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

PERSONNEL AND READINESS

JUL 15 2014

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

Dear Mr. Chairman:

The enclosed report responds to section 735 of the National Defense Authorization Act for Fiscal Year (FY) 2013, Public Law 112-239, which required the Secretary of Defense to conduct a study on health care and related support for dependent children of members of the Armed Forces. The Assistant Secretary of Defense (Health Affairs) established a working group to request information from the Services about their pediatric policies, programs, and personnel related to pediatric care. The enclosed report summarizes the Services' responses in conjunction with the analysis of the TRICARE claims data from FY 2012.

Children, with the complexities of their growth, development, and social needs, present a range of challenges. Children with routine and special medical needs utilize the Military Health System for timely diagnosis, intervention, and coordination of care. TRICARE continues to evaluate pediatric health care in relation to short and long-term health benefits or consequences for life expectancy; quality of life can be accomplished through primary prevention in the pediatric population. The report concludes that TRICARE and the Military Departments meet the medical and related service needs of the population, with areas for future studies recommended.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Sincerely,

Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

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

PERSONNEL AND READINESS

JUL 15 2014

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

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Sincerely,

Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

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

PERSONNEL AND READINESS

JUL 15 2014

The Honorable Barbara A. Mikulski
Chairwoman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Madam Chairwoman:

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Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Richard C. Shelby
Vice Chairman

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

PERSONNEL AND READINESS

JUL 15 2014

The Honorable Harold Rogers
Chairman
Committee on Appropriations
U. S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Sincerely,

Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

Report to Congressional Defense Committees: Study on Health Care and Related Support for Children of Members of the Armed Forces

Office of the Secretary of Defense
July 2014

The estimated cost of this report or study for the Department of Defense is approximately $115,000 in Fiscal Years 2013 - 2014. This includes $60,000 in expenses and $55,000 in DoD labor.

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EXECUTIVE SUMMARY

This report responds to section 735 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013, Public Law 112-239, which required the Secretary of Defense to conduct a study on the health care provided to dependent children of members of the Armed Forces: this report is organized in the following nine elements:

1. Review TRICARE policies.
2. Assess access to pediatric health care.
3. Assess access to pediatric specialty care.
4. Review and analyze reimbursement under the TRICARE program.
5. Assess adequacy of the ECHO [Extended Care Health Option] Program.
6. Assess adequacy of care management.
7. Assess support provided through other Department of Defense (DoD) or Military Department programs and policies.
8. Identify mechanisms for linking dependent children with special health care needs with State and local community resources.
9. Identify strategies to mitigate the impact of frequent relocations.

The Military Health System (MHS) combines health care resources from both the direct and purchased care components of the TRICARE program to provide access to high-quality health care for the 9.6 million Service members of the seven uniformed services, National Guard and Reserve members, retirees and their eligible family members, survivors, certain former spouses, and other individuals while maintaining the capability to support military operations worldwide.[1] TRICARE's direct care component is comprised of 149 Military Treatment Facilities (MTFs)[2] in the United States and around the world that provide primary and specialty medical and behavioral health care, ancillary services, and pharmacy services. TRICARE's purchased care component includes network and non-network providers of those services. Currently, approximately 2.4 million individuals from newborns to age 21 years receive benefits through TRICARE in direct, network, and non-network settings.[3]

This report presents a current analysis of health care and related support provided to dependent children of members of the Armed Forces, defined in this report as Army, Navy (including Marine Corps), and Air Force on active duty. "Military" refers generally to the Army, Navy and Marine Corps, and Air Force. "Related support" is defined as non-medical family assistance for information and referral. The non-medical support is provided through each Military

[1] TRICARE Welcome Page. http://www.tricare.mil/Welcome.aspx?sc_database=web.
[2] The term "Military Treatment Facilities (MTFs)" refers to the medical facilities of the Defense Health Agency and the Departments of the Army, Navy, and Air Force, including: academic medical centers (*e.g.*, Walter Reed National Military Medical Center, Bethesda; San Antonio Military Medical Center); military community hospitals; and military clinics.
[3] *DoD Evaluation of the TRICARE Program: Fiscal Year 2013 Report to Congress*. Accessed: March 25, 2014. Available at: http://tricare.mil/tma/dhcape/program/downloads/TRICARE2013%2002_28_13%20v2.pdf.

Department's Exceptional Family Member Program (EFMP) and is overseen by the DoD Office of Community Support for Military Families with Special Needs (OSN).

Methodology

To develop the report, the Assistant Secretary for Defense (Health Affairs) assembled an expert group, the Pediatric Report to Congress Working Group (WG). The Defense Health Agency (DHA) led the WG, whose goal was to review and evaluate the MHS's policies and programs as they relate to the elements of the NDAA. The WG included Service members and civilian personnel who work actively within DoD's systems of pediatric care.

Data were obtained directly from:

- Army;
- Navy, including the Marine Corps;
- Air Force;
- National Capital Region-Medical Directorate (Walter Reed National Military Medical Center [WRNMMC] and Fort Belvoir Community Hospital [FBCH]); and
- TRICARE Regional Offices (TROs) in the United States (*i.e.*, North, South, and West).[4]

Supplemental data were obtained from DHA systems.

Key Findings from the Elements of the Study

This report presents findings and recommendations for each element. Based on available data, it concludes that the MHS is meeting the needs of the children in its care, including those with special needs, as specifically addressed under each of the nine elements listed above. The data confirm that the MHS provides comprehensive and high-quality health benefit programs for all children. However, some areas require further study and analysis. The specific findings applicable to one or more of the nine elements of the study are:

1. Analysis of access to pediatric care in appropriate settings demonstrates that there is adequate access to care across all settings within the MHS.

2. The proportion of visits for specialty care suggests that direct care is providing adequate access to specialty visits for pediatric dependent children, including those with special or chronic medical care needs.

[4] Based on the proportionally low numbers of pediatric care overseas, data from the overseas TRO were not included in this analysis. In addition, data on TRICARE-eligible children of active duty members of the Commissioned Corps of the U.S. Public Health Service (USPHS) and the National Oceanic and Atmospheric Administration (NOAA) were not included, as beyond the scope of Section 735 of NDAA FY 2013.

3. Provision of pediatric specialty care by credentialed pediatric specialty providers is substantiated in 80 percent of specialty visits.

4. The MHS's reimbursement of pediatric care is adequate to meet the needs of this unique population. The accommodations and additional payment groupings accurately reflect the cost and payments involved in providing specialty care and services for children with special health care needs and chronic health conditions.

5. Military Department, community, and MHS resources are available to support beneficiaries for medical and non-medical transitions to strengthen family resilience during relocations.

6. DoD and the Military Departments provide multidimensional comprehensive programs to support the physical and behavioral health of dependent children, including those with special health care needs.

Areas for Clarification

1. Review the regulatory provision for TRICARE program cost sharing of private sector care, specifically whether the higher standard of medical necessity governing the purchased care component of the TRICARE program—which differs from the definition of medical necessity in the larger medical community and applicable to MTF care—should be modified.

2. TRICARE's well child benefit ends at age six years. The preventive care program as it relates to pediatric beneficiaries does not conform to the American Academy of Pediatrics (AAP) periodicity guideline, which recommends annual screening up to the age of 21 years. DoD should:

    - Review utilization of preventive care benefits by beneficiaries ages 6 to 21 years to assess if developmental- and age-appropriate care is being delivered as compared to the AAP recommended periodicity schedules and guidelines, the 2010 Patient Protection and Affordable Care Act, or Medicaid's Early and Periodic Screening, Diagnosis and Treatment benefit.

    - Review pediatric specialty care offered by pediatric specialty and subspecialty purchased care providers. Network adequacy reports do not provide sufficient coding detail or provider profile information to evaluate secondary level of specialty in order to confirm whether pediatric beneficiaries are being treated by credentialed providers in pediatric specialties and subspecialties.

3. There are no common data evaluation systems or metrics within DoD or the Military Departments to evaluate the multidimensional programs that support the physical and behavioral health care needs of children. Further study is needed to define the

overarching goals and corresponding metrics that best evaluate outcomes of wellness and resilience programs within TRICARE and DoD.

4. Data collection systems do not include a standardized definition of what identifies a child with special needs across DoD, the Military Departments, regional contracts, and pediatric specialty groups. DoD should evaluate the utility of adopting an enterprise-wide definition of "child with special needs" or use the National Institutes of Child Health and Human Development definition of child and youth with special health care needs (CYSHCN).[5]

5. Consideration should be given to including access satisfaction and quality evaluation specific to pediatric beneficiaries in future fiscal years of *The Evaluation of the TRICARE Program Report to Congress*. The expansion of the annual report could provide a comprehensive review of pediatric access, quality, and adequacy as a means to report on the status of pediatric care.

6. With multiple centralized data systems across DoD and the Military Departments, it is challenging to make analytic comparisons between DoD and the Military Departments, or across direct and purchased care components. DoD should evaluate ways to develop a representative method to compare and make analytical comparisons between DoD and Military Departments, and across direct and purchased care to evaluate access and accessibility for pediatric beneficiaries. This would provide a robust basis for future comparisons of care.

Summary

Children in military families face challenges that require unique services and care. The MHS provides the dependent children it serves with adequate access to high-quality care including appropriate specialty care and related non-medical support to support complex family needs. This comprehensive worldwide health care system allows our Service members to focus on their mission, assured that their family members are receiving the care they need, and reinforces the MHS message of "families first, mission always."

[5] It is important to distinguish the commonly used term "special needs" from the Department's use of the term "special needs child." For purposes of this report, the Department used the term "child with special needs" as defined in DoDI 1315.19 and discussed in this report.

INTRODUCTION

This report responds to section 735 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013, "Study on health care and related support for children of members of the Armed Forces," which required that the Secretary of Defense conduct a study of nine elements of the Department of Defense's (DoD's) health care policies and programs relevant to dependent children of members of the Armed Forces.

Overview of DoD's Military Health System

The Military Health System (MHS) is a blend of DoD health care resources of the direct care and purchased care system that provides access to high-quality health care services while maintaining the capability to support military operations. The 9.6 million TRICARE beneficiaries include Service members, National Guard and Reserve members, retirees and their families, survivors, certain former spouses, and other eligible individuals worldwide. This total includes an estimated 2.4 million beneficiaries from birth to age 21 years.[6] The MHS meets the medical needs of enrolled beneficiaries through a comprehensive worldwide health care system that combines the best of military medicine and community medical resources.

The largest proportion of MHS care is provided in the direct care component at Military Treatment Facilities (MTFs) by uniformed service personnel, DoD civilians, and/or contracted civilian health care professionals. Within the MTFs, eligible beneficiaries enrolled in TRICARE Prime (the Health Maintenance Organization [HMO]-like option), are assigned a Primary Care Manager (PCM),[7] and (where implemented) enrolled in a Patient-Centered Medical Home (PCMH).

Supplementing the direct care component, the purchased care component of TRICARE is composed of TRICARE-authorized[8] civilian health care professionals, institutions, pharmacies, and suppliers who have entered into a network participation agreement with a TRICARE regional contractor.[9] Network providers serve as PCMs for eligible beneficiaries enrolled in

[6] The terms "child" and "children" for purposes of this report refer only to dependent children of sponsors who are on active duty for more than 30 days in the Army; Navy and the Marine Corps; or Air Force. It does not include dependent spouses, dependents of retired members, dependents of participants in the TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR) or Continued Health Care Benefit Program (CHCBP) premium-based options, dependents of members of the U.S. Coast Guard, Commissioned Corps of the U.S. Public Health Service (USPHS) or the National Oceanic and Atmospheric Administration (NOAA), dependents of foreign military members who are TRICARE eligible, individuals granted access to MHS care based on Secretarial Designee status, or individuals who are members of the Armed Forces under age 22 years.

[7] A Primary Care Manager (PCM) at an MTF may be either a physician or, in certain cases, a Physician's Assistant (PA) or a Nurse Practitioner (NP).

[8] By law, the TRICARE program may only cost share the services and supplies of authorized providers meeting DoD-established criteria.

[9] TRICARE is managed worldwide by regional contractors: three in the United States—North, South, and West; and Overseas.

TRICARE Prime.[10] Network providers also function as TRICARE Extra providers (the Preferred Provider Option [PPO]).

The purchased care component of TRICARE includes:

> The TRICARE North Region administered by Health Net Federal Services includes: Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Iowa (including the Rock Island area), Kentucky (except Fort Campbell), Maine, Maryland, Massachusetts, Michigan, Missouri (including the St. Louis area), New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, and Wisconsin.
>
> The TRICARE South Region administered by Humana Military includes: Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, Texas (excluding the El Paso Area), and Ft. Campbell, Kentucky.
>
> The TRICARE West Region administered by United Military and Veterans includes: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (excluding Rock Island Arsenal area), Kansas, Minnesota, Missouri (except the St. Louis area), Montana, Nebraska, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern corner including El Paso), Utah, Washington, and Wyoming.

Non-network care is delivered by TRICARE authorized providers who may choose to "participate" in TRICARE on a claim-by-claim basis. Non-network authorized providers who choose to participate in TRICARE agree to accept the CHAMPUS Maximum Allowable Charge (CMAC) for a service or item rendered. Authorized providers in the United States who choose not to participate in TRICARE may charge an additional 15 percent above CMAC.[11]

In addition to TRICARE benefits, some military families and children also rely on state and other federal programs (*e.g.*, Medicaid, Medicare) to meet specific needs. For "dual-eligible" beneficiaries, such programs provide home care, disposable supplies, respite care, and equipment that augment TRICARE. Other non-medical programs available from the Military Departments and community programs provide additional resources for children connected to military families.

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[10] In addition to TRICARE Prime offered in the direct care component by enrollment with a PCM at an MTF and in the purchased care component offered by enrollment with a TRICARE network provider, Prime-eligible beneficiaries may choose to enroll with one of six Designated Providers under the U.S. Family Health Plan in locations where it is available.

[11] Charging up to 15 percent above CMAC is referred to as "balance billing." Note that, because the balance billing limit is established by Medicare law, it is applicable to TRICARE only where Medicare coverage applies. Therefore, in other areas overseas there is no balance billing limit to what authorized providers may charge for TRICARE-covered services.

Elements of the Study

Section 735 of NDAA FY 2013 required DoD to provide:

1. A comprehensive review of the policies of the Secretary and the TRICARE program with respect to providing pediatric care.

2. An assessment of access to pediatric health care by dependent children in appropriate settings.

3. An assessment of access to specialty care by dependent children, including care for children with special health care needs.

4. A comprehensive review and analysis of reimbursement under the TRICARE program for pediatric care or children with special health care needs.

5. An assessment of the adequacy of the ECHO [Extended Care Health Option] Program in meeting the needs of dependent children with extraordinary health care needs.

6. An assessment of the adequacy of care management for dependent children with special health care needs.

7. An assessment of the support provided through other DoD or military department programs and policies that support the physical and behavioral health of dependent children, including children with special health care needs.

8. Mechanisms for linking dependent children with special health care needs with State and local community resources, including children's hospitals and providers of pediatric specialty care.

9. Strategies to mitigate the impact of frequent relocations related to military service on the continuity of health care services for dependent children, including children with special health and behavioral health care needs.

Conclusions

Based on available data, as described in detail in this report, the MHS is in great measure meeting the needs of the children in its care, as specifically addressed under each of the nine elements contained in this assessment. The data confirm that the MHS provides comprehensive and high-quality health benefit programs for all children, including those with special needs. However, some areas require further study and analysis, in particular, gaps in preventive care, and lack of data regarding specialty care providers. Other areas for further exploration include the need to develop and coordinate metrics and data systems to support comparisons across direct and purchased care components.

The MHS recognizes that, in general, children tend to be healthy, requiring primarily health maintenance. However, there is a unique population of children born with or diagnosed with complex medical or genetic diseases/disabilities that requires complex ongoing care, either episodically or continuously over the course of a lifetime. The MHS has long recognized that the health of children and their quality of life—both short- and long-term—is improved through primary prevention and early intervention. The complexities of children's growth, development, and social needs present a range of challenges in both direct and purchased care components of the TRICARE program. Children with both routine and special medical needs require timely and accurate evaluation, diagnosis, and coordination of care.

This report responds to each of the elements of study requested by section 735 of NDAA FY 2013, including a discussion of methodology, which follows. For each section, gaps in benefits or programs are identified, followed by areas for review.

METHODOLOGY

DoD prepared this report using a number of approaches based on the information requested in each element of the NDAA language at section 735. This section summarizes the approaches used to support the analyses.

Establishment of the Pediatric Report to Congress Working Group

To develop the report, the Assistant Secretary for Defense (Health Affairs) assembled an expert committee, the Pediatric Report to Congress Working Group (WG). The Defense Health Agency (DHA) led the WG, whose goal was to review and evaluate the MHS's policies and programs as they relate to the elements of the NDAA. To ensure ongoing development, analysis, and depth of the undertaking, members appointed to the group were required to have the necessary authority and expertise to staff and obtain Military Department and organizational input and approval.

The Working Group included representatives of DHA, each of the Military Departments (Army; Navy, including the Marine Corps; Air Force), the TRICARE Regional Offices (TROs), the Office for Military Family and Community Support for Special Needs, and the National Capital Region-Medical Directorate (NCR-MD; which falls under DHA). The group met over an eight-month period to review data and prepare responses to the nine elements of assessment requested by NDAA FY 2013. In addition, children's advocacy groups provided the WG with information and perspectives on current and proposed changes in TRICARE pediatric benefits, including: American Academy of Pediatrics; Autism Speaks; Children's Hospital Association; Department of Defense Military Family Readiness Council; Easter Seals; Family Voices; March of Dimes; Maryland Coalition of Families for Children's Mental Health; Military Special Needs Network; Military Officers of America Association; National Military Family Association; and Specialized Training of Military Parents.

Working Group Definitions of Terms

The WG defined terms within each of the nine elements of the study to ensure that the scope and intent of each element was clearly addressed.

- Dependent children: Ages newborn through 21 years who are unmarried, natural born or adopted TRICARE-eligible and enrolled dependents of Service members.

- Children of Members of the Armed Forces: Dependent children of Active Duty Army, Navy, Marine Corps and Air Force members.

- Child with special needs: A summary based on the DoD Instruction 1315.19, paragraph E4.1 "a family member who requires a specialty consultant, other than a family practice physician or general medical officer, more than twice a year on a chronic basis." Criteria for all special needs conditions are available in the body of the Instruction.

- Appropriate care: Care that is sufficient in numbers and types of providers (pediatric or family medicine provider [*e.g.*, M.D., D.O.,], nurse practitioner, physician's assistants, or pediatric subspecialist) to assure that all services delivered to beneficiaries are accessible without unreasonable delay. Services are delivered by a provider who has the necessary skills and knowledge of current standard-of-care practices for a wide range of pediatric acute illnesses delivered in direct care, network, or non-network care.

- Appropriate setting: A direct, network, or non-network health care setting that can provide quality, cost-effective care and initial resuscitation and stabilization of pediatric beneficiaries.

- Adequate access: The ability of the direct and network care programs to offer providers sufficient in number and type to assure all services delivered to covered persons are accessible without unreasonable delay.

- Care management: A global term that includes medical and non-medical coordination for beneficiaries and families.

- Extraordinary special health care needs: Medical conditions/needs that require additional medical services beyond the Basic TRICARE program and obtained through eligibility and enrollment in the Extended Health Care Option (ECHO).

Data Sources

Data were obtained from each of the Military Departments, NCR-MD, TRICARE regions, and DHA. The Military Departments provided data related to provider numbers and specialty, programs, and policies specific to their department. Demographic data were obtained from the *Evaluation of the TRICARE Program: Fiscal Year 2012 Report to Congress*.[12] Data on MHS and beneficiary utilization and costs came from several sources. The Military Health System Data Repository (MDR) was accessed for utilization rates and cost data for health care obtained by

[12] Available at: http://www.tricare.mil/hpae/_docs/TRICARE2012_02_28v5.pdf.

individuals eligible for military healthcare benefits. The specific MDR data files evaluated for this report included: the TRICARE Encounter Data Institutional (TED-I) and Non-Institutional (TED-NI) files (*i.e.*, TRICARE claims data); the Comprehensive Ambulatory Patient Encounter Record (CAPER) files (*i.e.*, MTF professional encounter records); the Standardized Inpatient Data Record (SIDR) files (*i.e.*, MTF hospital encounter records); the Defense Enrollment Eligibility Reporting System (DEERS) Person Detail file (*i.e.*, TRICARE eligibility file); Defense Medical Human Resources System (DMHRS) file; and the National Plan & Provider Enumeration System (NPPES) file (*i.e.*, civilian health care provider file). Beneficiary category and sponsor service were taken from the health care encounter records, but were verified using DEERS data and corrected where appropriate.

Additionally, data from the *FY 2014 Report to Congress, Evaluation of the TRICARE Program: Access, Cost and Quality* related to the Health Care Survey of DoD Beneficiaries (HCSDB) were used to reflect beneficiary opinions about their DoD health care benefits. HCSDB data were analyzed to assess the experience of MHS beneficiaries within the system or with their alternative health plans.

Notes Regarding Data Analyses

- Numbers in charts or text may not sum to the expressed totals due to rounding.
- Percentages are rounded to the nearest whole number, rounded up from 0.5 or above and rounded down for 0.4 or less.
- Unless otherwise indicated, all years referenced are Fiscal Years (October 1-September 30).
- Due to the nature of the data in some of the charts, one beneficiary may be counted in more than one setting (direct, network, non-network) for each visit grouping (one, two, and more than two). Therefore, caution should be taken when making comparisons across settings because it may minimize differences across groups.
- NCR-MD data were added to Services data to represent two MTFs and many subordinate clinics subject to DHA oversight: Fort Belvoir Community Hospital (FBCH) and Walter Reed National Military Medical Center (WRNMMC).
- Navy data include dependent children of Marine Corps members.

Data Limitations

Data were obtained from disparate systems with varying levels of specificity and did not allow for cross comparison of pediatric access or adequacy within or between regions and Military Departments. TROs provided data from their respective regional contractor; United Health Care for Military and Veterans for TRICARE West, Humana for TRICARE South and Health Net for TRICARE North. The ability to retrieve data was complicated by data storage and compiling issues at the regional contractor level when attempting to retrieve data stored beyond the current contract year. Network Adequacy Reports (NAR) from regional contractors in some regions did not distinguish pediatric general providers from subspecialty providers, such as pediatric cardiologists, orthopedists, or psychiatrists.

Literature, Program, and Policy Reviews

The WG reviewed the statutes and regulations governing the TRICARE program; DoD policy and program documents, including the TRICARE Manuals--Operations, Policy and Reimbursement 2008 (which are incorporated by reference as terms of the regional managed care support contracts); Military Department policies; professional guidelines of the American Academy of Pediatrics (AAP) and American Academy of Pediatric Dentistry; and Medicaid policies and programs relevant to the pediatric population. In addition, materials submitted by pediatric advocacy groups were reviewed.

Other studies and reports consulted include but are not limited to the *Department of Defense Annual Report to Congressional Defense Committee on Plans for the Department of Defense for the Support of Military Family Readiness, Fiscal Year 2012*; and *Military Healthcare System Special Study Report, FY 2012 Childhood and Adolescent Overweight/Obesity Evaluation and Recognition, and Counseling, in Direct Care System Outpatient Care*.

ELEMENT 1:

A comprehensive review of the policies of the Secretary and the TRICARE program with respect to providing pediatric care. *(See APPENDIXES A and B for policies and programs reviewed for assessing this element.)*

The Pediatric Report to Congress Working Group (WG) conducted a comprehensive review of policies and programs that address aspects of care delivery, as well as Military Department support for families with pediatric beneficiaries.

TRICARE Program Structure and Authorities

The purpose of the TRICARE program as set forth in Chapter 55 of title 10, U.S. Code (U.S.C.), is to provide a uniform program of medical and dental care (10 U.S.C. § 1071) and pharmacy benefits (10 U.S.C. § 1074g) for members and certain former members of the uniformed services, and for their dependents. TRICARE program private sector purchased care medical benefits are provided under the "Basic Program" (which refers to the medical benefits set forth under Section 199.4 of Title 32, [C.F.R.] of Federal Regulations) and the "Uniform HMO Benefit" (which refers to the medical benefits set forth under 32 C.F.R. § 199.18). The TRICARE program, as implemented by Section 199.17 of Title 32, C.F.R., has a "triple option" structure: Standard is the default fee-for-service entitlement, Extra is the Preferred Provider Option and Prime is the enhanced Uniform HMO Benefit option. The TRICARE program private sector purchased care component coordinates care with the MTF direct care component, subject to the availability of MTF space and staff capabilities. Additional services for active duty dependents with a qualifying condition are authorized under ECHO (10 U.S.C. § 1079(d)-(f)).

TRICARE administers the congressionally mandated health benefit programs designed to allow beneficiaries choices for their health care related to eligibility. The TRICARE Basic program covers visits for diagnosis or treatment of an illness or injury based on medical necessity. TRICARE Regional Offices (TROs), which oversee the regional contractors, provide access and adequacy monitoring of the network systems while DHA monitors the direct care system. Beneficiaries make health care choices that include their preference for care delivery location and cost sharing. Beneficiaries can choose from a variety of TRICARE health care plans, including Prime, Standard, or Extra. These enrollment choices define the access to benefits and any cost shares associated with exercise of the benefits.

- TRICARE Prime is the HMO-like benefit offered in many areas. Each enrollee chooses or is assigned a Primary Care Manager (PCM), a health care professional who is responsible for helping the patient manage his or her care, promoting preventive health services (*e.g.*, routine exams, immunizations), and arranging for specialty provider services as appropriate. Depending on their status and geographic location, Prime-eligible beneficiaries may enroll with a PCM at a MTF, with a TRICARE regional network provider, or with a Designated Provider within

the U.S. Family Health Plan (USFHP). Access standards apply to waiting times to get an appointment and waiting times in doctors' offices. A point-of-service (POS) option permits enrollees to seek care from providers other than the assigned PCM without a referral, but with significantly higher deductibles and cost shares than those under TRICARE Standard.

- TRICARE Standard is the non-network benefit formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This traditional indemnity option is utilized for seeing either participating providers or non-participating TRICARE-authorized providers and is open to all eligible DoD beneficiaries, except Service members. A participating TRICARE-authorized provider is one who accepts the CHAMPUS Maximum Allowable Charge (CMAC) as payment in full and files claims on behalf of their TRICARE patients. TRICARE Standard also covers beneficiaries who are eligible for Medicare Part B for any services covered by TRICARE but not covered by Medicare. An annual deductible (individual or family) must be met and cost shares are required.

- TRICARE Extra is the PPO for beneficiaries eligible for TRICARE Standard. When TRICARE beneficiaries who are not enrolled in Prime obtain services from TRICARE network professionals, hospitals, and suppliers, they pay the same deductible as TRICARE Standard; however, TRICARE Extra cost shares are reduced by five percent. TRICARE network providers accept the CMAC and file claims for the beneficiary.

