective – Optimize efficiency and reduce waste (3) Achieve Trusted Care Objective – Improve communication (4) Achieve Full Spectrum Readiness Objective – Sharpen skillsets (5) Improve Staff Satisfaction Objective – enhance staff resiliency
Facility Type	Outpatient clinic, no ambulatory surgery
Square Footage	Building Gross: 50,193; Net Square Footage: 49,011
Deployable Medical Teams	FFEP2 (EMEDS) Frag – 1 Officer
FY17 Annual Budget[5]	$14.3M
MTF Active or Proposed Facility Projects	No Information
Performance Metrics	See Volume II, Part C and D for P4I measures and JOES-C data

Projected Workforce Impact

Active Duty	Civilian	Total
33	7	**40**

FY18 Assigned FTEs (Full Time Equivalents) [6]

	Active Duty	Civilian	Contractor	Total
Medical	91.4	24.4	1.5	**117.3**

Healthcare Services

(1) Medical
- Family Health
- Pediatrics
- Disease Management
- Case Management

[4] Defined by FY17 NDAA Section 702 Transition
[5] Source: https://www.hanscom.af.mil/About-Us/Biographies/Display/Article/846601/colonel-russell-l-pinard/
[6] Source: 66th Med Grp-Hanscom – Version 5 – 2019 March.pdf

	• Behavioral Health (2) Aerospace Medical • Public health • Flight medicine • Optometry • Health promotion • Occupational medicine • Bioenvironmental engineering (3) Dental • General dentistry • Preventive dentistry • Dental laboratory (4) Ancillary • Pharmacy • Laboratory • Radiology • Immunizations (5) Mental Health • Clinical counseling • Family advocacy • ADAPT (6) Other Services • Veterinary Medicine • Interpreting services available • Operational Support Team added in FY21 POM
Network Considerations - Average days to care by specialty category	• Anesthesiology – 31.5 days • Behavioral health – 43.8 days • Cardiology – 32.4 days • Dermatology – 33 days • ENT – 38.3 days • Hematology/Oncology – 49 days • OB/GYN – 33.7 days • Ophthalmology – 29.2 days • Psychiatry – 40.5 days • Pulmonology – 36.8 days • Urology – 34.9 days

2.0. Healthcare Market Surrounding the MTF

Description	In the Hanscom drive-time standard, there are currently 492 Primary Care Practices, which account for 1,375 Primary Care Physicians.
Top Hospital Alignment	▪ Boston Medical Center, Boston, MA ▪ Cambridge Health Alliance, Cambridge, MA ▪ Partners Healthcare System, Boston, MA ▪ Shriners, Boston, MA ▪ Steward Health Care System, Roxbury Crossing, MA ▪ UMass Memorial Health Care, Worcester, MA

Likelihood of Offering Primary Care Services to Tricare Members[7]

	Number of Practices	Number of Physicians
Contracted with Tricare	149	540
High Likelihood	0	0
Medium Likelihood	280	678
Low Likelihood	63	157
Total	**492**	**1,375**

2.1. TRICARE Health Plan Network Assessment Summary

Facts:

- Hanscom AFB, Massachusetts (Boston) has a market area population of approximately 1.5M[8]
- 66th Medical Squadron Hanscom has 3,696[9] non-AD enrollees who would enroll to the network
- MCSC has contracted 175[10] of 1,375[11] (13%) Primary Care providers (PCP) within a 15-mile radius of the MTF
- Rolling 12-month JOES-C scores ending October 2018 with a "health care rating" scored as a 9 or 10 on a scale of 0-10:
  - 66th Medical Squadron patients: 43.7% (145 respondents)
  - Network patients: 64.9% (314 respondents)
- TRICARE Prime Out-of-Pocket Costs for Retirees and their family members[12]
  - Preventive Care Visit: $0
  - Primary Care Outpatient Visit: $20
  - Specialty Care Outpatient or Urgent Care Center Visit: $30
  - Emergency Room Visit: $61
- TRICARE Prime enrollees should expect to drive no more than:
  - 30 minutes to a Primary Care Manager (PCM) for Primary Care
  - 60 minutes for Specialty Care

