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INFORMATION PAPER

DASG-HSZ
29 July 2014

SUBJECT: Army Medicine's Integrated Health Care System – Essential to Readiness

Executive Summary: Military beneficiary population participation in the military direct care system is essential and directly contributes to the combat readiness and preparedness of Army Medicine to respond to threats to our National Security. Army Medicine is a complex, integrated system, caring for over 1.37 million beneficiaries. 63% of these 1.37 million Army TRICARE Prime-enrolled beneficiaries are non-Active Duty Service Members (ADSM). 76% of inpatient workload and 59% of outpatient surgical workload is made up of Family members, retirees and other non-ADSM. 90% of complex surgical cases in our Medical Treatment Facilities (MTF) are non-ADSM. 49% of all outpatient care is provided to non-ADSM. To lose any of these beneficiary populations would dramatically reduce the preparedness and effectiveness of Army Medicine. Specifically, Army Medicine relies on our entire beneficiary population to maintain Medical Skills Readiness essential to the combat casualty care and readiness missions. Over the past 13 years, the results of having a ready and deployable medical force have been evident. The Operation Enduring Freedom survivability rate of 91.6% is the highest in the history of warfare. Additionally, readiness rates, inclusive of unprecedented readiness increases in the reserve components, are demonstrative of a system-wide, focused effort of well-trained medical professionals to ensure that our Army is ready and our Soldiers receive the care they deserve. Army Medicine's integrated system spans from medical personnel in Brigade Combat Teams and Special Operations units to some of the most capable MTFs in the United States. It includes a wide range of research efforts and the largest medical training program of its kind. At the core of our health care delivery system are our MTFs. They are essential to both training and maintaining a ready and deployable medical force and the readiness of the Total Army Force. They serve as readiness and training platforms directly linked to our unique ability to deliver world class combat casualty care. During the uncertain years ahead, our MTFs will remain necessary to optimize the health, resilience, readiness, and performance of our Soldiers, Family Members, and those entrusted to our care.

1. Purpose: To inform Senior Army Leaders regarding the complexity of Army Medicine's integrated health care system including our beneficiary population, military treatment facilities, training programs, medical skills readiness, and research. All of these components contribute to the essential tasks of maintaining Army readiness and

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our ability to provide the highest level of combat casualty care possible in support of our Nation's security.

2. Discussion:

a. A Ready and Deployable Medical Force: To ensure that Army Medicine is fully capable of performing the essential task of combat casualty care, Medical Skills Readiness must be maintained on a daily basis. This is a core task for Army Medicine and a national security requirement during any interwar period. The development of medical skills begins in defined training programs. MTFs serve as the platform for training in numerous programs. Upon completion of formal training programs, medical providers must maintain or enhance their skills through the daily delivery of health. While much focus has been oriented toward larger MTFs with high Case Mix Index (CMI), critical medical skills readiness occurs at all MTFs. Additionally, team training is essential to a ready medical force and the ability to conduct medical operations in any operating environment. Medical Skills Readiness to the full scope of practice for all our personnel, combined with team training is the only way to optimize combat casualty care for future conflicts.

1) Impact of the Beneficiary Population: The TRICARE Prime-enrolled beneficiary population is comprised of four primary beneficiary categories: Active Duty, Active Duty Family members, retirees and retiree family members. The total TRICARE Prime-enrolled population is 1.37 million. Active Duty Service Members only comprise 36.6% of the total beneficiary population. 76% of inpatient workload and 59% of outpatient surgical workload is made up of Family members, retirees and other non-ADSM. 90% of complex surgical cases in our Medical Treatment Facilities (MTF) are non-ADSM. 49% of all outpatient care is provided to non-ADSM. These statistics highlight the magnitude of losing any segment of the non-ADSM beneficiary population. Specifically, Army Medicine relies on our entire beneficiary population to maintain Medical Skills Readiness essential to the combat casualty care mission. The current beneficiary population adds both diversity and complexity to the case mix seen in our MTFs. This is critical to provider and care team comprehensive proficiency in their respective specialty. The loss of any segment of our beneficiary population will adversely impact having a ready and deployable medical force ready to provide combat casualty care.

2) The Enlisted Medical Provider: The enlisted Soldier military occupational specialties, particularly our medics, are a unique provider class only found within the Armed Forces. There is no true civilian equivalent. Initial training for enlisted medical

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providers occurs in 34 different MTFs with a 2013 throughput of 1629 personnel. After completion of initial training, enlisted personnel must maintain their Medical Skills Readiness. Their scope of practice is entirely dependent on demonstrated competencies and training. The emphasis in all Army Medicine MTFs is to ensure a broad scope of practice in preparation for the combat casualty care mission. No civilian healthcare system will provide comparable exposure and experience for our enlisted medical providers. With adequate training and demonstrated/documented competency, our personnel are able to be prepared for a broad range of medical contingencies in a combat zone. Their ability to work autonomously has directly and substantively contributed to the highest rate of survivability in history despite increased severity scores. All Army MTFs, even those with low case mix indexes, serve as an essential training platform for our enlisted medical providers.

