

POSTURE STATEMENT BY
LIEUTENANT GENERAL RONALD R. BLANCK
THE SURGEON GENERAL
UNITED STATES ARMY

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THE ARMY SURGEON GENERAL

ON HEALTH CARE IN THE UNITED STATES ARMY

Mr. Chairman and members of the Committee, I am Lieutenant General Ronald R. Blanck and I appreciate the opportunity to address this committee once again. I consider it an honor to have served as the Army Surgeon General for the past three-and-one-half years and to lead the Army Medical Department into the twenty-first century. I have seen tremendous changes in the delivery of healthcare since my first years of providing care to sick and wounded soldiers some thirty years ago in Vietnam.

It is a privilege to serve with the Army Medical Department team and I am extremely proud of our ability to keep our focus on providing quality healthcare to soldiers, retired and active, and their family members.

The Army Medical Department has demonstrated its capability to support the Army on the battlefield and in garrison. I would like to highlight these capabilities and the challenges that Army Medicine faces today and in the future, in the context of five initiatives I actively promoted during my tenure as the Surgeon General– READINESS, ORGANIZATION, VALUING PEOPLE,

TECHNOLOGY and TRICARE. An additional area I am committed to, and will discuss in detail, is the QUALITY OF HEALTHCARE.

READINESS

The Army Medical Department has developed a mission statement that stands on three legs; Protect and sustain a healthy and medically protected force, train, equip and deploy the medical force, and manage and promote the health of the soldier and the military family. These provide a convenient way to organize an overview of our current status and future plans. When not in combat, the Army Medical Department strives to keep soldiers “fit to fight” and to keep medical units and personnel ready for combat and demanding operations other than war, both humanitarian and peacekeeping. These missions mesh seamlessly with the Army Medical Department’s day-to-day work.

Hands-on, real-life experiences with a variety of people and with a variety of illnesses and injuries in real patient-care environments enhances our ability to provide our soldiers top-quality care in active operations. On a typical day in the Army Medical Department, we see:

- 1,764 patient occupied beds
- 40,386 clinic visits
- 41,400 dental procedures
- 476 admissions
- 6,012 immunizations

- 68 births
- 41,693 x-rays exposed
- 57,577 laboratory procedures
- 5,577 veterinary outpatient visits
- 66,942 pharmacy procedures
- \$21 million worth of food inspected

When our field hospitals deploy, most clinical professionals and support personnel come from the Army Medical Department's fixed facilities. Typically, our deployments are not in support of traditional combat scenarios, but rather for humanitarian assistance, peacekeeping and other stability and support operations. All the while, we must maintain day-to-day health care for soldiers, retired soldiers and their families. Under our Professional Officer Filler System, we send up to 26 percent of our physicians and 43 percent of our nurses to field units during a full deployment. To replace Professional Officer Filler System losses, Reserve units and many Individual Mobilization Augmentees (non-unit Reservists) are mobilized to work in our Army Medical Department facilities.

Many National Guard and Army Reserve units deploy in support of the Army Medical Department. The Army depends heavily on its Reserve Components for medical support. About 65 percent of the Army's medical forces are in the Army Reserve. We are truly an integrated healthcare system that deploys to war. Executing and sustaining these complex missions without loss or

interruption of service to our soldiers, families and retirees is a challenge we address on a daily basis.

The success of the Active Component to Reserve Component Professional Officer Filler System Program initiative is essential to support deployment of Reserve Medical Units. This initiative provides temporary active component Professional Officer Filler System personnel to fill vacant, critical Reserve Component positions. To alleviate critical Reserve Component personnel shortfalls, the United States Army Medical Command, in conjunction with United States Army Forces Command and United States Army Reserve Command, is in the process of developing and implementing this initiative, which will temporarily sustain Reserve Component units until critical shortages are filled. This initiative will improve the readiness level of more than half Reserve Component units.

Recruiting and retention are my continuing areas of concern. From late 1995 to early 1998, the Army Reserve lost 34.2 percent of physicians assigned to units sent to the Balkans. Two physicians departed for every new one recruited. To augment the excellent work of the Recruiting Command, the Army Medical Department began using Reserve recruiters, under contract, in certain locations to recruit the health professionals we need.

Surveys showed us that 81 percent of physicians could serve up to 90 days without incurring serious harm to their medical practices back home. Beyond 90 days, economic consequences to their practices begin to show a negative impact.

Because this caused an erosion of Reserve medical capability, the Army allowed the Army Medical Department to test a 90-day deployment policy for three years. The 90-day policy applies to physicians, dentists and nurse anesthetists who are involuntarily called up under a Presidential Selected Reserve Call-up. This policy does not apply to a partial, total or full mobilization. The first unit deployment under the 90-day plan will occur next September. In September 2002, the Army Medical Department will provide a final report to the Army on the policy's effect on recruiting and retention with recommendations.

