OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 20 2010

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

Dear Mr. Chairman:

The enclosed final report describing the results of cooperative health care pilot programs between military installations and non-military health care systems is in response to the requirements in Section 721 of the Ronald W. Reagan National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2005 and Section 707 of the NDAA for FY 2008.

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The Department supports cooperative health care agreements with non-military health care systems and other interested stakeholders as a positive mechanism to improve access to the continuum of health services at military installations. However, the results

of the pilot program indicate there is wide variation in how cooperative health care agreements might be used at other military installations. We will work with the Military Departments to further assess its suitability to other installations.

Thank you for your continued support of the Military Health System.

Sincerely,

Charles L. Rice, M.D.
President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 20 2010

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

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Enclosure:
As stated

cc:
The Honorable Lindsey O. Graham
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 20 2010

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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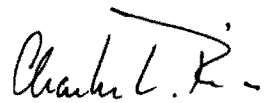

Charles L. Rice, M.D.
President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable Howard P. "Buck" McKeon
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 26 2010

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

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Enclosure:
As stated

cc:
The Honorable Joe Wilson
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 20 2010

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

Dear Mr. Chairman:

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Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable Thad Cochran
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 20 2010

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Committee on Appropriations
United States Senate
Washington, DC 20510

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Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 20 2010

The Honorable Norm Dicks
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Enclosure:
As stated

cc:
The Honorable C. W. Bill Young
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 20 2010

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

Report to Congress on Pilot Programs on Cooperative Health Care Arrangements Between Military Installations and Non-Military Health Care Systems

Prepared in Response to:

Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, Section 721

And

National Defense Authorization Act for Fiscal Year 2008, Section 707

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Report to Congress

Pilot Programs on Cooperative Health Care Arrangements Between Military Installations and Non-Military Health Care Systems

Executive Summary

In the Ronald W. Reagan National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2005, Congress authorized the Department to conduct a pilot program at two or more installations to test initiatives that build cooperative health care arrangements between military installations and local or regional non-military health care systems. The Department selected Fort Drum, New York, and Marine Corps Air Station, Yuma, Arizona, as pilot sites. Both installations have collaborated with non-military health care systems and other interested stakeholders to improve health care capability and capacities to serve both the local community as well as military beneficiaries. The Fort Drum Regional Health Planning Organization has had a substantial impact on health professional recruitment, emergency medical services, behavioral health services, improving the referral process, and monitoring access and quality of care for its support of 41,000 TRICARE beneficiaries in the area. The cooperative health care agreement in Yuma, Arizona, will likely add psychiatry capability where no permanent capability currently exists.

The Department supports cooperative health care agreements with non-military health care systems and other interested stakeholders as a positive mechanism to improve access to the continuum of health services at military installations. However, the results of the pilot program indicate there is wide variation in how cooperative health care agreements might be used at other military installations. We will work with the Military Departments to further assess its suitability to other installations.

Background

The Ronald W. Reagan NDAA for FY 2005, Section 721, Pilot Program for Health Care Delivery, required the Secretary to conduct a pilot program at two or more installations for the purpose of testing initiatives that build cooperative health care arrangements and agreements between military installations and local or regional non-military health care systems.

The statute indicated at least one of the selected military installations shall meet the following criteria:

- The military installation had members of the Armed Forces on active duty and members of reserve components of the Armed Forces that use the installation as a training and operational base, with members routinely deploying in support of the global war on terrorism.
- The numbers of members of the Armed Forces on active duty permanently assigned to the military installation was expected to increase over the next five years.
- One or more of the cooperative arrangements existed at the military installation with civilian health care entities in the form of specialty care services in the military medical treatment facility (MTF) on the installation
- There was an MTF on the installation that did not have inpatient or trauma center care capabilities.
- There was a civilian community hospital near the military installation with:
    - Limited capability to expand inpatient beds, intensive care, and specialty services; and
    - Limited or no capability to provide trauma care.

The Department consulted with each of the Military Departments to solicit nominations for MTF market areas to use as test sites. The criteria listed above were used to assess each nominated market area and determine which met all or most of the listed criteria. Fort Drum, New York, and Marine Corps Air Station, Yuma, Arizona, were selected as pilot test sites. An interim report on the program was required within 60 days after the commencement of the program and was provided to Congress on July 10, 2005.