Assumptions:

- MCSC could contract an additional 50% of the existing non-network PCPs
- The average PCP panel is approximately 2000[13]

[7] Contracted with Tricare: Providers are currently contracted to provide services to Tricare beneficiaries; High Likelihood: Providers are connected to organizations currently providing services to Tricare beneficiaries; Medium Likelihood: Providers are accepting Medicare and/or Medicaid; Low Likelihood: Providers are neither providing Medicare nor Medicaid

[8] Network Insight Assessment Summary (Independent Government Assessment)

[9] M2

[10] MCSC

[11] Network Insight Assessment Summary (Independent Government Assessment)

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

[13] MGMA

- PCPs generally have relatively full panels, able to immediately enroll:
    - Up to 2.5% more enrollees (49) easily
    - 2.5% - 5% (50-99) with moderate difficulty
    - > 5% (100+) with great difficulty
- Beneficiaries are reluctant to waive the 30-minute drive time for Primary Care
- Metropolitan networks will grow more rapidly than rural networks to accommodate demand

Analysis:

- Hanscom AFB is near a metropolitan area with a 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 767 PCPs
- Each PCP would have to enroll five (5) new patients to accommodate the 3,696 66th Medical Squadron enrollees.
- Based on the assumptions above, the MCSC network could likely expand rapidly to meet the new demand
- Beneficiaries rate network health care 21% higher than 66th Medical Squadron 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:

- MCSC network may not grow fast enough to accommodate beneficiaries shifted from 66th Medical Squadron
- 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)

- **Primary Care:** The MHS impacted population for Primary Care is approximately 3,000, which represents 0.1% of the population within a 30-minute drive-time radius. This is well below the 10% threshold, and thus will not materially impact the supply of, and demand for, care. Projected population growth for this area is 4.5% over the next five years (2019 to 2023)
- **Specialty Care:** The MHS impacted population for Specialty Care is approximately 19,000, which represents 0.3% of the population within a 60-minute drive-time radius. This is well below the 10% threshold, and thus will not materially impact the supply of, and demand for, care. Projected population growth for this area is 3.7% over the next five years (2019 to 2023)

Assumptions

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

Analysis

- **Primary Care:** Commercial Primary Care providers within the 30-minute drive-time could potentially absorb the incremental demand from beneficiaries who are being transitioned out of the MTF. The expected surplus of Primary Care providers across the primary and secondary geographies should potentially sustain the ability to service this incremental demand over time
- **Specialty Care:** Commercial Specialty Care providers within the 60-minute drive-time *potentially can absorb the incremental demand* from beneficiaries who are being transitioned out of the MTF. The network *could potentially maintain this level adequacy over time* (2019 to 2023)
    - Current **Psychiatry** providers in the market service area are covering current demand. There **is capacity** to potentially accept the incremental MHS population **with the current supply of providers**
    - The projected surplus, without new entrants, should sustain the ability to service the current MHS demand within the drive time standard over time

3.0. Appendices

Appendix A Use Case Assumptions

Appendix A: Use Case Assumptions

General Use Case Assumptions

1. Population impact that is greater than 10% of total population will impact the supply and demand of the provider network market
2. There will be no change in the TRICARE benefit to accommodate decisions
3. Readiness requirements for the final decision will be addressed in the Service QPP
4. There will be no changes to the existing Managed Care Support Contract (MCSC)
5. The MCSC could contract an additional 50% of the existing non-network Primary Care Providers (PCPs)
6. The average PCP panel is approximately 2000[14]