TRICARE purchased care is composed of both network and non-network care. Network care is provided by a "network provider" who serves TRICARE beneficiaries through a network participation agreement with the regional contractor as a member of the TRICARE Prime network, or any other preferred provider network, or by any other agreement with the regional contractor. Non-network care is provided by a "non-network provider" who has no agreement with the regional contractor to provide care to TRICARE beneficiaries, and who may choose to participate in TRICARE on a claim-by-claim basis.[13] Non-network providers are not required to file claims for beneficiaries and may require payment by the beneficiary at the time the services are rendered.

TRICARE Program Benefits and Authorities

In all TRICARE Basic Program options (*i.e.*, the medical benefit component of the TRICARE program), TRICARE may cover only services and supplies that are "medically or psychologically necessary" as required by Section 1079(a)(13) of Title 10, U.S.C., and as implemented by Section 199.4 of Title 32, C.F.R. The term "health care" under TRICARE includes "mental health care" (10 U.S.C. § 1072(10)). The terms "behavioral" and/or "psychological" are also used concerning "mental" health. Pediatric health care benefits are provided through the TRICARE Basic program that includes certain well child care and preventive care benefits. Pediatric health care benefits are specifically

[13] *TRICARE Operations Manual* 6010.56-M, February 1, 2008; Appendix B; definitions.

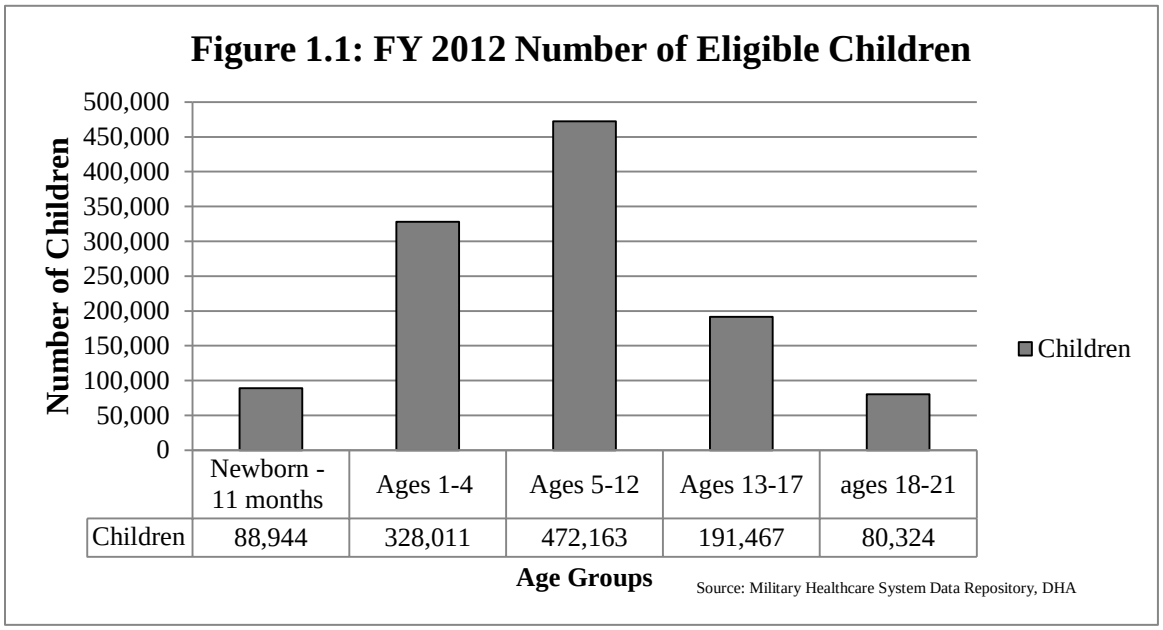
addressed in Section 199.4(c)(3)(xi) of Title 32, C.F.R. In addition to the medical benefits authorized under the TRICARE Basic Program, Active Duty family members (ADFMs) with qualifying conditions are eligible for supplemental services that are not otherwise covered under the TRICARE Basic Program if they enroll in their Military Department's Exceptional Family Member Program (EFMP) and ECHO.

TRICARE is a statutorily defined health benefits program. As such, the TRICARE program is only authorized to cost-share private sector purchased care supplies or services as part of a beneficiary's covered medical/mental health benefit when such care is medically or psychologically necessary (10 U.S.C. § 1079(a)(13)), absent specific additional statutory authority.

Preventive care is generally excluded by law from the Basic Program's medical benefits authorized under TRICARE's private sector purchased care (10 U.S.C. § 1079(a)(13); 32 C.F.R. § 199.4(g)(37)). Only those services specifically listed in 10 U.S.C. § 1077(a) (specifically authorized medical care for dependents in MTFs), 10 U.S.C. § 1079(a)(2) (specifically authorized content of health promotion and disease prevention visits), 10 U.S.C. § 1074d (specifically authorized primary and preventive health care services), and/or 10 U.S.C. § 1074g (pharmacy benefits program) are not otherwise generally excluded. Using the broad authority of 10 U.S.C. § 1097 to provide for the alternative delivery of health care under Chapter 55, the Uniform HMO Benefit (32 C.F.R. § 199.18(b)) authorizes certain preventive care services not covered under the Basic Program medical benefits when provided to TRICARE Prime enrollees by network providers. Standards for preventive care services must be developed based on guidelines of the U.S. Department of Health and Human Services and must establish a specific schedule, including frequency or age specifications.

This report discusses the 2.4 million dependent children of military members of the Armed Forces, defined in this report as Army, Navy (including Marine Corps), and Air Force on active duty. Figure 1.1 displays the distribution of the population included in this report. The age ranges are loosely based on AAP Healthy Children ages and stages; however, in this study the first category includes newborn to 11 months rather than 12 months to prevent double counting of the 1-year-old infants in different data groups, and toddler and preschool ages are combined in the age group of 1 to 4 years.[14] The age span in the groups is inconsistent, preventing comparison of beneficiary numbers in each group; the best comparison in groups is utilization rates. The largest number of beneficiaries is the newborn through 11 months subgroup. Approximately 44 percent of the active duty child beneficiary population is 5 years of age and younger.

[14] Health Children, Ages and Stages, American Academy of Pediatrics. Available at http://www.healthychildren.org/English/ages-stages/Pages/default.aspx.



Medical Necessity

The MHS is committed to delivering medically necessary, safe, and effective care in both the direct and purchased care components of the TRICARE program. Understanding the scope and limitations of authorized TRICARE program coverage is based on the meaning of "medical necessity" as applied to TRICARE cost-sharing of private sector care and MTF direct care.

The current TRICARE program regulations concerning the private sector purchased care component set a standard of what may be determined by DHA to be medically necessary for the purpose of authorizing TRICARE program cost-sharing of private sector purchased care (32 C.F.R. §199.4(g)(15)). In the purchased care component of the TRICARE program, medical necessity is defined based on a standard requiring review under the "hierarchy of reliable evidence," (32 C.F.R. §199.2(b)), which includes only published research based on well-controlled clinical studies, formal technology assessments, and/or published national medical organization policies/positions/reports—not just the common understanding of the general practice of medicine in the United States. The various sections of the TRICARE program regulations in Part 199 of Title 32, C.F.R., when read comprehensively, require that in order to be medically necessary, safe, and effective for TRICARE cost-sharing the treatment or service must be proven to be:

- medically or psychologically necessary and appropriate care based on reliable evidence, and
- rendered by a TRICARE-authorized provider in accordance with other TRICARE Program requirements.

Reflecting a commitment to evidence-based medicine, TRICARE is authorized to cost share private sector purchased care only when it meets this TRICARE program-specific definition of

medical necessity. In making such coverage determinations, TRICARE is expressly prohibited from relying on professional opinions of individual providers, groups of providers, or advocacy groups. For some particular services, the difference in the meaning of medical necessity as applicable to TRICARE cost-sharing of private sector care from its use generally in the medical community and regarding MTF direct care contribute to confusion in understanding the scope and limitations of authorized TRICARE program coverage.

Well Child Care

Well child care covers services provided to children from birth through age five years, which includes routine newborn care, health supervision examination, routine immunizations, and periodic health screening and developmental assessments in accordance with AAP guidelines. Well child visits should include screening with referral for appropriate evaluation if impairment is suspected. The TRICARE *Policy Manual* states that components of good clinical practice integrate assessments and age/behavior-appropriate surveillance during all provider visits. Primary care providers are in the best position to collaborate with the family to address health, developmental, and behavioral milestones.

MHS, through TRICARE, fully supports the basic tenants of AAP's Bright Futures program, including its screening tool for screening autism and developmental screening at each visit through five years of age.[15] At six years of age beneficiaries no longer fall within the scope of well child care as currently authorized by TRICARE program regulations, but are instead covered under the clinical preventive services as outlined in the *TRICARE Policy Manual*.[16] Preventive care is designed for asymptomatic individuals to maintain and promote good health and is performed as a periodic health screening, health assessment, or periodic health maintenance. The TRICARE preventive care program as it relates to pediatric beneficiaries does not conform to the AAP periodicity guidelines, which address the special physical, emotional, and developmental needs of children and includes recommended screening up to the age of 21 years.

Nutritional Therapy

The *TRICARE Policy Manual* Chapter 8, section 7.1 Nutritional Therapy, states that TRICARE may cost share medically necessary supplies and nutritional products when used as the primary source (greater than 50 percent of calories) of nutrients or a required macronutrient, for example, a protein.[17] Children with metabolic disorders require special preparations (formulas) that provide essential nutrients but are not the primary source of calories. These so-called "medical foods" are foods that are specially formulated and intended for the dietary management of a disease that has distinctive nutritional needs that cannot be met by normal diet alone. As such,

[15] Bright Futures is a national health promotion and disease prevention initiative of AAP that addresses children's health needs in the context of family and community. Available at: http://brightfutures.aap.org/.
[16] *TRICARE Policy Manual* 6010.54-M, August 1, 2002. Chapter 7, Section 2.5 for Standard beneficiaries, Section 2.2 for Prime. Available at: http://manuals.tricare.osd.mil/.
[17] *TRICARE Policy Manual* 6010.54-M, August 1, 2002. Chapter 8, Section 7.1. Available at: http://manuals.tricare.osd.mil/.

these formulas contribute to the ability to manage needed lifelong dietary requirements essential to the growth and development of children with metabolic, digestive, or medical conditions. Consultative and educational support regarding dietary and nutritional needs is essential to ensuring and monitoring adequate nutrition.

Habilitative Care

An important difference between rehabilitation and habilitation services and devices is the fact that habilitation services are provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. Rehabilitation services and devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or a disabling condition. As children grow and develop new skills those skills grow in complexity. Developmentally delayed children may need support to develop and maintain essential skills defined as "habilitative" care. Adults' rehabilitative care is distinct from pediatric habilitative care because adults have mastered skills and rehabilitative care assists in regaining previously mastered skills. Rehabilitation is a covered TRICARE benefit when medically necessary but habilitation services are available only through the ECHO program.

Compounded Medications

Compounding of medication is done when the health needs of a patient cannot be met with a Food and Drug Administration (FDA) approved medication. Compounding is a practice in which a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist, combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient, for example: to accommodate a patient allergy or sensitivity to certain dyes used in manufacturing; to provide medication in liquid form to a patient or child who cannot swallow a pill[18]; or to add a flavor to a medication for taste improvement. In November 2013 the President signed Public Law 113-54 (the Drug Quality and Security Act). In accordance with this law TRICARE beneficiaries received notification that their prescriptions of compounded medications would no longer be reimbursed. TRICARE suspended the implementation of the enhanced compound screening process scheduled for February 2014, pending publication and review of the qualifying list by FDA. Once FDA has published its list, DHA will review the results and move forward with a plan for provider and beneficiary education. Pediatric patients often use compounded medications based on their medical needs and developmental abilities and to increase the palatability of medications.

TRICARE Dental Program

[18] U.S. Department of Health and Human Services. FDA Website. Available at: http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/ucm339764.htm.

It is important that dental care start early in life as dental cavities are the most common chronic disease in children, 5 times more common than asthma, 4 times more common than early childhood obesity, and 20 times more common than diabetes.[19] Oral health is critically important to the overall health and wellbeing of children and adolescents. Oral health covers a range of health promotion and disease prevention concerns, including dental caries (tooth decay), periodontal health, and proper development and alignment of facial bones, jaws, and teeth requiring continuing health supervision.

Dental benefits under the TRICARE Basic (medical benefits) program are limited by law to adjunctive dental care only. TRICARE offers a premium-based dental program (TDP) in addition to the Basic medical program. The TDP is a worldwide dental care plan offered to eligible beneficiaries as a premium-based cost-share service. TDP coverage includes diagnostic and preventive services, restorative services, orthodontics, oral surgery, endodontics, and other non-medical services up to an annual cap on the total amount cost-shared by TRICARE.

Behavioral Health Benefit

The TRICARE program provides a behavioral health care benefit for pediatric patients that include inpatient, outpatient, and residential treatment services. Acute inpatient psychiatric care is covered on an emergency or non-emergency basis to include 30 or 45 days of acute inpatient psychiatric care per fiscal year (October 1- September 30), depending on the beneficiary age at the time of admission. TRICARE beneficiaries ages 18 years and under may receive medically or psychologically necessary acute inpatient psychiatric care for up to 45 days in a fiscal year or 45 days in a single admission if it overlaps fiscal years. Patients age 19 and older are limited to 30 days per fiscal year or in any single admission. The following benefits are available:

- Acute inpatient psychiatric care provides 24-hour availability of a full range of diagnostic and therapeutic services to establish an effective plan of care to reverse life-threatening and or severely incapacitating psychiatric symptoms.

- The Substance Use Disorder Rehabilitation Facility (SUDRF) inpatient benefit provides care 24 hours a day, 7 days a week to include: detoxification; rehabilitation; and outpatient individual, group, and family therapy. SUDRFs are appropriate for patients whose abuse of or dependence on alcohol or drugs or whose addiction-related symptoms or concomitant physical, emotional, and behavioral problems reflect persistent dysfunction in several major life areas.

- Eating Disorder Programs are institutionally based regimens for the treatment of mental disorders that are characterized by gross disturbances in eating behavior. Freestanding eating disorder programs are not eligible for status as an authorized institutional provider of services and supplies.

[19] American Academy of Pediatric Dentistry. Fact Sheet on Early Childhood Caries (ECC). Available at: http://www.aapd.org/assets/2/7/ECCstats.pdf.

- Residential Treatment Centers (RTCs) provide a medically supervised, interdisciplinary program of mental health treatment, 24 hours a day, 7 days a week, in a less restrictive environment than an acute care hospital. Such centers are appropriate for patients whose predominant symptom presentation is essentially stabilized, although not resolved, who have persistent dysfunction in major life areas and require a protected and highly structured therapeutic environment. For example, a center can be a step-down level of care after an inpatient psychiatric hospitalization or a step-up level of care when beneficiaries can no longer function at home and in the community. TRICARE covers payment for 150 days each fiscal year or 150 days per admission for RTC care; this limit is separate from the benefit limit for acute inpatient mental health care.

- Partial Hospitalization Programs provide an interdisciplinary program of medical therapeutic services at least 3 hours per day, 5 days per week. PHPs treat patients who do not require inpatient care, continue to exhibit problems, but can function with support in some major life areas. PHPs are appropriate settings for crisis stabilization, treatment of partially stabilized mental health disorders, and transition from an inpatient program to an outpatient program when medically necessary. Partial Hospitalization Program (PHP) rehabilitation treatment counts toward the 60-day psychiatric PHP limit.

- SUDRF Partial Hospitalization Program (PHP) provides addiction-focused services through day, evening, or weekend programs to treat patients outside the hospital environment with substance use disorders for defined periods of time with support in one or more of the major life areas.

- Intensive Outpatient Programs (IOP) provide an interdisciplinary program of medical therapeutic services in half-day programs that consist of 3 to 5 hours, 5 days per week for patients who do not require 24-hour-a-day inpatient psychiatric care, exhibit psychiatric problems, but can function with support in some of the major life areas. IOPs are appropriate settings for crisis stabilization, treatment of partially stabilized mental health disorders, and transition from an inpatient program to an outpatient program when medically necessary.

Regardless of the TRICARE option (Prime, Standard or Extra), parents may initiate the first eight outpatient behavioral health visits each fiscal year without a preauthorization in order to access behavioral care for their child. Additional behavioral health visits beyond eight in a fiscal year require authorization from the regional contractor, but do not require a referral.

TRICARE reimburses all medically necessary services for a diagnosed and covered behavioral health condition (*i.e.*, not merely counseling services for relationship or life skill issues) provided by authorized psychiatrists, clinical psychologists, certified clinical social workers, certified psychiatric nurse specialists, certified mental health counselors, certified marriage and family therapists, and supervised mental health counselors and pastoral counselors with the referral and supervision of TRICARE authorized physicians (when required). Behavioral health care includes individual, group, and family psychotherapy; play therapy; and psychoanalysis with prior authorization. Collateral visits are not therapy sessions, but are used to gather information and implement treatment goals. Psychological testing is provided six hours per fiscal year.

Medication management by an authorized provider is an independent, routine medical service. Case managers, both in medical and behavioral health, are available to all beneficiaries in the Prime, Standard, and Extra plans based on complexity of the medical or behavioral needs.

Findings and Areas for Clarification

Findings and proposed areas for clarification are based on a review of policies, programs, and practices listed at the end of each element. Analysis may require further review of the authority, statutory requirement, and/or cost associated with the finding.

1.1 Finding: Definitions of "medical necessity" differ between the broader healthcare system and the TRICARE program direct care component with the higher standard of medical necessity governing DoD's authority to cost-share private sector care in the TRICARE purchased care component.

> Gap: Stakeholders are confused or unaware of TRICARE program coverage and limitations related to medical necessity in the purchased care component.
>
> Area for Clarification: Review processes for evaluating emerging technology in use in the general community but not supported by the hierarchy of evidence required for the TRICARE purchased care program.
>
> Area for Clarification: Review regulatory provisions for TRICARE program cost-sharing of care that appears to have gained acceptance in the larger medical community but does not meet the TRICARE-specific definition applicable to the purchased care component.

1.2 Finding: TRICARE's defined well child benefit ends when a child turns age six years of age and is replaced with the generally authorized preventive care services.

> Gap: The preventive care benefit is not consistent with the periodicity table for age-related health promotion and disease prevention visits and screening guidelines of AAP's Bright Futures program.
>
> Area for Clarification: Analyze use of health care benefits by children ages 6 to 21 years to assess if developmental- and age-appropriate care is being delivered as compared to AAP-recommended periodicity schedules and guidelines, the 2010 Patient Protection and Affordable Care Act, or Medicaid's Early and Periodic Screening, Diagnosis and Treatment benefit.

1.3 Findings:

- TRICARE's medical food policy states: "When used as the primary source of calories or as the primary source or a required macronutrient (*i.e.*, protein), TRICARE may cost-share medically necessary supplies and nutritional products."

- Current policy supports dietary and nutritional counseling in conjunction with a provider visit or if related to diabetes self-management training, (see Chapter 11, Sections 3.14 and 3.5).

  Gaps:

  - Medical food is defined as the primary source of calories rather than as the source of essential nutrients to promote optimal growth and development.

  - Current policy does not recognize registered dieticians or nutritionists as approved providers able to manage and educate beneficiaries with complex metabolic disorders independently.

  Area for Clarification: Determine the extent of use of special metabolic formulas by children with complex metabolic or digestive disease to maintain essential nutrition and medical food.

  Area for Clarification: Assess the benefit of nutritional counseling and management when provided by nutritionists and/or registered dieticians as authorized providers for children with complex medical and metabolic medical conditions.

1.4 Finding: Habilitiative care is available only for Active Duty Family Members through ECHO.

Gap: The health care benefit of offering habilitative care as a TRICARE Basic program benefits (if it were no longer excluded by law) and its impact on "normalized" age-appropriate and developmental support for children who are not eligible for ECHO is unknown.

Area for Clarification: Determine if the current benefit of habilitative care authorized under ECHO only for ADFMs promotes age-appropriate and developmental support for children along with skill attainment and sustainment that is distinct from rehabilitative care, and whether legislative changes to remove the current statutory exclusion of habilitative care from the Basic program would be appropriate.

1.5 Finding: The 2013 announced but deferred halt of coverage for compounded medications may have negatively affected pediatric beneficiaries.

Gap: An unknown percentage of the eligible pediatric beneficiaries use compounded medications. Pediatric advocacy groups expressed concerns as to whether the halt had any impact on their access to medication.

Area for Clarification: Usage of compounded medication for pediatric beneficiaries and review the impact of the DHA decision on coverage for compounded medications in compliance with Public Law 113-54, Drug Quality and Security Act, once the FDA provides direction on implementation of the new law.

1.6 Finding: Advocacy groups recommend changes in TRICARE reimbursement policies.

Gap: Advocacy groups recommend changes in TRICARE reimbursement related to pediatric care requirements for utilization of the inpatient setting when outpatient settings are purportedly appropriate for some pediatric procedures and reimbursement rates based on discounted CMAC.

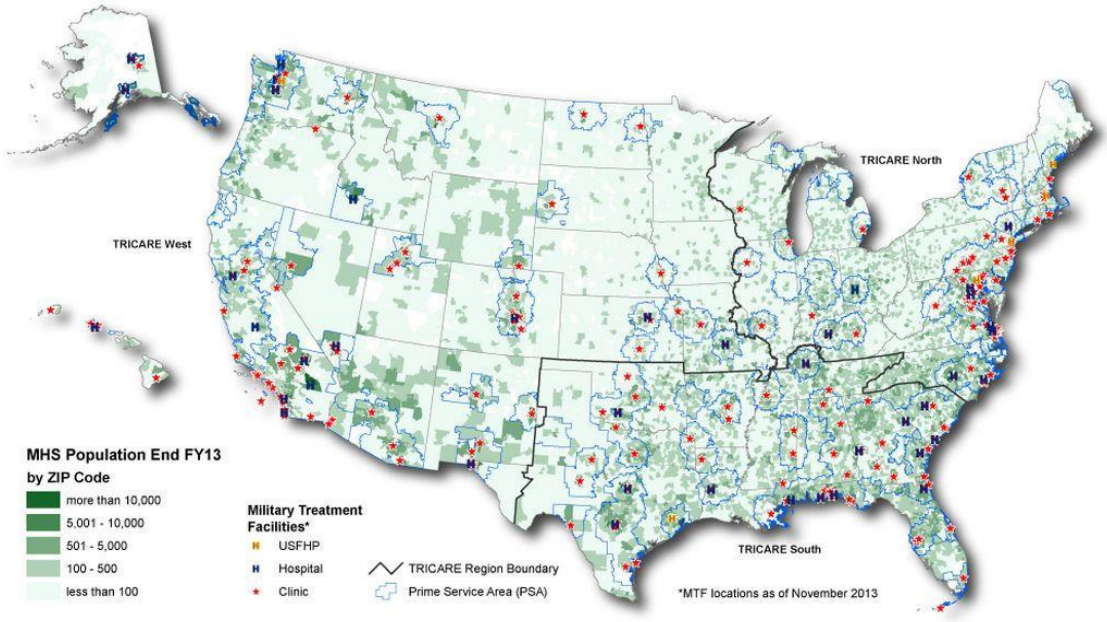
Area for Clarification: Reimbursement policies and their flexibility for safe and effective care of the pediatric beneficiary as pediatric health delivery models change.

ELEMENT 2:

An assessment of access to pediatric health care by dependent children in appropriate settings.

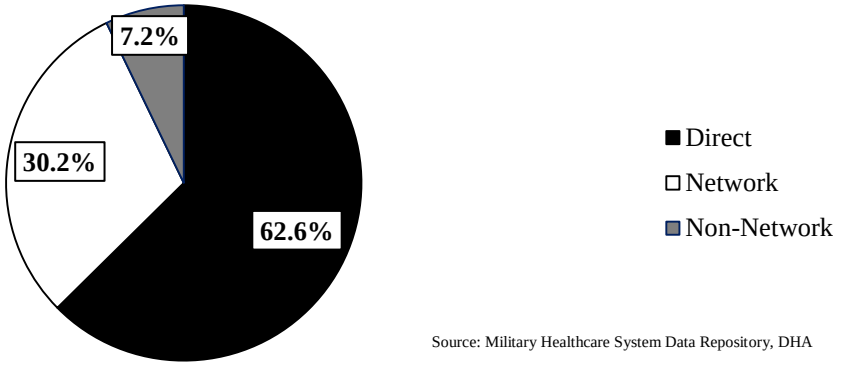
Analysis of available data demonstrates adequate access to pediatric care in appropriate settings. Use of non-network care tends to be higher for emergency room (ER) encounters. The largest proportion of inpatient admissions occur in the direct care and network settings. In addition, MHS combined network and direct care settings accommodated a large majority of same day surgeries. Future assessments should focus on more finely tuned access metrics, including wait times and referrals, reasons for higher rates of non-network ER use, and availability of providers.

Figure 2.1: FY 2012 Beneficiary Map



DoD delivers comprehensive care to its diverse, mission-focused, worldwide Service members and families. Analysis of health care utilization based on total encounters (ambulatory visits and hospital admissions) within the MHS shows that pediatric beneficiaries receive 63 percent of their care in the direct care system, 30 percent in the network, and 7 percent in non-network settings. (See Figure 2.3 in Appendix F to view encounters broken out by age groups.)

Figure 2.2: FY 2012 Total Pediatric Visits



Source: Military Healthcare System Data Repository, DHA

Adequate access is the ability of the direct and network components to provide sufficient numbers and types of providers (pediatric generalist or family medicine provider [M.D., D.O.,], nurse practitioner, physician's assistants or pediatric subspecialist) to assure that medical services delivered to a covered child will be accessible without unreasonable delay. Pediatric access to specialty providers is addressed in the next section. Pediatric encounters of all categories demonstrate that approximately 9 out of 10 times children are seen within the MHS in either direct (63 percent) or network (30 percent) components of care. Pediatric encounters were rarely (7 percent) with non-network providers, again demonstrating adequacy of the MHS system for access to pediatric care in appropriate settings.

Health care utilization is measured as the average number of encounters per beneficiary and compared across age groups and encounter (visit) type. This approach was used in the report for the pediatric age groups. The overall highest utilization rate of health care was in the newborn to 11 months age group (15 visits per child). Utilization in each age group was a follows: ages 1 to 4 years, 7 visits per child; ages 5 to 12 years, 5 visits per child; ages 13 to 15 years, 5 visits per child; and ages 18 to 21 years, 5 visits per person. A higher rate of utilization for newborns can be partially explained by the 6 visits recommended by AAP's periodicity schedule of visits, and demonstrates that newborns' utilization rates meet or exceed this recommendation.