The NDAA for FY 2008, Section 707, Extension of Pilot Program for Health Care Delivery, extended the pilot program for three more years and gave the Department the authority to collaborate with State and local authorities to share and exchange personal health information and data of military personnel and their families. Fort Drum, New York, and Marine Corps Air Station, Yuma, Arizona, continued as the test sites. The final report delivery date was extended to July 1, 2010.

The NDAA for FY 2009, Section 705, Program for Health Care Delivery at Military Installations Projected to Grow, and the NDAA for FY 2010, Section 713, Cooperative Health Care Agreements Between Military Installations and Non-Military Health Care Systems, gave similar authorities to the Department for cooperative arrangements with non-military health care systems. Responses to these authorities are not included in this report but will be provided under separate cover per the reporting requirements called for by each statute.

Reporting Requirements

This report fulfills the following reporting requirements as listed in the Ronald W. Reagan NDAA for FY05, section 721, in which the Secretary of Defense shall provide a final report describing the results of the program with recommendations for a model health care delivery system for other military installations.

To describe the results of the program, we will analyze each of the four requirements required for the pilot project. They were:

- Identify and analyze health care delivery options involving the private sector and health care services in military facilities located on the installation;
- Determine the cost avoidance or savings resulting from innovative partnerships between the Department of Defense and the private sector;
- Study the potential, viability, cost efficiency, and health care effectiveness of Department of Defense health care providers delivering health care in civilian community hospitals; and
- Determine the opportunities and barriers to coordinating and leveraging the use of existing health care resources, including Federal, State, local, and contractor assets.

Finally, we will provide recommendations for a model health care delivery system for other military installations.

Identify and Analyze Health Care Delivery Options Involving the Private Sector and Health Care Services in Military Facilities Located on the Installation

First we will identify and describe in general terms the two pilot program sites, then analyze the health care delivery options at each site.

Overview of Ft Drum, New York:

The Fort Drum health care delivery system evolved from the philosophy of community integrated services for Fort Drum and the families of Fort Drum soldiers that began in the 1980s with the reactivation of the 10th Mountain Division. Fort Drum's model, as it stands today, provides the highest percentage of purchased inpatient care within its Health Service Area (HSA) among comparison bases (92 percent). The model uses a mix of Army Medical Department Activity (MEDDAC) provided product lines, community provided product lines, and shared lines, bringing maximum benefit to the service members, their families and the civilian population in the surrounding community. The Fort Drum MEDDAC does not have inpatient capability and relies on

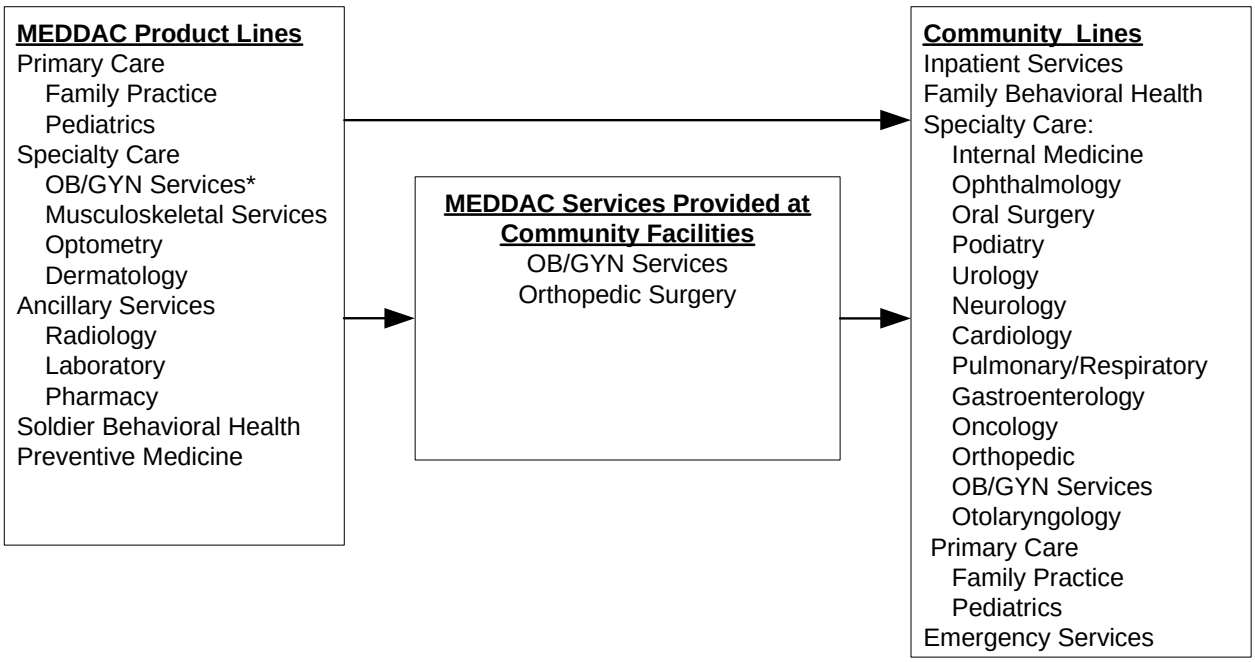
private sector community hospitals to provide the bulk of inpatient care needed by DoD beneficiaries.