Medical readiness tracking was a concern of mine, therefore, I directed the development of a centralized, automated medical readiness tracking system. This hugely successful, Army-wide Medical Protection System, tracks immunization data. The readiness module incorporates the already existing dental readiness classification system and collects all relevant factors of medical readiness identified by commanders and tri-service medical panels. This web-based system, accessible to the Army chain of command, provides commanders and supervisors with an invaluable tool to assess and manage unit medical readiness. No other health service in the world can replicate this capability.

Clearing the battlefield continues to be one of my highest priorities. Rapid transport of injured soldiers to definitive trauma care saves lives. The air and ground platforms designed to evacuate our wounded from the battlefield have not kept pace with the modernized force and can no longer guarantee rapid, modern

day, battlefield evacuation. Studies conducted on combat injuries clearly indicate prompt treatment and evacuation significantly reduce mortality rate. Nuclear, biological and chemical weapons on the battlefield significantly delay evacuation and require altering the mix of battlefield evacuation resources. To meet this prospective challenge, we are working to modernize evacuation platforms.

The UH-60Q is the number one near-term medical evacuation modernization issue for the Army Medical Department. It improves the medical, navigation, communication and treatment platform capabilities of our current UH-60A aircraft. With the UH-60Q, we significantly improve our capability to evacuate casualties from as far forward as the tactical situation permits, conduct combat search and rescue, transport medical material and teams on an emergency basis, and perform the shore-to-ship evacuation missions.

The UH-60Q program received partial funding in the 1999 Program Objective Memorandum, with funding starting in 2002. Additionally, we have a coordinated effort with the Army aviation community to align the UH-60Q production with the UH-60 Service Life Extension Program. As a result, we will gain a better performing aircraft; have commonality across the utility fleet; and save Research, Development, Test and Evaluation dollars.

The total objective force requirement is 387 medevac aircraft - 357 for the warfight and 30 for the operational readiness float count. Of the warfight 357, 192 go to the active component and 165 to the reserves. Current modernization

funding projections for the UH-60Q complete the 132 aircraft requirement for Force Package One by 2010 and the 150 aircraft in Force Package Two by 2020.

ORGANIZATION

We are continuing to refine our organizational structure to perform our mission in the most efficient and effective manner. The merger of the Medical Command Headquarters and the Office of The Surgeon General, in 1997, to create one staff under the authority and command of The Surgeon General, dual-hatted as the Medical Command Commander, is an undeniable success. It eliminates duplication, streamlines the process, and improves productivity and outcomes.

Our commitment to continuous quality improvement continues as we examine the feasibility of mirroring our Regional Medical Command structure with TRICARE Lead Agents. The Lead Agents are increasingly important organizations for coordinating health care throughout the Army, Navy and Air Force.

One way we are operating more efficiently is through closer cooperation with the Department of Veterans Affairs. The Army and Department of Veterans Affairs are benefiting from more than 130 Resource Sharing Agreements, at least 35 Memoranda of Agreement or Understanding and nine Interagency Support Agreements. These various kinds of agreements have different administrative and

funding details, but all involve using resources of both departments more efficiently.

The Army must maintain a number of deployable, fully staffed, combat support hospitals to meet the early bed requirement to support two nearly simultaneous Major Theater Wars as required by the National Military Strategy. Other Combat Support Hospitals are given "Caretaker" status and must be able to rapidly deploy within 30 days to round out the required number of beds needed to support the warfighting force. This helps maintain clinical skills and makes the best use of personnel to meet the daily demand for healthcare. Each Caretaker Hospital, with the staff working in the fixed facility, provides approximately \$24 million worth of healthcare per year to our beneficiaries. Reserve personnel will mobilize to staff the fixed hospital when its active personnel deploy with their Caretaker Hospital. Reserve personnel train with the hospital during their annual training period.

In 1998, we organized an array of Special Medical Augmentation Response Teams (SMART) Teams in our regional medical commands and major subordinate commands. These functional teams provide small, rapid-deployment capabilities and provide global coverage to Department of Defense, local, state and federal agencies responding to Weapons of Mass Destruction, terrorist, natural disaster and other complex emergencies. Special Medical Augmentation Response Teams provide expertise in the areas of trauma, burn injuries,

chemical/biological casualties, stress management, communications, telemedicine, preventive medicine, disease surveillance, veterinary care and health facility planning.

VALUING PEOPLE

The Army Medical Department strives to provide an atmosphere for people to reach their potential, and to have opportunities for personal and professional satisfaction. We endeavor to give our people just rewards and continually promote training challenges for our soldiers and civilians.

