Military Health System
Strategy Insights

Issue 01 | 2017
A Roadmap to an Integrated System of Readiness and Health

STRATEGIC LOGIC OF THE NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2017
OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR (HEALTH AFFAIRS)

BACKGROUND
The National Defense Authorization Act (NDAA) for 2017 is an enabler of positive change that will help the Military Health System (MHS) more rapidly achieve its mission and vision while remaining true to an enduring strategy based on an integrated system of readiness and health that delivers the quadruple aim – improved readiness, better health, better care, and lower cost. Perhaps more importantly, the NDAA reinforces a wealth of lessons learned from the last 15 years of war that have helped us learn how to make the warfighter medically ready to deploy across the world at a moment’s notice and provide world class care anytime, anywhere. Thus, the NDAA will accelerate our pace of change while preserving constancy of purpose in serving the needs of the warfighter and all those entrusted to our care.

Recently, several studies have identified opportunities to enhance our strategy and accelerate the pace of change:

• 2011: Deputy Secretary of Defense task force studied options for the governance of the MHS, ultimately establishing the Defense Health Agency (DHA) and an integrated delivery model for the largest MHS markets.
• 2013: Modernization study identified opportunities to provide the right type of care at the right location to simultaneously support quality outcomes and maintenance of skills for the entire health team.
• 2014: MHS Review supported strategy but challenged the MHS to achieve better performance and reduce unwarranted variation by adopting the principles and practices of high reliability.
• 2015: Military Compensation and Retirement Modernization Commission (MCRMC) report suggested options for restructuring the TRICARE contracts to align with value and support joint force readiness.
• 2016: The 2017 NDAA, building on all that had come before, included over 40 sections related to improvements in the function and structure of the MHS.

While daunting in its complexity, the NDAA can be understood as a set of interdependent initiatives that, together, will help the MHS achieve its mission and vision. In this paper, we will present our understanding of the strategic logic of the FY17 NDAA in an effort to make visible the elegant simplicity on the far side of complexity contained in the 150 page document that Senator McCain has described as the “most sweeping overhaul of the Military Health System in a generation.”

“This year’s NDAA is the most sweeping overhaul of the Military Health System in a generation.”

U.S. Senator John McCain (R-AZ)
Chairman of the Senate Armed Services Committee
IT’S ALL CONNECTED
With so many provisions, it is possible to get lost in the individual sections and miss the larger strategic context. When we step back from Title VII, Section 701 or 702 or 703 or Section “whatever,” several overarching goals emerge – the imperative to ensure trained and ready providers to support the Joint Force; the need to deliver an improved experience to TRICARE beneficiaries; and the urgency to act as one enterprise. This paper describes how the various provisions work together to accomplish these goals.

1 DEFINE AND MEASURE CLINICAL READINESS
First, we will define and measure the clinical readiness of the health team. To optimize any system, we start with a clear and measurable definition of what the system is supposed to produce.

For the MHS, the base task is to determine the number of providers, with which skills, located where, who are needed to support operational plans. As such, we will specify the number of personnel required in each combat casualty care medical specialty (e.g., emergency medical services, pre-hospital care, trauma surgery, critical care, anesthesiology) and then develop a complete list, by position, of the military and dental personnel requirements necessary to meet operational medical force readiness requirements.

In addition, a major effort is underway right now to define, with much more specificity, what capabilities are required for each person to go to war and to respond to humanitarian and disaster crises – the “Knowledge, Skills and Abilities” or KSAs military medical personnel must have to deploy. The surgical community was the first to move out on this, and efforts are underway to develop KSAs for other specialties. The key to operationalizing KSAs lies in the work we are doing to link clinical procedure codes to KSAs which gives us a more powerful tool to quantify the relationship between workload and readiness. This work may lead to decisions about where we can best sustain these skills, as well as personnel sizing of a particular capability. In a future state, some staff will be Active Duty, some civilian and contractor, and some may come from the Reserves.

2 OPTIMIZE TRAINING PLATFORMS FOR READINESS
Second, with clinical readiness more clearly defined, we will optimize training platforms (our hospitals and clinics) to support the ready medical force. This includes determining which Military Treatment Facilities (MTFs) will be designated as Medical Centers (MEDCENS) – our primary training platforms for critical wartime specialties. These MEDCENS will have Level I or II trauma capability, function as tertiary or quaternary care facilities, and be the bedrock of military Graduation Medical Education (GME). Concurrently, we will do a full review of all GME programs to ensure proper focus and sizing to support operational medical force readiness requirements. Next, we will assess all other MTFs and classify them appropriately as hospitals or ambulatory care centers, based on the needs of the force and their families, and the capabilities of available civilian health care facilities.