This element reviews the types of MHS health care visits experienced by the pediatric population covered in this report. Health care visits are categorized as outpatient office visits (face-to-face visits with a primary care provider or specialist in an outpatient setting), ER visits, inpatient admission, or same day surgery in either the direct care, network, and non-network programs. Health care delivered in direct and network components, under the TRICARE Prime and TRICARE Extra options, is considered to be delivered within the TRICARE regional network structure. Non-network health care is part of TRICARE Standard option and includes cost sharing as part of the TRICARE

regional network structure.[20] In FY 2012 there were more than 7 million pediatric ambulatory visits and hospital admissions in the direct and purchased care components of the TRICARE program: 87 percent were outpatient office visits, 9 percent were ER visits, 2 percent were inpatient hospitalizations, and 2 percent were same day surgeries.

Outpatient Office Visits

There were approximately 6.1 million outpatient pediatric office visits in FY 2012. Visits to pediatric generalists or pediatric family medicine providers accounted for approximately 81 percent of all outpatient office visits. The remaining approximately 19 percent of visits were specialty visits, further described in Element 3 in this report. In the direct care component, MTFs have implemented the Patient Centered Medical Home (PCMH) model of health care. All TRICARE beneficiaries have access to primary care providers; those beneficiaries not enrolled with a PCMH under the Prime Option may choose to see any TRICARE authorized primary care provider. All pediatric beneficiaries enrolled in the MTF direct care are enrolled in a PCMH. A key element to a PCMH is the collaboration of health care providers, team members, and families to achieve the best care outcome. The PCMH is a team-based model; led by a primary care manager (PCM) who provides continuous, accessible, family-centered, comprehensive, compassionate, and culturally sensitive health care in order to achieve the best outcomes. The PCMH model is based on the concept that the best health care has a strong primary care foundation with quality and resource efficiency incentives.

TRICARE does not require network providers to function within a PCMH or other medical home model, so there are no data on enrollment in PCMHs for beneficiaries using purchased care in any other option settings, such as enrolled to a network PCM, under the USFHP, seeing network providers under the Extra option, or using the non-network Standard option.

Outpatient office visit utilization rates (average number of outpatient office visits per beneficiary) for the age ranges is as follows: newborn to 11 months, 13 office visits; ages 1 to 4 years, 6 office visits; ages 5 to 12 years, 4 office visits; ages 13 to 17 years, 4 office visits; and ages 18 to 21 years, 4 office visits. The largest proportion of outpatient office visits was in the MHS System. The location of outpatient office visits occurred in the following proportions: direct care, 66 percent; network care, 30 percent; and non-network care, 4 percent (see Appendix F: Figure 2.4).

Emergency Room Visits

There were approximately 650,000 pediatric ER visits in FY 2012. More than half of all ER visits occurred in the MHS direct and network care components. As a measure of successful access to the health care system, the MHS uses ER visits as an indirect measure for access to medical appointment. The MHS expects ER utilization to increase

[20] Upon implementation of the TRICARE triple-option structure in 1998, the fee-for-service component involving private sector purchased care that was formerly referred to as “CHAMPUS” was termed “TRICARE Standard.”

when beneficiaries are unable to get timely access to their primary provider under the normal appointment process. Consequently, a decreasing rate of ER utilization could be used as a proxy measure that there is adequate and timely access to medical appointments for beneficiary needs/conditions. The initial option for an acute episode of care in most cases should be through the primary care provider for same day visits, before accessing the ER. Not all MTFs offer ER services so families choose the most appropriate level of care based on the health needs or issues of the family member. On average, across the age groups, the rate of ER utilization (average number of ER visits per beneficiary) was less than 2 visits per child in 2012. The ER utilization rate was highest in the newborn to 4-year-old population (1 ER visit). The majority of ER visits occurred in the direct care component (*i.e.*, at MTFs). ER visits occurred in the following proportions: direct care, 49 percent; network care, 16 percent; and non-network facilities, 35 percent. The reason for the higher utilization of non-network facilities for ER care is not known. Current reimbursement policy reimburses hospital-based ERs with a facility fee and a professional fee; freestanding urgent care centers receive only professional fees (similar to an office visit). If families are using urgent care centers at a proportionally higher frequency than hospital based emergency rooms that could explain utilization of non-network facilities. Families utilized direct care in a largest proportion of ER visits than network or non-network ER settings (see Figure 2.5 in Appendix F).

Inpatient Hospitalizations

There were approximately 125,000 pediatric inpatient hospitalizations in FY 2012. As with ER visits, on average, across the age groups, the rate of hospital utilization (average number of hospitalizations per beneficiary) was less than two hospital stays in 2012. The hospital utilization rate was highest in the newborn to 11-month-old age range (1.1 hospitalizations) followed by the 18- to 21-year-old group (0.1 hospitalizations). Mood disorders (depressive) had a rate of hospitalization highest in the 15- to 17-year-old group based on the January 2013 Healthcare Cost and utilization project statistical brief #148. Most hospitalizations occurred in the direct care component. Hospitalizations occurred in the following proportions: network care, 48 percent; direct care, 44 percent; and non-network, 7 percent. MHS data obtained for this study did not include indications for hospital admission (see Figure 2.6 in Appendix F).

Same Day Surgeries

There were approximately 130,000 pediatric same day surgeries in FY 2012. The utilization rate (average number of same day surgeries per beneficiary) was less than one per beneficiary, but was highest in the 18- to 21-year-old group and in newborns to 11-months (0.2 same day surgeries). Direct care had the smallest proportion of same day surgeries, but MHS combined network and direct care components accommodated 88 percent of same day surgeries. The surgeries occurred in the following proportions: network care, 78 percent; non-network care, 13 percent; and direct care, 9 percent. Most of the same day surgeries were performed in network facilities (see Figure 2.7 in Appendix F).

Most Frequent Diagnoses

Acute respiratory infections were the most frequent diagnoses for outpatient office visits and ER visits. Acute conditions such as respiratory and viral infections (pneumonia and acute bronchitis) constituted the most common reasons for pediatric treatment and release in ER visits. Consistent with the Overview of Children in the Emergency Department (2010) study ("2010 Study"), regardless of age, MHS data show that acute respiratory infections were among the top three primary or secondary diagnoses for all age range categories.[21] The incidence of asthma in the MHS was the most frequent ER diagnosis among children ages 5 to 14 years, consistent with the finding of the American Lung Association asthma and children fact sheet of 2012, citing asthma as the third leading cause of hospitalization among children under 15 years of age and one of the most common chronic disorders in childhood.[22]

Access Standards

Direct Care Standards

TRICARE program regulations set forth in C.F.R., title 32, section 199.17(p)(5), detail the access standards. Urgent care visits shall be available within 24 hours, routine visits shall be available within one week, and specialty care appointments shall be available within four weeks. The normal drive time from the patient's home to their primary care site should not exceed 30 minutes, unless there is an absence of providers in the local area. Travel time for specialty care shall not exceed one hour under normal circumstances unless there is an absence of providers in the area. Under non-emergency situations, office waiting times should not exceed 30 minutes. This study did not review data for appointment availability (routine or specialty), office waiting times, or drive time.

In February 2011, the Assistant Secretary of Defense for Health Affairs (ASD)(HA) published a revised TRICARE Policy for Access to Care (HA Policy 11-005). This policy outlines the access standards and provides specific guidance to MTFs on adherence to these standards, including pediatric care. TRICARE Prime beneficiaries who are enrolled to an MTF must seek urgent and routine care from their PCM. Access standards for Prime beneficiaries are as follows:

- If an appointment is not available within access standards, they will be given a referral to seek care from a provider in the regional contractor network of providers.

[21] Wier LM (Truven Health Analytics), Hao Y (RAND), Owens P (AHRQ), Washington R (AHRQ). Overview of Children in the Emergency Department, 2010. HCUP Statistical Brief #157. June 2013. Agency for Healthcare Research and Quality, Rockville, MD. Available at: http://www.hcup-us.ahrq.gov/reports/statbriefs/sb157.pdf.
[22] Asthma and children Fact sheet, American Lung Association, October 2012. Available at: http://www.lung.org/lung-disease/asthma/resources/facts-and-figures/asthma-children-fact-sheet.html.

- If a network provider is not available, an authorization will be given by the contractor for the beneficiary to be seen by a non-network provider.

Network Care Standards

TRICARE program regulations (32 C.F.R. § 199.17 (p)(5)(iv)) require TRICARE civilian networks to include sufficient numbers of specialists to reasonably meet the anticipated needs of the "enrolled" (*i.e.*, Prime) population. As set forth in their contracts with DoD, each regional contractor is required to develop networks that are adequate to meet the TRICARE access standards for the Prime population in their geographic area. This includes general pediatricians, pediatric subspecialists, and institutional providers capable of delivering high-quality care to pediatric patients. Each regional contractor is required to provide their TRICARE Regional Office (TRO) with a monthly Network Adequacy Report (NAR) demonstrating they have fulfilled this requirement. In addition, each regional contractor must publish and keep current a provider network directory for use by beneficiaries listing all providers in their network. As stated in the Element 2, future assessments should focus on more finely tuned access metrics, including wait times and referrals, reasons for higher rates of non-network ER use, and availability of providers.

Findings and Areas for Clarification

2.1 Finding: Analysis of access to pediatric care in appropriate settings demonstrates that there is adequate access to care. MHS pediatric beneficiaries have adequate access to care; approximately 9 out of 10 children used outpatient visits rather than emergency care and receive over 90 percent of their comprehensive care within MHS settings (direct, 63 percent); network (30 percent).

> Gap: Data on appointment availability wait times for appointments, and referrals were requested but not available for this report.
>
> Area for Clarification: Future assessments should focus on more finely tuned access metrics, including wait times and referrals, reasons for higher rates of non-network ER use, and availability of providers. Evaluate currently available metrics and data sources to assess if they effectively address adequacy of access for pediatric beneficiaries.

2.2 Finding: Thirty-five percent of ER encounters occur in non-network care, which is much higher than the less than ten percent rate observed for office visits, hospitalizations, or outpatient surgery.

Gaps:

- It is unknown if the proportionally higher utilization of non-network providers is related to utilization of freestanding urgent care rather than hospital-based ER.

- It is unknown if pediatric ER encounters are increasing, decreasing, or stable.
-
- Due to the nature of ER visits, it is unknown if there is potential to safely recapture some of the non-network encounters in direct or network care.

Areas for Clarification:

- Specific analyses of the pediatric population in the annual *Evaluation of TRICARE Programs: Access, Cost and Quality* would provide a comprehensive review of adult and pediatric ER utilization rates in the MHS.

- Strategies are needed to accurately differentiate between utilization of freestanding versus hospital-based ER utilization and cost differences, which could inform assessment of access of services.

- Potential recapture of pediatric ER visits through review of diagnoses and acuity of visits would inform access of services.

2.3 Finding: The largest proportion of inpatient admissions occurred in the direct care and network settings.

2.4 Finding: MHS combined network and direct care settings accommodated 86 percent of same day surgeries.

2.5 Finding: Acute respiratory infection was the most common diagnosis for outpatient office visits and ER visits consistent with national data.

2.6 Finding: Access standards exist for appointment availability (urgent, routine, and specialty), but data were not reviewed to determine drive time and office waiting time.

Gap: TROs reported that finely tuned access metrics, to include wait times and referrals, were not available for this report.

Area for Clarification: Study of regional contractor required reports to evaluate the need for contract modifications to have data available for finely tuned access metrics, including wait times and referrals, reasons for higher rates of non-network ER use, and availability of providers.

2.7 Finding: Network Adequacy Reports (NAR) are monthly reports provided by regional contractors to TROs for review of access and adequacy of the network of providers.

Gap: TROs reported that the NAR should not be used to determine access to care, as it simply states the number of contracted providers, not the availability of those providers to see new patients or TRICARE beneficiaries.

Area for Clarification: Evaluate the need for contract modifications to develop NARs that would reflect availability of providers on a monthly basis.

ELEMENT 3:

An assessment of access to specialty care by dependent children, including care for children with special health care needs.

Available data show that direct care accounts for the largest proportion of specialty care visits across all types of specialties. Data on specialty visits in direct and purchased care show that 80 percent of total pediatric encounters are attributed to specialists (*i.e*., not general pediatricians or family medicine providers). However, better data collection is required to understand the exact specialty or subspecialty of providers delivering care to pediatric beneficiaries.

This element reflects the fact that 19 percent of care delivered to pediatric beneficiaries involves specialty visits, as identified by Military Healthcare System Data Repository (MDR) visit type. The DoD criteria for special medical needs is found in DoD Instruction 1315.19 and summarized in this statement: "A family member who requires a specialty consultant, other than a family practice physician or general medical officer, more than twice a year on a chronic basis."[23] The full description of special needs includes more global and specific conditions. Other conditions and or chronic medical/physical conditions in the definition found in DoD Instruction 1315.19 include: mental health conditions (including attention deficit disorder/attention deficit hyperactivity disorder) requiring multiple medications; diagnosis of asthma with scheduled use of anti-inflammatory agents/bronchodilators; and/or requiring adaptive equipment, for example, an apnea home monitor, home nebulizer, wheelchair, splints, braces, orthotics, hearing aids, home oxygen therapy, or home ventilator.

C.F.R. 199.17(p)(5)(iv) requires TRICARE civilian networks to include sufficient numbers of specialists to meet the anticipated needs of the enrolled population. As set forth in their contracts with DoD, each regional contractor has the responsibility to develop networks that are adequate to meet the TRICARE access standards for the Prime population in their geographic area. This includes general pediatricians, pediatric subspecialists, and institutional providers capable of delivering high-quality care to pediatric patients. Each regional contractor is required to provide its TRO with a NAR demonstrating it has fulfilled this requirement. In addition, each regional contractor must publish and provide beneficiaries with a current provider network directory listing all providers in their network, including behavioral health providers.

DHA provides an annual report to Congress, the *TRICARE FY 2014 Evaluation of the TRICARE Program Access, Cost and Quality*. This report provides relevant information related to the general beneficiary population, availability and ease of obtaining health care, ability to get appointments with specialty providers, and global satisfaction. Additionally the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a tool used by TRICARE to assess beneficiary access and satisfaction. Neither the annual report nor the CAHPS address pediatric specialty care, access, or family satisfaction related to care of children.

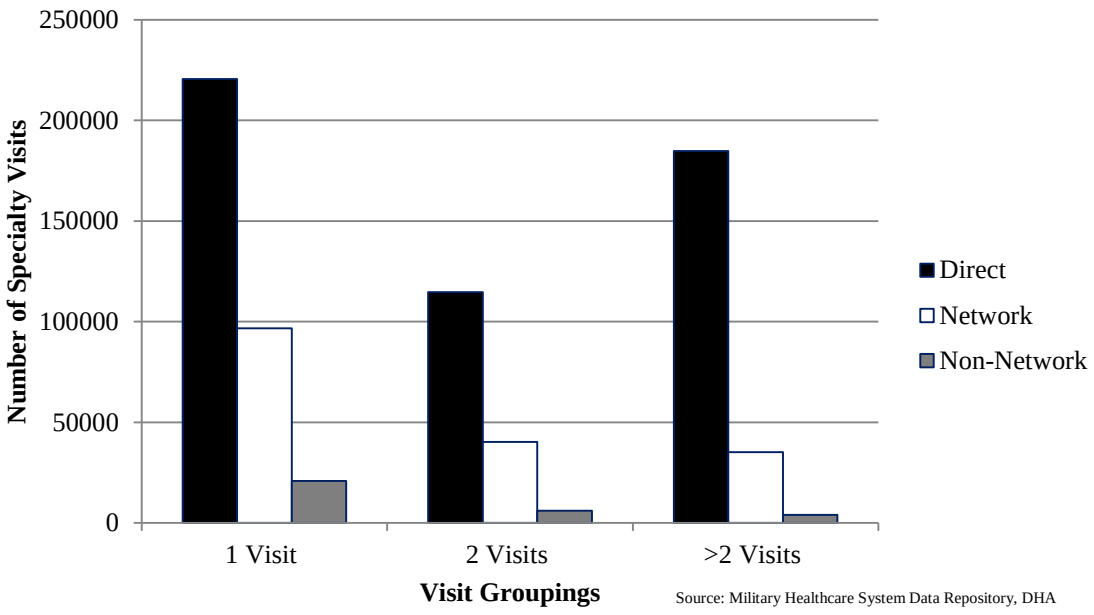
Data presented in this section are based on a single year, so chronicity of illness cannot be assumed. The unavailability of data and complexity of retrieving data from regional contractors beyond the current contract year contributed to the inability to extend this study beyond one fiscal year. Regional contractors were not contractually obligated to provide access to historic

[23] DoD Instruction 1315.19 Section 4.2, E4.1

data that predated their current contracts. Data from previous contracts are often stored in a manner that made access and analysis a difficult task for the TROs.

Figure 3.1 represents groupings of pediatric visits by the number of specialty visits of the pediatric beneficiary group in 2012 (one visit, two visits, and more-than-two visits). The specialty visits were additionally grouped based on the setting of care (direct, network, and non-network). It is important to note that caution should be taken when evaluating these findings. The groupings do not represent individual beneficiary visits. Rather, they are a combination of number of visits for the entire pediatric population. In these data, a beneficiary who had one specialty visit in direct care, one specialty visit in network care, and/or one specialty visit in non-network components would be considered in the "one visit" group because they had only one specialty visit in any single care setting in that year. To be included in the "two visit" grouping a beneficiary would have had two specialty visits in the same setting in FY 2012. Therefore, caution should be taken when making comparisons across settings due to the potential for duplication of beneficiary counts. This may minimize differences or similarities across groups.

Figure 3.1: FY 2012 Number of Specialty Pediatric Encounters



Source: Military Healthcare System Data Repository, DHA

Data show that direct care component accounts for the largest proportion across visit groupings. In the "two visit" and "more-than-two visit" categories, the number of beneficiaries using network and non-network decreased while visits in direct care increased. These data demonstrate single visits with specialty providers were proportionally more common in direct care components than in network or non-network settings.

The largest difference in number of specialty visits was found between the "one visit" and "more-than-two" visits groupings. The assumption from these data was that conditions were short-term and beneficiaries were referred back to the PCM for follow up after initial specialty consultation. When beneficiaries utilized more than two specialty visits, the majority of those

visits occurred in direct care component. These data demonstrate that utilization of the direct care component appears to be five times greater in the "more-than-two" visit group compared to the non-network component. This also indicates the adequacy of access and capacity of the direct and network providers to accommodate the health needs for specialty and chronic dependent pediatric beneficiaries.

As noted above, data on specialty visits in direct and purchased care show that 19 percent of total pediatric office visits are attributed to specialists (*i.e.*, not general pediatricians or family medicine providers). NARs reviewed from purchased care reported total providers in each specialty and the numbers of providers available based on the contracted metric. NARs did not separately list or monitor adequacy related to pediatric specialty providers. Pediatric specialty encounters from DHA encounter data were broadly categorized into the following groups: allergy and immunology; behavioral health; cardiology; dermatology; developmental; dietary and nutrition; endocrine; ear, nose and throat (ENT); ophthalmology and vision; genetics; gastrointestinal; neurology; obstetrics and gynecology (OB/GYN); oncology, orthopedic; pulmonology; renal; rheumatology; speech and language; surgery; urology; and other.

There was less than one specialty visit per beneficiary in 2012. These data show that OB/GYN was the most commonly utilized specialty with an average of 0.5 specialty visits per beneficiary for ages 18 to 21 years. This rate may be related to services for birth control, cervical cancer screening, or pregnancy. These data could reflect previous guidelines that recommended that females have their first Pap test three years after they start having sexual intercourse. In March 2012, updated screening guidelines were released by the United States Preventive Services Task Force and jointly by the American Cancer Society, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology recommending that women have their first Pap test at age 21. Repeated reports could track trends in light of the updated guidelines.

The two specialties that were of highest proportion in the MHS were OB/GYN and behavioral health. In 18- to 21-year-olds, OB/GYN had the highest specialty visit rate at 0.5 visits per beneficiary. The second highest utilization rate was for behavioral health within the age ranges of 13 to 17 years, with 0.3 visits per beneficiary, and ages 5 to 12 years and 18 to 21 years, each with 0.2 visits per beneficiary. The MHS behavioral health utilization data are consistent with the Centers for Disease Control and Prevention's National Health and Nutrition Examination Survey (NHANES), which reports that approximately 13 percent of children ages 8 to 15 years had a diagnosable mental disorder. The most common disorder is attention-deficit/hyperactivity disorder (ADHA), which affects up to 9 percent of this population.[24] It is not surprising that with less than 20 percent of pediatric beneficiary visits being specialty visits, the proportion of utilization of specialty care is less than one visit per beneficiary per year.

Other specialties with utilization rates per beneficiary were:

- ENT in ages 1 to 4 years (0.1 visits per beneficiary);

[24] Center for Disease Control and Prevention's National Health and Nutrition Examination Survey (NHANES). Available at: http://www.cdc.gov/nchs/nhanes/DataAccomp.htm.

- Dermatology in ages 13 to 17 years (0.1 visits per beneficiary);
- Eye and vision in ages 5 to 12 years and 13 to 17 years, with each age group having 0.1 visits per beneficiary;
- Orthopedics in ages 13 to 15 years (0.1 visits per beneficiary);
- Speech and Language in newborn to 11 months (0.1 visits per beneficiary).

When an attempt was made to further divide the specialty visit data to evaluate the number of specialty visits conducted by pediatric specialty providers, 72 percent of the visits could be attributed to a pediatric specialty provider. The remaining 28 percent of visits were attributed to specialty providers who did not have a pediatric specialty or subspecialty code. These providers could be adult providers or they could be pediatric providers without a second subspecialty code beyond their area of specialty. The conclusion is that access to specialty care in the MHS is adequate and 72 percent of the care is delivered by providers with the necessary skills and knowledge of current standard-of-care practices for a wide range of pediatric acute and chronic illnesses.

Findings and Areas for Clarification

3.1 Finding: Data show that direct care accounts for the largest proportion of specialty care visits across all specialties. In the "two-visit" and "more-than-two" visit groupings, the number of beneficiaries using network and non-network care decreased while direct care visits increased.

3.2 Finding: Data on specialty visits in direct and purchased care show that 80 percent of total pediatric encounters are attributed to specialists (*i.e.*, not general pediatricians or family medicine providers).

> Gap: Providers' pediatric specialty or subspecialty codes were not available for 20 percent of specialty visits.
>
> Area for Clarification: Potential methods for coding that will more easily identify pediatric specialty or subspecialty providers, or allow for dual (adult and pediatric) coding.

3.3 Finding: Data show that OB/GYN was the specialty with the highest utilization rate of 0.5 per beneficiary for ages 18 to 21 years; the second highest rate was for behavioral health for ages 13 to 17 years, at 0.3 visits per beneficiary.

> Gap: Data were not requested related to diagnosis for specialty visits as part of this study.
>
> Area for Clarification: Further define diagnosis for high-utilization specialty providers and access standards between referrals and appointments.

3.4 Finding: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a TRICARE tool used to assess beneficiary access and satisfaction.

> Gap: MHS survey data could not be extrapolated to the pediatric beneficiary experience.

Area for Clarification: Collecting data on pediatric access and provider specialty in the annual MHS TRICARE survey could be a useful tool for tracking pediatric access and satisfaction, including use of specific questions on CAHPS to assess family satisfaction specific to pediatric care.

3.5 Finding: Network Adequacy Reports (NARs) from regional contractors are inadequate for determining the availability of pediatric specialist and specialty appointments.

Gaps:

- Provider data from the regional contractors and the Military Departments were obtained from disparate systems that do not allow cross comparison between direct and purchased care. The WG was unable to evaluate availability in the TRICARE Regions of pediatric specialty provider based on NARs in purchased care systems.

- TROs reported that NARs provided by regional contractors did not differentiate between adult and pediatric specialists.

- TROs reported that NARs showed the number of providers contracted with regional contractors, but availability of providers to accept new patients or TRICARE patients was not included in the report.

- Direct care did not appear to have an enterprise or regional distribution of specialty providers that were available for this report.

Areas for Clarification:

- Determine the components of a consistent NAR for direct and purchased care component that identifies for referrals and consultations the participating pediatric subspecialty providers.

- Regional contract requirements for NARs to include network adequacy as measured by utilization of pediatric subspecialty providers.

- Consider the inclusion of the pediatric population in the annual *Evaluation of TRICARE Programs: Access, Cost and Quality* report to provide a comprehensive review of adult and pediatric care in the MHS.

ELEMENT 4:

A comprehensive review and analysis of reimbursement under the TRICARE program for pediatric care.

The MHS's reimbursement of pediatric care is adequate to meet the needs of the pediatric population. Specific TRICARE accommodations and additional payment groupings accurately reflect the cost and payments involved in providing the specialty care and services for children with special health care needs and chronic health conditions. However, periodic review of reimbursement policies is required.

This report of TRICARE and Federal statues/regulations explains the complexity of the process for reimbursement for pediatric care. The statutory provision, Title 10, U.S.C., section 1079(j)(2), is the primary legislative authorization for care provided by DoD for child dependents of members of the uniformed Services. This provision defines TRICARE payment methods for institutional care. It requires that payment methods be determined, to the extent practicable, in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. Further, children's health care needs are different and distinct from those of adults. Children's hospitals, designated as such by the DoD, are paid differently from other types of civilian hospitals through a children's hospital differential payment.

A July 2007 study by the United States Government Accountability Office (GAO), *Under TRICARE Children's Hospitals Paid More Than Other Hospitals After Accounting for Patient Complexity*, examined the appropriateness of TRICARE's differential payment rates for children's hospitals.[25] This study found that MHS pediatric patients at children's hospitals had a similar level of complexity to those at other hospital types. The study acknowledged that TRICARE's differential payment was functioning as DoD expected, and that increasing payments to children's hospitals was not supported on the basis of patient complexity. TRICARE accommodations for the specialized treatment needs of children include:

- TRICARE payment of a children's hospital differential ($2,635), which is added to each predetermined payment amount normally allowed for a hospital stay under the Inpatient Prospective Payment System (IPPS). 32 C.F.R. § 199.14(a)(1) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under TRICARE based on prospectively set rates. Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat TRICARE patients in that DRG. This provides additional reimbursement for the complexity and intensity of care inherent in the treatment of children in a specialized setting.

- TRICARE has children-specific DRGs, as specific condition groupings are critical in accurately reflecting costs of treating children in a specialized setting. DRGs are based on

ICD (International Classification of Diseases) diagnoses, procedures, age, sex, discharge status, and the presence of complications or comorbidities.