Three years ago, the Secretary of the Army approved my request to change restrictive Army regulations pertaining to the command of medical treatment facilities. Although veterinary, dental, aviation, garrison and logistics commands generally remained corps specific, virtually all other commands became Army Medical Department corps immaterial. The implementation of corps immaterial commands within the Army Medical Department presented the first opportunity for Army Medical Department officers to compete for commands designated as corps immaterial. Results of these boards yielded increased command opportunities for highly qualified Medical Service, Army Medical Specialists Corps, and Army Nurse Corps officers. In addition, the Army Medical Department identified and opened appropriate non-command senior leadership positions to the best-qualified officers of each Army Medical Department Corps.

A phased implementation of new standards to train all medical soldiers for combat support began October 1, 1998. These new standards are not intended to revolutionize the substance of training, but rather to ensure wider understanding of requirements and greater consistency in implementation. The eight standards relate to survival skills, weapons training (for selected personnel), collective training, competency-based orientation, Deployable Medical Systems training, job-specific medical training, job-specific readiness training and Medical Force Doctrine.

The Army is the executive agent for the Department of Defense program to immunize all United States military personnel against the grave and urgent threat of “weaponized” anthrax. The Anthrax Vaccine Immunization Program began in March of 1998 for all military personnel assigned, attached or scheduled to deploy to the 10 designated high-threat countries within the Arabian and Korean peninsula. Our Anthrax Vaccine Immunization Program Agency provided execution and management oversight of over 1.4 million immunizations delivered safely to over 391,540 Service Members worldwide. Less than 500 adverse events, mostly local, temporary reactions, have been formally reported since March 1998. This represents a safety profile similar to most common vaccines.

Each adverse event is reviewed by an independent committee of national experts commissioned by our Anthrax Vaccine Immunization Program Agency

and represents an unprecedented level of effort to ensure the health of our soldiers is protected.

Through our direct efforts, we successfully coordinated, staffed and synchronized the Federal Strategic Force Health Protection Initiative with the Army, Veterans Affairs, and Department of Health and Human Services. This nationwide network of Department of Defense, Veterans Affairs and Federal Occupational Health clinics allows us to provide not only the anthrax vaccination, but also medical and dental support to the Reserve components within reasonable distances of individual members.

The Army tracks all immunizations, to include the anthrax immunizations, through the Medical Protection System. Medical Protection System is an internet based, automated immunization tracking system allowing the Army to track all immunizations by name, location, dose, route, provider and lot number. There is literally no health organization in the world matching this accomplishment.

We provided numerous tools and media to the Army to meet their Anthrax Vaccine Immunization Program leadership and healthcare provider educational goals. We are confident that every soldier receiving the anthrax immunization receives information materials, has opportunities to ask questions and is informed on the process for reporting adverse reactions. Our comprehensive education initiatives include an internet web site, www.anthrax.osd.mil, a toll-free information hot line; and an effective speakers bureau.

TECHNOLOGY

We are enthusiastically incorporating advanced technology into the way we provide world-class care to our patients. Some of our initiatives are:

- The Medical Personal Information Carrier will store Service Member medical and personal information. It facilitates seamless, permanent recording and transfer of information in peacetime and on the battlefield. A demonstration of the Personal Information Carrier was conducted in a field environment in December 1999. The demonstration clearly showed the ability of the Personal Information Carrier to accept, store, and transfer battlefield medical care information. The next step is to incorporate this technology into our doctrine and practice both in deployed settings as well as home station. Further demonstrations are planned for this year.
- A dry fibrin sealant bandage was developed by the United States Army Medical Research and Materiel Command in cooperation with the American Red Cross. The bandage is made from the last two proteins in the human blood coagulation cascade, and freeze-dried on absorbable packing. The bandage will set a clot within two minutes and research shows it can reduce blood loss by 50 to 85 percent. The United States Army Medical Research and Materiel Command is working multiple protocols, with several potential manufacturers, to determine the ultimate capabilities of this novel product.

- A high-tech litter with resuscitative and life-sustaining capabilities, which allows field surgery and care en route during evacuation. The Life Support for Trauma and Transport prototype was approved for human use by the United States Food and Drug Administration. This approval permits greater evaluation in actual hands-on treatment situations in both a forward deployed environment, such as Kosovo support, as well as civilian trauma centers under the control of patient informed consent guidelines. These evaluations follow Department of Defense acquisition demonstration methodologies to gather user feedback and design considerations early, quickly, and effectively.
- Telemedicine is a technology to efficiently leverage healthcare delivery over long distances. The aims of this technology are to improve quality, improve access, enhance provider and patient satisfaction, and reduce cost. Most of Army Medical Department telemedicine is store-and-forward technology usually sent over the internet; this involves the capture of still images via digital camera attached to a personal computer. Tertiary care physicians can review the images, render a diagnosis and return the diagnosis back to the referring physician via the internet. There are more than 50 projects being done in the Army Medical Department. The majority of projects are in the areas of radiology, dermatology, and

psychiatry and teledentistry. The projects can be reviewed at the following website: <http://www.tatrc.org/paaes/projects/armypoi.html>.

