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PRESENTATION TO THE COMMITTEE ON ARMED SERVICES

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SUBJECT: Defense Health Program

STATEMENT OF: Lieutenant General Charles H. Roadman, II
Air Force Surgeon General

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Mr. Chairman and members of the committee, thank you for this opportunity to address the goals and accomplishments of the Air Force Medical Service (AFMS) in

realizing our vision for the future. I consider it a privilege to appear before this committee who has worked so hard on our behalf.

As the Air Force prepares to enter the next millennium with a new organizational paradigm, the Expeditionary Air Force, the Air Force Medical Service will provide expeditionary medical support by transitioning from hospital-focused support to primary care and essential care. The AFMS "Parthenon" strategy will continue to be the foundation for Air Force health care into the next century. Our efforts under the strategic pillars of medical readiness, employing TRICARE, tailoring the force, and building healthy communities, with the capstone of customer satisfaction, have resulted in the most fit and healthy force in our history. We have the ability to provide state-of-the-art medical care to our personnel under any condition, anywhere in the world. Our strategy also has ensured a health care system able to provide high quality care to our Air Force family members. Now this strategy is mature enough to support our vision of population-based health care management (PBHM), using a total community approach. We believe this is an important template for the Military Health System.

Population-based Health Care

Population-based health care seeks to improve the overall health of a specific population through needs assessment, proactive delivery of preventive services, condition management, and outcome measurements. Its success depends on an interactive relationship among all elements of the community. The community approach has already been tested and proven by the Air Force. For example, in response to a community problem, suicide, the Air Force established an Integrated Product Team (IPT), comprised of members from various functional specialties –such as chaplains, security police, family

advocacy, legal services, and mental health – and chaired by the AFMS. As a result of the IPT's efforts, suicides have declined 40 percent within the Air Force during the past two years – in 1998, we had the lowest number of suicides in 20 years. The Air Force suicide prevention program has been applauded as a benchmark for both the public and private sector.

Following this success, the IPT concept was expanded to our Integrated Delivery System (IDS), which links the synergy among base agencies to promote help-seeking behavior and integrate prevention programs. The IDS addresses risk factors through a collaborative, integrated, customer-focused prevention effort designed to offer programs such as stress and anger management, personal financial management, and effective parenting. These programs support readiness by reducing risk factors and building the performance-enhancing life skills of our community members.

The concepts of a healthy community involve more than just medical interventions. They include local environmental quality and hazards; quality of housing, education, and transportation; spiritual, cultural and recreational opportunities; social support services; diversity and stability of employment opportunities; and effective local government. Impacting these elements requires long-term, dedicated planning and cooperation between local Air Force commanders and civilian community leaders. The process will also involve changes in doctrine and policy. If we are serious about improving quality of life for our personnel – and the senior Air Force leadership has testified that we are – then we must impact all areas that touch people's lives – they are the essence of quality of life.

Medical Readiness

Population-based health care is essential to our first pillar, medical readiness. By ensuring that active duty members can deploy anywhere, anytime, with little notice, we provide our leaders and commanders with their most critical weapons system: a healthy and fit fighting force. Our tool to assure individual readiness for any contingency is the Preventive Health Assessment (PHA). The PHA changes the way the Air Force performs periodic physical examinations from a system based on episodic intervention, which has not been effective, to a system that stresses an annual review of the entire population using principles of epidemiology and prevention. The goal is to identify risk factors from a person's life-style -- such as whether a person smokes, how frequently he exercises, and his diet -- as well as his genetic background, individual health history and occupational exposure. Then, through proper prevention practices, we assist the member to moderate those risks, resulting in a more fit member capable of accomplishing the mission.

By managing the health of our active duty members, we in turn manage the health of entire units, addressing the requirements of the theater commanders. We have now established five readiness metrics for evaluation by our Performance Measurement Tool (PMT): PHA completion, medically related lost duty days, immunizations status, dental readiness and fitness status. This data will provide the unit commander vital information about the health readiness of his or her unit.