[14] 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

Part A	Data Call
Part B	Relevant Section 703 Report Detail Glossary
Part C	DHA TRICARE Health Plan Network Review
Part D	Network Insight Assessment Summary (Independent Government Assessment) P4I Measures
Part E	JOES-C 12-month Rolling Data
Part F	Command Brief
Part G	MTF Portfolio (Full)
Part H	

Appendix E: Trip Report

MHS Section 703 Workgroup Site Visit Trip Report

MTF: 66th Medical Squadron

Hanscom 11 February 2019

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Summary of Site Visit

Key Findings

Key Findings	Description
Overall	• Hanscom's market is sufficiently robust to accommodate the non-Active Duty (AD) and Guard/Reserve (GRD/RES) population's demand for primary care services • The 66th Medical Squadron functioning as a regional deployment hub for 250 Geographically Separated Units (GSUs) from all Services, spread over 99,000 square miles. Related duties add administrative workload significantly greater than what would be demanded by the MTF's enrolled population • Support for these GSUs is dictated by numerous support agreements and AF policy. The 66ABG is relooking at all agreements to justify additional resources for support
Base/Mission Impact	• The 66th Medical Squadron provides expertise, guidance, and support for numerous one-off requests from across Services and agencies (e.g., storage of vaccines for Natick, furnish Drug Enforcement Administration (DEA)-registered vault for the Department of Health and Human Services), which places additional burden on staff
MTF Impact	• Many Military Treatment Facility (MTF) functions (e.g., pharmacy, lab) are already operating at "open-door" levels; further reductions in staff could result in reductions of capabilities • Pharmacy serves beneficiaries from around the northeast region. Reductions in pharmacy capacity will be politically charged
Network	• MTF experience is consistent with Managed Care Support Contractor (MCSC) and Network Insight hypotheses that local area network is adequate • Transition from HealthNet to Humana in this market has not been smooth, resulting in frustrated beneficiaries and providers

Key Risks and Mitigation Strategies

Key Risks	Description	Mitigation Strategy
Base/Mission Impact	• If the MTF is still responsible for family advocacy for the Active Duty Family Member (ADFM) population that is pushed to the civilian market, it must be resourced to do so • Changes in capabilities have been proposed for numerous MTFs across the Northeast. The MTFs in this region rely on one another for support, and change in capabilities at one could impact others	• The Defense Health Agency (DHA) and Services must agree on a policy and business rules to ensure continuous care coordination and management for EFMP and other beneficiaries that need it • The 703 workgroup should assess the collective regional impact of proposed changes, and make recommendations that mitigate the cumulative effects
MTF Impact	• Further reductions in staff would result in potential loss of service to supported GSUs and other AD personnel, and compound already-prevalent burnout among staff	• Assess manpower needed to effectively care for AD workload, and staff accordingly
Network	• Provider frustrations related to rough transition from HealthNet to Humana may lead to providers dropping out of the market	• Work with Humana to expedite improvement of billing and other processes

Summary of Base Leadership Discussion

List of Attendees

The following were in attendance during the Base Commander discussion:

Name	Title	Affiliation
Lt Col Kenneth Ferland	Deputy Commander (representing Col Chad Ellsworth)	Base Leadership
Mr. Thomas Fredericks	Deputy Director	Base Leadership
Col Mark Wilson	IMA to the 66ABG/CC	Base Leadership
CMSgt Henry Hayes	Command Chief	Base Leadership
Col Russel Pinard	Commander 66th Med Squadron	MTF Leadership
Dr. David Smith	Reform Leader for Health Care Management for the Department	703 Workgroup
Col James Mullins	Director, Biomedical Sciences Corps Operations, AFMOA	703 Workgroup
Col Jamison Elder	Director of Medical Services, AFMOA	703 Workgroup
CAPT Nate Price	Chief of the Facilities Enterprise for the Defense Health Agency	703 Workgroup
Ms Denise Comfort	Division Chief, AFMS Analytics (North)	703 Workgroup (telcon)
CAPT Christine Dorr	BUMED Healthcare Operations M3	703 Workgroup (telcon)