The decision to assign the Third Brigade permanently at Fort Drum created an approximately 59 percent increase in the soldiers and families at and around Fort Drum between FY04 and FY07. This decision, along with a desire to retain all additional workload associated with the increased population in the MEDDAC's core competencies but not expand those product lines made it an ideal time to conduct a pilot to identify opportunities and barriers to a community-based model. Further, there was strong support for communication and collaboration between civilian and military resources.

The MEDDAC provided primary care, limited specialty care, ancillary services, soldier behavioral health, and preventive medicine service on the installation. These lines provide referral to community-based services and specialty care not provided on the installation, including all inpatient services. MEDDAC obstetricians, orthopedic surgeons, and podiatrists had privileges in local hospitals to provide surgery and obstetric/gynecological care in the community hospitals for Fort Drum soldiers and their families.

Figure 1 identifies the product lines being provided to DoD beneficiaries in the Fort Drum Health Service Area (HSA) by MEDDAC and community resources.

Figure 1 – Fort Drum Health Service Area Product Lines



Overview of Marine Corps Air Station (MCAS) Yuma: Located in the southwestern corner of Arizona, Yuma is home to two military installations with an outpatient MTF on each installation:

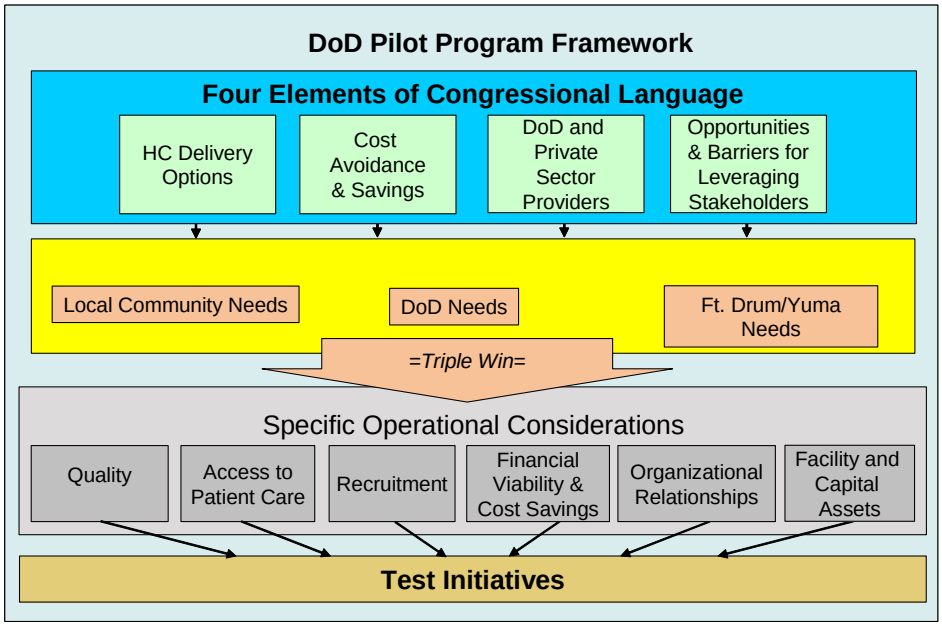
- Marine Corps Air Station (MCAS), Yuma, with Branch Health Clinic (BHC) Yuma: MCAS, Yuma, is an aviation training base, each year hosting numerous units and aircraft from the US and North Atlantic Treaty Organization (NATO) forces. As the medical support for Marine Air Group 13, as well as an additional 4,000 Operational Forces training in Yuma at any given time, BHC Yuma is an outpatient ambulatory care center that focuses on primary care and family medicine and has very limited specialty services available. BHC Yuma is an outlying clinic of Naval Hospital Camp Pendleton (NHCP), located 220 miles northwest of Yuma, and relies on NHCP for specialty care support for active duty, as well as on Naval Medical Center San Diego (NMCSD), located 170 miles west of Yuma.