We also seek to safeguard the readiness of our troops through force health protection initiatives. For example, we have an extensive array of deployable medical capabilities, which ranges from four-person Air Transportable Clinics to 90-bed Air Transportable Hospitals. In addition, wide ranges of preventive health teams exist, such

as the Preventive Aerospace Medicine Team, Theater Epidemiology Team, and the Bioenvironmental Engineering Nuclear-Biological-Chemical (NBC) Team. We have continued the deployment of new specialty teams -- such as infectious disease, mental health rapid response, air transportable dental clinic, and pediatric teams -- which we will complete by the end of the year 2000. In July of 1997 we conducted a form, fit, and function test of these newly reengineered specialty teams. We incorporated the results of this test into the improved Concept of Operations (CONOPs) and allowance standards (equipment sets), and have just concluded a second test to assess the improvements made to the specialty teams. Our next step will be to procure the new specialty sets.

In April 1998, a multidisciplinary team completed development of the Air Force Theater Hospital (AFTH) CONOPs. These facilities will replace our current contingency hospitals by the end of Fiscal Year 2000. They will provide a modular, incrementally deployable capability to provide essential care. They use existing ATH and specialty teams, along with pre-positioned (buildings) and deployable (tents) AFTHs.

Our top priority at this time is to formulate an expeditionary medical support package to support the Expeditionary Air Force (EAF) concept. Our goal is to reengineer our core assemblages so we can deploy first responder packages with multi-skilled personnel to any theater of operation within 72 hours. Our efforts in previous years to develop modular, flexible, and interoperable teams provide an excellent working base. We recognized the need to reengineer the Air Transportable Hospital to ideally support the EAF as well as to better mesh with the Air Force Theater Hospital CONOPs. The objective is to provide required capability while at the same time absolutely minimizing weight and cube. The new Air Force Theater Hospitalization and Expeditionary Medicine

(EMEDS) CONOPs, personnel packages, and allowance standards are projected to be completed by September 1999.

Within the EMEDS, forward resuscitative surgical capability will be provided by the Mini Field Surgical Team (MFST), a five-person, man-portable (300 pounds) team. Stabilization will be done by a ground version of our new Critical Care Air Transport Team (CCATT).

In addition, the AFMS will support the EAF with a robust and capable aeromedical evacuation (AE) system that will facilitate transport of the stabilized casualty as we provide primary care and essential care in theater. Throughout contingency and humanitarian operations, Air Force AE flight crews and CCATTs provide in-flight care to quickly move stable and stabilized patients.

The CCATT, which adds an intensive care capability to routine medical flight crews, provides high quality enroute care without draining staff and equipment from theater commanders. For example, the AFMS sent two CCATT teams to Ecuador in February 1998 in response to Ecuador's largest pipeline explosion, which caused a fire that killed 11 people and badly burned another 60. The teams, from Wilford Hall Medical Center, Lackland AFB, successfully evacuated six patients to burn hospitals in Galveston, Texas. To support this valuable asset, we began a certified CCATT course in October 1997 and now have trained 133 CCATTs, and will have more than 50 kits in the inventory by this summer.

Last September, we began the Aeromedical Evacuation Contingency Operations Course (AECOT). This course will ensure we have well trained personnel familiar with standardized aeromedical ground support. Later this year, the course will be conducted

simultaneously with the ATH course, allowing personnel from both weapons systems to benefit from their synergy.

Telemedicine will play an increasingly important role in our aeromedical evacuation mission under EAF. As DoD Executive Agent for airborne telemedicine, the AFMS continues to pursue the insertion of telemedicine into the aeromedical environment. Air Force human systems experts researched available technologies and recommended the use of existing Government Off-the-Shelf (GOTS) military satellite technologies to provide communications links from the aerovac platforms. Medical data can be transmitted to/from the patient compartment of the cargo aircraft and sent to the appropriate telemedicine referral centers as required. Additionally, clear voice communications can be utilized for provider-to-provider consultation as needed. We will be conducting the operational testing phase of this system this year in concert with major exercises, such as Patriot Medstar, and the Joint Medical Operations Telemedicine Advanced Concept Technology Demonstration.