Summary of Base Commander Discussion

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

Topic	Key Discussion Points
Opening Remarks and Introductions	• Representation from the Med Clinic and the Base Leadership
Service Medical Leadership Perspective	• Recognize this effort is one of a number of transformational changes occurring right now that will affect the Air Force Medical Service •
Background and Timeline	• Section 703 asked us to look at what we need to sustain medically ready force • Looking at CONUS facilities for readiness and network capability • Primary reason to be here: to hear from the base about the mission that needs to be supported so we can be sure you get the support you need.
703 Workgroup Objective	• Fact-finding mission to develop Use Cases that will be reviewed by Senior Leadership Team • Final decisions from Senior Leadership Team, with agreement from Service Leadership, will go to Congress for Review before implementation
Overview of the Visit	• Primarily want to hear from Hanscom Base and MTF leadership to get a better understanding of how the MTF contributes to base, Line, and Department missions
Base Mission Overview	• Lifecycle Management primary mission area • Operations have ebbs and flows (e.g., this spring they will surge to accommodate 1,000 Marines) • Large Joint Force component – “We are a joint base without the joint name”

	• Significant growth of the base over the past decade, and still growing - $500 Million in MILCON from FY10-FY22

Voice of the Customer	• Current manpower is not aligned to all the functions they need. The numerous service agreements alone require up-staffing.
	• Medical Squadron unofficially functioning as a regional deployment hub for 250 Geographically Separated Units (GSUs) from across the Services, spread over 99,000 square miles
	• Demand for medical capabilities more similar to what would be expected for a larger base
	  o EFMP management of over 250 cases
	  ▪ Enables reassignment of AF personnel with EFMP requirements to PCS to New England
	  ▪ Expands pool of qualified AD personnel to fill key positions
	  o Process all Medical Evaluation Boards (MEBs)
	  ▪ 70% are ANG and 20% are AFRC personnel
	  ▪ Volume on par with much larger MTFs (i.e., Wright Patterson)
	• Medical Squadron serves a Guard/Reserve population that is larger than its Active Duty population
	• Many Military Treatment Facility (MTF) functions (e.g., pharmacy, lab) are already operating at "open-door" levels; further reductions in staff could result in reductions of capabilities
	• Concerned that converting to an AD clinic would mean that they were staffed for AD only. Dr. Smith confirmed that Guard/Reserve, Occupational Health, Public Health, and other areas would be considered in manning decisions
	• Recent climate assessments suggest that the staff is burned out
	• Pharmacy serves Tricare beneficiaries from all over New England. The pharmacy has extended its hours to accommodate demand.
	• Humana feels that the network can easily accommodate the ~3,800-beneficiary primary care volume generated by a transition from outpatient clinic to AD only. However, the transition from HealthNet to Humana in the Eastern Region has not been a smooth one, which has led to frustration among beneficiaries and providers

Next Steps	• Once Use Case is developed, it will be shared with Hanscom leadership • Determine how to quantify time spent on administrative and GSU-related activities that are not well reflected in workload and volume data

Voice of the Customer

Question	Notes
Medical Mission Perspective	
How well are the current medical capabilities meeting your base mission requirements?	• "Current medical capabilities are critical to overall success of base and New England region mission requirements" • Across the board, but especially in Med Squadron there is a short bench (i.e. minimum or just above minimum open-door staffing) • Med Squadron provides a vast number of services with very limited staff. The 66th Medical Squadron assists GSUs across all Services, acting as a regional hub for all GRD/RES support in the New England region