- US Army Proving Ground Yuma (YPG) with YPG Army Health Clinic (AHC): Yuma Proving Ground is an evaluation range for military systems, including aircraft weapons, tanks, and artillery. As a small aid station, YPG AHC treats a small contingent of active duty and active duty family members on post. At the close of FY2006, there were approximately 2,200 TRICARE eligible beneficiaries who lived within the catchment area of YPG; however, the majority of care is provided to active duty service members (ADSMs). By FY2008, YPG AHC was limited to serving ADSMs. The remaining TRICARE beneficiaries seek care either in the local community or at BHC Yuma.

Analysis of Health Care Options

The framework shown in Figure 2 was followed by both sites to analyze the health care capabilities at each site and to determine opportunities for collaboration and improvement of health care capabilities in their areas.

Figure 2 – DoD Pilot Program Framework



Analysis – Fort Drum, New York

The initial analysis was accomplished in April 2005, at a health summit hosted by the MEDDAC to present the pilot program objectives and to identify health service gaps for the Watertown, New York, area.

Based on the gaps, identified in FY 04 and since, action has been taken to forge stronger Fort Drum MEDDAC and civilian health care provider partnerships. This includes Fort Drum MEDDAC Command participation on the boards of the civilian hospitals and other health care organizations, and the formation of the FDRHO in October, 2005.

The Fort Drum Regional Healthcare Planning Organization (FDRHPO) was formed to address the community's health care planning needs. It is a 501(c)3 organization consisting of representatives from the MEDDAC, Fort Drum, Samaritan Medical Center, Carthage Area Hospital, Northern Area Health Education Center, Community Services Board, Fort Drum Regional Liaison Organization, Jefferson County Public Health Service, Northern New York Rural Health Care Alliance, Jefferson Physician Organization, and the Department of Veterans Affairs.

The FDRHPO performed a gap analysis of the health care needs in the Fort Drum / Watertown, New York, area, and identified potential gaps for the following clinical services.

- Emergency Services
- Neurosurgery
- Child Psychiatry
- Urology
- Neurology
- Adult Psychiatry
- Child Psychology
- ICU Beds

They also identified areas of concern that affected the Watertown health care community as a whole. They included:

- Access Standards;
- Aging Civilian Infrastructure;
- Weather Impacts;
- Specialty / Subspecialty Care;
- Emergency Medical Services;
- Quality Outcomes;
- Distance to Trauma Centers;
- Medical Staff Availability;
- Ambulance Staffing; and
- Masked Unmet Demand.