- INPATIENT ONLY LIST. TRICARE's Inpatient Only Procedure List (IOPL) is a list of procedures designated as "inpatient only" that are not considered appropriate to be furnished in a hospital outpatient department. Inpatient only services are generally surgical services that require inpatient care because of the nature of the procedure, the typical underlying physical condition of patients who require the service, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be discharged safely. TRICARE adopted Medicare's IOPL when the Outpatient Prospective Payment System (OPPS) was implemented. The most common method of reimbursement for covered inpatient facility charges of children's hospitals is that of billed charges or negotiated rates for network providers. The claims submitted by children's hospitals are subject to the IOPL at this time. The most common method of reimbursement for covered services of hospitals is that of billed charges or negotiated rates for network providers. The IOPL is an area that advocacy groups find constraining in the treatment of children. Advocacy groups have provided opinions that the IPOL should be unique for pediatric beneficiaries and not the same as the adult list.
- TRICARE covers medically necessary (as that term is defined under TRICARE program regulations) outpatient care provided in acute care children's hospitals. Children's hospitals are exempt from OPPS.
    - This exemption accommodates the reimbursement levels necessary to sustain the complexity and intensity of outpatient services provided in children's hospitals. Ambulatory surgery services are reimbursed using TRICARE's ambulatory surgery reimbursement system.
    - Outpatient services, such as professional services or diagnostic tests provided in children's hospitals, are reimbursed using the CHAMPUS Maximum Allowable Charge (CMAC) methodology. Most procedures are paid using the national allowable charge system, with amounts for each procedure adjusted to reflect the cost of doing business. These locality adjustments are the same as those used by the Medicare payment program.
    - Facility charges for other services are paid the lower of the negotiated rate or the billed charge. Billed charges are generally significantly higher than the established OPPS levels. TRICARE continues to evaluate its reimbursement of pediatric care to ensure comparable and cost-effective care for the pediatric population.
    - TRICARE adjusts DRG-based payment amounts only as permitted in federal regulation. At this time, the payment adjustments include the children's hospital differential, and children's hospital and neonatal outliers. These adjustments

should be sufficient in covering the cost of devices associated with high-priced procedures, thereby ensuring continued access to care.

- TRICARE covers medically necessary (as that term is defined under TRICARE program regulations) inpatient and outpatient care provided in a skilled nursing facility (SNF).
    - Inpatient services are reimbursed under the TRICARE SNF Prospective Payment System (PPS) with the exception of beneficiaries under age 10 years. For beneficiaries under age 10 (at the time of admission to a SNF), the SNF will be reimbursed using any of the payment methodologies listed for hospitals that are not subject to the TRICARE DRG-based payment system or the mental health per diem payment system.
- TRICARE offers a mental health/behavioral health care benefit to children and adults. Care may include individual psychotherapy, group psychotherapy, psychological testing, and medication management. Reimbursement depends on place of service (*e.g.*, inpatient care is reimbursed under the DRG; outpatient care under OPPS or TMAC/CMAC rate). Individual professional providers are reimbursed at the TMAC/CMAC rate. Other types of services are reimbursed as follows:
    - Acute Inpatient Psychiatric Care: Reimbursement is made at a hospital-specific per diem (high-volume provider) or the regional per diem (low-volume provider).
    - Psychiatric Partial Hospitalization Programs (PHP): TRICARE reimburses PHPs a per diem amount.
    - Substance Use Disorders: Inpatient care is reimbursed at the DRG amount. Outpatient care provided by the Substance Use Disorder Residential Facility (SUDRF) is paid the CMAC rate.
    - Residential Treatment Centers: TRICARE reimburses centers a per diem amount.

The MHS continues to evaluate reimbursement for pediatric care to ensure comparable and cost-effective care, and continued access to specialty inpatient care tailored to best serve military children and their families. Advocacy groups (AAP and Children's Hospital Association) have provided opinions related to TRICARE reimbursement practices and policies. Children's Hospital Association recommends that TRICARE adopt flexible payment policies that allow providers to make the best care decisions for the child. AAP recommends that TRICARE review rates for pediatric care and eliminate or modify the ability of regional contractors to require providers to provide a "discount" from the CMAC. The MHS remains committed to modification of and/or exemptions to existing reimbursement systems, both inpatient and outpatient, consistent with statutory requirements, to continue to ensure access to quality pediatric care for military families.

Findings and Areas for Clarification

4.1 Finding: The MHS's reimbursement of pediatric care is adequate to meet the needs of this unique population. The accommodations and additional payment groupings accurately reflect the cost and payments involved in providing the specialty care and services for children with special health care needs and chronic health conditions.

> Gaps: Advocacy groups report concerns related to reimbursement of comprehensive services due to billing requirements.
>
> Area for Clarification: Periodically review reimbursement policies in order to collaborate on innovative processes needed to continue to meet the unique health care needs of children as health care delivery models change.

ELEMENT 5:

An assessment of the adequacy of the ECHO program in meeting the needs of dependent children with extraordinary health care needs.

Available data show that ECHO enrollment tripled from 2009 to 2012 and 60 percent of enrollees used services. Moreover, ECHO benefits have recently been expanded. A 2013 analysis of the Applied Behavior Analysis (ABA) program for Autism Spectrum Disorder (ASD) found parental satisfaction, with a positive impact on lives of some of the children, retention, and family readiness. However, better tracking of use of services among the enrolled is needed.

Extended Care Health Option (ECHO)

The Extended Care Health Option (ECHO) program, established in law at section 1079(d)-(f) of Title 10 of the U.S.C. and implemented in 2008 supports ADFMs and other eligible beneficiaries with extraordinary health care needs not met by the medical benefits that are covered under the TRICARE Basic program. ECHO replaced the former Program for Persons with Disabilities (PFPWD) that dated back to 2001 as a means to provide additional non-medical services to dependents of active duty members who face unique challenges in accessing special needs services due to the nature of military service (*e.g.*, frequent relocations, absence of the service member from the home, *etc*.) By law other "public facilities" (*i.e.*, state Medicaid waiver programs, services provided by local school systems and other state and local resources) must be used before payment of ECHO services may be authorized. MHS regional contractors administer ECHO.

TRICARE program regulations (32 C.F.R. § 199.5(h)(2)) require ADSMs to provide evidence of enrollment in the Exceptional Family Member Program (EFMP) with their sponsor's branch of Service. EFMP is a personnel system administered by the Military Departments to assist in the process of reassignment of members and families, and to provide supplemental community-based support for families with special needs.

ECHO was implemented as a program to support ADFMs with an additional set of integrated services to support the unique challenges of families during the relocations in their military career. The ECHO program allows families to supplement TRICARE Basic program medical benefits with additional services, including training; rehabilitation; special education; assistive technology devices; institutional care in private nonprofit, public, and state institutions/facilities; if appropriate, transportation to and from such institutions/facilities; home health care; and respite care for the primary caregiver of the ECHO-registered beneficiary. The ECHO program as a supplementary program includes cost shares based on the ADSM's rank.

To qualify for the ECHO program, beneficiaries must verify enrollment in the EFMP (if applicable) and meet specific qualifying mental or physical conditions, including:

- diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler expected to precede a diagnosis of moderate or severe mental retardation or serious physical disability;
- extraordinary physical or psychological condition causing the beneficiary to be homebound, to include ASD;
- moderate or severe mental retardation;
- multiple disabilities which may quality if there are two or more disabilities affecting separate body systems;
- serious physical disability.

The ECHO program works with other programs to ensure that ADFM beneficiaries have resources to support their needs. ECHO requires that public facilities be used first for services and items to the extent that they are available and adequate, based on statutory requirements. The three regional contractors manage ECHO and assign case managers to all ECHO enrollees. Case management support is one tool for ECHO families to use as they transfer from one TRICARE regional contractor to another. Collaboration among direct care, purchased care, primary care providers, ECHO case managers, and families facilitate smooth transitions.

ECHO has three distinct programs and user groups including: ABA for ASD, ECHO Home Health Care (EHHC), and all other users. As of February 2014, there were 13,635 beneficiaries registered in ECHO. ECHO programs are evaluated based on enrollee utilization due to the ECHO enrollees with differing needs for services, with some enrollees utilizing services each month and others utilizing services less often, or ceasing use after a period of time. ECHO continued enrollment is evaluated only when services are accessed, so there may be many ECHO enrollees who no longer meet the criteria for enrollment but remain in the system. ECHO cost shares are paid only when the services are used in a particular month. In FY 2012, approximately 62 percent of enrolled beneficiaries utilized any ECHO services. Utilization of the three ECHO programs for qualified beneficiaries was as follows for FY 2012; 84.9 percent utilize ABA for the Autism Spectrum Services, 7.3 percent utilize EHHC, and 7.7 percent utilized other services. ECHO enrollment nearly tripled between FY 2009 and FY 2012 from 2,292 to 7,791. Overall utilization of ECHO services tripled between FY 2009 and 2012. Since 2012 utilization of ECHO services has incrementally decreased; that decrease is attributed to the accessibility of ABA in the TRICARE Basic program, minimizing the need for ECHO enrollees to receive ABA services.

Both ECHO and the benefit of the ABA program are addressed in detail in other reports:

- Senate Report 112-173, Page 128, to accompany S.3254, The National Defense Authorization Act for Fiscal Year 2013.
- Report on Participation in the Extended Care Health Option (ECHO) program by eligible dependents with special needs Feb 2013.[26]

[26] DoD. *The DoD Autism Pilot and Demonstration Projects Report to Congress*, 2013. Available at: http://www.tricare.mil/tma/congressionalinformation/downloads/Report%20on%20DoD%20Autism%20Pilot%20Projects.pdf.

Enhanced Access to Autism Services Demonstration (the ECHO Autism Demonstration)

In addition to the extensive medical benefits provided under the TRICARE Basic program and other services for special needs children provided by DoD, the MHS provides one of the most comprehensive sets of specialized services for children with an ASD diagnosis. The Program for Persons with Disabilities (PFPWD) included the provision of ABA starting in 2001. The ECHO program replaced PFPWD in 2005, and the Autism Pilot and Demonstration project began in 2008. Subsequent changes in the ECHO program were implemented in response to various NDAAs (FY 2007 and FY 2009) with the goal to improve quality, efficiency, convenience, and cost-effectiveness of providing services to eligible ADFMs with ASD.

Beginning in April 2009, the limit of government liability for ECHO benefits increased from $30,000 annually, to $36,000. Central to the ECHO Autism Services Demonstration was the authority to provide reimbursement for one-on-one ABA services provided by individuals who are not TRICARE-authorized providers. The key feature of the ECHO Autism Demonstration was to provide "educational services" to those ADFM beneficiaries with ASD by a two-tiered delivery model whereby supervised non-certified providers deliver one-on-one ABA interventions. In 2012, ABA under the ECHO Autism Demonstration became an "other service" and is no longer considered purely educational. The ECHO Autism Demonstration's tiered delivery model provides services by:

1. Individuals certified as "supervisors" by the Behavior Analyst Certification Board (BACB) at the Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA) level, who have a contractual relationship with TRICARE, either individually or as an employee of a TRICARE authorized provider; and

2. Noncertified individuals, *i.e.*, ABA "tutors," who provide one on one ABA services under the supervision of a BCBA or BCaBA. Tutors are also referred to as "ABA Technicians" by the BACB.

Program evaluation findings, as measured by parental satisfaction,[27] support the conclusion that the ABA services provided in the ECHO Autism Services Demonstration may generally have had a positive impact on the lives of some of the children with autism and their families, and may be positively related to retention and family readiness. While the ECHO Autism Demonstration has not measured clinical outcomes or treatment progress, the program has increased the number of beneficiaries and their access to the services of authorized ABA providers, as evidenced by the sustained monthly growth in the number of enrollees. With the growing number of children with an ASD diagnosis in the military and worldwide, TRICARE continues to increase access to ABA services by extending the Autism Services Demonstration for TRICARE beneficiaries under ECHO that was implemented on March 14, 2008 for a period of two years, to March 14, 2012, again through March 14, 2014, and currently extended through March 15, 2015.

[27] See *The DoD Autism Pilot and Demonstration Projects Report to Congress*, noted above.

ECHO Home Health Care

EHHC provides medically necessary (as that term is defined under TRICARE program regulations) skilled services to those ECHO beneficiaries who are homebound and generally require up to 28 to 35 hours per week of home health services or respite care. In order to assure the quality of care for ECHO beneficiaries, all ECHO respite care services are provided only by Medicare- or Medicaid-certified Home Health Agencies (HHAs) that have in effect at the time of services a valid agreement to participate in the TRICARE program. Consequently, the EHHC benefit is available only in locations where there are Medicare- or Medicaid-certified HHAs; the 50 states, District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. The beneficiary's PCM or attending physician reviews the eligibility and determines if the patient is eligible for EHHC services. TRICARE EHHC beneficiaries have the following diagnosis distribution: cerebral palsy/other brain damage, 25 percent; spina bifida/congenital conditions, 14 percent; and pulmonary (including respirator use), 14 percent. EHHC users (400) have the highest per capita cost.

Other ECHO Services

The ECHO program "other services" category provides an option for families to supplement TRICARE Basic with additional services, including training; rehabilitation; special education; assistive technology devices; institutional care in private nonprofit, public, and state institutions/facilities; if appropriate, transportation to and from such institutions/facilities; home health care; and primary caregiver respite care based on eligibility for the program. Respite care[28] is planned or emergency care provided to a child or adult with special needs in order to provide temporary relief to family caregivers who are caring for that child or adult. In order to assure the quality of care for ECHO beneficiaries, all ECHO respite care services are provided only by Medicare- or Medicaid-certified HHAs that have in effect at the time of services a valid agreement to participate in the TRICARE program. ECHO respite care is meant to be used in addition to other ECHO benefits and can include up to a maximum of 16 hours in a calendar month in which beneficiaries also receive any other ECHO-authorized benefit other than the EHHC benefit. EHHC eligible beneficiaries who require frequent interventions may receive eight hours of respite care services on 5 days per calendar week.

Hippotherapy is a unique type of exercise that utilizes equine (horse) movement as part of an integrated intervention program. Hippotherapy was added to ECHO benefits in September 2013. The therapy is covered as a nonmedical ECHO benefit for those beneficiaries with a primary or secondary diagnosis of multiple sclerosis or cerebral palsy.

Findings and Areas for Clarification:

5. 1 Finding: ECHO enrollment tripled from 2009 to 2012.

[28] The Military Departments offer other services separate and apart from the TRICARE program and ECHO that may be referred to as "respite care." Such services should not be confused with the scope and limitations of the respite care authorized under ECHO.

5. 2 Finding: ECHO services were utilized by more than 60 percent of enrollees.

5. 3 Finding: ECHO benefits have recently been expanded.

5. 4 Finding: ABA program evaluation in 2013 reported parental satisfaction with a positive impact on lives of some of the children and positively related to retention and family readiness.

Gaps: ECHO programs outcome measurements are based on the assistance in reduction of the disabling effects of the beneficiary's qualifying condition and do not include a component of beneficiary satisfaction.

Areas for Clarification:

- Review data regarding EFMP family members eligible for ECHO enrollment, current ECHO-enrolled beneficiaries who continue to be eligible for services, and current ECHO-enrolled beneficiaries who due to changes in condition are no longer eligible for ECHO services. Collaborate with the MHS Beneficiary Education and Support Division, the Military Departments, TROs, the Office of Special Needs, and contractor partners to provide information to all eligible families and track ECHO enrollment and utilization.

- Develop satisfaction or outcome measurements for all ECHO programs with regard to impact on beneficiaries and family readiness.

ELEMENT 6:

An assessment of the adequacy of care management for dependent children with special health care needs.

Case management and care management are integral to the direct care and purchased care components for beneficiaries with special medical needs; however data are needed on best practices, optimal patient/care manager ratios, and outcomes. In addition, although the Patient Centered Medical Home (PCMH) model is a priority in MHS direct care metrics are needed for tracking its impact over time.

"Care management" and "care coordination" are terms used within the PCMH and by primary care providers to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to facilitate an individual's and family's comprehensive health needs. Collaborative care for children with special needs and their families that includes medical and community resources best serves our beneficiaries.

Dependent children with special health care needs have access to many programs through their sponsor's Military Department and TRICARE benefits. The TRICARE Basic program is the primary source of medical care for all family members and can be supplemented for family members with extraordinary health care needs with ECHO program benefits. When a family member is identified with special medical and/or educational needs, the needs are documented through enrollment in the Military Department EFMP. Enrollment ensures that the family member's medical and educational needs are considered during the assignment process. Military Department medical personnel consider the assignment of the Service member based on mission and make the recommendation to support or deny family relocation with the Service member based on availability of appropriate medical/behavioral/educational services to support the EFMP family member. There is a collaborative process with the DoD Education Activity (DoDEA) if educational special needs are present. If the medical/behavioral/educational resources are not available in the new assignment location, the personnel office may deny orders to allow the EFMP family member to accompany the Service member. Each Military Department has a process for re-evaluation of assignments when family co-location is not recommended. The intent of EFMP is to prevent unnecessary family hardship and personnel practices such as the early return of the dependents or reassignments of the Service member due to unavailability of medical/behavioral/educational support at the gaining location. EFMP Family Support provides the non-medical information and resources to assist families prior to, during, and after assignments to help them identity and access services when they arrive at the new duty station. The military's community approach empowers families with tools necessary to advocate for the services required by their family members with special needs.

Care management is the key element to a PCMH in the MHS, where health care providers, team members, and families collaborate to achieve the best care outcome. The PCMH is a team-based model, led by a physician, which provides continuous, accessible, family-centered, comprehensive, compassionate, and culturally sensitive health care in order to achieve the best

outcomes. The model is based on the concept that the best health care has a strong primary care foundation with quality and resource efficiency incentives. The PCMH model is a departure from previous traditional health care models because it focuses on the "whole person" concept, preventive care, and early intervention and management of health problems rather than on high-volume, episodic, overspecialized, and inefficient care. The PCMH concept has been endorsed by American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), American Osteopathic Association (AOA), and 18 other physician organizations including the Academy of Neurology and the American College of Cardiology.

All pediatric beneficiaries who received care at one of the 440 MTF health settings are enrolled in the MTF-based PCMH model of care. PCMH in the direct care component can include family medicine, community-based medical homes, pediatric clinics, and general primary care clinics. Ninety-one percent of pediatric beneficiaries enrolled to a PCMH are seen by a pediatrician or pediatric nurse practitioner (more than 59 percent), family medicine physician, or nurse practitioner (32 percent), or physician's assistants. The PCMH program is evaluated monthly for access of appointments and continuity of care. PCMH is not a requirement for network providers and cannot be tracked at this time.

One example of effective care coordination is the Army's system-wide innovative program aligning Behavioral Health (BH) support and interventions to the PCMH. The Child and Family Behavioral Health System (CAFBHS) provides a consultative and collaborative system of BH care that maximizes the role of the primary care provider in the PCMH. This model is strongly supported by the medical literature and places BH care and resources within the framework of primary care, where family members' health care is located. This model supports universal screening and early intervention as part of a whole person, wellness model. The CAFBHS Model consists of four major interrelated components in support of the PCMH: 1) consultative and collaborative BH care to primary care providers and/or PCMH BH teams caring for family members; 2) a School Behavioral Health Program in on-post schools; 3) BH outreach and coordination services on the installation, and 4) regional level teleconsultation and telebehavioral health services with child and family subject matter experts to support primary care and BH providers.

TRICARE utilizes the definition of case management employed by the Case Management Society of America, as follows: "A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to facilitate an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes."[29] Case management is provided through direct or purchased care for beneficiaries with chronic, catastrophic, or complex, high-risk and or high-cost health issues who meet applicable case management criteria and would likely benefit from case management services. The MHS has recently implemented an administrative coding mechanism in order to review the utilization of case management services in direct care.

[29] Case Management Society of America. (2010). *Standards of Practice for Case Management.* Available at: http://www.cmsa.org/portals/0/pdf/memberonly/StandardsOfPractice.pdf. Page 24.

Beneficiaries with complex medical or behavioral needs should have a case manager assist in referrals and coordination of services. The regional contracting representative and the TRICARE regional offices have developed and are utilizing a transition of care practice for beneficiaries utilizing case management (medical/surgical or BH). This collaboration by case managers provides comprehensive assessments of the beneficiary's condition, available benefits, and resources for use in a care plan with performance goals. Coordination of case management is more complex when the beneficiary receives segments of their medical care in the direct care component and in the purchased care components. Collaboration between direct care and regional contracting representative is not as robust as the process between TRICARE regions. A comprehensive system is needed for evaluating wellness or health benefit outcomes attributed to care management between direct and network with complex beneficiary care.

Related Support

The primary Military Department-based support program for beneficiaries with special needs and their families is the EFMP. The DoD Office of Community Support for Families with Special Needs (OSN) reports as of September 2013 that there were 128,582 family members enrolled in EFMP. The OSN monitors the availability and accessibility of programs provided by other Federal, State, local and non-governmental agencies to military families with special needs. The OSN was created to enhance and improve DoD support around the world for military families with special needs, non-medical or educational. The OSN and the Military Departments are conducting a multi-year functional analysis. The analysis will include:

- review of current EFMP criteria to determine if revisions are needed;
- development of a standard screening process for Family Member Travel Screening;
- standardization of Family Needs Assessment and Service plans to document family needs;
- development of an Inter-Service Transfer Summary to document family support assistance for use with transferring families; and
- development of the Quick EFMP Reference Guide.

The OSN collaborates with the Military Departments and families to prioritize the processes to support and assist the non-medical family needs.

Findings and Areas for Clarification

6.1 Finding: Case management and care management are integral to the direct care and purchased care components for beneficiaries with special medical needs.

Gaps:

- There is no clear inter-care collaborative process for direct care, purchased care, and related support to address medical and non-medical complex beneficiary needs.

- It is not known if there is a best practice with regard to optimal ratios of EFMP family members and case management in purchased care components.

- TROs report that data are not available to review ECHO beneficiaries and case manager ratios and clinical outcomes.

Areas for Clarification:

- DoD collaborative review to establish a formal family-focused process to evaluate the adequacy of care and case management in meeting complex individual health needs and promoting quality cost-effective outcomes.

- Develop a formal collaborative process in and between direct and purchased care to define and review outcomes for appropriate care/case management of pediatric beneficiaries and their families.

- Develop outcome/efficacy metrics for the impact of case management in direct and purchased care for beneficiaries with significant medical/behavioral health issues.

6.2 Finding: PCMH is a priority in MHS direct care.

Gap: Longitudinal metrics for tracking health and wellness of the pediatric population in direct care PCMH have not been developed.

Area for Clarification: Future longitudinal study on the impact of PCMH on pediatric beneficiaries in the MTF setting.

ELEMENT 7:

An assessment of the support provided through other Department of Defense or military department programs and policies that support the physical and behavioral health of dependent children, including children with special health care needs.
(See APPENDIX C for listing of DoD and Service programs for this element)

Children with special needs have access to a broad range of services delivered through the TRICARE programs. DoD and the Military Departments provide multidimensional appropriate programs to support the physical and behavioral health of dependent children, including children with special health care needs. However, criteria are needed to measure program effectiveness and families need assistance in navigating the array of services available to them.

DoD

Morale, Welfare and Recreation Service (MWR) programs function within each Military Department and are designed to boost family resilience during deployment, relocation, employment, finances, and the challenges of military life. The opportunities offered involve body, mind, and spirit working together to build resilience for the Service member and their family through a variety of activities that create family cohesion, social support, engagement, strength, and endurance, all of which support the Total Force Fitness (TFF) framework. The TFF framework was established to understand, assess, and maintain the fitness of Service members and their families as it relates to mission readiness. The TFF approach requires the mind, body, and spirit to work together to achieve and sustain well-being even under the most difficult conditions. Physical fitness is a fundamental element in physical and mental health, mission performance, and readiness. Families can prepare for the demands of military life by staying fit and healthy.

- Warfighter and Family Services (WFS) include a variety of programs to improve quality of life and family readiness, which assists in managing the competing demands of the military mission and family. The programs offered by WFS can help families with decision making skills, coping skills, family cohesion, and social support and include the following services: Mobility and/or Deployment Assistance; Relocation Assistance; Personal Financial Management; and Family Life Education and Crisis Assistance. The programs offered through WFS and MWR are available worldwide on military installations and online.

DoD is committed to supporting families and the military mission by addressing and ending domestic abuse. Each Military Department has an arm of the Family Advocacy Program (FAP), which works to prevent abuse by offering programs to put a stop to domestic abuse before it starts. The FAP works to prevent domestic abuse and child abuse and neglect by providing education and awareness programs for all members of the military community. If abuse does occur, the FAP works to ensure the safety of victims and helps military families overcome the effects of violence and change destructive behavior patterns. FAP staff members are trained to respond to incidents of abuse and neglect, support victims, and offer prevention and treatment.

The FAP provides services when one of the parties is a military member or, in some cases, a DoD civilian serving at an overseas installation.

Domestic abuse is violence or a pattern of behavior resulting in emotional or psychological abuse, economic control, or interference with personal liberty directed toward a current or former spouse, a person with whom the abuser has a child, or a current or former intimate partner with whom the abuser shares or has shared a common domicile. Child abuse and neglect are defined as injury, maltreatment, or neglect to a child that harms or threatens the child's welfare. For the FAP to be involved in reports of child abuse, alleged victims must be under 18 years of age or incapable of self-support due to physical or mental incapacity, and in the legal care of a Service member or military family member. The FAP will also intervene when a dependent military child is alleged to be the victim of abuse and neglect while in the care of a DoD-sanctioned family child care provider or installation facility such as a Child Development Center, school, or youth program.

New Parent Support Program (NPSP) is a standardized secondary prevention program under the Family Advocacy Program to prevent child abuse and neglect. The NPSP identifies expectant parents and parents of children from birth to 3 years of age whose life circumstances place them at risk for child abuse or neglect. Voluntary intensive home visitation-based prevention services are provided to all identified at-risk Active Component parents and Reserve component parents ordered to all Federal active duty and their family members to support their roles as DoD personnel and parents.

Army

BH support and interventions have been provided through two major programs: Child and Family Assistance Centers (CAFACs), and School Behavioral Health (SBH) Programs. CAFACs are operational at five Army installations, providing comprehensive behavioral health care to support military children, their families, and the Army community throughout the Army Force Generation (ARFORGEN) and Family Life Cycle. SBH programs exist in 46 on-post schools across 8 Army installations. The programs utilize a public health model continuum of care, focusing on prevention and early intervention to promote wellness and resilience, and providing a higher level of behavioral health care when needed. In addition to CAFACs and SBH Programs, traditional child and family BH services are provided at many other Army installations. All legacy child and family BH programs and services will transition into the Child and Family Behavioral Health System, which is an integrative, consultative, collaborative care model of BH service delivery to be implemented Army-wide.

Navy

The Navy Respite program, established in 2009 under Child and Youth Programs, provides up to 40 hours of care a month for category 4 (major medical) and category 5 (homestead) children with special needs. The Navy Respite Care program has worked hard to increase respite care spaces from a total of 425 to 600 fluid spaces. Fluid spaces allow Navy to move space from location to location as needed for care shifts. The goal and intent of the Navy EFMP Respire Care Program is to operate at a status of less than 90-day average for placement.