What do you think the biggest value is from your current medical capabilities?	• Serving beneficiary population and vast array of GSUs and GRD/RES from across New England • The pharmacy is highly valued by enrollees and retirees. Beneficiaries come from all over New England to fill prescriptions at the pharmacy
What gaps in current mission support capabilities might appear if the outpatient clinic changed to an Active Duty only clinic? What do you recommend to mitigate those gaps?	• Reduction to AD only would cause cuts across the board that would destroy the mission of the base. This is not just about the PCMs, but support for the base, guard, reserve (tri-service – we get everyone here) would all have to be cut
Network	
What is your perception of the civilian market and its ability to accommodate the healthcare needs of your beneficiaries?	• While we are close to Boston, and there are a number of services available, the drive time and perception of care would adversely affect our population • Availability of care is not as large as you would think being so close to Boston • Humana is struggling to rebuild/update the network. In many places, contracts have expired, or we do not have contracts
Community	
Are there community agencies/ organizations/ groups who rely on services from the MTF through existing agreements?	• 18 Agreements with Federal, State, and Local agencies for Regional Readiness / Emergency Management • Medical components to 44 Federal, State, and Local agency readiness/emergency preparedness agreements
What do you think the impact of changing to an Active Duty only clinic would be on the local community?	Biggest concern is that we would not be right-sized – not really accounted for in the standards • Staff are burnt out: across the AF we are doing more with less. At Hanscom they may technically have small population relative to workforce, but need to surge regularly and have a number of unaccounted for populations that seek services from Hanscom • Drive times: Yes we are close to Boston, but the convenience factor and want to reduce Boston traffic • Lab downsizing: Any reduction in staff is very concerning for patient safety reasons • Support agreements: They add up! This creates mission creep, which is felt in the medical space • Ability to flex: There is a slim bench. As people leave positions effects are felt across the mission center • Medical proficiencies: Use it or Lose it. May atrophy if we aren't able to use them frequently • Active political interest: Sen Warren – with presidential run, Sen Markey, Rep Clark, Rep Moulton) Large contingent of AD and retirees who utilize the base. This one is political/strategic

Summary of MTF Leadership Discussion

List of Attendees

The following were in attendance during the MTF Leadership discussion:

Name	Title	Affiliation
Col Russel Pinard	Commander 66th Med Squadron	MTF Leadership
Maj Edward Walters	Flight Commander Aerospace/Op Medicine	MTF Leadership
CMSgt Adam Page	66 MDS/CCC Superintendent	MTF Leadership
Lt Col Bankston	66 MDS/SGN Chief Nurse	MTF Leadership
Lt Col Bostrom	66 MDS/SGH Chief of Medical Staff	MTF Leadership
Maj Gustafson	Dental Operations Flt/CC	MTF Leadership
Dr. David Smith	Reform Leader for Health Care Management for the Department	703 Workgroup
Col James Mullins	Director, Biomedical Sciences Corps Operations, AFMOA	703 Workgroup
Col Jamison Elder	Director of Medical Services, AFMOA	703 Workgroup
CAPT Nate Price	Chief of the Facilities Enterprise for the Defense Health Agency	703 Workgroup
Ms Denise Comfort	Division Chief, AFMS Analytics (North)	703 Workgroup (telcon)
CAPT Christine Dorr	BUMED Healthcare Operations M3	703 Workgroup (telcon)

Summary of MTF Commander Discussion Agenda

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

Topic	Key Discussion Points
Opening Remarks and Introductions	• *Covered in Base Commander Discussion*
Service Medical Leadership Perspective	• *Covered in Base Commander Discussion*
MTF Medical Mission Overview	• Mission is to support our past, present, & future war fighters and their families through innovation, training and sustained quality care • Full scope MTF, but a “flat” organization with low staff numbers and many people dual-hatted • Joint in function. Only 41% Enrollees are AF, also serves Army, Navy/Marines, and Coast Guard • Hanscom has a “Cannot say no” policy. • Hanscom is the care coordinator for an Airman Medical Transition Unit (AMTU) (patient squadron) – inpatient/complex patients assigned to this market (often assigned to Hanscom because of high quality medical care available in the market); average AMTU census is 4-6 with a high of 10 (current census is 2) • Most functions are at minimum “open door” cost, i.e. they only have one provider for the service. If downsize, they won’t be able to do “more with less,” they will lose the function • Hanscom is acting as the official “hub” for AF in the New England region supporting many small detachments and GSUs. They do a lot of admin work