Finally, no discussion of Air Force medical readiness is complete without recognition of our Guard and Reserve counterparts'contributions to our mission. The Guard and Reserve have long been recognized for their vital role in our wartime aeromedical evacuation mission, for which they provide 93 percent of the capability. Our Mirror Force strategy, which provides a blueprint to organize, train and equip active duty, Guard and Reserve medics as one integrated team, will increasingly prove its value as more operational missions transfer to the Guard and Reserve in the future. Last summer, the Air Force Reserve Command and Air National Guard deployed ATH units to support Operation SOUTHERN WATCH at Prince Sultan Air Base, Saudi Arabia. In addition,

the Air National Guard began rotations at the Eskan Village Clinic in Riyadh in January. Medical readiness personnel from the Air Force Reserve Command and Air National Guard will continue to serve rotations in the Joint Task force-Southwest Asia theater planner position.

These Air Reserve Component deployments have been so successful that the senior medical leadership has decided to conduct integrated deployments in the future – active, Guard and Reserve members will deploy *together* to provide medical support in theater. Additionally, the Guard and Reserve are actively participating in the planning and implementation of the Expeditionary Air Force for medical forces. They will continue to be active partners in our efforts to maximize the medical readiness capability of the AFMS by achieving a seamless, integrated medical force through the use of all components.

Employ TRICARE

Because combat readiness begins with the health and fitness of individuals -- who depend on highly skilled health care providers -- our peacetime health care system, TRICARE, remains the backbone of our medical readiness mission. Therefore, it is essential that TRICARE continue to evolve to meet the needs of the military population. Fortunately, TRICARE Prime represents a solid foundation for population-based health care, which must be built on an enrollment system to more accurately capture the size, characteristics, and unique needs of the patient population. Thus our second pillar, Employ TRICARE, is key to the success of our population-based health care management goals.

TRICARE, the Department of Defense's managed care system, concluded its implementation during this last year with the standup of the Northeast U.S. regions.

While this makes TRICARE available to all of our eligible beneficiaries, there are still several hurdles to overcome to maximize its effectiveness, such as difficulties with claims processing and CHAMPUS Maximum Allowable Charge (CMAC) rates, and improving beneficiary awareness. We are working these issues diligently with the Lead Agents and the DoD TRICARE Management Activity. Unfortunately, as with the civilian sector, we are frequently met with local resistance to managed care, from local medical societies, civilian providers and our patients. This is all part of the education process with which we are challenged.

We are encouraged by the steady increase in patient satisfaction with TRICARE, as evidenced by recent survey data. This data shows that 93 percent of TRICARE Prime users would reenroll in TRICARE. We are particularly proud of the fact that TRICARE fares extremely well when compared to patient satisfaction with civilian HMO benefit packages.

TRICARE Prime brings together all the tools of population-based health care. In concert with the TRICARE support contractors, self-care and health-care information line programs have been instituted at each medical treatment facility (MTF), forming the basis for demand management. By providing such services as the Health and Wellness Centers (HAWCs), the Health Enrollment Assessment Review (HEAR) survey, and Put Prevention Into Practice (PPIP), we enable patients to access the best possible resources for improving their overall health and to become educated, responsible consumers. We're developing policy and programs where each MTF will use population needs and health assessment information to prioritize and proactively deliver evidence-based clinical preventive services. As part of our PPIP program, we established prevention committees

at each of our MTFs. The senior medical staff, in consultation with the MTF Prevention Committee and using demographic and health assessment information, can ensure that appropriate appointments and ancillary services are available to support preventive interventions for the empanelled population.

Over the next year, we look forward to continued refinement of the health care delivery process in Air Force facilities, to include sharing arrangements with the Department of Veterans Affairs (DVA), as well as managing our Medicare Subvention and Federal Employee Health Benefits Program (FEHBP) demonstrations, which will help us serve the needs of our over-65 retiree population.