Air Force

The Adolescent Substance Abuse Counseling Service (ASACS) program includes a comprehensive program for substance abuse prevention, education, identification, and referral and treatment. ASACS is provided free of charge to all adolescent family members who hold an military ID card and are eligible for TRICARE services.

The Air Force's Exceptional Family Member Program (EFMP)-Family Support oversees the Air Force Respite Child Care of 12 hours per month for families whose children (from birth to 18 years) have moderate or severe special needs. The Air Force's EFMP Respite program requires the family to be enrolled in EFMP and active duty, including Air Guard and Reserve, if activated for at least 31 days. Additionally the program is open to siblings of the child with special needs[30].

EFMP-Family Support Coordinators establish, implement, and maintain the family support portion of the EFMP in coordination with the installation's medical and assignments functions to enhance the quality of life of family members of active duty sponsors who have special needs. They provide coordination of family support services on and off the installation to families with special needs, promote the EFMP by establishing and maintaining contact with Federal, State, and local governments to include civilian sector educational and sector organizations to ensure maximum availability of resources/services for families, outreach and awareness, and caregiver support activities.

Educational and Development Intervention Services (EDIS): The Air Force's medical department provides EDIS pursuant to the Individuals with Disabilities Act on six OCONUS and one CONUS military installation supported by DoD schools.

National Capital Region-Medical Directorate

Healthy Habits Clinic: Childhood obesity prevention and treatment multi-disciplinary program encompassing the services of pediatric endocrinology, general pediatrics, adolescent medicine, child psychology, and nutrition. The program utilizes the concept of behavior modification to effect lifestyle modification with optimal outcome of healthier Body Mass Index (BMI). The clinic also treats/evaluates comorbid conditions associated with childhood obesity with the inclusion of group exercise, didactic lectures in curriculum, and motivational sessions for children.

In sum, the Military Departments provide innovative and strategic programs to meet the pressing military and community needs of their unique communities.

[30] AFI 36-3009, Airman and Family Readiness Centers 7 May 2013, Incorporating Change 1, 4 December 2013.

Findings and Areas for Clarification

7.1 Finding: DoD and the Military Departments provide multidimensional appropriate programs to support the physical and behavioral health of dependent children, including children with special health care needs.

> Gap: There are no formal criteria for outcomes or program-effectiveness measures in many DoD or Military Department programs.
>
> Area for Clarification: Develop a common core of programs/benefits that support families available at all installations with criteria for evaluating effectiveness of programs and outcomes.

7.2 Finding: Diverse programs throughout DoD and the Military Departments are directed to support the physical and behavioral health of pediatric beneficiaries including children with special health care needs.

> Gap: There is no single point of contact for families to obtain assistance in evaluating the most appropriate medical, community, and Military Department programs to meet their needs.
>
> Area for Clarification: Evaluate a process for a “one-stop-shopping system” to support families in evaluating the multitude of services available in the Military Departments, DoD, and community to meet their needs.

ELEMENT 8:

Mechanisms for linking dependent children with special health care needs with State and local community resources, including children's hospitals and providers of pediatric specialty care.
(See APPENDIX D for a listing of programs from DoD and Services for this element)

Formal and informal networks link dependent children with State and local resources including children's hospitals and providers of specialty care. However, levels of communication and collaboration among the programs and services should be assessed.

Military children make tremendous sacrifices for their parents' military service and deserve quality choices of youth development activities. DoD continues to be committed to military children and youth by providing consistent guidance, dynamic and predictable quality programs that include command and community support, on and off military installations and in communities where they live. Linkages, both formal and informal, are created at the local and command level through the collaboration of families, providers, and Military Department representatives to maximize the network of agencies, programs, and available services to support the unique needs of the family.

Medical Care Management

Medical care management and coordination for beneficiaries in direct care is provided by the PCMH team, formal case management, and the primary provider in network and non-network care. The MHS health care network includes MTFs with specialty children's inpatient units with the availability of community-based children's hospitals and pediatric specialty care services to provide comprehensive quality pediatric care. The regional contractor referral process provides linkages for direct, network, and non-network providers and facilities to meet the medical needs of the beneficiaries. Many children's hospitals and providers of pediatric specialty care are integrated into MHS purchased care in both network and non-network settings. Element 3 discusses the specialty utilization of pediatric beneficiaries in the MHS.

Related Support for Families

The EFMP enrolled beneficiaries are diverse and varied in their needs. Enrollment in the Military Department's EFMP program is over 128,000 and is found in the following proportions among the departments: 53 percent Army, 25 percent Air Force, and 21 percent Navy or Marines. EFMP Family Support assists these families with special needs by helping them identify and access programs and services through providing information and referral services to military, State, and local community resources regardless of the sponsor's Military Department affiliation or enrollment status in the EFMP. EFMP Family Support on each installation also provides non-medical case management to military families with special needs. The installation EFMP Family Support collaborates with community organizations and State and local agencies to share and exchange information unique to the specific community to best serve the beneficiaries. EFMP Family Support also serves as the point of contact with Military Department leadership in identifying and addressing collective or unique community support requirements of

military families with special needs. Part of the OSN's role is to monitor the availability and accessibility of programs provided by other Federal, State, local and non-governmental agencies to military families with special needs. The EFMP Family Support services offered include, but are not limited to, the following:

- Information and referral for military and community services
- Education and outreach about issues related to the special need
- Referral to other family center providers
- Local school and Early Intervention Services information
- Warm handoffs to Family Support at the next location
- Nonclinical case management, including individualized services plans

Families with medical issues are referred to their Primary Care Manager or the medical case management office; if families have TRICARE benefit related questions they are referred to the regional support contractor.

A wealth of information is available to families on Military OneSource (http://www.militaryonesource.mil)(MOS). MOS offers online information and connection to live operators to receive information and referral support at no cost. MOS Special Needs Specialty Consultants are licensed, master's-level professionals with extensive experience in the field of special needs. As such, MOS is an important resource for military families with special needs who are looking for immediate information or are remote from military installation.

Community resources on installations are funded through Military Department budgets and are uniquely crafted to meet the needs and structure of the Military Department and its mission.

Findings and Areas for Clarification:

8.1 Finding: Formal and informal networks link dependent children with State and local resources including children's hospitals and providers of specialty care.

> Gap: It is unknown if there is a consistent process of communication and collaboration between nonclinical and clinical providers to plan, facilitate, coordinate, advocate, and evaluate the most supportive networks to meet family needs.
>
> Area for Clarification: Future study to develop and test consistent processes of communication and collaboration between nonclinical and clinical support for the family's network of needs.

ELEMENT 9:

Strategies to mitigate the impact of frequent relocations related to military service on the continuity of health care services for dependent children, including children with special health and behavioral health care needs.
(See APPENDIX E for a listing of DoD and Service programs for this element)

The Military Departments offer comprehensive support programs to consider family members' medical and educational needs during the assignment coordination process. Military Departments have successfully implemented programs to provide for stabilization or continuation at a specific location for unique family members with special needs. The military mission is the driving force behind the assignment process of Service members and their families. However, transfer between regions can result in extended wait times for appointments with specialty providers for children with special medical needs. There is no comprehensive system for evaluating care coordination and quality outcomes resulting from care coordination in the direct and network care settings. In addition, not all eligible family members are enrolled in Military Department EFMP programs, suggesting a need to understand the reasons for lack of enrollment and to improve outreach to eligible families.

Assignment coordination occurs in order for EFMP family members to receive the care and support they require, and allow the Service member to focus more clearly on mission-related responsibilities. Assignment coordination is composed of the Military Department personnel command medical or educational professionals reviewing a EFMP family member's documented needs (available because of the EFMP enrollment) to determine availability of services at a projected location. This coordination is important because access to appropriate medical and educational services may be limited in some remote locations or overseas. Service members and their families have primary responsibility for their well-being; TRICARE and military departments' resources enhance their abilities to fulfill that responsibility. Collaboratively with the family, their Military Department, TRICARE, and the community, a network of resources is developed to facilitate navigation through relocation with complex health needs.

All pediatric beneficiaries receiving care in direct care component are fully enrolled in PCMH model of care. Primary care teams provide strong linkages and support systems for families. Relocation of families with complex needs should be facilitated among medical/behavioral providers utilizing the PCMH as a hub for transfer of information and referrals as a strong resource to families. Pediatric beneficiaries in the purchased care component utilize their PCM as a coordinator of care. In the purchased care component, regional contractors are aligned to provide the families with resources and support to locate new providers in the new geographic region.

Beneficiaries with complex medical or behavioral needs should have a case manager assigned to assist in mitigating the impact of relocation through referrals and coordination of services. Case management in the purchased care component is an "opt in" program and beneficiaries have the ability to decline case management services. The complexity of care coordination is intensified when the beneficiary receives some medical care in the direct care component and some medical/behavioral care in the purchased care components. Collaboration between direct care

and regional contracting representatives is not as robust as among TRICARE regions. A comprehensive system for evaluating care coordination between direct and network care settings would facilitate complex care coordination between care components to mitigate the impact of frequent relocations.

In 2009, a collaborative meeting of the TRICARE regional offices and the three regional contracting representatives developed a transition of care practice for beneficiaries utilizing case management (medical surgical or behavioral health) in the purchased care component. The algorithm includes a "warm hand off" notification between sending and receiving regional contractor of the beneficiary's special needs. This "warm hand off" provides coordination for beneficiaries with complex medical and or behavioral health needs enrolled in the case management program. In 2013, the algorithm was reviewed and updated to include the new regional contractor in the West region.

A current challenge to relocation is the TRICARE restriction that does not allow for enrollment in two regional contractors systems at one time. The receiving regional contractor or MTF cannot begin arranging appointments with a specialty provider prior to beneficiary relocation due to this TRICARE restriction. Prior to relocation with a child with special needs, the family and case managers should understand and be able to plan continuity of care knowing the availability of follow-up appointments for chronic conditions with specialty care providers in the new region. Provider specialty practices have wait times for new client appointments and openings in the practice for new TRICARE beneficiaries that can result in a 4- to 6-month wait beyond scheduled follow-up visits for some high-demand specialties (child neurology, developmental pediatrics, child psychiatry, pediatric pulmonology). The increased wait time for provider availability stems from national shortages in pediatric specialists such as child psychiatry[31] and is not an issue unique to relocating military families. Regional care contractors are in a unique position in the communities to provide some of this assistance.

Health Information Technology

TRICARE provides worldwide health care for Service members and their families. Recent and continued use of Information Technology (IT) helps to mitigate the impact of frequent relocation on the continuity of health care services for dependent children, including children with special health and behavioral health care needs. Defense Enrollment Eligibility Reporting System, (DEERS) registration is the key to getting TRICARE benefits eligibility established. DEERS is a computerized database of military sponsors, families, and others worldwide who are entitled under the law to TRICARE benefits. Active duty and retired Service members are automatically registered in DEERS, but they must take action to register their family members and ensure they are correctly entered into the database. Mistakes in the DEERS database can cause problems with TRICARE claims, so it is critical to maintain DEERS information. DEERS information can be updated by contacting the appropriate regional TRICARE support contractor or the nearest uniformed services personnel office (ID card facility). To enhance family member enrollment and access strategies, updates have been made to allow online access to these DEERS services.

[31] Pediatricians, FPs Help Tackle Child Psychiatrist Shortage, Deborah Brauser, February 21, 2013. Available at: http://www.medscape.com/viewarticle/779680.

Beneficiary Web Enrollment is a secure online service that allows eligible TRICARE beneficiaries to update information in DEERS. This information can be utilized to enroll or disenroll eligible beneficiaries from DEERS; transfer DEERS enrollment to a new location; select or change a PCM; view DEERS and correct enrollment information; check pending changes in DEERS enrollment status; request a new DEERS enrollment card; add information about other health insurance to your DEERS record if applicable (when first enrolling); and enroll in TRICARE dental program.

TRICARE regional contractor enrollment improvements allow the Service member or ADFM moving to a new location to transfer regional health care enrollment with a call to the current regional contractor to begin the process. The current regional contractor will send information to the accepting regional contractor, who will follow up with the family to complete the enrollment transfer after arrival at their new location.

An advancement that has made continuity of health care services more manageable for families and providers during relocation is the electronic health record (EHR). The EHR has replaced the cumbersome paper medical charts that often were copied and hand carried among providers during relocations to facilitate care of family members with chronic medical needs. Technological advances have provided families and providers with a functional record allowing worldwide access within the MHS system of care. Families can access online copies of their records and test results and stay connected through secure messaging. This technology replaces the pounds of photocopied records, the long waits to receive an update about their condition, and allows providers to leave messages for families on next steps in care.

The outpatient medical record system, Armed Forces Health Longitudinal Technology Application (AHLTA), marks a significant new era in health care for the MHS and the Nation. In 2011, DoD completed the implementation of AHLTA, the interoperable, globally accessible, protected, and always-available EHR for Uniformed Services members, retirees, and their families. AHLTA gives health care providers access to data about beneficiaries' conditions, prescriptions, diagnostic tests, and additional information essential to providing quality care. The Department has implemented the Blue Button self-service logon as a tool for families to access personal health data including outpatient medication profiles, allergy profiles, problem lists, visits/encounters, laboratory results, radiology results, and vital signs. The Blue Button technology tool makes medical records easily available for patients to download and share with members of their health care team. The Blue Button transparency application makes health data increasingly available to beneficiaries, allowing them to participate in their own health care by inputting their own data and information to medical records. These tools have replaced the need for multiple paper copies of volumes of charts for each family member in order to have the most up-to-date information. In case of health care emergencies families can access the EHR for emergency providers. These tools also mitigate the impact of relocation by giving families and providers unlimited access to essential and comprehensive medical information, allowing families to provide a complete EHR to their new providers. In addition, beneficiaries are able to share their health care information with family, care givers, and providers both inside and outside DoD.

Secure messaging is another technology advantage that supports families with medically complex care needs, allowing private communications with their provider team. Secure messaging provides an interactive website where beneficiaries can begin or respond to communications with their provider team. TRICARE online appointment scheduling is another technology that saves time for families by allowing them to choose from available options for appointment days and times, at any time of day through a TRICARE On Line (TOL) web link.

The Military Departments also have diverse programs designed to support continuity of health care for families and mitigate the negative impact of frequent relocation on medical and behavioral family needs.

Military Departments

The Military Departments offer comprehensive support programs to consider a family member's medical and educational needs during the assignment coordination process. The military mission is the driving force behind the assignment process of Service members and their families. Service members with children who have special medical needs are enrolled in EFMP to ensure that their child's special needs are considered during the assignment process. Assignment coordination occurs when the Military Department's personnel command requests medical or educational professionals to review a family member's documented needs (available because of the EFMP enrollment) to determine availability of services at a projected new assignment location. Assignment coordination is important, because access to appropriate medical and educational services may be limited in some locations, especially in overseas and remote areas. Some Service members have chosen not to enroll their family members in their Military Department's EFMP program, and some families decide to continue with relocation in an unofficial capacity with "unaccompanied" orders resulting in regional support contractors and or direct care components being unable to support the chronic health care needs of the family member. These actions of circumventing the EFMP system can result in a return to the previous location by the family and lack of available specialty care for the complex family member. When assignment coordination does occur, family members receive the care and support they require, and the Service member can focus more clearly on mission-related responsibilities. Service members and their families have primary responsibility for their well-being; TRICARE and military department resources enhance their abilities to fulfill that responsibility**.**

Army

Stabilization

The Army effort is committed to the health, safety and well-being of its Soldiers and their family members with special needs. Army policy allows for families with special needs to be stabilized for four years so that medical or educational services, which cannot be immediately replicated or acquired elsewhere, are not disrupted. While the exceptional family member may be stabilized at a support location, the Soldier may be required to travel away from home station to participate in combat or operational deployments, training exercises, or for personnel management or professional development reasons. The four-year stabilization period starts on the date the family

member began receiving the required services. One or more of the following criteria must be met in order to establish eligibility for stabilization under this program:

- A permanent station move would disrupt access to necessary medical or educational services that would place the exceptional family member's health, safety, or development in jeopardy.
- The exceptional family member has a diagnosis that requires extensive support from TRICARE, State, or local resources that would be difficult to replicate and/or reacquire in a timely manner.
- The family has multiple exceptional family members receiving a combination of TRICARE, State, or local services that would be difficult to replicate and/or reacquire in a timely manner.

School Behavioral Health Programs and Child and Family Behavioral Health System

For family members who are receiving BH care as part of the School Behavioral Health program, assistance is provided to facilitate transition of children and adolescents needing ongoing services at their new duty station. In addition, assistance is provided by the CAFBHS program for children and adolescents requiring ongoing treatment who are enrolled in care to facilitate transition and follow-up at a new duty station.

For family members who are receiving BH care as part of the School Behavioral Health program, assistance will be provided to facilitate transition of children and adolescents needing ongoing services at their new duty station.

Navy

Children with special health and BH care needs are screened by senior developmental pediatricians on one of three Central Screening Committees for continuity of health care services. The exceptional family member's needs are categorized on a 5-point scale (Category I, for monitoring purposes only; Category II, to pinpoint need for specific geographic locations; Category III to denote no overseas assignments; Category IV alerts to need for major medical areas in CONUS; Category V establishes the Homestead location designation.) Category V beneficiaries require highly specialized, complex, and/or severe medical support entitling them to Homesteading to ensure continuity of care. The Service member receives a long-term assignment to an area, called a Homestead Assignment. This assignment is covered by a policy that permits a Service member, whose family member is identified by the Case Study Committee as severely disabled, with an opportunity to remain in a particular geographic location. Homestead sites are selected based on their ability to provide requisite services for the family and appropriate sea/shore rotation, which allows for a Sailor's or Officer's career progression and milestones. Homestead sites include Norfolk, VA; Mayport / Jacksonville, FL; San Diego, CA; Bangor/ Bremerton/Puget Sound/ Seattle, WA; and the Washington DC Capital beltway area.

As long as continuity of care and/or services is recommended by Medical, the Sailor or Officer will not be relocated. Occasionally, the Service member may elect to travel to a location unaccompanied to meet a specific milestone and the family is allowed to stay at the present duty station for continuity of care. The child's case is reviewed every three years, whenever there is a change to their medical and/or educational requirements, or 12 months prior to a Service member's permanent change of station orders. Currently, 24 percent of children enrolled in EFMP are homesteaded for continuity (3,021 beneficiaries are currently homesteaded).

Air Force

The Air Force has a policy to support EFMP assignments. The intent of the EFMP assignment policy is to locate the Air Force member, based on current or projected manning requirements, at sites where required medical, educational, early interventions or related services are available either through the military medical system, through civilian resources utilizing TRICARE, or a combination of those services combined with local resources.[32]

Reassignments/Deferments are considered when continuity of care or required care is essential in assuring AF families' medical needs are met. The EFMP provides an initial 12-month deferment for a newly diagnosed condition when the Service member's presence is essential in establishing and/or participating in the treatment program. Deferment from reassignment may also be appropriate if a treatment program is at a critical juncture and the Service member's continued presence is absolutely essential to continuing the treatment program. The EFMP also provides reassignment when a Service member is assigned to an area and a new medical, special education, related service, or early intervention need arises for which the needed services are not available within the assignment locale. Once a treatment program is established, whether formally through the EFMP, or on the Service member's own initiative, the Service member is then considered worldwide assignable. (A25.4.3)

National Capital Region-Medical Directorate

The NCR-MD continues to follow the service-specific policies as designated by the Army, Navy, Marine Corps, and Air Force. The EFMP offices at FBCH and WRNMMC consistently provide administrative and clinical services to Service members with exceptional family members, irrespective of the active duty member's affiliated Military Department. They must ensure that the services provided at the MTF comply with the program as defined by the Military Department-specific instruction. The EFMP offices work very closely with each other, as well as with outlying MTFs to include Bolling AFB, Andrews AFB, Fort Myer, and Quantico, to ensure close collaboration and sharing of information as necessary to provide adequate services for family members. This collaborative effort includes enrollment, update, and disenrollment of all Service members into the EFMP, as well as assisting with assignment and discussing the transfer of beneficiaries into and out of the NCR-MD. In addition, the respective MTF EFMP offices assist with coordination with Military Department-specific community programs, including Army Community Services (ACS), Fleet and Family Support (Navy/Marine), and Air Force Family Support Center.

[32] AFI 36-2110, Air Force Training Program On The Job Training Administration, 8 June, 2012. Available at: http://static.e-publishing.af.mil/production/1/af_a1/publication/afi36-2110/afi36-2110.pdf.

Related Support

DoD Instruction (DoDI) 1315.19, created in collaboration with the OSN, provides guidance to the Military Departments on the identification, enrollment, and assignment coordination aspects of the EFMP. When a Service member is being considered for an assignment, the family member's special medical requirements are submitted to the receiving military medical component.[33] When a Service member is considered for an overseas assignment, the family member's special educational requirements are submitted to the DoD Education Activity (DoDEA), or to the Military Department responsible for children under the age of three years. The EFMP medical reviewer, DoDEA representative, and EFMP Family Support can make recommendations to the military personnel system whether the overseas community has the services necessary to meet the family member's needs. EFMP Family Support staff at the sending and receiving installation provides non-medical assistance to families before, during, and after relocation, including coordination of information and resources for needed support services with the gaining installation's EFMP family support program.

MOS web resources include links to programs for children and family related to moving such as Military Youth on the Move, Plan My Move, Relocation Assistance Programs, and Moving to Your New Duty Station with a Family Member with Special Needs.

1. Findings and Areas for Clarification:

9.1 Finding: Transfer between regions can result in extended wait times for appointments with specialty providers for children with special medical needs.

Gap:

- There is no comprehensive system for evaluating care coordination and quality outcomes resulting from care coordination in the direct and network care settings.
- EFMP medical reviews do not consistently include regional contractors in determination of available medical services in relocation decisions.

Areas for Clarification:

- Formalized collaboration of EFMP Military Department medical and regional contractors in determination of availability of medical resources in complex medical case prior to relocation.

[33] The family member's special medical and/or educational needs are documented on DD Form 2792, Family Member Medical Summary, and DD Form 2792-1, Special Education/Early Intervention Summary.

- Evaluate limited dual enrollment within two regional contractors for a specified time during relocation to allow for appointments to be made for continuity of care in chronic conditions.

9.2 Finding: All eligible family members are not enrolled in their Military Department's EFMP program.

Gap: The number of EFMP beneficiaries not enrolled in current program is not known, nor are the reasons for EFMP non-enrollment.

Area for Clarification: Education of stakeholders on EFMP process, health care coordination benefits, and ECHO eligibility with follow-up enrollment review.

9.2 Finding: TRICARE enrollment has been enhanced with use of technology to assist families in updating and transferring regional contractor enrollment when they change locations.

9.3 Finding: Extensive Military Department, community, and MHS resources are available to support beneficiaries for medical and non-medical transitions to strengthen the family's resilience during relocations.

Gap: Purchased and direct care are not linked electronically to provide an integrated medical record or secure messaging for beneficiaries who receive care in both settings.

Area for Clarification: Review the Military Departments and regional contractor coordination process to consider the level of standardization necessary to create an effective harmonization process for EFMP beneficiaries.

CONCLUSION

1. The Findings of the Study

This report demonstrates sufficient access and adequacy of the TRICARE network for pediatric beneficiaries. However, review is needed of several policies, benefits, or manual language as well as authorities, requirements, and costs before next steps can be defined.

Summary Findings

This report presents findings and recommendations for each element. Key findings are listed individually below and summarized as follows:

1. Analysis of access to pediatric care in appropriate settings demonstrates that there is adequate access to care with certain exceptions across all settings within the MHS. Exceptions include:

    - Regional relocations to areas where medical/behavioral specialties are experiencing long waiting lists for new appointments or accepting new TRICARE beneficiaries.
    - Family members are not enrolled in EFMP or ECHO.
    - Family members arrive in locations when the Service members has “unaccompanied” orders.

2. The proportion of visits for specialty care suggests that direct care is providing adequate access to specialty visits for pediatric dependent children, including those with special or chronic medical care needs.

3. Provision of pediatric specialty care by credentialed pediatric specialty providers is not sufficiently well defined to support identification and access to appropriate pediatric specialist to match beneficiary needs with the appropriate credentialed provider.

4. The MHS’s reimbursement of pediatric care is adequate, with certain exceptions, to meet the needs of this unique population. The accommodations and additional payment groupings accurately reflect the cost and payments involved in providing the specialty care and services for children with special health care needs and chronic health conditions.

5. Military Department, community, and MHS resources are, with certain exceptions, available to support beneficiaries for medical and non-medical transitions to strengthen the family’s resilience during relocations.

6. DoD and the Military Departments provide multidimensional comprehensive programs that are adequate, with certain exceptions, to support the physical and behavioral health of dependent children, including children with special health care needs.

Individual Element Findings:

1.1 Finding: Definitions of "medical necessity" differ between the broader healthcare system and the TRICARE program direct care component with the higher standard of medical necessity governing DoD's authority to cost-share private sector care in the TRICARE purchased care component.

1.2 Finding: TRICARE's defined well child benefit ends when a child turns age six years and is replaced with the generally authorized preventive care services.

2.1 Finding: Analysis of access to pediatric care in appropriate settings demonstrates that there is adequate access to care. MHS pediatric beneficiaries have adequate access to care; approximately 9 out of 10 children used outpatient visits rather than emergency care and receive over 90 percent of their comprehensive care within MHS settings (direct, 63 percent); network (30 percent).

> Gap: Data on appointment availability wait times for appointments, and referrals were requested but not available for this report.
>
> Area for Clarification: Future assessments should focus on more finely tuned access metrics, including wait times and referrals, reasons for higher rates of non-network ER use, and availability of providers. Evaluate currently available metrics and data sources to assess if they effectively address adequacy of access for pediatric beneficiaries.

2.2 Finding: Thirty-five percent of ER encounters occur in non-network care, which is much higher than the less than ten percent rate observed for office visits, hospitalizations, or outpatient surgery.

Gaps:

- It is unknown if the proportionally higher utilization of non-network providers is related to utilization of freestanding urgent care rather than hospital-based ER.
- It is unknown if pediatric ER encounters are increasing, decreasing, or stable.
- Due to the nature of ER visits, it is unknown if there is potential to safely recapture some of the non-network encounters in direct or network care.

Areas for Clarification:

- Specific analyses of the pediatric population in the annual *Evaluation of TRICARE Programs: Access, Cost and Quality* would provide a comprehensive review of adult and pediatric ER utilization rates in the MHS.

- Strategies are needed to accurately differentiate between utilization of freestanding versus hospital-based ER utilization and cost differences, which could inform assessment of access of services.

- Potential recapture of pediatric ER visits through review of diagnoses and acuity of visits would inform access of services.

2.3 Finding: The largest proportion of inpatient admissions occurred in the direct care and network settings.

2.4 Finding: MHS combined network and direct care settings accommodated 86 percent of same day surgeries.

2.5 Finding: Acute respiratory infection was the most common diagnosis for outpatient office visits and ER visits consistent with national data.