	related to the GSUs without having a formal designation or hours dedicated to that work. Hanscom does logistics and ordering for many GSUs
Background and Timeline	• *Covered in Base Commander Discussion*
703 Workgroup Objective	• *Covered in Base Commander Discussion*
Overview of the Visit	• *Covered in Base Commander Discussion*
Voice of the Customer	• Workload numbers vs. population numbers. These are dramatically out of sync for Hanscom and it is causing problems – must figure out a way to capture and quantify this work • MTF leadership concern that moving to AD only will lead to a reduction in staff that would not allow the MTF to effectively serve the full Military population, including AD, GRD/RES, and GSUs. When the AF undertook an analysis of this scenario, they proposed nearly cutting the 66th Medical Squadron's labor in half. Believes there are limited manpower savings to be gained through transitioning to AD only
Next Steps	• *Covered in Base Commander Discussion*
Closing Remarks	• N/A

Voice of the Customer

Question	Notes
Overall Risk and Impact	
If the current outpatient clinic was changed to an Active Duty only clinic, what concerns would this bring?	• Relegating family practice doctors to very healthy population. That is not why the family practice docs got into the business in the first place. Satisfaction will probably fall more, worse retention • While assigned PCM cannot deploy because it would leave the clinic without enough doctors • If a service is already operating at minimum open door, you may be left with an unlicensed provider/junior provider as the only option o Lab was scoring lowest across MHS because of lack of oversight (no lab officer was assigned, only technicians) – very junior physicians were providing oversight of the lab. After getting a lab officer assigned, in the most recent CAP inspection, Hanscom was a top performer • Often, families prefer to receive care from the same provider or provider group. A transition to AD only would break families apart • Decreased beneficiary convenience, perceived loss of benefits • Civilian sector doesn't understand military readiness requirements – if any AD have to go to network (if Hanscom staff was reduced too severely) there is a risk and time constraints to teach the network providers how to handle patient load
How do you think we would mitigate gaps between current medical capabilities and a possible future state of an Active Duty only clinic?	• Need more workload to keep surgical and specialty providers' skills current *(not specifically relevant to Hanscom, but true across the MHS)* • Recommend using Hanscom as gateway to Boston market – keep AF specialists and surgeons current by sending them into Boston market • We need to have our surgeons imbedded where there is trauma through robust partnerships between military and network