To address these concerns, the FDRHPO partners have accomplished:

- The completion of comprehensive behavioral health and emergency medical service gap analyses.
- Two more licensed and operational outpatient mental health clinics.
- Eight additional inpatient mental health beds and 12 additional TRICARE credentialed behavioral health providers.
- A unique standalone Soldier behavioral health clinic that partners with the MEDDAC, Health Net Federal Services, the regional TRICARE managed care support contractor, and a community provider.
- An annual commitment of $500,000 from New York State (NYS) for behavioral health supportive services for family members.
- Award of two NYS grants totaling $148,000 to develop detailed business implementation plans for Emergency Medical Service systems consolidation and improvement.
- Award of a $1.9 million Federal Communications Commission grant for telecommunications infrastructure.
- Award of a $6.7 million NYS Department of Health grant to implement electronic medical records in physicians' offices and the five hospitals that serve the Fort Drum beneficiaries. It is based on an interoperable Health Information Exchange to improve quality of care, access to information, and the receipt of clear and legible reports.
- A $90,000 NYS Department of Health award to assist with a telemedicine project to improve access to care in the Fort Drum region.
- A $580,000 community investment for physician and allied health professions education and recruitment in the Fort Drum region.

- $1.1 million from NYS Doctors Across New York to provide physician loan repayment incentives for physician recruitment.
- A partnership with Upstate Medical University to bring health care education programs to the region to address workforce shortages.
- Increased the number of psychiatric and family nurse practitioners from the Fort Drum region enrolled at the Upstate Medical University; medical students from Upstate Medical University began clinical rotations at the Fort Drum MEDDAC.
- Increased credentialed community behavioral health providers serving the Fort Drum region from 39 providers in 2005 to 109 providers in 2009, an increase of 70 percent.

Analysis –Marine Corps Air Station, Yuma

An analysis was conducted in 2005 to establish existing capacity in the direct care and purchased care systems. At that point in time, the direct care system at Branch Health Clinic (BHC), Yuma, was providing services in Primary Care/Family Practice, Mental Health (active duty only), Optometry, Physical Therapy (active duty only), and basic Laboratory, X-Ray and Pharmacy. A review was then performed on the adequacy of the private sector network to identify any shortfalls in its ability to meet the needs of the TRICARE beneficiaries. BHC's top specialty care services in FY2004 and FY2005 for their enrollee population were Obstetrics/Gynecology, Chemotherapy/Oncology services, Cardiovascular, Orthopedic procedures, Magnetic Resonance Imaging (MRI) procedures, Physical Therapy, and Dermatology. The health care resources of the local community, NHCP and NMCSD adequately met the demand for these top specialty care services; however, the market analysis identified that Yuma area TRICARE beneficiaries were traveling long distances in order to obtain mental health services.

A subsequent analysis was performed in January 2006, to examine the orthopedic care needs of the active duty population. NHCP had been providing orthopedic services through a circuit rider program, whereby personnel would commute to Yuma once per week to see active duty patients at BHC Yuma. If an ADSM required surgery, the service member traveled to NHCP, over 200 miles one-way, to receive the care. Non-active duty TRICARE beneficiaries were receiving orthopedic care in the local Yuma community and had not experienced any issues related to network adequacy. While there are no financial cost savings stated, it is assumed that, through the elimination of travel to NHCP, there would be savings in active duty travel costs. More importantly, orthopedics was studied and considered as a pilot focus area due to the qualitative benefits such an initiative could provide for the active duty population. Through the various types of analyses that were performed, two initiatives were identified and implemented that met the intent of the pilot program, Orthopedics and Mental Health.

After analysis, it was determined that orthopedic care would continue to be provided via providers traveling from other military bases.

Cooperative efforts at Marine Corps Air Station, Yuma, have since centered on obtaining the services of a psychiatrist to be shared between the military installation and the local Yuma, Arizona, community.

The Branch Medical Clinic (BMC) at Marine Corps Air Station, Yuma, serves approximately 3,500 active duty Marines and an additional 3,500 non-active duty enrollees. The clinic has one psychologist billet, but there is no assigned psychiatrist to manage psychiatric medications. On a monthly basis, the Naval Hospital Camp Pendleton has sent a "circuit rider" psychiatrist to provide services, but this is not an optimal solution and requires three hours of travel to and from Yuma. The community of Yuma is served by Yuma Regional Medical Center (YRMC), a sole community 333-bed not-for-profit acute care facility. There is no psychiatrist on staff.

The BMC and YRMC agreed to share a psychiatrist between the military installation and the local community. They agreed on how the psychiatrist's start-up salary costs would be shared for the first year. The position requires board certification within one year of hire. Promising candidates were close to being hired in both FY 08 and FY 09, but ultimately declined. A promising candidate has been identified and has indicated intent to accept the position upon completion of residency in summer 2010.