As these decisions come into focus, we will develop implementation plans for markets and MTFs. These plans may include changes to medical services provided at MTFs, identify opportunities to fill gaps in readiness related workload that could be met by expanding care to Veterans and civilians, and review authorized strengths at MTFs including possible conversions of military to civilian billets.

Figure 01 - Overarching goals

<table>
<thead>
<tr>
<th><strong>Overarching goals:</strong></th>
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<tbody>
<tr>
<td>• Ensure a trained and ready health system to support the Joint Force</td>
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<tr>
<td>• Deliver an improved experience to TRICARE beneficiaries</td>
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<tr>
<td>• Act as one enterprise</td>
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<table>
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<tr>
<th>To start, we will...</th>
<th>Define and measure clinical readiness</th>
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<tr>
<td>Which allows us to...</td>
<td>Optimize training platforms for readiness</td>
</tr>
<tr>
<td>And...</td>
<td>Centralize administration and management of MTFs to enable greater focus on readiness</td>
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<tr>
<td>Which can only work if we...</td>
<td>Improve the patient experience so we are the venue of choice</td>
</tr>
<tr>
<td>All supported by...</td>
<td>Modernizing the TRICARE program to focus on readiness and value</td>
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Given that there are rich opportunities to continue or expand readiness training in civilian facilities, we will evolve partnerships with civilian academic medical centers and large metropolitan teaching hospitals to provide integrated trauma teams maximum exposure to patients with critical injuries. This builds on the existing relationships with state of the art trauma centers in Baltimore, Cincinnati, St. Louis, Miami, Los Angeles and elsewhere. Finally, given the criticality of having a trained and ready combat casualty care team, we will further develop our Joint Trauma System and establish a Joint Trauma Education and Training Directorate in the DHA, focused on standards of care, translating research to practice, and spreading lessons learned.

3 CENTRALIZE ADMINISTRATION OF THE MTFs

Third, we will centralize administration and management of MTFs to enable greater focus on readiness. The DHA will become responsible for the administration of all MTFs with regard to budgetary matters, information technology, health care administration and management, administrative policy and procedure, and other matters determined by the Secretary of Defense. The Services will then be able to focus on ensuring the readiness of the medical force. These changes will increase the level of functional integration (the extent to which key support functions are coordinated across the enterprise) and clinical integration (the extent to which patient centered health services are coordinated across medical specialties, sites of care, and time). While money is not the primary driver, we anticipate cost savings as waste is identified and removed from the system. To clarify accountability, we will develop common performance standards for military and civilian leaders in the areas of quality of care, access of beneficiaries to care, health outcomes, and safety.

4 IMPROVE THE PATIENT EXPERIENCE SO WE ARE THE VENUE OF CHOICE

An assumption in all of this is that the direct care system will continue to be the first choice to support readiness and with this in mind, the fourth part of our plan is to improve the MHS patient experience so that the direct care system is the venue of choice for TRICARE beneficiaries. Toward this end, ensure greater access to urgent care and expand primary care clinic hours to better align with what the working population is used to in the private civilian sector. A single system for scheduling appointments at MTFs – standardized throughout the MHS – will enable timely access to care for beneficiaries. And we will display wait time in pharmacies at MTFs, and in general strive to achieve the overall goal of eliminating waiting times for any service. One way to do that is to bring services to our patients not vice versa so we will drive the expanded use of telehealth.

While quality in U.S. health care has historically been assumed to be approximately equal across providers (because of intensive medical training, licensure, certification and accreditation) we are fully committed to being a leader in health outcomes, quality of care, and safety. We will adopt and share standard core quality metrics to ensure that we can continue to assess our performance relative to nationally accepted measures and benchmarks to eliminate undesired variability in health outcomes and improve quality at MTFs by documenting and spreading evidenced-based best practices. Finally, we will establish Military Treatment Facility Advisory Committees that will provide the facility’s leadership with advice on improving the experience of care; we are committed to co-creating our future integrated system of health and readiness with our patients.