	• Solution to currency issues is to put medics into civilian facilities – we have to be ready to go to war – our population doesn't generate war-time trauma. The two are very different. Between deployed trauma and regular trauma – surgery is less invasive in civilian care. Need to develop surgeon's intuition, doesn't mean I need to face war-time trauma every day i.e. if they can transplant a liver, they can do a resection after liver has been shot. Sewing blood vessels is sewing blood vessels • Personally deployable, currency deployable
Would changing to an Active Duty only clinic impact base mission requirements? If yes, what?	• If the MTF maintains levels of staffing similar to current state, then impacts on mission requirements (base and beyond) would be relatively limited. If staff and capabilities are cut, then impacts will be felt across New England • Mass deployment is not the norm, but it happens one-to-two times a year. They aren't easily able to flex so resort to blocking days, doing clinics on weekends to make it happen. This becomes priority one • The one-off GSU support is a daily occurrence that puts lots of strain on existing services. Processing MEBs is very time consuming. GRD/RES typically have significant medical needs to become ready to deploy, and are difficult to track down, particularly when they are non-AF o Hanscom does not have a good list of Unit Commanders outside the AF • IMR statistics are passed through to Hanscom, so if those individuals are "red" (not ready), it reflects poorly on the Squadron
How would changing to an Active Duty only clinic impact the local community?	• GSUs: o they can keep track of AF relatively easily, but for Army/Navy they are not able to track down patients/commanders because the lists aren't well defined or updated o Immunizations – we do all the ordering, we go all over the place (if there are more than 30 people we go to them). One/Two – they have to come to us o Logistics – for 12 other GSUs!! Medical Supplies, every day clinic and deployment, for reserve and guard clinics. All equipment maintenance for these places too • Hanscom only AF clinic in NE so for any AFIT student (BU, Harvard, BC students mostly all come to Hanscom for clinic) – they also come for other exams, those looking to enlist
What "quadruple aim" concerns and issues do you think would arise?	• Potential risk that beneficiary health might be compromised by pushing care out to the market (e.g., Hanscom has experienced pharmacy script errors related to handwritten scripts from network providers)
Civilian Network Perspective	
What are your concerns, if any, about network specialty care access for non-active duty beneficiaries?	Capacity is there in the network for primary and specialty care • 66MDS Commander perspective: Biggest challenge is that Humana is not on top of their work – network is a mess for specialty care. People haven't made the transition from Health Net to Humana. People are being sent all over NE. Billings do not function, every referral ends up in collections because they cannot figure out how to get the network paid. • If Humana says there is 200% capacity to absorb, is that realistic? For primary care, yes. But access to specialty care has not smoothed out one- year post implementation of new MCSC • It is the headaches behind the scene that make this less viable

What is your impression of the current TRICARE Network capacity to absorb more Prime enrollees if family members are no longer enrolled to the MTF?	• Strong existing relationships with community partnerships – Hanscom recognizes that their primary care capacity could easily go to network. Network is slightly short on adolescent behavioral health, but that is an issue around the country
What is your impression of the potential to expand the TRICARE Network Prime enrollment capacity?	• Current network could likely take on the population that could no longer access the MTF if Hanscom was AD Only for primary care • There is a US Family Health Plan (USFHP) clinic that currently supports primary care for ~15K Tricare enrollees, also located on Hanscom AFB
Are there specialty (other than Primary Care or Aerospace Medicine) or ancillary services currently performed at the MTF that you believe would not be sufficiently available in the network?	• Ancillary services as the "hub" coordinator for AF in New England. Any reduction in medical services would mean cuts to admin services • MCSC has not done well in performing the care coordination role for EFMP beneficiaries. If more dependents became reliant on the market, there would need to be a clear policy developed to identify whether the MCSC or the MTF was responsible for care coordination. If the MTF is responsible, it should be staffed accordingly
What are your concerns, if any, about shifting non- active duty beneficiary enrollment to the network?	• See comments above regarding pharmacy issues and beneficiary convenience
Partnerships / Resource Sharing	
To what extent do clinicians go downtown for readiness purposes?	• Hanscom's providers do not generally go downtown to practice, but the Boston area is replete with partnership opportunities that could support clinician readiness
What agreements does the MTF have with off-base entities in the following categories: 1) External Resource Sharing, 2) Training Affiliation Agreements, 3) VA sharing agreements and 4) on-base diagnostic services (MRI, mammography, etc.)?	• "Often we cannibalize each other in one market. We resource markets as if the other Services do not exist. We sized facilities as if the other Services facilities didn't exist" • Key partnerships include: o Emerson Hospital o Lahey Clinic Hospital o Mass General Hospital o Newton-Wellesley Hospital (Sexual Assault Nurse/Forensic Examinations) o Beth Israel Deaconess Medical Center o Veterans Administration Medical Center, Bedford o Domestic Violence Services Network, Inc. o Commonwealth of Massachusetts Office of the Medical Examiner o Massachusetts State Laboratory Institute o Massachusetts Department of Children and Families o Commonwealth of Massachusetts Department of Public Health o Stop the Bleed Program o 14K TRICARE providers/specialists in network
Are there community organizations/groups that Hanscom has partnered with or that relies on the MTF for care? If so, is there	• Changes to Hanscom will have region-wide impacts – there are support agreements around the region. In addition to what is noted above, there are 18 agreements with Federal, State, and Local agencies: o Mutual Aid and Military Working Dog support with Police Departments