The Air Force has a long heritage of resource sharing with the DVA. Today we have 100 agreements with the DVA, sharing more than 270 services. In addition to our two joint ventures at Albuquerque, New Mexico, and Las Vegas, Nevada, we will be establishing a new joint venture in Alaska with the May opening of our new hospital at Elmendorf AFB. We're pursuing numerous joint initiatives with the DVA to improve mutual efficiencies. For example,

- Clinical guidelines improving the standards of care will be shared across the Services and DVA, enhancing continuity and outcomes
- Discharge physicals will be "one-stop shopping" through one organization
- Numerous DoD and DVA staff have been collaborating to establish one computerized record that could be used during and after active duty service
- DVA representatives are participating on the DoD pharmacy redesign working group to establish standardization between agencies where feasible

We are also excited about our efforts to better serve the over-65 retiree population. All of our five Senior Prime demo sites have now begun seeing patients, and additional enrollment capacity still exists at most sites. We are optimistic about the prospects of Senior Prime for our older retirees, and believe that these demos will show we can provide high quality medical care for less money than can the civilian sector, particularly in our larger facilities. However, we do have some concern regarding the financial implications of Senior Prime for our smaller facilities, which will be required to buy a significant amount of needed care from the civilian sector. That is the value of the demonstration: a trial period to test whether the program is financially viable at our small facilities as well as our large ones.

Our alternative demo at MacDill AFB, MacDill Senior, has enrolled all 2,000 participants and provides the full scope of primary care services while meeting TRICARE access standards. MacDill also will provide specialty care within the capabilities of the facility. Reports of the demo so far have been very positive -- our patients are delighted!

These demos are an important first step for our Medicare-eligible retirees. We welcome the opportunity to test other alternatives and fully support the FEHBP demonstration and pharmacy benefit redesign requested by Congress. Along with our sister Services, we remain committed to fulfilling "the promise" these deserving beneficiaries believe were made to them.

Tailored Force

Our ability to continue providing quality health care to the military family depends on the effective use of all our resources – people, facilities and money. Population-based health care management is driving the methods the AFMS uses to plan for and allocate

resources to our MTFs, and is therefore vital to our tailored force pillar. Financial and manpower resources will be determined first by the unit's readiness mission, second by operational support to the base mission, and third by the health care needs of the enrolled population. We have developed and implemented tools such as Enrollment-Based Capitation (EBC) and the Enrollment-Based Reengineering Model (EBRM) to properly size and resource our MTFs to meet their mission requirements and the health care needs of their population. The primary objective of tailored force is to develop an overarching strategy that will optimize the overall force size, while it ensures we have the right number of people with the right skills at the right place and right time.

Enrollment-Based Capitation (EBC). The AFMS is a strong supporter of the Defense Department's development and implementation of a capitation model that allocates funds to a specific medical treatment facility (MTF) based on their enrolled population, rather than merely allocating between the three services based on an estimated user population. EBC results in making MTF commanders fully accountable for all the resources used by their TRICARE Prime enrolled population. The evolution from a workload-based resource allocation system to an MTF-enrolled population system makes this possible. Unlike the past, commanders will know which TRICARE Prime patients they are financially responsible for and how much they are being given for the care of these patients.

Enrollment-Based Reengineering Model (EBRM). The traditional method of using historical workload of an "unenrolled" population to determine staffing requirements for Military Health System (MHS) components is outmoded. The EBRM is the Air Force's latest tool for determining manpower requirements for a managed care delivery

system with an enrolled population. This model relies on civilian studies validating physician-to-beneficiary-population ratios, AFMS-generated data on support staff-to-physician ratios, and MTF-reported enrollment projections. The model was developed by an Air Staff Integrated Process Team (IPT), which included representatives from all Major Air Commands. Consistent with changes in the civilian sector delivery of health care, the model shows more primary care physicians are required than specialists, particularly as the health care industry shifts from an inpatient to an ambulatory care setting. The EBRM also suggests the "ideal" support staff ratios, according to our consultants involved in the development of the model; they were not constrained by the old ways of doing things. Finally, the EBRM IPT modeled a "robust" primary care delivery system in which the Primary Care Manager (PCM) is expected to provide comprehensive care in the primary care setting, rather than merely acting as a gatekeeper of care.