- As I previously mentioned, the Medical Protection System, a Medical Occupational Data System application, has been a highly successful centralized system to record, report, and archive soldier and unit readiness.
- The Ambulatory Data System captures diagnosis and procedure information on outpatient visits. Capturing this more detailed clinical information is critical for decision-making and to support our new costing methodology.

TRICARE

TRICARE, the Department of Defense's managed-care initiative, is now fully operational worldwide. Implementation has been a challenging journey since the first TRICARE contract became operational in March 1995 at Madigan Army Medical Center, in the Northwest Region.

This program is gaining momentum and we want TRICARE Prime to be the number one choice of beneficiaries. To reach that goal, we will continue to stress quality of care, ease of access and customer-focused service.

A study of the Northwest Region, where TRICARE is most mature, revealed increases in the use of preventive care, obtaining care when needed and satisfaction in making an appointment. There was a decrease in use of the

emergency room as a walk-in clinic, keeping it free for true emergencies. Most beneficiaries surveyed reported they were satisfied with the quality of their care.

We are forging closer relationships between the services and the TRICARE Lead Agents to ensure issues requiring immediate action are handled without delay. And, as TRICARE continues to mature over the coming years, I am confident it will produce the desired benefits in terms of healthier military beneficiaries.

One excellent example of increased cooperation is the many Veterans Administration (Veterans Affairs) facilities participating as TRICARE providers. Veterans Affairs is treating outpatients in community-based clinics at Fort Belvoir, VA., and Fort Leonard Wood, MO. Tripler Army Medical Center provides care for most veterans in the Pacific region. A Joint Venture there includes a renovated wing for administrative services, an ambulatory care center and a 60-bed "Center for the Aging" facility. Veterans Affairs patients receive easier access to care, and both agencies benefit by expanding training and research opportunities. This is truly a "win-win" partnership.

Another highlight of 1999 was the full implementation of the TRICARE Senior Prime demonstration (sometimes known as "Medicare subvention"), which began in selected locations throughout the Department of Defense. Army medical treatment facilities participating are at Madigan Army Medical Center, Tacoma,

Washington; Brooke Army Medical Center, San Antonio, Texas; Fort Sill, Oklahoma; and Fort Carson, Colorado.

Medical treatment facilities in the six participating TRICARE regional sites phased into the test as each site received Health Care Financing Agency approval as a Medicare+Choice plan. Healthcare delivery for TRICARE Senior Prime, began on September 1, 1998. The last site phased into the program on January 1, 1999. The demonstration is scheduled to end December 31, 2000. The collective target enrollment was 27,800 persons; currently 29,325 persons are enrolled, including some who have "aged" into the program.

The purpose of this three-year program is to deliver accessible, high-quality care to people eligible for both Medicare and military medical benefits, without increasing the total federal cost to either Medicare or the Department of Defense.

The Department of Defense continues to provide the level of care it has historically provided for these "dual-eligible" patients, as a precursor to retention of Medicare interim payments. The General Accounting Office and DoD evaluations will shed more light on the financial methodology and reimbursement mechanisms supporting the demonstration.

The FY 99 National Defense Authorization Act authorized several demonstration projects for the Military Health System. The first is three-year demonstration of Federal Employee Health Benefits Program from 2000-2002. The Department of Defense/Federal Employees Health Benefits Program

demonstration will include a maximum of 66,000 Medicare-eligible military retirees and family members in the following geographical areas: Dover, Delaware; Fort Knox, Kentucky; Dallas, Texas; Greensboro-Winston Salem-High Point, North Carolina; Puerto Rico; Camp Pendleton, California; Humboldt County, California area; and New Orleans, Louisiana.

The Fiscal Year 1999 National Defense Authorization Act specifies separate risk pools for Department of Defense/Federal Employees Health Benefits Program demonstration from other Federal Employees Health Benefits programs. Therefore, premiums may be higher for fee-for-service plans and experience-rated Health Maintenance Organizations in the Federal Employees Health Benefits Program demonstration than those in the Federal Employees Health Benefit program. The rates will probably equal that of community-rated Health Maintenance Organizations. Government contributions for demonstration premiums may not exceed the amount of contributions payable if the beneficiary were an employee enrolled in the same Federal Employees Health Benefit Program. Federal Employees Health Benefits Program Demonstration Program Premium Rates for Year 2000 rates can be found at www.tricare.osd.mil/fehbp. Mailings announcing the program were provided to beneficiaries in early October 1999.