2.6 Finding: Access standards exist for appointment availability (urgent, routine, and specialty), but data were not reviewed to determine drive time and office waiting time.

> Gap: TROs reported that finely tuned access metrics, to include wait times and referrals, were not available for this report.
>
> Area for Clarification: Study of regional contractor required reports to evaluate the need for contract modifications to have data available for finely tuned access metrics, including wait times and referrals, reasons for higher rates of non-network ER use, and availability of providers.

2.7 Finding: Network Adequacy Reports (NAR) are monthly reports provided by regional contractors to TROs for review of access and adequacy of the network of providers.

> Gap: TROs reported that the NAR should not be used to determine access to care, as it simply states the number of contracted providers, not the availability of those providers to see new patients or TRICARE beneficiaries.
>
> Area for Clarification: Evaluate the need for contract modifications to develop NARs that would reflect availability of providers on a monthly basis.

3.1 Finding: Data show that direct care accounts for the largest proportion of specialty care visits across all specialties. In the “two-visit” and “more-than-two” visit groupings, the number of beneficiaries using network and non-network care decreased while direct care visits increased.

3.2 Finding: Data on specialty visits in direct and purchased care show that 80 percent of total pediatric encounters are attributed to specialists (i.e., not general pediatricians or family medicine providers).

3.3 Finding: Data show that OB/GYN was the specialty with the highest utilization rate of 0.5 per beneficiary for ages 18 to 21 years; the second highest rate was for behavioral health for ages 13 to 17 years, at 0.3 visits per beneficiary.

3.4 Finding: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a TRICARE tool used to assess beneficiary access and satisfaction.

3.5 Finding: Network Adequacy Reports (NARs) from regional contractors are inadequate for determining the availability of pediatric specialist and specialty appointments.

4.1 Finding: The MHS's reimbursement of pediatric care is adequate to meet the needs of this unique population. The accommodations and additional payment groupings accurately reflect the cost and payments involved in providing the specialty care and services for children with special health care needs and chronic health conditions.

5. 1 Finding: ECHO enrollment tripled from 2009 to 2012.

5. 2 Finding: ECHO services were utilized by more than 60 percent of enrollees.

5. 3 Finding: ECHO benefits have recently been expanded.

5. 4 Finding: ABA program evaluation in 2013 reported parental satisfaction with a positive impact on lives of some of the children and positively related to retention and family readiness.

6.1 Finding: Case management and care management are integral to the direct care and purchased care components for beneficiaries with special medical needs.

6.2 Finding: PCMH is a priority in MHS direct care.

7.1 Finding: DoD and the Military Departments provide multidimensional appropriate programs to support the physical and behavioral health of dependent children, including children with special health care needs.

7.2 Finding: Diverse programs throughout DoD and the Military Departments are directed to support the physical and behavioral health of pediatric beneficiaries including children with special health care needs.

8.1 Finding: Formal and informal networks link dependent children with State and local resources including children's hospitals and providers of specialty care.

9.1 Finding: Transfer between regions can result in extended wait times for appointments with specialty providers for children with special medical needs.

9.2 Finding: All eligible family members are not enrolled in their Military Department's EFMP program.

9.2 Finding: TRICARE enrollment has been enhanced with use of technology to assist families in updating and transferring regional contractor enrollment when they change locations.

9.3 Finding: Extensive Military Department, community, and MHS resources are available to support beneficiaries for medical and non-medical transitions to strengthen the family's resilience during relocations.

Please see the body of report under each Element for the gaps and recommendations associated with the following findings:

2. Plan to improve and continuously monitor the access of dependent children to quality health care.

- Develop pediatric quality measures, based on MHS care priorities, including obesity measures and ER utilization.

- Centralized care coordination: Develop a comprehensive system for evaluating care coordination and quality outcomes resulting from care coordination in the direct and network care settings.

- Population management: Include the pediatric population in the annual *TRICARE Quality Access and Cost* report.

3. Consideration of legislative action that the Secretary considers necessary to maintain the highest quality of health care for dependent children.

- The MHS is unable to make directly recommendations to Congress. Recommendations concerning the issues discussed in this report will be evaluated for possible submission as part of the DoD's annual Unified Legislation and Budgeting (ULB) Process.

- Clarifications needed and evaluations were made for individual elements in this report

Areas for Clarification:

Areas for clarification and evaluation are noted within this report and summarized below.

1. Review regulatory provisions for TRICARE program cost-sharing of care that meets the definition of medical necessity in the larger medical community but that does not meet the TRICARE-specific definition applicable to authorizing TRICARE program cost-sharing of private sector purchased care.

    - Review processes for evaluation of emerging technology in use in the general community but not supported by the hierarchy of evidence required by the TRICARE purchased care program

2. TRICARE's well child benefit ends when a child turns age six years old. The preventive care program as it relate to pediatric beneficiaries does not conform to the AAP periodicity guideline, which recommends annual screening up to the age of 21 years.

    - Review utilization of preventive care benefits by children ages 6 to 21 years to assess if developmental- and age-appropriate care is being delivered as compared to AAP recommended periodicity schedules and guidelines, the 2010 Patient Protection and Affordable Care Act, or Medicaid's Early and Periodic Screening, Diagnosis and Treatment benefit.

    - Review pediatric specialty and subspecialty credentials of purchased care providers of pediatric specialty care. Network adequacy reports do not provide fidelity to evaluate secondary level of specialty needed to confirm that pediatric beneficiaries are being treated by providers with pediatric specialties.

3. Develop common data evaluation systems or metrics within the DoD or the Military Departments to evaluate the multidimensional programs that support the physical and behavioral health care needs of children. Further study would be to define the overarching goals and corresponding metrics that best evaluate outcomes of wellness and resilience programs within TRICARE and DoD.

4. Data collection systems do not have a standardized definition of what identifies a child with special needs throughout DoD, the Military Departments, regional contractors, and pediatric specialty groups. DoD should adopt an enterprise-wide definition of "child with special medical needs" or adopt the National Institute of Child Health and Human Development definition of child and youth with special health care needs (CYSHCN).

5. Pediatric metrics of access to care, satisfaction with care, and quality of care should be considered for inclusion in future fiscal years of *The Evaluation of the TRICARE Program Report to Congress*. The expansion of the annual report could provide a comprehensive review of pediatric access, quality, and adequacy as measures of the status of pediatric care.

6. A representative method to compare and make analytical comparisons of pediatric access to and adequacy of care between DoD and the Military Departments across direct and purchased care would provide a solid basis for future comparisons of care. Current processes with multiple centralized data systems across DoD and the Military Departments prevent analytic comparisons between DoD and the Military Departments, or across direct and purchased care components.

Summary

Children in military families face challenges that require unique services and care. The MHS provides the pediatric dependent children it serves with adequate access to high-quality care including appropriate specialty care. This comprehensive worldwide health care system allows our Service members to focus on their mission, assured their family members are receiving the care they need, and reinforces the MHS message of "families first, mission always."

APPENDIX A: DoD Policies and Programs Linked to ELEMENTS

Topic	Explanation	TRICARE Policy	CRF/Statute	Manual
The TRICARE Policy Manual 6010.57-M, February 1, 2008,	Policy guidance for implementation of the regulatory language prescribed in the CFR.		The Code of Federal Regulations (CFR), Title 32, Parts 199.4 (c) (2) (xiii) and 199.4(c) (3) (xi),	TRICARE Policy Manual (TPM)
Well Child Care	Under 6 years old	Chapter 7, Section 2.5	32 CFR 199.4(c)(2)(xiii) and (c)(3)(xi)	TPM
Clinical Preventive Services - TRICARE Standard	Preventive care is not directly related to specific illness, injury, a definitive set of symptoms, or obstetrical care, but rather is performed as a periodic health screening, health assessment, or periodic health maintenance.	Chapter 7, Section 2.1	32 CFR 199.4(e)(3)(ii), (g)(37), and 10 USC 1079(a)	TPM
Clinical Preventive Services-TRICARE Prime	TRICARE Prime enrollees may receive Prime Clinical Preventive Services from any network provider without referral or authorization.	Chapter 7, Section 2.2	32 CFR 199.17	TPM
Access Standard	Definition for appointment to visit an appropriately trained provider routine care, urgent care, emergency care, well patient visits, referrals for specialty care.	Revision 2011: TRICARE Policy for Access to Care (HA Policy 11-005).	The Code of Federal Regulations (CFR), Title 32, Part 199.17 (P) (5) details the access standards for the TRICARE program	NA
Provider Adequacy	Preferred provider networks will have attributes of size,		CFR 199.17 (P)(5)(iv)	NA

	composition, mix of providers and geographical distribution so that the networks, coupled with the MTF capabilities, can adequately address the health care needs of the enrollees.			
Applied Behavior Analysis (ABA) for Non Active Duty Family Members (NADFM) Who Participate in the ABA Pilot	TRICARE-eligible NADFMs with Autism Spectrum Disorder (ASD) may continue to receive ABA services under the Basic Program guidelines without seeking additional ABA reinforcement services under the Department of Defense (DoD) Applied Behavior Analysis Pilot (ABA Pilot).	Chapter 7, Section 3.19	10 USC 1079(a), section 705 NDAA FY 2013 Public Law No: 112-239, 32 CFR 199.4(c), and 32 CFR 199.6	TPM
Applied Behavior Analysis	4.1TRICARE covers ABA services for all eligible beneficiaries, including retirees and their dependent family members, with a diagnosis of Autism Spectrum Disorder (ASD).	Chapter 7, Section 3.18	10 USC 1079(a), and 32 CFR 199.4(c)	TPM
Psychiatric Partial hospitalization program Pre Authorization and day limits	Psychiatric partial hospitalization is a treatment setting capable of providing an interdisciplinary program of medical therapeutic services at least three hours per day, five days	Chapter 7, Section 3.3	32 CFR 199.4(b)(6)(iii) and 10 USC 1079(a)	NA

	per week.			
Limits on Residential treatment centers	No funds shall be used to pay for Residential Treatment Center (RTC) care in excess of 150 days in a fiscal year or 150 days in an admission (hereinafter referred to as the 150 day limit).	Chapter 7, Section 3.2	32 CFR 199.4(b)(8) and 10 USC 1079(a)	TPM
Substance Use Disorders	Rehabilitative care in an authorized hospital or SUDRF, whether freestanding or hospital-based, is covered on either a residential or partial care (day, evening or weekend) basis.	Chapter 7, Section 3.7	32 CFR 199.4(e)(4) and (h)	TPM
Nutritional Therapy	Nutritional therapy provides medically necessary nutrient intake for individuals.	Chapter 8, Section 7.1	32 CFR 199.4(a)(1)(i), (d)(3)(iii), (g)(57), and 32 CFR 199.5(c)	TPM
Extended Care Health Option-Respite Care	Extended Care Health Option (ECHO) registered beneficiaries are eligible to receive a maximum of 16 hours of respite care in any calendar month in which they also receive any other ECHO authorized benefit other than the ECHO Home Health Care (EHHC) benefit.	Chapter 9, Section 12.1	32 CFR 199.5(c)(7) and (d)(20)	TPM
ECHO Home Health Care	The ECHO Home Health Care (EHHC) benefit	Chapter 9, Section 15.1	32 CFR 199.5(e), (f)(3), (g)(4), and 32 CFR 199.6(b)(4)(xv)	TPM

	provides medically necessary skilled services to eligible homebound beneficiaries whose needs exceed the limits of the Home Health Agency Prospective Payment System (HHA PPS) as described in the TRICARE.			
Home health agencies (HHA)	This policy is mandatory for the reimbursement of services provided either by network or non-network providers.	Chapter 12	32 CFR 199.2; 32 CFR 199.4(e)(21); 32 CFR 199.6(a)(8)(i)(B); 32 CFR 199.6(b)(4)(xv); and 32 CFR 199.14(j)	TRM

APPENDIX B: Military Department Policies and Programs Linked to ELEMENT 1.

Army	
AR 40-3	MEDICAL, DENTAL, AND VETERINARY CARE Services include counseling for parents of children with hearing loss. Surveillance and education regarding fluoridation of water on post. Assistance for installation child care facilities, including nutrition. Essential air ambulance equipment includes child-specific equipment. Child capacity to consent.
AR 40-35	DENTAL READINESS AND COMMUNITY ORAL HEALTH PROTECTION Evaluate fluoridation of water and use of tooth sealants on post.
AR 40-400	PATIENT ADMINISTRATION Defines what children are eligible to be provided care as dependents.
AR 40-5	PREVENTIVE MEDICINE Services for child development centers, child and youth services, school-age health, lead poisoning, child abuse, pets in child care settings.
AR 40-562	IMMUNIZATIONS AND CHEMOPROPHYLAXIS FOR THE PREVENTION OF INFECTIOUS DISEASES Requires immunization of adults working with Army child dependents (child care, and the like).
AR 40-66	MEDICAL RECORD ADMINISTRATION AND HEALTH CARE DOCUMENTATION Maintenance of dependent child medical records.
AR 40-68	CLINICAL QUALITY MANAGEMENT Processes for oversight of the quality of infant and child health care.
AR 215-1	MILITARY MORALE, WELFARE, AND RECREATION PROGRAMS AND NONAPPROPRIATED FUND INSTRUMENTALITIES
AR 600-8-14	IDENTIFICATION CARDS FOR MEMBERS OF THE UNIFORMED SERVICES, THEIR ELIGIBLE FAMILY MEMBERS, AND OTHER ELIGIBLE PERSONNEL Outlines the administrative procedures for ensuring child eligibility for medical care in unique circumstances.
AR 608-1	ARMY COMMUNITY SERVICE Helps direct resources for suicide risk identification for youth suicide.
AR 608-10	CHILD DEVELOPMENT SERVICES This change implements the reissue of Department of Defense Instruction 6060.2, Child Development Programs. The change expands policy on administering medication to children with

	special needs, and revises policy on placement of children with disabilities in Child Development Services programs pursuant to the Rehabilitation Act of 1973, as amended.
AR 608-18	THE ARMY FAMILY ADVOCACY PROGRAM This regulation contains the policies for handling spouse and child abuse within the Army.
AR 608-75	EXCEPTIONAL FAMILY MEMBER PROGRAM
AR 608-99	FAMILY SUPPORT, CHILD CUSTODY, AND PATERNITY This regulation prescribes Army policy on financial support of family members, child custody and visitation, paternity, and related matters, including eligibility for health care.
AR 930-4	ARMY EMERGENCY RELIEF Process for provision of medical assistance to surviving orphans, with special health care needs, of deceased military personnel.
AR 930-5	AMERICAN NATIONAL RED CROSS SERVICE PROGRAM AND ARMY UTILIZATION Details the processes for returning soldiers to the bedside of their sick child in an emergency.
OTSG/MEDCOM Policy 10-043	DISTRIBUTION OF INFANT CARE AIDS PROVIDED BY FORMULA COMPANIES
OTSG/MEDCOM Policy 10-046	MANDATORY BRIEFINGS ON SHAKEN BABY SYNDROME (SBS) AVOIDANCE
OTSG/MEDCOM Policy 11-044	ARMY MEDICAL DEPARTMENT (AMEDD) FAMILY ADVOCACY PROGRAM (FAP) DOCUMENTATION POLICY FOR AHLTA
OTSG/MEDCOM Policy 11-099	MEDICAL MANAGEMENT FOR SOLDIERS AND THEIR FAMILIES TRANSITIONING FROM MILITARY PROVIDERS TO CIVILIAN INPATIENT SERVICES AND BACK TO MILITARY PROVIDERS
OTSG/MEDCOM Policy 12-021	FAMILY ADVOCACY (FA) ASSESSMENTS PERFORMED IN THE HOME
OTSG/MEDCOM Policy 12-037	PROPER CODING AND DOCUMENTATION FOR THE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP)
OTSG/MEDCOM Policy 13-041	SCREENING FOR CONGENITAL CYANOTIC HEART DISEASE WITH PULSE OXIMETRY
OTSG/MEDCOM Policy 13-061	MEDICAL COMMAND MILITARY TREATMENT REFERRAL MANAGEMENT OFFICE-OVERARCHING CORE BUSINESS OPERATIONS (general guidance)
Milper Message 13-235	STABILIZATION OF SOLDIER AND MILITARY FAMILIES WITH SPECIAL NEEDS
PAM 40-11	PREVENTIVE MEDICINE Details the establishment of preventive health programs for children.

US Army OPORD 11-20	ARMY PATIENT-CENTERED MEDICAL HOME (general guidance)
US Army OPORD 13-25	NURSING CASE MANAGEMENT GUIDANCE (general guidance)
Air Force	
AFPD 40-6	Educational and Developmental Intervention Services
AFPD 40-7	Medical Support To Family Member Relocation and Exceptional Family Member Program-Medical (EFMP-M)
AFI 36-2110	Assignments
AFI 36-3009	Airman and Family Readiness Centers
AFI 40-301	Family Advocacy
AFI 40-701	Medical Support To Family Member Relocation and Exceptional Family Member Program
AFI 44-102	Medical Care Management
Navy	
OPNAVINST 1754.2	EFM policies (17Oct2005)
SECNAVINST 1754.5	EFM enrollments, assignments (03Nov2010)
BUMEDINST 1755.1	EDIS & EIS policies (17Oct2005)
BUMEDINST 6300.17	Navy Medicine Clinical Case Management (23Nov2009)
BUMEDINST 6000.15	Referral Management Program (10Oct2013)
OPNAVINST 1700-9E	Child and Youth Programs (24Sep2012), Child Development Center/School Age Children (CDC/SAC)
OPNAVINST 1710-11	DoN Morale Welfare Recreation Programs (04Nov2010), Paragraph 7 Responsibilities
OPNAVINST 1754-1B	Fleet and Family Services C Program (05Nov2007), Paragraph 6, also Paragraph 6(k)(3) & Encl (1) for clinical counseling
OPNAVINST 1754-5B	Family Readiness Groups (31Mar2011), structure/rules governing Family Readiness Group
SECNAVINST 1754-1B	DoN Family Support Programs (27Sep2005), see Encl (1) for clinical counseling
NCR-MD	
JTF Directive 8180.01	Referral management Operations within the Joint Operations Area (JOA)
JTF NCR MDInst 6025.05	Joint task force NCR-MD Patient centered medical home instruction
JTF NCRMDInst 6490.01	Family advocacy program
JTF NCRMDInst6010.01	Family Planning services
OPNAVINST 1754.2D	EFMP enrollment
FBCH manual 6205	Administration of Human Papilloma Virus Vaccine
FBCH manual 6055	EFMP at FBCH
FBCH Manual 6055	Pediatric Specific Immunization Policies
FBCH manual 6485	Pediatric infection control policy
FBCH standing order	Standing order for pneumococcal vaccination in pediatrics

P3086	
FBCH manual 6055	
FBCH standing order for admin of rotavirus vaccine	Referrals and consults pediatrics
FBCH inst 5210.03	Rotavirus vaccinate standing order
FBCH manual 6055	Infant child abduction policy
FBCH Manual 6055	Standing order for immunizations
FBCH Inst 6490.05	Treatment of anaphylaxis in the pediatric clinic
FBCH Inst 6490.07	Family presence and family guests
FBCH Inst 6025.17	Identification of abuse/neglect in children
WRNMMCINST 1300.2B	Infant child safety and security
WRNNMCINST 1650.10	Suitability processing for overseas assignment of services and family members
WRNMMCINST 1700.4B	Patient and family centered care excellence recognition program
WRNMMCINST 1740.3D	Child development center multi-disciplinary inspection team
WRNMMCINST 1900.1C	Family care plan
Military children and Families Journal, Volume 23 (2), Fall 2013	Policies concerning Pregnancy and parenthood of service members
USMC	
71.54.4B	Marine Corps Order Exceptional Family Member Program
McBul 1754	Exceptional Family Member Program Respite Changes

APPENDIX C: Responses linked to ELEMENT 7

DoD	
Little Children, Big Challenges	DoD and Sesame Workshop have unveiled a book and DVD to develop resilience in young children.
I Am Moving, I Am Learning Program	A collaborative effort between the military services, DoD, and the University of Nebraska – Lincoln.
Let's Move: Obesity prevention	Child and youth development centers and morale, welfare, and recreation programs on military installations offer programs that emphasize eating healthy foods and pursuing active lifestyles.
5-2-1-0 Healthy Military Children: Obesity prevention	This DoD collaboration with the National Institute of Food and Agriculture, U.S. Department of Agriculture is focused on young children and adolescents. This Military wide plan aims to improve child health through the spread of a common message throughout children's communities where families work, live, and play.
New Parent's Support Program (NPSP)	Promotes resilient families, healthy parenting attitudes, and skills to prevent child abuse, neglect, and domestic abuse.
Family Advocacy Program (FAP):	This program aims to prevent child and domestic abuse in military families through public awareness, education, and family support. This program delivers an intensive home visitation program called the New Parent Support Program (NPSP) for prevention of child neglect and abuse. A measure of the programs' success is that 96% of NPSP participants were not reported for child abuse or neglect for 12 months after the program.
Families Overcoming Under Stress (FOCUS) Program:	This is an evidence-based program that enhances parent, child, and family resilience through; individual family resilience training which is an eight-session program to teach families the best way to communicate, solve problems, regulate emotions and set goals; and skills that foster family resilience in the face of stress caused by deployment and combat-related psychological problems.
Cessation of Tobacco Use	Access to online and print tobacco-cessation material is available through the "Quit Tobacco—Make Everyone Proud" campaign, an initiative informed by extensive research and testing that was launched by TRICARE Management Activity (TMA) in 2006. Campaign goals include increasing awareness of tobacco's negative social and physical effects and decreasing its acceptance and use throughout the military.
Task Force on Common Services for Service Member and Family Support Programs	The Office of Assistant Secretary of Defense for Military Community and Family Policy (ODASD (MC&FP)), which plays a pivotal role in military family readiness by providing DoD-wide military family readiness policies and program and

	resource oversight, is leading this effort.
Child Care	Child Care Service members remain a crucial program that leads to Service member and family readiness as well as Force retention. The DoD Child Development Program System of care serves more than 200,000 military children daily from 0 to 12 years old, operating more than 750 Child Development Centers and School Age Care facilities at more than 300 locations worldwide and approximately 4,400 Family Child Care homes.
DoD Schools:	The Department of Defense Education Activity (DoDEA) is a unique school system, as it serves students worldwide, crossing far more than school district and state boundaries, with schools on three continents. A total of 195 schools in 14 school districts are operated in 12 foreign countries, 7 states, Guam, and Puerto Rico. More than 84,000 students are attending DoDEA schools worldwide. This program serves nearly 2,800 children in 132 foreign locations.
Minimizing Disruption for School Age Children of Military Families:	Frequent relocations across state lines can hamper educational opportunities for military children because of different policies applied to transferring students between the "sending" state and the "receiving" state. In cooperation with the Council of State Governments, DoD developed the Compact in collaboration with an array of Federal, state, and local officials as well as national stakeholder organizations.
Army	
Army School Behavioral Health Program	Provide Behavioral Health intervention in on-post Schools. School BH (SBH) services are directed at improving academic achievement, maximizing wellness and resilience of Army Children and Families, and ultimately promoting optimal military readiness. SBH non-direct care services emphasize prevention and resiliency building through educational programs available to students, Families, and the community promoting "help-seeking behavior," reducing stigma, and providing support and coping strategies for dealing with military stressors. Direct care programs include screening, early intervention, evaluation, and treatment. Services include individual, group, and/or family interventions.
Army Child and Family Assistance Centers	Behavioral Health support and interventions at 5 installations Child and Family Assistance Centers (CAFAC) provide comprehensive, integrated behavioral health system of care to support military Children, their Families, and the Army Community throughout the Army Force Generation (ARFORGEN) and Family Life Cycle. CAFACs focus on coordinating, integrating, and synchronizing available Behavioral Health and related services on an installation, and filling identified service gaps. The overarching goals are to

	facilitate access to care by having one point of entry for behavioral health concerns, and to provide state of the art prevention, evaluation, and treatment through standardization of behavioral health services and programs. The programs utilize a Public Health Model continuum of care, focusing on prevention and early intervention to promote wellness and resilience, and providing a higher level of behavioral health care when needed.
Army Child and Family Behavioral Health System (CAFBHS)	The Child and Family BH System provide a consultative and collaborative system of BH care that maximizes the role of the primary care provider in the Parent Centered Mental Health (PCMH). This model is strongly supported by the medical literature and places BH care and resources within the framework of primary care where FMs health care is located. This supports universal screening and early intervention as part of a whole person, wellness model. The CAFBHS Model consists of 4 major interrelated components in support of the PCMH: 1) Consultative and collaborative BH care to primary care providers and/or PCMH BH Teams caring for Family Members; 2) A School Behavioral Health Program in on-post schools; 3) BH outreach and coordination services on the installation, and 4) Regional level teleconsultation and telebehavioral health services with Child and Family subject matter experts to support primary care and BH providers. All CAFAC and SBH legacy programs will transition into CAFBHS.
Army Child Guidance Centers and Clinics	Current Traditional Services at many installations to be replaced by CAFBHS.
CYS Services - Youth Sports, Fitness and Nutrition	Children with special needs are included in sport programs. The goal of this initiative is physical, cognitive and social development and team building.
SKIES Unlimited Instructional Classes	Children with special needs are included in programs (ex: dance classes, ballet, martial arts, etc.). The goal is physical, cognitive and social development.
START SMART	An introduction/orientation to baseline sports; to include children with special needs.
Kids Included Together (KIT)	KIT provides training and support to CYS Services staff who are working with children who have special needs. This is a partnership between OSD and the Services. KIT also provides behavioral health support.
Exceptional Family Member Program	The Exceptional Family Member Program partners with the Communication Recreation Services to provide recreational opportunities for children with special needs; i.e. bowling, Special Olympics, Camps, handicap accessible playgrounds, etc.
Exceptional Family	The EFMP staff (Systems Navigators) and Child Youth School

Member Program and CYS Services	Services staff assist the Family in obtaining access to community services. Child Youth and School Services also have Military Family Life Consultants which assist children through the deployment cycle and in general support services.
Air Force	
Educational and Developmental Intervention Services	Educational and Developmental Intervention Services (EDIS) provides services to support families of children developmental delays, disabilities, or special learning needs. It delivers Early Intervention Services (EIS) to eligible infants and toddlers and their families in domestic and overseas areas.
Pediatric Behavioral Medicine at Ramstein Air Base, Germany	Provides child and adolescent therapy.
Military Family Life Consultant (Child)-SG is not the OPR	Military & Family Life Counselors (MFLC) are working under this contract, called Child and Youth Behavioral Military & Family Life Counselors (CYB-MFLC) support the children participating in the CYS Program as well as faculty, staff and parents. They also support military children through DoDEA Summer Programs and Purple Camps.
Adolescent Substance Abuse Counseling Service (at select AF installations)	The ASACS program includes a comprehensive program for substance abuse prevention, education, identification and referral and treatment. ASACS services are provided free of charge to all adolescent family members that hold an military ID card and are eligible for TRICARE services.
Integrated Behavioral Health in Primary Care	Behavioral Health Support in Primary Care at approximately 15 AF MTFs for Pediatric patients.
New Parent Support Program	New Parent Support Program (NPSP) is a standardized secondary prevention program under the Family Advocacy Program to prevent child abuse and neglect. The NPSP identifies expectant parents and parents of children from birth to 3 years of age whose life circumstances place them at risk for child abuse or neglect. Voluntary intensive home visitation-based prevention services are provided to all identified at-risk Active Component parents and Reserve component parents ordered to all Federal active duty and their family members to support their roles as DoD personnel and parents. Available at all Air Force installations.
Mental Health	Guidance for operation of Mental Health services and the assessment and treatment of USAF personnel and beneficiaries with Mental Health problems.
Airman and Family Readiness Centers	The EFMP-Family Support Coordinator establishes implements and maintains the family support portion of the EFMP in coordination with the installation's medical and assignments functions to enhance the quality of life of family members of active duty sponsors who have special needs as defined by the EFMP on installations with a full time EFMP-

	FS. Thirty-five AF installations have a full time Family Support.
Navy	
Exceptional Family Member Program	The primary goal of the EFMP is to ensure Service members are assigned only to those geographic areas where the medical (physical, mental, or developmental) or educational needs of their EFMs can be met. EFMP enrollment provides family support throughout the sponsor's career as well as a warm hand-off during a permanent change of station to include assistance before, during, and after PCS move. **EFMP –** Total number of dependents ages 0-21 enrolled in Navy's Exceptional Family Member Program: 16,993. Navy's 2011 EFMP Quick Poll showed that 12% of the Enlisted Service members who had dependents enrolled in EFMP received services or assistance from TRICARE ECHO and 10% of the Officers. An assessment was not conducted on the adequacy of the ECHO Program in meeting the needs of dependent children with extraordinary health care needs. Hiring of 32 EFMP Regional Case Leads and installation Case Liaisons which provide information and referral, non-clinical case management, assistance before, during, and after a PCS move, develop and maintain individual service plans, and partner with MTF Coordinators to provide information, education, and marketing. Adding Case Liaisons (family support) in the major Navy medical centers. Navy Medicine hired 5 full time EFMP Coordinators to assist Exceptional Family Members at major medical centers and Marine Corps Activities. Collateral duty EFMP Coordinators are provided at all Navy military medical treatment facilities to facilitate identification and enrollment in the EFM program. Installation Commanders are responsible for establishing EFMP coordination committees to facilitate coordination and integration of services to EFM families. Command that have an EFM family member, ensure updates are done on time, refer them to the Case Liaisons and Family Service Centers for family support, and conduct EFMP training within their commands. Regional training and town hall meetings by a team comprised of Navy Personnel Command, Bureau of Medicine and Surgery, and the Navy Installations Command to provide oversight, discuss new initiatives, and answer questions by Navy families with special needs.