3) Team Based Training: Military medical team based training takes place every day in every Army MTF. A system-wide replication of this outside Army MTFs will be a challenge. One example of team based training is the 2007-2008 employment of the TeamSTEPPS™ approach in MTFs. TeamSTEPPS™ is an evidence-based teamwork system designed to improve communication and teamwork skills among health care professionals. After application in our MTFs, the system was applied in the operational environment at a Combat Support Hospital which demonstrated a 38% reduction of incident reports, 67% reduction in communications errors, 70% reduction of needle sticks and 83% reduction in medication errors. Team based training occurs daily in our MTFs regardless of size, location or case mix index. The statistics above reflect the importance of daily actions within our MTFs and how they contribute to optimizing combat casualty care.

4) Medical Diplomacy: Medical personnel working in MTFs are subject to support requirements generated by Combatant Commands. Army Medicine supports engagement efforts aligned with the DoD mission to ensure geopolitical stability and security across the globe. We are a force multiplier and an enabler of theater security cooperation, humanitarian assistance, and global diplomacy. Over 80 international engagements were conducted in FY13, primarily focused on Africa and Asia-Pacific.

5) Leadership Development: 64% of Army Medicine leaders are assigned to MTFs. In accordance with Army regulation (ADP 6-22, Army Leadership), all AMEDD officers are expected to lead, but most do not have the opportunity to acquire traditional leader development experiences by serving in positions such as platoon leader, company commander, and primary staff. MTFs serve as the primary formation through which critical leadership development occurs. Leadership is developed within the

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AMEDD by utilizing key positions located in the MTFs to provide a leader experience in support of the three domains of leadership. Leaders in our MTFs also provide the subject matter experts required for the Army Emergency Management Program (EMP) at each installation.

6) Telehealth (TH): The Army is providing tomorrow's medicine today through the use of TH. Approximately 95% of our TH encounters globally are provided by clinicians in MTFs. Overall, TH supports many elements of readiness. First, TH supports a medically deployable force through increasing provider proficiency and currency. For example, our garrison-operational teleconsultations system and Pacific Asynchronous TeleHealth (PATH) provider-provider consultation platform enable our clinicians to diagnose and treat conditions found across the globe. This helps our clinicians maintain their wartime skills by preparing them to provide care in support of combat operations in remote locations. Additionally, our MTF-based garrison clinicians support our deployed clinicians by providing consultation support through Army TH garrison-operational reach back systems. Further, operating on a global scale enables Army Telehealth to cross-level clinical care capacity for routine and emergent needs. As an example of the latter, after the recent Ft. Hood incident, clinical support from Washington D.C., Honolulu, and San Antonio were surged via tele-Behavioral Health to support our Soldiers at Ft. Hood, Texas. Overall, in FY13, Army TH provided over 34,000 patient encounters and teleconsultations in garrison and operational environments across 18 time zones and in over 30 countries/territories. It would be challenging for a civilian health care system to be able to replicate this capability due to (a) civilian licensure and malpractice laws; (b) lack of global provider panels; and (c) lack of worldwide system integration on a single electronic medical record.

(7) Training Deployable Unit Personnel: Across the Army, over 17,229 medical personnel are assigned to deployable medical units, Brigade Combat Teams, and other maneuver or maneuver support units. On a regular basis, these medical personnel formally or informally train in or rely on the presence of a local Army MTF or Army Dental Treatment Facility to hone Medical Skills Readiness or collaborate within the context of an integrated health care system.

b. Readiness of the Total Army Force: Army Medicine is a critical enabler to the Army in maintaining and improving readiness. In light of health-related population demographics in the United States, efforts to optimize human performance are becoming increasingly important. A proactive, wellness-based system working collaboratively with unit commanders to optimize human performance is a readiness

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imperative. MTFs and components of the system provide the following value toward achieving readiness of the force:

1) Medical Readiness and Profiles: Army MTFs played a key role in enabling the Army to attain an 84.5% fully medically ready rate. Through standardization across all readiness platforms, the Army has increased overall Medical Readiness from 73% in March 2012 to the current 84.5%. During that time period, the Army has standardized the utilization of electronic physical profiling (eProfile) which allows commanders to view the physical limitations affecting readiness immediately. There are currently over 225,000 Soldiers with electronic profiles and the eProfile system is utilized by almost 43,000 users across military treatment facilities and Army commands.

2) Military Specific Care: The Soldier Centered Medical Home (SCMH) is the medical readiness platform for our Active Duty Soldiers. By FY16, 398K Soldiers will receive their care within an SCM. The SCM utilizes a team-based model that incorporates behavioral health, physical therapy, clinical dieticians and clinical pharmacists to maximize health and readiness. The model also incorporates medical assets in Brigade Combat Teams and other deployable units with MTF personnel in order to deliver comprehensive care that is tailored to the Soldier and unit's needs. The SCM model has already demonstrated a 3% decrease in Soldiers that are classified as not medically ready. This percentage is equivalent to an additional Brigade Combat Team of Soldiers who are now medically ready to deploy. SCMs have also decreased polypharmacy rates by 7% and improved continuity with primary care managers by 7.4%. The primary advantage of the SCM model is the team's understanding of the unique Soldier medical readiness requirements and direct communication with unit leaders.