Cost Avoidance or Savings Resulting From Innovative Partnerships Between the DoD and the Private Sector

We will discuss both the tangible and the intangible cost avoidance or savings resulting as a result of the pilot programs at the two sites. First, it is helpful to understand that it is difficult to separate the actions taken as a result of the pilot program from the actions taken by the TRICARE Regional Offices and the Military Services in conjunction with their MCSC partners in their normal course of business providing health care to military beneficiaries at both pilot sites.

Cost Avoidance or Savings – Fort Drum, New York

The most tangible evidence of cost avoidance due to the pilot program was the use of military providers treating inpatients at local civilian hospitals via external resource sharing agreements. Over the course of four years of data, the Government estimated savings at the Fort Drum site were over $2.78 million in the specialties of Gynecology, Obstetrics, Podiatry, and Orthopedics.

Figure 3 – Tangible Cost Savings – Fort Drum, New York

	2007	2008	2009	2010	Totals
Encounters	1,652	3,109	2,064	1,107	7,932
RVUs	8,076	15,975	11,116	5,766	40,933
Savings	$533,107	$1,076,450	$769,454	$401,590	$2,780,599

However, as for intangible benefits, due to the efforts of the MEDDAC commander, the MCSC partner, and the partnerships developed as a result of the pilot program, the most notable area of success was in improved access to care. As Fort Drum experienced significant challenges in obtaining specialty care, in particular behavioral health services, great effort was made to improve access to providers in the local area to keep both military beneficiaries as well as the local populace from traveling several hours to receive specialty care. For example, see Figure 4 below for the results of the efforts at Fort Drum to improve access to behavioral health services.

Figure 4 – Impact of TRICARE Network Behavioral Health Serving Fort Drum Region

Credentialed Provider	Pre-Pilot (2005)	Post Pilot (2009)	Increase During Pilot
Child or Adolescent Therapy	9	29	20
Eating Disorders	3	3	0
Licensed Clinical Social Worker	10	26	16
Marriage and Family Counselor	0	1	1
Mental Health Counselor	0	9	9
Neuropsychologist	2	1	-1
Nurse, Clinical Psychiatric	1	3	2
Psychiatric Hospital	1	1	0
Psychiatrist, Child	1	4	3
Psychiatrist	3	12	9
Psychologist	8	14	6
Substance Abuse	1	3	2
Warrior Support	0	3	3
Total	39	109	70

In the areas of collaboration between Fort Drum and the local health care community through the efforts of the FDRHPO, they have been successful in addressing a variety of issues affecting the Watertown, New York, health care community as

identified in the previous gap analysis and its resulting collaborative efforts. While not directly relating to government cost savings, the efforts have improved the capabilities of the local health care community by addressing key issues affecting the community as identified by the initial gap analysis and ongoing dialogue and collaboration between FDRHPO members.

In terms of the cost of the cooperative health care arrangements, initially manpower was provided by each participating organization via donated labor. Starting in Fiscal Year 2007, funding for the FDRHPO was provided by the Defense Health Program (DHP) to pay for personnel and office expenses. The total budgeted amounts of Defense Health Program dollars are shown in Figure 5. These amounts were authorized in the National Defense Authorization Acts. The increase in the FY 2009 funding was to provide matching funds for a fiber optic project.

Figure 5 – DHP Funding for Fort Drum Regional Health Planning Organization

FY	Funding
2007	$400, 000
2008	$400,000
2009	$640,000
2010	$430,000

Cost Avoidance or Savings – MCAS Yuma, Arizona

No cost savings have occurred to date, but planned actions to hire a psychiatrist jointly to treat both military beneficiaries as well as the Yuma community should improve access to behavioral health care as well as eliminate significant travel time to existing sources of psychiatric care. The participants will continue to work together collaboratively to improve health care services in the Yuma area.

In terms of the cost of the cooperative care arrangements or agreements at the Yuma, Arizona, pilot project, there were no stated costs as each partner in the arrangement assumed the cost of any collaboration efforts.