a substitute available in the region?	o Explosive ordinance mitigation and disposal o Installation action to epidemic / pandemic outbreaks o Staging facility for federal quick reaction force to acts of terrorism o Aircraft rescue-firefighting, confined space rescue, Hazmat response o Mass casualty, medical disaster, care and overflow o Firefighting response and support (Fourth Cliff reservation) o Investigation / cataloging of firearms used in the commission of crimes • Base bed down and logistics support to FEMA, USNORTHCOM, ICE and sister service units in Northeast US for exercises and real-world disaster response and contingencies • Medical components to 44 Federal, State, and Local agency readiness/emergency preparedness agreements
Other Questions	
Are there supported missions that drive services in the MTF beyond Primary Care, Aerospace Medicine, Optometry, Lab, Pharmacy and Radiology? If so, please describe the mission, the type of medical services	• Yes – see notes on GSU support
What, if any, impacts would come if pharmacy services for beneficiaries were reduced?	• Eliminating MTF pharmacy access for retirees would be a major dissatisfier, and could result in increased copay and pharmacy costs to the MHS if beneficiaries switch to network pharmacies
Do you have any occupational health assets supporting civilians? If so, please describe	• The MTF does not have a dedicated Occupational Health clinic, but Flight Medicine, Bioenvironmental Engineering and Public Health provide support for Occupational Health needs (e.g., audiology) on the base, and for a unit in Rome, NY
Are there any capital projects or MILCON budgeted for or currently started, related to the clinic? If so, please describe these projects	• Hanscom is currently home to the second-largest MILCON project in the AF o MIT Lincoln lab – $225 million project in FY19 o $500 million DoD investment over the last decade

MTF Tour Notes

Location Visited	Notes

66th Medical Squadron	• Primary Care Clinic
	  o On average, two exam rooms per provider (two physicians and two physicians' assistants)
	  o One pediatrician
	• Public Health assists with
	  o Food and water vulnerability assessments
	  o Occupational Health tasks (e.g., audiology). Do not have a dedicated Occupational Health clinic, but resources at Hanscom support needs for the base as well as for a unit in Rome, New York
	• Case Management
	  o Most experienced case manager is retiring. Must determine how to mitigate loss, given that she has strong relationships with providers around the region
	  o Coordinate care for ~250 EFMP beneficiaries
	• Medical Logistics
	  o Provide supply and equipment management for local units (e.g., stores vaccinations for Natick), as they have the only DEA-registered vault in the local area
	  ▪ Provide equipment maintenance support for Rome, NY unit that would normally receive support from Andrews and Scott AFB, as Hanscom is closer and has capabilities (e.g., an electrical cable assembly system (ECAS) was repaired by Hanscom Biomedical Engineering Technician (BMET), preventing a critical mission failure)
	  o Provides upgrade training for GSUs, including GRD/RES units
	  o Estimated time spent on GSU support:
	  ▪ Logisticians – Three-to-four hours per week
	  ▪ BMET – Six-to-eight hours per week
	• Dental
	  o Only clinic in the area that makes custom face masks for fighter pilots
	  o Hanscom supports an in-house lab to provide faster, more responsive manufacturing of crowns and implants
	  o 50% of workload is in support of GSUs
	• Mental Health Clinic
	  o Provides care for AD only
	• Family Advocacy and Patient Admin/Check-In Area
	  o Approximately 50% of family advocacy workload is linked to GSUs
	  o Nearly two-thirds of patient files linked to GSU patients, rather than enrolled Hanscom beneficiaries, approximately half of whom are pediatric patients