These system improvements are crucial in allowing us to effectively execute our tailored force strategy. This strategy, although initially directed from senior leadership, has been validated through a comprehensive strategic planning process, essentially a bottom-up review and analysis. The end product is a roadmap that will reengineer how care is delivered in the AFMS. Programmed changes will result in fewer inpatient services throughout the AFMS. Inefficient small hospitals will convert to clinics as we move to a prevention-based system. Inpatient care at these clinics will shift to the civilian community resulting in a greater partnership within the community and significant improvement in efficiency and quality of care. At the same time, this shift will allow increased access to primary care services in the MTF as we free up precious resources that have been underutilized in inpatient care. While we have already completed 50 percent of this

reengineering effort, we have a formidable two years ahead of us as we strive to achieve the strategy by the end of Fiscal Year 2000. Our facilities are committed to communicating these changes promptly and openly with their beneficiaries – your constituents – and their local civic leaders and members of Congress.

In summary, the ultimate outcome of a reengineered system using EBC and EBRM is a system in which the MTF's enrolled population drives money and manpower. The majority of health services will be delivered through prevention programs and well-supported PCMs. EBC and EBRM encourage MTF commanders to enroll their beneficiaries and retain them as satisfied customers while emphasizing preventive and primary care as the preferred delivery setting.

Building Healthy Communities

The prevention paradigm of our fourth pillar, Building Healthy Communities, is the cornerstone of the population-based health care management system. Previously we concentrated on individual health care through clinical intervention, but now we are using the community-approach, population-based initiatives. For example, three major areas we are targeting at the community level are decreases in tobacco use, alcohol abuse, and injuries. The Under Secretary of Defense for Personnel and Readiness has established a DOD Health and Safety Promotion and Injury/Illness Prevention Council, with the Air Force as its executive agent, to address these areas. The Air Force is the lead service for promoting tobacco use avoidance and cessation; the Navy is the lead service for alcohol abuse, and the Army for injury and illness prevention. We feel very confident in our ability to lead in the fight against tobacco use – thanks to years of hard work, tobacco use is at an all-time low in the Air Force.

We're also very proud of our success in the prevention of family violence, and I make particular note of this in light of a recent "60 Minutes" story on domestic violence in the military. The Air Force Family Advocacy Program (FAP) is a comprehensive network of family programs and services, with 600 professionals serving families at 80 installations worldwide. Our proactive approach and emphasis on early intervention allows us to provide services to families at an earlier stage of the domestic violence cycle. We believe these efforts are paying off. Not only are substantiated rates of child and spouse abuse declining, but the rates of severity of abuse are also decreasing. From 1990-1994, we averaged six deaths a year as a result of domestic violence – since 1995 we've averaged less than one death a year, clear evidence that our awareness and prevention programs are making a difference. However, we must continue to improve, for any loss of life or emotional scar is too many.

Our Health and Wellness Centers (HAWCs) continue to promote health and fitness for our people. These centers have been established at each Air Force installation as central points to focus on opportunities to promote and enhance health, fitness, and performance in the general beneficiary population. All Air Force bases have at least a full-time Health Promotion Manager, and every HAWC has an exercise physiologist to manage the USAF (including the Air Reserve Component) fitness assessment program and provide fitness counseling and prescriptions.

Another essential element of our Building Healthy Communities pillar is the Health Enrollment Assessment Review (HEAR) survey, which identifies behavioral health risk factors, the need for clinical preventive services and management of chronic diseases. Information from this survey is used at multiple levels: the individual, the primary care

manager, the MTF, the TRICARE region, and the Air Force itself. In November 1998, the Department of Defense began to use a software program automating the HEAR. This incorporates the use of numerous survey data into a global approach to understanding population health needs and status, and provides information from all branches of the service.

We have an aggressive fitness and performance enhancement research program headed by a newly created Force Enhancement and Fitness Division at our USAF School of Aerospace Medicine, Brooks AFB, Texas. In support of an Air Force Chief of Staff decision, the AFMS will enhance the USAF fitness program by adding muscular strength, endurance, and flexibility assessments for all members, and will develop performance-based occupation-specific physical conditioning programs. We will be testing these changes and determining the standards throughout 1999, and anticipate final implementation in January 2000. We've invested in our personnel and most are certified in their specialty (i.e., as health promotion managers, physiologists) and attend annual professional conferences to enhance their certification or education. Aerospace medicine, public health, bioenvironmental engineering, and occupational medicine personnel focus on opportunities to promote and enhance worksite health.