3) Behavioral Health: A Behavioral Health System of Care (BHSOC) cannot be purchased. Since 2011, the Army has transformed its Behavioral Health (BH) clinics from a traditional, hospital-based operation, similar to that found in the civilian sector, into a forward-positioned, cohesive system of care tailored to meet the specific needs of Soldiers, family members and line leaders. In total, this effort has successfully increased overall BH utilization from approximately 900,000 encounters in FY07 to over 2 million in FY13 and led to numerous advancements in quality and continuity of care. With more Soldiers receiving care in the outpatient setting, BH conditions are being managed earlier, before crises occur. At the 10 largest CONUS installations where the Army has implemented the BH system of care, Soldiers required 28,057 fewer inpatient psychiatric bed days (103,904 in FY12 and 75,847 in FY13) resulting in an estimated cost savings of approximately \$31.9M. While still an area of significant concern,

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suicides by AD Soldiers decreased from 165 in CY12 to 126 in CY13 and continue to trend downward in CY14. A similar transformation and expansion would never have been possible through the civilian sector. In addition, nearly 100% of BH care for Soldiers, family members and retirees stationed in Germany, Japan and other OCONUS locations is provided through Army MTFs. Army Behavioral Health is a national leader in integrated, outcome-driven care that provides value and supports readiness in ways that could not be replicated in the private sector.

4) MTF-Based Research: A key to the treatment, restoration and rehabilitation of our wounded warriors has been the ability to research how to optimize treatment and care. MTF-based research programs provide essential data for Army and DoD strategic readiness decisions, such as return to duty, suicide prevention, and disease prevention. Of particular note, military MTFs are the only sites with a confluence of wounded warriors where such research can be conducted; if care for our wounded warriors is conducted outside our MTF structure, the cost of conducting trials focused on this unique population would be prohibitive with life-saving and health-restoring medical advances suffering as a result. Researchers from around the world seek opportunities to conduct research within our MTFs, with our providers, and with our patient population for this reason. There are more than 1,200 ongoing research studies being conducted within our Army MTFs seeking better solutions to treat and care for our wounded. Of the more than 1,200 ongoing studies, 115 are research initiatives directed by the Army and other federal entities, and 40 of the 115 are multi-site clinical investigations.

5) System For Health Transformation: Army Medicine is executing a strategic shift from a healthcare system to a System for Health. The shift requires a cultural change within the entire health delivery system in order to successfully accomplish and model a cultural change in the beneficiary population that improves health and readiness. A secondary effect of the System for Health is intended to be a reduction in long-term costs to the DoD as patients take greater personal responsibility for their overall health. The System for Health will enhance health and individual readiness to ensure combat readiness. Army Medicine will accomplish this through 1) the Performance Triad which focuses on sleep, activity, and nutrition to optimize human performance directly impacting the readiness of the force, 2) focusing on the delivery of health to optimize reconditioning of warriors after injury or illness, and 3) ensuring healthy environments which serves as a foundation to enable the health of Soldiers, Families, and Retirees. Army Medicine is leading the transition through cultural change toward the System for Health to optimize the performance of our Soldiers and enhance readiness.

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6) Preventing Loss of Training Hours/Days: Directing Soldiers to off-post civilian health care facilities will increase the loss of training hours (time away from the unit) due to increased travel time requirements. The magnitude of this is significant; Soldiers attended 122,119 physical and occupational therapy appointments in military medical facilities proximate to their place of duty in March 2014 alone.

3. Conclusion: In summary, great caution should be exercised relative to impacting the complex, interdependent system of care represented by Army Medicine. Our MTFs serve as readiness and training platforms. Our entire beneficiary population serves a vital purpose to the security of our nation by ensuring both the readiness of our Soldiers and proficiency of our medical force for the combat casualty care mission. Significant changes to the network of MTFs will have an impact on the ability to maintain a ready and deployable medical force and deliver world class combat casualty care. Impacting this system of care may have an unintended effect on Soldier morale and the will to fight that comes from knowing that a capable medical system stands ready to render world class care. There are access to care risks associated with increasing reliance on the civilian healthcare network when both Affordable Care Act (ACA) and Veterans Administration beneficiaries are also increasing the use of those networks, particularly in medically-underserved areas. Army Medicine must continue to maintain the trust of our beneficiaries, the Army and the American public while preparing for future National Security requirements. We must do everything possible to ensure that the start of any future conflict is highlighted by a ready and deployable medical force and the readiness of the Total Army Force.

Prepared by LTC Peder Swanson / (703) 681-4677

Approved by: BG Sargent