EFM Assistance through Other Programs (CNIC Managed	TRICARE ECHO: financial assistance, ABA therapy, assistive services, durable equipment, medical and rehabilitative services, ECHO Respite Care (16 hours per month), and training.
Family Accountability and Assessment System (NFAAS)	EFMP IT initiative. IT data system released on 31 August 2011 facilitates program enrollment by establishing an electronic workflow process to expedite submission, review, and final designation of enrollment forms for enrollees; facilitates non-clinical support by providing the ability for Case Liaisons to electronically track information and referral requests and develop individualized service plans; and, provides reporting capabilities such as enrollment letters as well as metrics.
Formal Command EFMP Point of Contact Training	Service directed training.
Webinars	2013 webinars included NFAAS, ABA Pro Bono Project, School Liaison Program, TRICARE/ECHO, Liaison/Coordinator Relationship, Non-medical counseling, Virtual Care Program, DoDEA/DoDDS, Navy EFMP Respite Care, Overseas/Suitability Screening, and OMBUDSMAN Program.
EFMP Family Support Activities	In 2013 included Summer kick-off in Bangor, EFMP day at the fire station, EFMP submarine simulator experience, school reading outreach, Hornblower dinner cruise, EFMP day at the Oceana Air Show, Military appreciation day at the Virginia zoo, Hampton Roads EFMP forum and resource fair, EFMP day at King's Dominion, EFMP rest stop at the Great Lakes 4th of July celebration, EFMP Lunch and Learn at the Walter Reed National Military Medical Center, Sensory play group in Yokosuka, ABA workshop, Hurricane preparedness event for families with special needs, EFMP Story time at Child Development Center (Gulfport, MS) and EFMP lunch and learn at Naval Station Mayport.
Community of Practice	Bi-monthly forum for idea sharing.
Quick Poll Survey	2011 EFMP Quick Polls showed: Overall improvement in satisfaction with Customer Service Aspects of EFMP Coordinator. Of those who receive services from a civilian provider, large majority are satisfied. Overall, most believe EFMP makes a positive contribution to family's Quality of Life. Of those with an EFM child who use childcare, majority are satisfied with the aspects of child care. Of those who are eligible and have used respite care services, vast majority are satisfied.
Navy Respite Care	Established in 2009 under Child and Youth Programs, provides up to 40 hours of care a month for category 4 (major

	medical) and category 5 (homestead) children with special needs. The Navy Respite Care program has worked hard to increase respite care spaces from a total of 425 to 600 fluid spaces. Fluid spaces allow Navy to move space from location to location as need for care shifts. Goal and intent of Navy EFMP Respire Care Program is to operate at COL II status (less than 90 day average for placement).
Humanitarian Transfers	No-fault transfer or humanitarian reassignment due to an emergency medical condition of a family member or when a family member's medical needs can't be met.
Incapacitated Dependent Program	Allows service member to extend military ID card privileges for children over 21 that are unmarried, disabled before the age 21, and incapable of self-support.
Suitability Screening Program	Ensures medical and/or educational requirements can be met overseas or remote locations.
NCR-MD	
Cystic Fibrosis Foundation, NCR (Staffed at Walter Reed National Military Medical Center (WRNMMC)supports entire National Capital Region eMSM)	Cystic Fibrosis Foundation (CFF) accredited care center. We currently care for about 45 patients. We are classified as an Affiliate Center. This status confers a relationship with a core center. Our core center is currently located at Bassett Army Medical Center, though that may shift to Naval Medical Center Portsmouth. There are 6 DoD Cystic Fibrosis centers (5 affiliates and a core). As part of the CFF Care Center Network, we adhere to all clinical practice guidelines and undergo reaccreditation every 5 years. There are approximately 125 Care Centers within the United States and the vast majority of cystic fibrosis patients are cared for within this network.
Health Habits Clinic (staffed at WRNNMC but supports entire NCR eMSM)	Childhood obesity: multi-disciplinary program encompassing the services of pediatric endocrinology, general pediatrics, adolescent medicine, child psychology and nutrition. Utilizes concept of behavior modification to effect lifestyle modification with optimal outcome of healthier Body Mass Index (BMI). Also treats/evaluates comorbid conditions associated with childhood obesity. Includes group exercise, didactic lectures in curriculum, motivational sessions.
Neuromuscular/ Cerebral Palsy Clinic WRNMMC	Children of all ages with Cerebral Palsy (CP), neuromuscular disease, or concern for these are referred and assessed in this clinic. Children with disabilities are followed longitudinally (usually annually or biannually) in this clinic. They are screened and tracked for common CP sequelae, amongst other common health maintenance guidelines. Botox injections are also done in this clinic for children who require it. Equipment needs are assessed (for mobility – wheel chairs, standers, walkers, orthotics, etc.) It is a multidisciplinary team which includes Developmental

	Behavioral Pediatrics, Pediatric Physical Therapy, Pediatric Occupational Therapy, Child Neurology, and Pediatric Orthopedic Surgery. Team Recommendation summaries are provided and typically include therapy, educational, and home environmental goals based on child's abilities. When appropriate referrals are made for wrap around services through the county Birth to three programs, Educational/school System, Durable Medical Equipment vendors, etc. The family receives help with EFMP enrollment/updates.
Multidisciplinary Craniofacial team	multidisciplinary craniofacial team (accredited only two in DOD including WRNMMC and NMCP), currently 150 families enrolled; genetics, developmental Peds, Peds ENT, Peds speech/swallow, cognitive psychologist, neurosurgery, plastics, audiology, OMFS, Prosthodontist, Orthodontist), currently 150 enrolled patients.
Pediatric dentistry WRNMMC	families of children with special needs given complexity of TRICARE dental will generally offer first time complimentary initial evaluation/consultation after EFMP office arranges consultation.
Pediatric Diabetes clinic at WRNMMC, supports Fort Belvoir Community Hospital (FBCH) as well	Multidisciplinary team working with juvenile diabetic patients and their families who manages and counsels newly diagnosed juvenile diabetic patients with multidisciplinary approach to include case management, nutritionist and pediatric endocrinologist. This clinic occurs weekly at WRNMMC and pediatric endocrinologists also send 2-3 of WRNMMC providers/fellows to FBCH on a weekly basis as well. The pediatric endocrinologists have established pediatric endocrinology support at Malcom Grow monthly. Clinic is also at the Annapolis clinic - every other month and Ft. Bragg monthly.
Spina Bifida Clinic at WRNMMC, supports FBCH as well	Children of all ages with spina bifida, neural tube defects or concern for these are referred and assessed in this clinic. Children with disabilities are followed longitudinally (usually annually or biannually) in this clinic. They are screened and tracked for common SB sequelae, amongst other common health maintenance guidelines. Equipment needs are assessed (for mobility – wheel chairs, standers, walkers, orthotics, etc.) It is a multidisciplinary team which includes Developmental Behavioral Pediatrics, Pediatric Physical Therapy, Pediatric Occupational Therapy, Child Neurology, Pediatric Neurosurgery, Pediatric Urology, Physical Medicine & Rehabilitation, and Pediatric Orthopedic Surgery. Team Recommendation summaries are provided and typically include therapy, educational, equipment, functional, and home environmental goals based on child's abilities. When appropriate referrals are made for wrap around services

	through the county Birth to three programs, Educational System, Durable Medical Equipment vendors, etc. The family receives help with EFMP enrollment/updates.
Seating Clinic at WRNMMC, supports FBCH as well	Children with disabilities who have equipment needs are referred to this clinic for assessment. Equipment needs are assessed (for mobility – wheel chairs, standers, walkers, orthotics, etc. or self-care, etc.). It is a multidisciplinary team which includes Developmental Behavioral Pediatrics, Pediatric Physical Therapy, Pediatric Occupational Therapy, Case management, and the representative from all local vendors. The families can ask questions about types of equipment to match their child's specific needs. They are provided information from all vendors. They can review and decide which equipment to trial. When the equipment type/style is determined, the family then is provided with the appropriate DME referral.
Synagis Clinic at WRNMMC, supports FBCH as well	Mission: To provide respiratory syncytial virus (RSV) prophylaxis for infants and children who are at high risk for for severe RSV disease. Goal: 1. To decrease hospitalization and severity of RSV disease in high-risk infants and children. 2. To provide bi-monthly clinics for accessible care and timely appointments. 3. To provide medical education to patients, families, and physicians-in-training.
Sickle Cell/Oncology clinic at WRNMMC	To provide all the annual screening and subspecialty consultation required for patient with Sickle Cell Disease in a one day visit. Subspecialties Participating: 1. Pediatric Hematology, 2. Pediatric Pulmonary/PFTs, 3. Pediatric Cardiology/echocardiograms, 4. Optometry/Ophthalmology, 5. Neurology/Transcranial Doppler Ultrasonography, 6. Neuropsychology/School Assessment, 7. Child Psychiatry, 8. Pediatric Social Work
Pediatrics Lupus Clinic at WRNMCC	To provide comprehensive care to children and families with complex and severe autoimmune diseases, particularly lupus, as a multidisciplinary team. Goal: 1. To provide the best care on each child and family. 2. To promote center of excellence at WRNMMC for lupus and life-threatening pediatric autoimmune diseases of DoD. 3. To provide house staff teaching and provide family education.

	4. To provide convenience schedule to family.
Autism Clinic at WRNMMC	This clinic assesses children who are referred for an Autism assessment. The patient is seen by several subspecialists and they provide a team recommendation summary, which typically includes educational, social and communication goals. The family receives help with EFMP and ECHO eligibility paperwork, which is needed for Applied Behavioral Analysis services (if they are indicated). When appropriate referrals are made for wrap around services through the county Birth to three programs, school system, Ophthalmology, Audiology, Feeding clinic, private therapy services, etc. It is a multidisciplinary team which includes Developmental Behavioral Pediatrics, Pediatric Occupational Therapy, and Child Psychology.
High risk Clinic at WRNMMC	Infant born prematurely or who had significant prenatal courses are referred to this clinic. The clinic screens these infants and children (age's 0-3years old) longitudinally for sequelae of their prematurity. The children have a full developmental assessment with a Capute Scales, Alberta Infant Motor Scale, and Gessell. It is a multidisciplinary team which includes Developmental Behavioral Pediatrics, Pediatric Physical Therapy, Neonatology, EDIS coordinator/PNP. Team Recommendation summaries are provided and typically include therapy, educational, and home environmental goals based on child's abilities. When appropriate referrals are made for wrap around services through the county Birth to Three program, Ophthalmology (ROP follow up), Audiology, Feeding clinic etc. The family receives help with EFMP enrollment/updates.
Family advocacy Program (FAP)	Program which aims to prevent Child and domestic abuse in military families through public awareness, education, and family support. It provides programs and activities for military families who have been identified as being at risk for committing child/domestic abuse. It promotes coordinated, comprehensive intervention, assessment, and support for military family members who are victims of child/domestic abuse. It assess/rehabilitates, and treats children and victims in coordination with civilian authorities.
Family advocacy program new parent support program (NPSP)	Service-specific program affiliated with either FAP or Family support center. The program is staffed by nurses, social workers, or home visitation specialists. It promotes resilient families, healthy parenting attitudes, and skills to prevent child abuse, neglect, and domestic abuse. Through intensive home visits, offered on a voluntary basis, NPSP personnel help parents cope with hardships of raising children. This program also makes hospital visits, refers patients to other resources

	and offers prenatal/parenting classes, and play groups.
Families Overcoming under stress (FOCUS) Program	FOCUS is an evidence-based program that enhances parent, child, and family resilience; individual family resilience training which is an 8-session program to teach families the best way to communicate, solve problems, regulate emotions and set goals; skills that foster family resilience in the face of stress caused by deployment and combat-related psychological problems.
DoD sponsored child care	Parents who are eligible for DoD-sponsored child care include Active-duty service members, DoD civilian employees, National Guard and reserve members who are on active duty or attending personnel training and DoD contractors. Over 900 child development centers and school-age programs at more than 300 sites, along with more than 4,500 family child-care homes which employ 23,000 child-care workers and constitute the largest employer-sponsored child-care program in the nation. This network provides and subsidizes daily care for more than 200,000 children from birth to 12 years of age.
New parent support programs (NPSP)	Service-specific associated Family Advocacy Program or Family Support Center program which is staffed by nurses/social workers/home visitation specialists and which promotes resilient families, health parenting attitudes, and skills to prevent child abuse, neglect and domestic abuse.
Military OneSource	Free DoD service which offers resources and support to service members and their families primarily through its website and a 24-hour call center staffed with master's level consultants who are familiar with military life. Consultants can provide comprehensive information about any aspect of military life including: deployment, reunions, relationships, grief, employment and education opportunities, parenting and child care.
Military Family Network	Website/blog for parental resource and information sharing
The Feeding clinic WRNMMC (supports FBCH as well)	Infants and Children with feeding difficulties or disorders are referred to this clinic for assessment. Feeding trials are incorporated into the visit. Areas of focus on feeding and feeding behaviors. It is a multidisciplinary team which includes Developmental Behavioral Pediatrics, Pediatric Occupational Therapy, Child Psychiatry, Child Psychology, and Nutritionist. Team Recommendation summaries are provided and typically include therapy, educational, and home environmental goals based on child's abilities. When appropriate referrals are made for wrap around services through the county Birth to three program, school services, and if needed for further assessment Pediatric Gastroenterology. Ears, Nose and Throat and dysphagia clinic depending on the needs.

Long-term Cancer Survivorship Clinic	Provides the annual screen and subspecialty consultation required for long-term survivors of childhood cancer in a one day visit. Subspecialty appointments individualized to a specific patient need. Subspecialties participating: pediatric oncology, pediatric pulmonology, pediatric cardiology, pediatric endocrinology, ophthalmology/optometry, neuropsychology/school assessment; child psychiatry; pediatric social work; audiology; reproductive medicine/gynecology.
USMC	
HQ EFMP Assignment Coordinators MCO 1754.4B	The Headquarters EFMP Assignment Coordinators will review and access for appropriateness of the proposed orders, either CONUS or OCONUS, by contacting the sponsor if EFMP status is not current. Researching all accepted Tricare Prime medical specialists and subspecialists for availability and accessibility. Collaborating with the MOS Monitors to properly assign sponsors with EFM.
Semper Fit	Semper Fit Programs available through Marine Corps Community Services (MCCS) offers a wide variety of recreation and fitness programs to provide Marines and their families with resources to lead active healthy lives.
Semper Fit/EFMP Collaboration	Collaboration between MCCS Services, Semper Fit and EFMP to provide options for families to get healthier and increase fitness and to give additional support to special needs families.
Semper Fit/EFMP Collaboration	Offering a cooking show/ demonstration provided by a Registered Dietician. Preparation of quick healthy after work meals as well as, nutritional information including some general information for adapting meals to meet dietary requirements.
Semper Fit/EFMP Recreation and Fitness Inclusion	Semper Fit and USMC EFMP have established a collaborative relationship which is focused on increasing participation of individuals with special needs in existing Semper Fit fitness and recreation programs. In support of these efforts, Semper Fit has provided a Certified Inclusion Fitness Trainer at most Marine Corps installations. EFMP and Semper Fit maintain quarterly in-service trainings and educational opportunities for staff to become more aware of the barriers to participation faced by individuals with special needs.
Kids Run the Nation/ Road Runners Club of America/Semper Fit/EFMP	Semper Fit sponsored program through a grant from The Road Runners Club of America. EFMP collaborated with this program to utilize inclusion to allow special needs children to participate in the bi-annual run.
Installation EFMP Learning Library	Offers learning materials including books to support the special needs family, videos, equipment such as walkers, wheelchairs, and air purifiers. Learning library also loans toys, computer learning devices i.e.: leap frog and hosts sensory

	story time.
EFMP Family Support Groups	Each USMC installation offers month support groups tailored to special needs of military families. These groups include caring for your special needs child, Autism, deployment support, bereavement support groups, and advocacy workshops.
Special Education 101	Workshop to allow parents of children with special education needs to not only have access to the basics needed but the laws that affect their children and their special education needs.
Workshop Autism	Workshop on use of inclusion therapy and using token economies with children with autism.
EFMP Modified Swimming	Swimming program hosted by Installation EFMP's using specialized aquatic equipment to assist with low impact exercise and enhancing confidence while in the water.
Advanced Individual Education Plan (IEP) and Transition	The IEP is a critical legal document that sets goals and standards of special education. This class serves as a tool to assist parents with PCS moves, transition and guidance with the child's IEP and advanced educational needs.
EFMP Family Picnic	Picnic at Balboa Park to facilitate networking and support between the two neighboring installations and EFMP family members.
Special Olympics Fun Field Day	Special Olympics will allow each special need participant to have the ability to participate in an athletic event. Each child will have a "buddy" to assist him/her throughout the entire event. Special Olympic events include: 25 meter run, 50 meter run, Bean bag shuttle run, obstacle course, Triple Hula Hoop Jump, Standing long jump, Bean bag/shot put toss and soccer kick.
Epic Program (Educational Pursuits Involving Children)	EPIC provides behavioral health treatment (individual and groups), medication management, training and workshops, etc., and services are provided by Tripler Psychiatrists, Psychologists and LCSWs. EFMP participates in EPIC meetings, which occur monthly.
New Parent Support Program	The New Parent Support Program is a prevention program that provides support for expectant parents and parents with children ages 0 - 5. Services include baby boot camp, parenting classes and home visitation by social workers, counselors and Registered Nurses. This is a DOD program that serves children 0-3. The Marine Corps provides an expanded program servicing children up to age 5.
Community Counseling	Community Counseling, staffed with licensed providers credentialed by the USMC Credentialing Review Board, is providing the following services: evidence-based client screening tools and assessments; psycho-education for individuals and families; clinical case management to improve coordination of referrals to medical treatment facilities and

	specialty care appointments; non-medical counseling to individuals (children, adolescents, and adults), families, and couples; and program/service navigation between Community Counseling and other care services.

APPENDIX D: Responses linked to ELEMENT 8

DoD	
DoD Directive 1020.1	"Nondiscrimination on the Basis of Handicap in Programs and Activities Assisted or Conducted by the Department of Defense," Mar. 31, 1982 certified as current Nov. 21, 2003. This directive prohibits discrimination based on disability in programs and activities receiving federal financial assistance disbursed by the DoD and in programs and activities conducted by the DoD.
DoD Instruction 1000.13	DoD Instruction 1000.13, "Identification Cards for Members of the Uniformed Services, Their Dependents and Other Eligible Individuals," Dec. 5, 1997. This instruction establishes policy, responsibilities and procedures for the issuance of ID cards to members of the uniformed services of the United States. Children who become incapacitated prior to the age of 21 (or between 21 and 23 if enrolled as a full time student) and are incapable of self-support, remain entitled to benefits and privileges authorized by the uniformed services if medical sufficiency is met and the sponsor is providing more than 50 percent of their support.
DoD Instruction 1342.22	DoD Instruction 1342.22, "Military Family Readiness," July 3, 2012 This instruction establishes policy, assigns responsibilities and establishes procedures for the provision of military family readiness services. It also sets requirements for financial education and counseling, relocation assistance, family readiness in the reserve components and emergency family assistance.
DoD Instruction 1315.19	DoD Instruction 1315.19 "Authorizing Special Needs Family Members Travel Overseas at Government Expense," Dec. 20, 2005, certified as current Feb. 16, 2011 This instruction assigns responsibilities and prescribes procedures for authorizing family member travel at government expense for active duty service members who are assigned overseas and who have family members with special needs. The instruction also provides guidance for processing civilian employees who have family members with special needs for an overseas assignment. The instruction directs the branches of service and DoD components to verify the availability of medical services essential to meet the needs of family members with special medical needs and ensure the availability of early intervention services and related services essential to meet special education needs pursuant to the child's individualized family service plan or the individualized education program.
DoD Instruction 1342.12	DoD Instruction 1342.12, "Provision of Early Intervention and Special Education Services to Eligible DoD Dependents," April

	11, 2005. This instruction establishes policy for the provision of early intervention and special education services for eligible children with disabilities (birth through 21).
Army	
Exceptional Family Member Program Staff/Systems Navigators and ACS Information and Referral Staff	Information and Referral services to military and civilian resources based on individual/family needs.
Child Youth and School Services School Liaison Officers	The Installation Support Services support Families and students, communicates with school districts, support installation commanders and links students and Families to education and post-secondary opportunities. School Liaison Officers provide predictable support services that assist military students with relocation, life transitions and promotes parent and community involvement, to help achieve academic success.
Navy	
EFMP	There are EFMP Case Liaisons or information and referral personnel at every installation Fleet and Family Service Center to assist families with local or regional information for families with special needs. Every Exceptional Family Member is assigned a Case Liaison which will assist them with their individual case as well as providing a warm hand-off for the family to a new Case Liaison at their perspective duty station when they have to relocate. The Regional EFMP Case Leads and installation case liaisons have developed EFMP Resource Guides (lists) for their specific region and installation which they provide to their families with special needs. The Resource Guides provide information on enrollment, EFM program support such as local Hospital EFMP Coordinators point of contact information, Humanitarian Transfers, Incapacitated Dependent Program (INCDP), ECHO, and official EFMP websites. The Resource Guides provide information on local support to include name, description, phone number and website information as well as National online support websites. Staff at the Fleet and Family Service Centers assists families with questions that they may have as well as help them navigate the system to get the services best suited for their specific needs. The TRICARE Regional websites provide military families with specific details on medical specialists and facilities at every location including military medical treatment facilities. The site also lets the family know if the specialist is accepting new TRICARE patients or not. The Navy assigns service members who have children with

	chronic medical needs to major medical areas that have a children's hospital and the required pediatric specialist. When a child with special needs is enrolled into the EFMP, the case is referred to a Central Screening Committee (CSC) at one of Navy's medical centers to be referred by a team headed by a senior developmental pediatrician. The CSC makes an assignment recommendation to the EFMP office at the Navy Personnel Command on whether or not the family needs to be assigned to a major medical area that has a children's hospital or whether the services at a community hospital is sufficient. The CSC also makes assignment recommendations on whether services are available overseas or remote locations. Since these providers travel regularly overseas to treat Navy pediatric patients, they are very familiar with the theatre and services that are available. This screening is done prior to suitability screening done prior to military orders being executed and family travel overseas authorized. The CSC also provides reach back capability for the EFMP assignment analyst in reviewing specific cases. The CSC has the capability of reviewing the patient's electronic medical record for specific medical case management. There are EFMP Case Liaisons or information and referral personnel at every installation Fleet and Family Service Center to assist families with local or regional information for families with special needs. Every Exceptional Family Member is assigned a Case Liaison which will assist them with their individual case as well as providing a warm hand-off for the family to a new Case Liaison at their perspective duty station when they have to relocate. The Regional EFMP Case Leads and installation case liaisons have developed EFMP Resource Guides for their specific region and installation which they provide to their families with special needs. The Resource Guides provide information on enrollment, EFM program support such as local Hospital EFMP Coordinators point of contact information, Humanitarian Transfers, Incapacitated Dependent Program (INCDP), ECHO, and official EFMP websites. The Resource Guides provide information on local support to include name, description, phone number and website information as well as National online support websites. Staff at the Fleet and Family Service Centers assists families with questions that they may have as well as help them navigate the system to get the services best suited for their specific needs. The TRICARE Regional websites provide military families with specific details on medical specialists and facilities at every location including military medical treatment facilities. The site also lets the family know if the specialist is accepting new TRICARE patients or not.