Open season for enrollment that opened in November was extended to January 2000. Additional Federal Employees Health Benefits Program

enrollment/information fairs will be conducted in demonstration sites. Current enrollment as of December 1999 is approximately 1,500. The Federal Employees Health Benefits Program-Military demonstration began on January 1, 2000. A toll-free call center to answer questions and provide information was activated in September 7, 1999 (1-877-DOD-FEHB).

The minimum period of enrollment in the Department of Defense/Federal Employees Health Benefits Program is three years. Participants need not be enrolled in part B of Medicare. Beneficiaries covered under the Department of Defense/Federal Employees Health Benefits Program demo are not eligible to receive care at a medical treatment facility or through the TRICARE program, including mail-order pharmacy.

The National Defense Authorization Act for Fiscal Year 1999 also authorized a three-year demonstration of a TRICARE Senior Supplement Demonstration Program. Medicare will be the first payer for payment of care and services received by the eligible individuals. TRICARE will be the second payer. The pilot program will be located in Cherokee, Texas and Santa Clara, California.

Finally, The National Defense Authorization Act for Fiscal Year 1999 authorized a TRICARE Pilot Pharmacy Benefit. The pharmacy demonstration program will provide Medicare-eligible beneficiaries who enroll in the program access to network retail and mail order pharmacy benefits. The pilot program will be located in two counties: Okeechobee, Florida; and Fleming, Kentucky.

In 1999 there were important improvements in the process of health care delivery for remotely assigned active duty service members within CONUS. The TRICARE Prime Remote program began in October 1999.

TRICARE Prime Remote is the new healthcare delivery program designed to improve access to healthcare for active duty service members who reside and work more than 50 miles, or one-hour drive time, from a military medical treatment facility.

The regional managed care support contractors are currently enrolling remote active duty service members into TRICARE Prime Remote. The enrollment process is not automatic. An enrollment form must be completed by the soldiers and submitted to the managed care support contractors. The regional Lead Agents and unit commanders play a critical role in identifying eligible members, and facilitation the enrollment process.

Enrolled active duty service members are provided access to civilian providers for primary care where contractor primary care networks exist. In places where there are no networks, service members may get primary care services from any TRICARE authorized provider.

Pre-authorization for primary care is not required. Primary care includes services for acute care (for example, colds, sinus infections), management of stable, chronic problems (high blood pressure), preventive care (for example, wellness examinations), and acute injury (for example, cuts, ankle sprains).

Pre-authorization is required for specialty care (for example, referrals for orthopedics, surgery, mental health, obstetrics, etc.). When specialty care is needed, the primary care provider or the service member contacts the managed care support contractor's Health Care Finder via a 1-800 number. Before authorizing the specialty care, the Health Care Finder will contact the Military Medical Support Office. The Military Medical Support Office is a tri-service staffed central office that provides military oversight for all remote active duty service members health care. If the soldier has an illness/condition that has fitness for duty implications, the Military Medical Support Office will direct the Health Care Finder to authorize the care at a medical treatment facility only. If the illness/condition is not a fitness for duty issue, the Health Care Finder is directed to authorize that care be provided locally. Care is automatically authorized if the process takes more than 48 hours. If specialty care is clinically required in less than 48 hours, the active duty service member may proceed with the care and a retrospective review will be done to determine potential fitness for duty implication.

Medical and dental care is covered along with prescription drugs and there are no cost shares or deductibles. In cases where up-front payment is required, the active duty service member submits a claim to the managed care support contractors (for medical claims) or the Military Medical Support Office (for dental claims) for full reimbursement.

A program that includes the family members where network providers exist (the Geographically Separated Unit program) is already in place in Regions 1, 2, 5, and 11. Expansion of the program for family members in the other Regions is projected for late FY 2000 pending enactment of necessary legislative authority. The proposal would provide eligibility for the program and enhanced access, even in areas where there are not network providers.

Better financial decisions will be made with an accurate count of beneficiaries enrolled in TRICARE Prime through each facility, and with the ability of the Corporate Executive Information System to keep "score" of resources expended. However, there is a bottom below which we cannot responsibly go. Our priorities must be to provide quality medical care, to keep faith with our service members and to invest in the future so the quality of our medical program will keep pace with advances in medical science. The Administration will present a legislative proposal to this effect this spring.

In 1999, I whole-heartedly participated in a senior level cooperative effort with my fellow Surgeons General and the Department of Defense to develop a more integrated health services delivery system that emphasizes effective use of medical treatment facilities, focusing on beneficiary expectations and satisfaction. The result was the Military Health System Optimization Plan. We all agreed to implement the critical components of the plan as quickly as possible.