Customer Satisfaction and Quality Care

Prevention is the key to a better quality of life for our personnel and their families. Healthy, happy patients are satisfied customers. This is so important to us that we've identified customer satisfaction as the capstone for the AFMS strategy. We must ensure that our customer satisfaction efforts include our external customers, our military leaders and patients, as well as our internal customers, our medical staff personnel.

As a means to provide overall guidance, a customer satisfaction task force, known as our "Skunkworks," was formed in 1996. The task force developed a three-phase strategy to create a climate and culture where customer focus and service permeates all that we do in the AFMS. In Phase I, we researched best business practices in the public and private sectors to establish our program framework and develop tool kits. We are currently in Phase II of our three-phase strategy, which involves deployment to the field. By early 1999, we will have completed six rollout meetings. When the rollouts are completed, every AFMS organization will have trained representatives. We will use "report card data" and the AFMS customer satisfaction metrics that are part of the Performance Measurement Tool to monitor and measure our success. Finally, Phase III of our program, known as "Sustainment and Partnering," will be focused on maintaining a high level of momentum for customer service and continued monitoring of the data.

While we're excited about the potential of our Skunkworks program, we also recognize that no amount of provider training can replace high quality care as a means of satisfying our customers. We have plenty of proof that the quality of our care has never been better and that we have many satisfied customers.

Quality is the hallmark of our MTFs. With 97 percent of our facilities surveyed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Air Force continues to match or exceed civilian scores. The average Air Force hospital accreditation score has risen from 92.38 percent in 1997 to 94.43 percent in 1998. Clinics maintained an accreditation score of 97 percent, and an impressive 48 percent were accredited with Commendation.

Let me offer you another example of the high quality of care we provide. Many of our facilities have participated in the Maryland Hospitals Association Quality Indicator Project for more than eight years. Air Force inpatient facilities have maintained significantly better rates than the aggregate average of more than 1,000 participating inpatient facilities on five clinical indicators including inpatient mortality, perioperative mortality, unscheduled readmissions, unscheduled returns to the operating room, and unscheduled returns to the special care unit.

This level of quality is reflected in our patient satisfaction. Not only do we know that 93 percent of our Prime enrollees would reenroll, we've received outstanding kudos from other customers. For example, our line commanders are delighted with the preventive health assessment, used to track and manage data on the readiness status of their troops. They have praised the program because it addresses their troops'readiness capabilities. They were especially pleased when their units were prepared to go to the field for deployment exercises without any medical discrepancies.

We're proud of our record in delivering quality care, but there will always remain room for improvement. We take this very seriously, and continue to work hard with our sister Services to fulfill the mandates of the quality initiatives established by the former Assistant Secretary of Defense (Health Affairs). Some of these things I've addressed in the course of this testimony. Among others is ensuring that every Air Force MTF has a health care council or consumer committee to offer beneficiaries an open line of communication. In fact, this is an item on the checklist of the Air Force Inspection Agency during their Health Services Inspection. During the past two years, all Air Force MTFs inspected received a satisfactory or higher rating on this item.

I'm also pleased to say that 100 percent of our MTFs have published a directory of providers to better inform patients about professional information relating to their providers. Air Force MTFs are also 100 percent compliant in posting their "report cards" for patients to see when they visit the facility. Report cards contain "how are we doing" data on access times for major service areas, patient satisfaction, and JCAHO scores as well as information on patient education, patient rights and web site availability.

Our bottom line: The AFMS is dedicated to maintaining the finest professional work force, the best quality care and truly satisfied customers!

Conclusion

Our responsibility as providers and caregivers is to our customers – our nation, our patients, our leaders, our families, ourselves. We believe there must be changes in how military medicine is currently managed and a strategy to prepare for the future 10, 20 or 30 years from now – that strategy is population-based health care management. To succeed, it must be reinforced with a foundation that sustains medical readiness, employs TRICARE, tailors the force, builds healthy communities, and – ultimately – delights our customers. We confidently and wholeheartedly accept that challenge, the challenge of stewardship of resources, responsibility for our patients and our nation's health and support of our national security interests. Our strategy is about stewardship.