The Potential, Viability, Cost Efficiency, And Health Care Effectiveness of DoD Health Care Providers Delivering Care in Civilian Community Hospitals

As mentioned earlier, the MHS works with its MCSC partners and local health care communities to allow government health care providers to deliver specialty and inpatient services for military beneficiaries in civilian community settings and hospitals.

Fort Drum's experience during the pilot project to maximize the capability of its military obstetrics, gynecology, podiatry, and orthopedics providers to provide a fuller range of services while keeping that provision of care in the local area was noteworthy. The MHS believes that external resource sharing agreements (ERSAs) can be a very valuable tool to provide care to military beneficiaries, particularly when there is a shortage of that particular specialty in the local health care community.

These arrangements are also very effective for both the providers and beneficiaries. Providers are able to keep up their surgical and inpatient skills, keeping their skills honed for military readiness reasons. Beneficiaries also benefit since care is provided in the local area by military providers. For non-active duty beneficiaries, there are no co-payments associated with professional fees, as permitted by TRICARE policies.

As shown in Figure 3 above, the ERSAs at Fort Drum were very cost effective and well received by all parties as the Government saved $2.78 million over the course of the pilot project.

Opportunities for and Barriers to Coordinating and Leveraging the Use of Existing Health Care Resources, Including Federal, State, Local, and Contractor Assets

Opportunities. In combination with its MCSC partners, in most cases, the DoD is able to ensure health care can be delivered in a timely, quality, and cost-effective manner covering the full range of services that are required. In certain communities where the capability to provide care for all residents in that area is lacking, there is the opportunity to coordinate and leverage the use of existing health care resources from all sources. The DoD relies on the capabilities of the local health care resources when care is needed beyond the capabilities of the MHS resources in that area. The DoD can also call upon the framework of DoD MCSC contracts, DoD / VA resource sharing agreements, and partnerships with other federal agencies such as the Indian Health Service.

In particular, the Fort Drum Regional Health Planning Organization was a valuable asset, bringing together military and civilian organizations to identify optimal health care plans to meet the needs of the Soldiers, their families, and the local community. The FDRHPO has improved the local health care system capacity and infrastructure available in the health service area surrounding Fort Drum. There is a strong desire by all participants for the FDRHPO to continue.

Barriers: From a DoD perspective, there are few barriers for DoD and its MCSC partners to coordinate and leverage the use of existing health care resources to provide services for MHS beneficiaries on and off the installation. In most instances the same civilian provider that serves the community can also provide services to MHS beneficiaries

though resource sharing agreements, TRICARE authorized status, TRICARE network affiliation, or through direct contracts.

Local communities face barriers to coordinate and leverage health care resources that do not affect the DoD. These include:

- Barriers to service provision: Certificate of Need process at the State level, municipal law barrier to local EMS, no financial mechanism to expand mental health initiatives (traditionally funded with State aid and Medicaid revenues), limited reimbursement for telemedicine / telepsychiatry.
- Barriers to provider recruitment and retention: Physical distances and rural setting.
- Barriers to service provision, growth or change: Credentialing, bureaucratic or legal processes (mostly relating to technology), communication between local health care resources.
- Barriers to Funding: Sustained funding for community or regional health planning organization if one does not already exist.

Results of the Program

As a result of the pilot programs, substantive partnerships, significant cooperative health care arrangements and agreements have been established between the Fort Drum and Yuma MTFs and their respective civilian communities. These partnerships will continue to have long-lasting benefits for military and civilian beneficiaries in these areas.

However, the results of the pilot programs indicate there is wide variation in the health care challenges that communities near military installations face and how cooperative health care agreements might be implemented. For instance, an unfunded informal coordinating structure was used at MCAS Yuma while a funded formal coordination organization was established at Fort Drum.

Recommendations for a Model Health Care Delivery System for Other Military Installations

The Department is committed to improving access to the continuum of health services at military installations that may lack the current or planned medical treatment facility or TRICARE network capacity to satisfy the current or proposed number of beneficiaries at military installations. The Department realizes that health care in the United States is a dynamic process with numerous independent variables, but is committed to ensure that our military beneficiaries will have ready availability of the high quality health care they deserve.

As such, we will work with the Military Departments to further assess its suitability to other installations.