With the first generation of managed care contracts in place and current versions of the managed care support contracts beginning to elapse, the Military Health System Optimization Plan supports the next generation of TRICARE 3.0 support contracts that put in place needed TRICARE improvements. TRICARE 3.0 is a two and one half-year evolution to move away from highly prescriptive government requirements and processes. The beneficiary's satisfaction is at the forefront with mandatory performance outcomes. The contracts will include a more effective mechanism for holding contractors to contract terms. The elaborate and complex funding mechanisms of current Military Health System contracts are simplified under TRICARE 3.0.

The goal of TRICARE 3.0 is to migrate to a contract vehicle that has appropriate financial incentives to support the military direct care system in the recapture of purchased care. Specifically, TRICARE 3.0 strives to streamline the funding mechanism to better focus risks and financial incentives between the direct care system and contractor so that overhead cost is reduced. TRICARE 3.0 provides the contractor bonus incentives for superior performance to include performance linked to beneficiary satisfaction. The new contract vehicle moves away from prescriptive government requirements and allows the use of best business practices.

Although much thought and energy has been invested in TRICARE 3.0 development, there are some key concerns. The objectives-based contract

methodology chosen for TRICARE 3.0 works well for building aircraft, but has never been tried in a large medical service contract such as this one. Managed care commercial best practices are not standardized and may produce confusion for beneficiaries as they move from region to region. TRICARE 3.0 is anticipated to live up to the expectation that it will really fix the problems encountered in the execution of past contracts and produce a more cost effective and patient friendly healthcare system.

QUALITY OF HEALTH CARE

I would like to discuss the issue of quality of health care. Two years ago, we collectively agreed to improve healthcare by implementing thirteen quality points. I would like to report that the Army Medical Department continues to make improvements in the delivery of quality health care in the following areas:

Phase out accessions and deployment of general medical officers. To ensure clarity, a general medical officer was defined as a physician who has completed one year of graduate medical education and is serving in a non-training status. In 1998 there were 476 general medical officers in the Army. In 1999 there are 291. They serve as brigade surgeons, flight surgeons, and in clinics and hospital. At this time about 60% of these billets have been converted. A detailed study of all current general medical officer billets will be done, by the Medical Corps Branch at United States Army Personnel Command, to determine by site which positions still require conversion. Changes have also been made in graduate medical

education to decrease the number of individuals in nonspecific internships. This decreases the numbers available to serve as general medical officers. A complete elimination of general medical officers is not necessary as long as adequate oversight and opportunity for consultation and continuing education is available.

Establish centers of excellence to provide improved patient outcomes for complicated surgical procedures. The Assistant Secretary of Defense for Health Affairs established policy in 1995 for the implementation of the Specialized Treatment Program. The goal is to promote the highest standard of care throughout the Military Health System. A medical treatment facility could be designated as a national or regional Specialized Treatment Services facility. Assistant Secretary of Defense for Health Affairs established policy in 1997 that only medical treatment facilities designated as Specialized Treatment Services facility could continue providing health care in one or more 20 designated Diagnostic Related Groups. In 1998, Assistant Secretary of Defense for Health Affairs expanded the Specialized Treatment Services policy to include Center of Excellence designation. This enabled non-Specialized Treatment Services facilities to continue providing clinical care in one or more of the designated Diagnostic Related Groups.

Immediately resolve all malpractice and adverse action cases pending and file complete reports to the National Practitioner Data Bank where required. The Headquarters, United States Army Medical Command is responsible for the

administrative processing of the medical malpractice claims backlog. The Command conducted an analysis of the claims management process. Process design changes specifically identified to eliminate and prevent the case backlog were implemented over the past year. The United States Army Medical Command allows ninety days for processing the case upon receipt of legal settlement/judgment and a standard of care determination by the Consultation Case Review Branch. All cases not processed within that time limit constitute the backlog and are prioritized for completion. There is currently no adverse action backlog. Reports were submitted to the National Practitioner Data Bank in cases where moneys were paid, the standard of care was deemed not met and a provider was identified. Seventy-three were filed during Fiscal Year 1999. There are currently ninety medical malpractice cases undergoing administrative processing at Quality Management-United States Army Medical Command

All military providers must have a valid, unrestricted and current license.

The Assistant Secretary of Defense for Health Affairs issued a memorandum dated January 29, 1999 that required all physicians to hold a full-scope license by October 1, 1999. All providers engaged in the independent practice of medicine are now required to possess a current valid and unrestricted license. There are no physicians with an Oklahoma Special license engaged in the independent practice of medicine in the Army. The United States Army Medical Command Quality Management Directorate began site visits to medical treatment facilities in

January to assess organizational management of compliance with licensure, and the process for dealing with the impaired practitioner.