5 MODERNIZE TRICARE TO FOCUS ON READINESS AND VALUE

The fifth part of our plan is to modernize TRICARE to focus on value and readiness. We will condense multiple plans into two comprehensive TRICARE options – a managed care option (Prime) and a no-referral network option (Select) – while ensuring no changes to out-of-pocket costs for the current group or retirees. We will develop an overall value-based care strategy that rewards quality, safety, experience, and health outcomes (rather than volume and intensity of treatment), and ensures that local, regional, and national health plans have opportunities to compete. The strategy will be implemented on all future managed care support contracts. Finally, we will establish high-performance military-civilian integrated health delivery systems in regional areas improve access, care, outcomes, and experience for patients while simultaneously helping military providers sustain and improve their skills.

IF READINESS IS WHAT MAKES THE MILITARY HEALTH SYSTEM UNIQUE - WE MUST KNOW HOW TO DEFINE IT.
The 2017 NDAA is a welcome prescription for the change that will transform the MHS to more rapidly achieve its long term strategy. The provisions in this NDAA work together, ensuring that a trained and ready health team fully supports the Warfighter and the Joint Force. In addition, these provisions deliver an improved experience to TRICARE beneficiaries and enable the MHS to act as one enterprise.

Our understanding of the critical strategic shifts brought on by the NDAA are recapped in Figure 2 - NDAA Change Agenda. Warfare is changing, medicine is changing, and we need to change with it. However, as we make the changes needed to sustain readiness, a few things remain constant. Our mission of maintaining readiness and ready medical skills is why we are in this business, why we have a direct care system, and will always be our highest priority. Moreover, we have important professional and statutory obligations to our beneficiaries: to receive the highest quality care and best health outcomes. This NDAA in all its complexity, simply and explicitly gives us additional authority to accomplish our mission and strategic vision.

### Figure 02 - NDAA Change Agenda

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>Readiness</td>
<td>Lacking common standards</td>
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<tr>
<td>MTF Footprint</td>
<td>Focused on beneficiary care</td>
</tr>
<tr>
<td>MTF Management</td>
<td>4 federated entities</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Uneven</td>
</tr>
<tr>
<td>Quality</td>
<td>Pockets of excellence</td>
</tr>
<tr>
<td>TRICARE Benefit</td>
<td>Pay for volume</td>
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### Summary of CHANGEd AGENDA

**Readiness of Force**
- % of combat casualty care specialties with defined KSAs (e.g. general surgery, critical care, emergency medicine, orthopedics, anesthesiology, etc.)
- Number/ % of providers meeting KSA readiness standard (combat casualty care specialites)

**Readiness of MTFs**
- Total readiness generating capability of direct care system (aggregate KSA score)
- Total readiness generating capability from strategic partnerships (aggregate KSA score, value per partnership)

**MTF Management**
- Operational metrics (productivity, OR utilization, network leakage, ROFR rate, etc.)
- Reduction in HQ staff (FTE and $$) + additional shared services savings
- Standardization of functional and clinical processes

**Patient Experience**
- Satisfaction with getting care when needed, overall satisfaction (IP/OP)
- % of non face-to-face visit touches (telehealth)

**Population Quality of Care**
- Outcomes and variation in specific conditions of high importance to MHS population
- Quality metrics (direct and purchased care) in comparison to national benchmarks

**Health/MTF Management**
- Overall Health and wellbeing (Health Related Quality of Life)
- Healthy Behaviors (smoking, nutrition, activity, substance use)

**TRICARE Benefit**
- % of payments tied to proven alternative payment models
Figure 03 - Achieving synergy from bedside to battlefield

Appendix A: Strategic Aims Aligned to NDAA Title VII Sections

<table>
<thead>
<tr>
<th>Objective</th>
<th>Sections</th>
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<tbody>
<tr>
<td>Define and measure clinical readiness</td>
<td>708, 721</td>
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<tr>
<td>Optimize training platforms for readiness</td>
<td>703, 707, 717, 718, 721, 724, 725, 749</td>
</tr>
<tr>
<td>Centralize administration of MTFs, allow Services to focus on readiness</td>
<td>702, 730</td>
</tr>
<tr>
<td>Improve the patient experience so we are the venue of choice</td>
<td>704, 709, 718, 726, 728, 731, 744</td>
</tr>
<tr>
<td>Modernize the TRICARE Benefit</td>
<td>701, 705, 706</td>
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*Not all sections of Title VII are reflected in the table above.*