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NCR-MD	
Specialized Training of Military parents (STOMP)	Beneficiaries in NCR, FBCH and WRNMMC, federally funded Parent Training and Information (PTI) center established to assist military families who have children with special education or healthcare needs. The staffs of the STOMP Project are parents of children who have disabilities and have experience in raising their children in military communities and traveling with their spouses to different locations.
Case management services	Pediatrics case managers ensure referrals are processed accordingly and Durable Medical Equipment is ordered/delivered to beneficiaries in accordance with ordering provider's prescribed plan of care.
EFMP liaison	EFMP liaison at WRNMMC liaison works with network pediatrics specialty care and services for beneficiaries to augment care provided at MTFs.
Respite care services	Families enrolled in EFMP may receive 8-40 hours of respite care per month to family with children with special needs, provides child care during appointments. www.naccrra.org
ECHO	Extended care health option offers beneficiaries integrated services and supplies beyond those offered by basic TRICARE health benefit programs.
Military OneSource	Provides "coming together around military families," which is a comprehensive packet of materials for parents, caregivers, and professionals who work to meet the needs of young children challenged by the stressors of military life, such as deployment

	and relocation.
Children's hospital association	Advances child health through innovations in the quality, cost, and delivery of care. Champions public policy.
Zero to three program	National nonprofit organization that provides parents, professionals, and policymakers the knowledge to nurture early development.
Exceptional Family member program (EFMP)	Service members with children with identified special needs are required to enroll in the EFMP. This program allows medical and educational personnel to review the resources required to meet the child's special needs. The program determines whether enrolled families can be sent on certain assignments. Also, once assigned to new posts, the EFMP helps families find and access the services their children need. It also provides information about local schools and early intervention services, as well as non-clinical case management.
Service-specific special needs review boards	US Army Special Needs Accommodation Process, USMC Special Needs Evaluation Review Team, and US Navy Special Needs Review Board (SNRB) all convene multidisciplinary teams to determine safest/least restrictive and most appropriate placement for pediatric services.
Military Childcare in Your Neighborhood (MCCYN)	Program that provides fee assistance for families of Active Duty Army Service members and Army Civilians who are unable to access on-post child care.
Children's National Health System	Referral based through AHTLA/CHCS, referrals management.
Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP)	A consultative program for pediatric primary care providers for behavioral health services.
Maryland Department of Health and Mental Hygiene	Referral based through AHTLA/CHCS, referrals management.
District of Columbia Department of Behavioral Health	24 hour crisis line.
IRMAC (Integrated Referral Management Appointment Center); referral guidelines; Pediatrics and Family Practice medical home port	MTF providers place consults to for Durable Medical Equipment(DME), pediatric subspecialty care not provided within the MHS; deferred to network on case-by-case basis coordinated by the pediatrics case management system/pediatrics social work in conjunction with the ECHO program. Referrals to the private sector are for services associated with the need for Cardiac Anesthesia. WRNMMC does not have any Pediatric Cardiac Anesthesia ability. If a child has a need for minor services then they are sent to CNMC for procedure. Services such as Physical Therapy, Occupational Therapy and Speech are obtained in the network. ABA therapy, Second Opinions,

	Transplant Services and Intensive Subspecialties beyond our scope of Practice are referred to the Network. We also have a Medicaid Waiver program. All Inpatient BH patients are referred out. Feeding programs, BH (eating disorder and substance abuse) outpatients are sent to the Network.
USMC	
Marine Corps Exceptional Family Member Program	The program offers many exciting roles for volunteers in which they can make a difference. Volunteers serve families who have children with disabilities and are carefully matched with a child one-on-one for our community respite trips and in-center activities. Volunteers can also assist with recruitment and planning special events.
Marine Corps Exceptional Family Member Program	The program provides direct family support services to include non-clinical case management, outreach, family training, special needs forum, family support groups and assist with local resources.
Marine Corps Exceptional Family Member Program	FCW assist with enrollment and updates within EFMP. MCO 1754.4B, Section 18, 2-19-2-22
Marine Corps Exceptional Family Member Program	Provides Relocation Assistance- assists sponsors with relocation, before, during, and after PCS moves. Ensuring both gaining and losing Marine Corps installations' EFMP will collaborate for a seamless transfer. MCO 1754.4B; Section 18, 2-19-2-22
Marine Corps Exceptional Family Member Program	Support the family while the sponsor is deployed to include resources, information and referrals to assist with their unique needs of having a deployed sponsor. MCO 1754.4B; Section 18, 2-19-2-22
Marine Corps Exceptional Family Member Program	Serves as a liaison and assists with coordinating medical, state, and educational provider's to include Medicaid/Medicare, SSI, Disability Services and State Mental Health Services. MCO 1754.4B; Section 18, 2-19-2-22
Marine Corps Exceptional Family Member Program	Attends local meetings during business hours to support efforts to ensure the provision of medical, state, or educational services. MCO 1754.4B; Section 18, 2-19-2-22
Marine Corps Exceptional Family Member Program	Ensuring EFMP families are represented during the Child Youth and Teen Programs (CYTP) Special Coordination with the School Liaison to identify students needing special education. Needs and Review and Evaluation Team (SNERT) meetings. MCO 1754.4B; Section 18, 2-19-2-22
Marine Corps Exceptional Family Member Program	Provide outreach to the sponsors, the commands and families to market and educate families about the EFMP Program. MCO 1754.4B; Section 18, 2-19-2-22
Marine Corps Exceptional Family Member Program	Provide family training to increase the knowledge of EFMP needs and related laws, family training will be provided on a variety of topics no less than semi-annually.

	MCO 1754.4B; Section 18, 2-19-2-22
Marine Corps Exceptional Family Member Program	Hosts Special Needs Forums at least quarterly, to include Installation Leadership, EFMP, EFMP sponsors, MCCS program representatives and base housing and facilities shall attend these forums. MCO 1754.4B; Section 18, 2-19-2-22
Marine Corps Exceptional Family Member Program	Provide opportunities for families to attend support groups with the goal to increase family to family support and networking. MCO 1754.4B; Section 18, 2-19-2-22
Marine Corps Exceptional Family Member Program	Establish and maintain a library of special needs education and resources, education, referral materials to assist EFMP personnel, commands, and family members.
USMC Children, Youth and Teen Programs	Maintain contact with EFMP families by phone, email, fax, and through face to face meetings. Families will be contacted quarterly, at a minimum. Critical needs families should be contacted as often as needed. MCO 1754.4B; Section 18, 2-19-2-22
USMC Children, Youth and Teen Programs	Programs are nationally accredited facility-based child care services that support child care needs for children ages 6 weeks through 12 years. Care options include full-day, part-day, and hourly care. Operating hours vary from installation to installation as determined by the needs of the base community and available resources. MCO 1710.30E 1005.1
USMC Children, Youth and Teen Programs	Policies shall be implemented to ensure that appropriate services are provided for children, youth and teens with special needs. Such policies shall meet the requirements of the Rehabilitation Acts and the Department of Defense Directive 1020.1 MCO 1710.30E 1006
EFMP Installation Training Education and Outreach Specialist (TEO)	Upon request for services, annually after placement or upon transition, a team of qualified, cognizant personnel shall make an assessment of the accommodations necessary for a special needs child to participate in the program and determine the most appropriate placement for the child. This team shall be called a Special Needs Evaluation Review Team (SNERT). The SNERT shall include, but not be limited to the following members: CYTP Administrator, Exceptional Family Member Program Coordinator, medical personnel, parent(s) of child (ren), child or youth when appropriate, and other applicable CYTP or community agency personnel. The team shall report to the installation commander or his designated representative. MCO 1710.30E 1007.2&3
Local Health Departments	The TEO works under the EFMP Program Manager. The TEO's job is to conduct EFMP training, deliver and coordinate training and education, and develop the EFMP outreach program plan. Work includes delivering and coordinating training for EFMP

	staff, Marines and their families and coordinating marketing to promote awareness, education and provide resources for the Exceptional Family Member Program. Links eligible family members and their families with a variety of support services and resources at the command. Seeks out eligible members using an outreach concept and approach that fosters self-reliance and a sense of belonging. Ensures emphasis on positive customer experience for enrolled families and acts as the primary point of contact for resources and referral for Marines and families seeking assistance. MCO 1754.4B; Section 18, 2-20-2-21
Local Depts. Of Social Services	Provides health and nutrition resources.
Community Counseling	Provides child and family intervention programs.

APPENDIX E: Responses linked to ELEMENT 9

Army	
EFMP Nominative Review	The Army mitigates the impact of frequent moves through a policy of sending Family Members to locations where their special needs can be met. Whenever possible, the Army will send Families to locations where there are resources to meet the medical needs of exceptional Family Members. Prior to placing a Soldier, who is enrolled in EFMP, on assignment instructions, the Human Resources Command will send an inquiry to the military treatment facility at the proposed new duty location and inquire about the availability of medical care for the registered Family Member(s). If care is not available, the Human Resources Command will look for another assignment for the Soldier. The Army also screens all Families who are on assignment instructions to areas outside the continental United States. If medical care is not available at the proposed location, the Army will not approve Family Member travel.
Stabilization	The Army is committed to the health, safety and well-being of its Soldiers and their Family Members with special needs. Army policy allows for military Families with special needs to be stabilized for four years so medical or educational services, which cannot be immediately replicated and/or acquired elsewhere, are not disrupted. The stabilization for the exceptional Family Member (EFM) does not apply to the Soldier. The Soldier may be required to travel away from home station to participate in combat or operational deployments, training exercises, or for personnel management or professional development reasons. The four year stabilization period starts on the date the EFM began receiving the required services. Criteria. One or more of the below must be met in order to establish eligibility for stabilization under this program: a. A permanent station move would disrupt access to necessary medical or educational services that would place the EFM's health, safety, or development in jeopardy. b. The EFM has a diagnosis that requires extensive support from TRICARE, state, and local resources that would be difficult to replicate and/or reacquire in a timely manner. c. The family has multiple EFM's receiving a combination of TRICARE, state, and local services that would be difficult to replicate and/or reacquire in a timely manner.
Exceptional Family Member Program	Systems Navigators are Army Community Service EFMP staff members located on the installation. There are 45 Systems Navigation offering support at 26 installations. They are trained and knowledgeable about the systems of care used by Families with special needs. The primary role of a Systems Navigator is to navigate Families through the available systems of care.

	A Systems Navigator can help Families: 1. Identify EFM and Family strengths and needs. 2. Help identify and prioritize EFM and Family goals. 3. Develop a Family Service Plan to reach goals. 4. Make referrals to required services. 5. Provide information about disabilities or medical conditions of concern. 6. Find transportation to appointments related to the Family Service Plan. 7. Identify support groups and social activities. 8. Strengthen Family's ability to advocate for EFM. Systems Navigation enhances mission readiness, retention and quality of life. In addition, System Navigation supports the goals of the Army Family Covenant.
CYS Services School Support Services	School Support Services: The Installation Support Services support Families and students, communicates with school districts, support installation commanders and links students and Families to education and post-secondary opportunities. School Liaison Officers provide predictable support services that assist military students with relocation, life transitions and promotes parent and community involvement, to help achieve academic success.
CYS Services Parent Support and Outreach	Parent and Outreach Services - Provides registration, enrollment, records management, and payment services for all CYS Services programs at "one-stop" locations on all installations. The Parent and Outreach Services program is responsible for mandated Parent Advisory Council and parent education classes. This program also provides short term child care options, e.g., Kids on Site (hourly child care provided at same location as parents), Parent Co-Ops (traditional parent provided on-site child care), Volunteer Child Care in Unit Settings (child care provided on site by trained volunteers), and CYSitters babysitter training and referral program. The Parent and Outreach program also provides program information, sends e-News publications and messages, and contributes to CYS Services web sites of interest to parents.
Army School Behavioral Health Program	For Family Members who are receiving BH care as part of the School BH program, assistance will be provided to facilitate transition of children and adolescents needing ongoing BH services at their new duty station.
Army Child and Family Behavioral Health System	Assistance is provided by the CAFBHS program for children and adolescents, requiring ongoing treatments that are enrolled in care, to facilitate transition and follow-up at a new duty station.
Air Force	
AFI 36-2110 attachment 25 EFMP Assignments	Reassignments/Deferments are considered when continuity of care or required care is essential in assuring AF Families' medical needs are met. AFI 40-701
Navy	

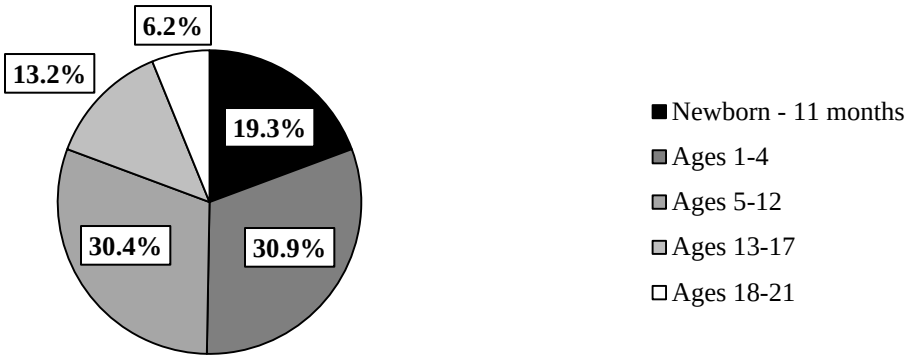
EFMP	Children with special health and behavioral health care needs are screened by senior developmental pediatricians on one of three Central Screening Committees for continuity concerns. Children whose developmental, medical, or behavioral health care needs require continuity of care are assigned an assignment category 5 which allows those families to homestead at one of Navy's five major fleet concentration areas which allow for a sailor or officer's career progression, milestones, and sea/shore rotation. As long as continuity of care and/or services is recommended by Medical, the sailor or officer will not be relocated. Occasionally the service member may elect to travel to a location unaccompanied to meet a specific milestone and the family is allowed to stay at the present duty station for continuity of care. The child's case is reviewed every three years, whenever there is a change to their medical and/or educational requirements, or 12 months prior to a service member's permanent change of station orders. Currently 22 percent of children enrolled in EFMP are homesteaded for continuity (3,647 of 16,993).
NCR-MD	
Physician to physician dialogue ("warm hand-off")	Provider to Provider update on beneficiary health and medical status when transferring between medical centers.
Consultation with specialty leaders and detailers	Consultation within medical group to ensure collaborative decision making for beneficiary. Formal and informal discussions with detailers related to 'best fit' for beneficiary family.
Coming Together Around Military Families (CTAMF) program	DoD contracted with "Zero to Three: National center for Infants, toddlers, and families (ZTT)" (which is a nonprofit organization that teaches, trains, and supports professionals, policy makers, and parents in their efforts to improve the lives of infants and toddlers) in 2009 to increase awareness -both military installations and in communities where National guard and reserve families reside--of how trauma, grief, and loss affect children of service members. Program was implemented in 65 communities across the USA and offered specialized training and support for professionals and organizations that assist military families.
Military OneSource	provides "coming together around military families," which is a comprehensive packet of materials for parents, caregivers, and professionals who work to meet the needs of young children challenged by the stressors of military life, such as deployment and relocation.
TRICARE	
Moving Made Easy Webinar	For Active Duty Service Members and their Families TRICARE and military One Source webinar on transferring Prime enrollment.
Frequently Asked Questions	On variety of sources as short summary of benefit program.
TRICARE Dental Program Benefit	Comprehensive summary of Dental programs, cost shares and benefits.

Booklet and fact sheet	
TRICARE Health Matters	(North, South, Overseas, Standard and West) Electronic newsletters.
TRICARE Prime, Standard, Overseas Program and Prime Remote Handbook	Handbook with comprehensive summary of programs, cost shares and resources in Overseas and remote areas. Hand book with comprehensive summary of Prime and Standard benefit options.
TRICARE Overseas Program Fact Sheet	(Prime, Standard, Remote) concise review of benefits and resources.
Fact sheets	Registering in the Defense Enrollment Eligibility Reporting Systems; Vaccine coverage, Vision Benefits; Women, Infants and Children (WIC), TRICARE Young Adult, Preventive Health; Pharmacy; TRICARE for Life; TRICARE and the Affordable Care Act, Traveling with Prime and Cognitive Rehabilitation therapy.
USMC	
EFMP Warm Hand Off	Losing Installation Program manager sends "Warm Hand Off" email to gaining program; Family Case Worker (FCW) is assigned at gaining program. Losing FCW ensures needs of family prior to PCS are met and questions or assistance for gaining FCW are met. Gaining FCW alerts PM if there are significant needs such as Priority Housing or base school coordination. Gaining FCW contacts SM to introduce them and provide contact information.
EFMP Respite Care	MCO 1754.4B 2-22-2-26 MCBul 1754 11 June 2013 EFMP respite care program is intended to reduce stress on sponsor families by providing temporary rest periods for family members who care for those who have special needs. The installation EFM Program Managers shall facilitate the EFMP respite care program. Respite levels are determined during medical screening.
Assignment Coordination	MCO 1754.4B 2-9-2-13 HQ EFMP Assignment Coordinators review all CONUS and OCONUS orders generated by MOS monitors for EFMP enrolled sponsors to determine availability medical and educational services per the DD2792.
Sponsorship Program	MCBO 1320.3A The Sponsorship Program is designed to provide assistance for transferring personnel before detachment, during transit, and after arrival at their new permanent duty station. Because of the benefit it provides, personnel in the grades of E-1 through E-6, WO-1 and CWO-2, O-1 through O-3, and all overseas accompanied personnel will be assigned a sponsor. All other personnel will be assigned a sponsor upon request.
Transition Assistance Management	The TAMP provides career/employment assistance, vocational guidance and transition information to Marines and their families separating from the Marine Corps.

Program (TAP)	
New Parent Support Program	The program provides parent education on topics such as developmental milestones, infant care, parenting stressors, and age appropriate discipline.
Community Counseling	Community Counseling, staffed with licensed providers credentialed by the USMC Credentialing Review Board, is providing the following services: evidence-based client screening tools and assessments; psycho-education for individuals and families; clinical case management to improve coordination of referrals to medical treatment facilities and specialty care appointments; non-medical counseling to individuals (children, adolescents, and adults), families, and couples; and program/service navigation between Community Counseling and other care services.

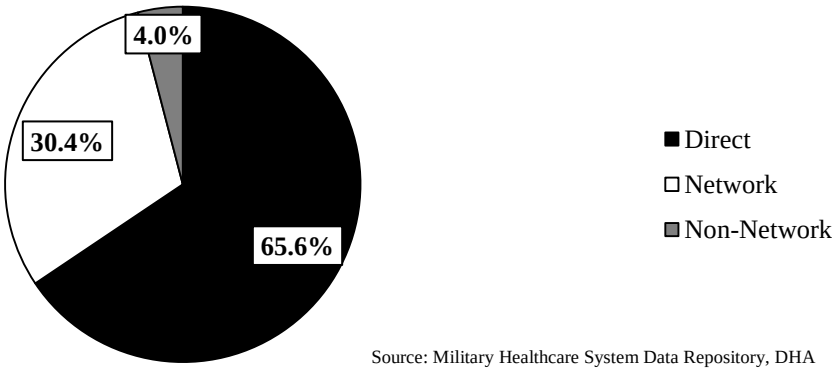
APPENDIX F: Supplemental Data Figures

Figure 2.3: FY 2012 Total Visits By Age



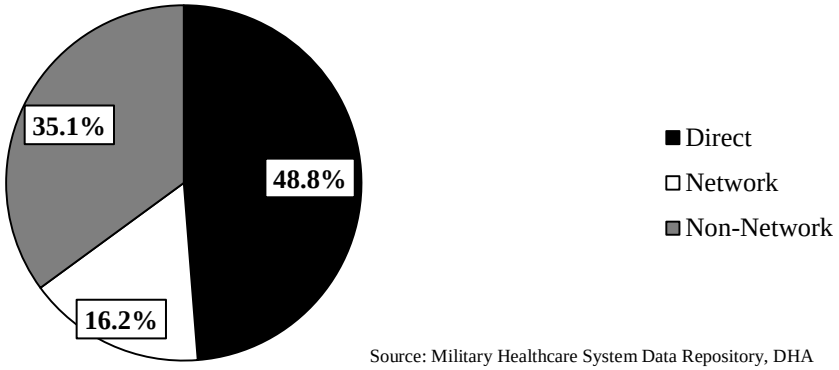
Source: Military Healthcare System Data Repository, DHA

Figure 2.4: FY 2012 Pediatric Outpatient Office Visits



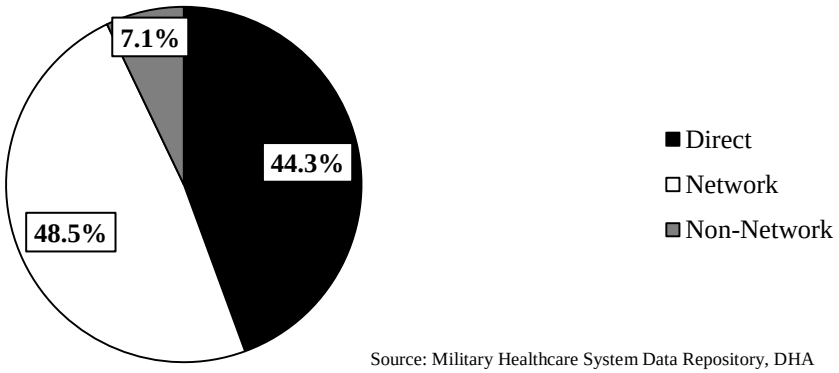
Source: Military Healthcare System Data Repository, DHA

Figure 2.5: FY 2012 Pediatric ER Visits



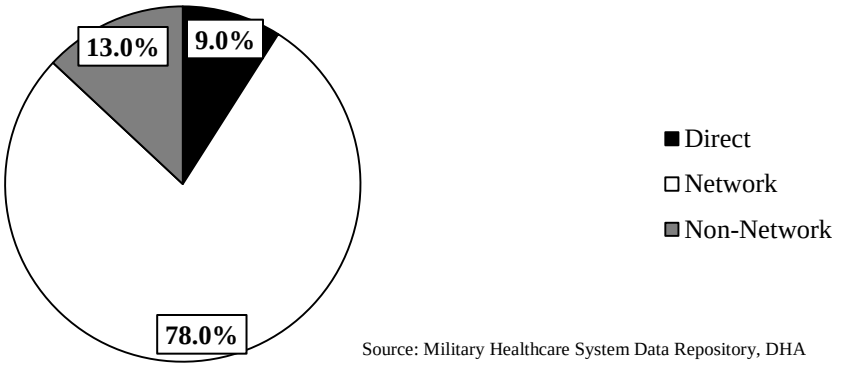
Source: Military Healthcare System Data Repository, DHA

Figure 2.6: FY 2012 Pediatric Inpatient Visits



Source: Military Healthcare System Data Repository, DHA

Figure 2.7: FY 2012 Pediatric Same Day Surgeries



Source: Military Healthcare System Data Repository, DHA

APPENDIX G: Abbreviations

AAFP	American Academy of Family Practice
AAP	American Academy of Pediatrics
ABA	Applied Behavior Analysis
ACA	Patient Protection and Affordable Care Act
ACP	American College of Physicians
ADSM	Active Duty Service Member
ADFM	Active Duty Family Member
AF	Air Force
AMEDD	Army Medical Department
AOA	American Osteopathic Association
AR	Army Regulation
ARFORGEN	Army Force Generation
ASACS	Adolescent Substance Abuse Counseling Service
ASD	Autism Spectrum Disorder
BACB	Behavior Analyst Certification Board
BCaBA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst (BCBA)
BH	Behavioral Health
CAFAC	Child and Family Assistance Center
CAFBH	Child and Family Behavioral Health System
CAHPS	Consumer and Healthcare Provider System
CAPER	Comprehensive Ambulatory Patient Encounter Record
CDC	Center for Disease Control and Prevention
CDC	Child Development Center
CF	Cystic Fibrosis
CFC	Cystic Fibrosis Foundation
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMAC	CHAMPUS Maximum allowable charge
CFR	Congressional Federal Register
CP	Cerebral Palsy
CONUS	Continental United States
CPT	Current Procedural Terminology
CYS	Children and Youth Services
CYB	Child and Youth Behavioral
CYB MFLC	Child and Youth Behavioral Military & Family Life
DEERS	Defense Enrollment Eligibility Reporting System
DHA	Defense Health Agency
DMHRs	Defense Medical Human Resource System
DoD	Department of Defense
DODDs	Department of Defense Duty Station
DoDEA	Department of Defense Education Activity
DoN	Department of Navy
DO	Doctor of Osteopathy

DRG	Diagnostic Related Grouping
DTF	Dental Treatment Facility
ECHO	Extended Care Health Option
EDIS	Educational and Developmental Intervention Services
EFMP	Exceptional Family Member Program
EFM	Exceptional Family Member
EFM IT	Exceptional Family Member Intelligence Technology
EHHC	ECHO Home Health Care
EIS	Early Interventions Services
ENT	Ears, Nose and Throat
FAP	Family Advocacy Program
FCBH	Fort Belvoir Community Hospital,
FFSC	Fleet and Family Services Center
FOCUS	Families Overcoming Under Stress
FRG	Family Readiness Group
FY	Fiscal Year
GAO	United States Government Accountability Office
HCSDP	Health Care Survey of DoD Beneficiaries
HHA	Home Health Agency
HMO	Health Maintenance Organization
ICD	International classification of Diseases
IPPS	Inpatient Prospective Payment System
JOA	Joint Operations Area
KIT	Kids Included Together
MCCS	Marine Corps Community Services
MD	Medical Doctor
MDR	Military Healthcare System Data Repository
MHS	Military Healthcare System
MS	Mississippi
MTF	Military Treatment Facility
MWR	Morale Welfare and Recreation
OTSG	Office of the Surgeon General (Army)
PFPWD	Programs for Persons with Disabilities
NCR-MD	National Capital Area-Medical Directorate
NDAA	National Defense Authorization Act
NMCP	Naval Medical Center Portsmouth
NPPES	National Plan and Provider Enumeration System
NPSP	New Parent Support Program
OCONUS	Outside Continental United States
OPPS	Outpatient Prospective Payment System
OSD	Office of Secretary of Defense
OSN	Office of Special Needs
PCM	Primary Care Provider
PCMH	Patient Centered Medical home
PCS	Permanent Change Duty Station
POS	Point of Service

PPS	Prospective Payment System
PHP	Psychiatric Partial Hospital Program
RTC	Report to Congress
RTC	Residential Treatment Center
SAC	School Aged Children
SB	Spina Bifida
SBH	School Behavioral Health
SBS	Shaken Baby Syndrome
SIDR	Standardized Inpatient Data Record
SNF	Skilled Nursing Facility
SUDRF	Substance Use Disorder Rehabilitation Facility
TDP	TRICARE Dental Program
TEDI	TRICARE Encounter Data Institutional
TED NI	TRICARE Encounter Data Non Institutional
TFF	Total Force Fitness
TMAC	TRICARE Maximum Allowable Charge
TRO	TRICARE Regional Office
TRDP	TRICARE Retiree Dental Program
TROSS	TRICARE Outpatient Satisfaction Survey
TRISS	TRICARE Inpatient Satisfaction Survey
TYA	TRICARE Young Adult
ULB	Unified Legislation and Budgeting Process
USC	United States Code
USFHP	United States Family Health Plan
USMC	United States Marine Corps