Provide Service input for the Annual Quality management Report. The Department of Defense Quality Management Report is an annual requirement in which Department of Defense specified service data from each Army medical treatment facility (military treatment facility) is consolidated and provided to the Assistant Secretary of Defense for Health Affairs. This data is integrated with input from the other Services to complete the report. The anticipated date for the most recent draft to be ready for review by the Services is April 2000. When the draft has been approved by the Services the final report will be published.

Fully implement TRICARE by assigning all enrollees a primary care manager or team. All TRICARE Prime enrollees must be assigned to a specific individual care manager.

Generate a public report card at each facility sharing information concerning our Military Health System. The minimum elements that are required to be included are waiting times for major services, patient satisfaction at the medical treatment facility (overall satisfaction with clinics and overall satisfaction with medical care), Joint Commission on Accreditation of Healthcare Organizations Summary Grid Score and the selected Joint Commission on Accreditation of Healthcare Organizations Grid Elements in the areas of credentialing, assessing competence, infection control, and nursing. All Army medical treatment facilities

have reported that they are in 100 percent compliance with the requirement for the development of and displaying of the report card in their facilities.

Establish a healthcare council at each facility. The requirements for the healthcare council are that it be chaired by the medical treatment facility commander, include consumers from the military community, solicit and address concerns of the enlisted service member and their families and meet quarterly. The most recent update for the Department of Defense Healthcare Quality Initiatives Report indicated that 100 percent of the Army medical treatment facilities had fully implemented the requirements for the council.

Implement a directory of providers in a medical treatment facility specific patient information handbook that will be updated annually. The requirements for the directory are that the contents include medical treatment facility providers who are primary care managers as well as providers in specialty referral clinics who are most likely to receive consults from primary care managers. The design must conform to the template created by the TRICARE Marketing Office and be available to all prime enrollees. The most recent report on implementation of Department of Defense Healthcare Quality Initiatives indicated that 100 percent of the Army medical treatment facilities were in total compliance.

Place greater emphasis on the best clinical practices identified through our National Quality Management Program. National Quality Management Program initiatives to identify best clinical practices continue. The National Quality

Management Program completed baseline studies in Fiscal Year 1999, determining the extent of compliance with Department of Defense/Veterans Affairs and/or other national clinical practice guidelines so that the impact of implementing evidence-based disease management practice guidelines system-wide can be determined. The program will facilitate the benchmarking of Department of Defense facilities against their federal and civilian peer facilities on Department of Defense/Veterans Affairs Practice Guidelines and Department of Defense Putting Prevention into Practice evidence-based process and outcome quality indicators. The Joint Commission on Accreditation of Healthcare Organizations ORYX measurement program, Special Studies and the annual Quality Management Reviews continue to be utilized to benchmark Department of Defense facilities and identify best practices.

Place greater emphasis on direct use of clinical guidelines wherever appropriate. The Department of Defense's partnership with Veterans Affairs, to adapt and monitor the implementation of practice guidelines, continues to flourish. The Army Medical Department leads in the development of guideline "tool-kits" which facilitate provider implementation of adapted guidelines by "making the best way the easiest way." Tool kits incorporate provider point of care, patient self-management and process/system tools to support guideline utilization. Three tool kits have been developed through the coordinated efforts of Department of Defense/Veterans Affairs providers, with another under

development. The tool-kit supported Department of Defense/Veterans Affairs Acute Low Back Pain Clinical Practice Guidelines have been piloted in two Army Regional Medical Commands. The Army Medical Department implementing a system-wide deployment of the Department of Defense/Veterans Affairs Acute Low Back Pain Guidelines based on preliminary results from a pilot study conducted by the Army Medical Department and the RAND Corporation demonstrating improvements in access and quality. Early results include increased access to care due to efficiencies in Primary Care and Troop Medical Clinics and a decrease in inappropriate referrals to specialty care. From the quality perspective, there has been an increase in the quality of documentation of the care of patients with low back pain and identification of clusters of injuries so that primary preventive efforts can be targeted at identified work sites.

Honestly evaluate our weaknesses and immediately improve them. There is an ongoing quality improvement/reengineering effort to analyze, review and make recommendations on 29 initiatives that have been identified by Department of Defense for improving the Military Health System. The Reengineering Coordination Team published the Military Health System Optimization Plan to address these initiatives in February 1999. This Plan has been sanctioned by the Surgeons General in a memorandum for the Assistant Secretary of Defense for Health Affairs dated November 1999. The Optimization Plan provides the strategy for improving the efficiencies of the Military Health System and

improving the responsiveness to the line and the health of all the beneficiary population. Policy guidelines are being developed to support many of the critical reengineering components, including assignment of primary care manager by name; standardized enrollment, Health Enrollment Assessment Review survey implementation, and appointment processes; and improved data quality and clinic management. Clinical optimization has been addressed specifically in the Reengineering Coordination Team-chartered Population Health Improvement Plan, which is currently under review. The Reengineering Coordination Team has approved the Population Health Improvement Plan. This plan includes process elements covering the reengineering components noted above throughout the spectrum of care. Processes necessary to assure optimal population health and quality of life are addressed beginning with population needs assessment at enrollment, continuing through prevention and education, to efficient and timely intervention strategies. Implementation of the Population Health Improvement Plan in a demonstration project is forthcoming early in 2000. Lessons learned from this demonstration will serve to define a tri-service Military Health System Support Center to sustain optimal strategies, and develop and update relevant strategies and policies over time.

Work to improve our patient satisfaction through communication and education. This area is a part of TRICARE Operational Performance Statement and is tracked by region, facility and clinic at the Department of Defense level via

the annual and monthly Customer Satisfaction Surveys. Initiatives to improve customer satisfaction with quality include increased customer informational efforts and employee hospitality training initiatives. Customer informational handbooks, briefings, computerized presentations and a variety of other media mechanisms are used to inform beneficiaries of available services. Data is also solicited from each beneficiary regarding their satisfaction with services offered and access to care. One product that has been developed as a result of the focus groups is the TRICARE Personal Profile Program, an interactive CD-ROM that simplifies and personalizes the TRICARE message. The prime focus of customer service and thus of patient satisfaction must remain the provision of timely, efficient, high-quality care. These communication processes are also vital because they reassure beneficiaries who are not currently under care and provide specific, detailed, up-to-date guidance on how to use the system when care is needed.

The rate of medical errors has recently gained national attention. The Army Medical Department has implemented a wide variety of initiatives to prevent medical errors:

- The Unit Dose Drug Distribution System automated drug dispensing technologies, and the use of specially trained and certified Registered Pharmacists certified for preparation of IV admixtures and specialty drugs

(such as chemotherapy) are safeguards against medication errors. These have long been the standard of care in Army medical treatment facilities.

- All Adverse Drug Events are reviewed locally by the medical treatment facility Pharmacy and Therapeutics Committee with significant drug events reported to the Food and Drug Administration. The Department of Defense is currently working to implement the Pharmacy Data Transaction System, which will integrate all Department of Defense pharmacies, civilian retail pharmacies, and the National Mail Order Pharmacy in an all-out effort to prevent adverse drug events.
- Several “models of excellence” have been studied by the Department of Defense Pharmacy Board of Directors and adapted by the Army Medical Department to safeguard patients against medication errors. The Composite Health Care System provider order entry gets the right drug to the right patient by eliminating the errors inherent in hand-written prescriptions. Barcoding, and robotic technology for drug selection and labeling also decrease human error.
- Many of the safeguards generated by Composite Health Care System order entry system are also applicable in the clinical laboratory. In addition, the bi-directional interface of clinical analyzers (downloads orders from Composite Health Care System to the analyzer and uploads results back to Composite Health Care System) also significantly reduces transcription

errors. Presently, the Department of Defense Laboratory Joint Working Group has an initiative to standardize laboratory data and gain interoperability between Composite Health Care System host computers.

- In the Blood Bank arena, the use of barcodes has been one method of improving specimen identification processes. This has been emphasized throughout the entire laboratory. The sites with donor and/or transfusion functions have installed the Defense Blood Standard System supported computers to assist in the issue of blood products.
- Risk management assessment by the Quality Management Division focuses special attention on high volume, high risk, or problem prone procedures. Trends are analyzed for lessons learned and performance improvement. All medical treatment facilities use a systematic process (root cause analysis) to assess and evaluate significant events.
- Peer review process is a mechanism used in all medical treatment facilities to determine if standards of care were met when there is a question about appropriateness of practice. Findings from the process are used to educate staff, improve practice and implement changes to prevent further occurrences.
- A Congressionally funded pilot project to evaluate the MedTeam concept is underway at three medical treatment facilities. The MedTeam concept was modeled after the successful error prevention initiative in the aviator

community and uses a team based approach to reduce errors in the Emergency Department. Early results indicate as much as an 84% reduction in errors in those Emergency Rooms studied.

I would like to close this discussion by expressing my concern that past and future funding challenges facing medical facilities have the potential to contribute to reduced quality of care. The full support of maintenance, repair, renovation and replacement of aging inventory is the only way to avoid systems failures that disrupt the normal delivery of healthcare services and significantly increase future repair requirements and costs. Historical MILCON funding trends have shifted the burden to an already stretched Repair and Maintenance program to maintain facilities.

In conclusion, I believe today's Army Medical Department is more flexible and better prepared to meet diverse missions than ever before. I thank you again for the opportunity to testify today and for your continued support of our efforts to provide the finest quality of medical support to America's Army.