Keeping Warfighters Ready. For Life.

2007 TRICARE Stakeholders Report

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A Letter to Our Stakeholders

Our nation and our armed forces have been at war for over five years now, fighting an enemy dispersed across the globe. In Iraq and Afghanistan, together with our coalition partners, our military men and women have been engaged in sustained combat operations. We have removed two tyrannical regimes, yet terrorists and others opposed to freedom remain.

In this combat environment, our medical forces have excelled—we have reached and stabilized the wounded more quickly and with more medical capability than ever witnessed; we have moved them to Landstuhl, Germany and to medical centers in the United States with increasing speed; and our investments in technology have allowed us to move and treat severely wounded patients at the same time. Our pre-deployment and preventive service programs have ensured we are deploying the most ready, fit forces for combat. The outcomes are remarkable: the lowest Disease, Non-Battle Injury rates ever; the lowest deaths from wounds rate ever; and more.

We have made great strides in addressing the mental health needs of our service members. We are embedding mental health specialists in units throughout the theater of operations; we are assessing our troops both before and after deployment; and—perhaps most importantly—we are truly reducing the stigma associated with seeking mental health care, encouraging our service members to seek counseling and support. And we are widening the circle of who we must reach and how we reach them. Family outreach and family counseling are essential elements in providing effective, comprehensive services.

We simultaneously responded to humanitarian crises in our country and around the world. We are providing critical medical services to populations at risk, and enhancing the world's appreciation for the US military medical professionalism and skill.

Many of these accomplishments have come about from our military medics. We applaud their courage, spirit and the uniquely American military mindset and training that encourages decision-making "on the ground."

We are also indebted to those who have left military service, yet infused today's medical forces with their leadership and foresight. Our predecessors crafted strategic plans that anticipated the needs of our commanders and service members.

Over the past eighteen months, the Military Health System (MHS) leadership—the Surgeons General, medical commanders and the civilian leadership in Health Affairs—have forged a new MHS Strategic Plan, which our medical forces have embraced. Over the next three years, our leadership team will concentrate our time, resources and effort on six vital goals for our enterprise:

- Enhance our Deployable Medical Capability.
- Sustain the Military Health Benefit.
- Provide Globally Accessible Health and Business Information.
- Transform to a Performance-Based Management System.
- Develop Our People.
- Align, Manage and Transform the MHS Infrastructure.

Each of these goals captures hundreds of activities that must be synchronized so that we sustain the quality already embedded in our culture and our performance, yet allows us to achieve even more.

In the coming year, a number of steps will be taken that will improve our ability to achieve these goals. Our organizational structure will change—providing a platform from which we will better organize Department of Defense-wide activities in support of local military treatment facility (MTF) commanders. We will increase clarity, responsibility and authority at headquarters and local MTFs. We will accelerate the deployment of critical tools—medical products, information systems and practices—reducing the "bench to battlefield" times. And we will be taking the first steps in instituting command structure changes in our joint military medical markets, particularly in Washington, DC and San Antonio, Texas.

We must also work even more effectively with other federal agencies. Our collaborative efforts with the Department of Veterans Affairs have achieved a great deal. But more is expected—by our veterans, their families and the American people—and we will meet their expectations. Close coordination with the Departments of Health & Human Services and Homeland Security are essential for successfully preparing for, and responding to, a range of events—whether it's a naturally occurring disaster, or a terrorist event on our homeland.

More than 9 million Americans rely on us for their health care needs today. And 300 million Americans are reassured that we are ready to respond if events require. It is an awesome responsibility we have, and we will continue to meet this responsibility with the exceptional talent that perseveres and excels in these turbulent times.

I thank you for your commitment, hard work and unwavering support of our warfighters, retirees and their family members. It is through your dedicated service that we provide the best health care in the world.

- William Winkenwerder, Jr., M.D.
Assistant Secretary of Defense (Health Affairs)
Director of the TRICARE Management Activity

Messages from the Surgeons General

Surgeon General of the Army
LTG (Dr.) Kevin C. Kiley

The Army Medical Department continues to transform, putting strategies into action with programs such as Lean Six Sigma that improve our effectiveness and allow us to implement efficiencies. We are combining waste elimination principles and variation reduction to produce consistent repeatable performances in all areas of Army medicine.

We continue to provide the world's very best medical care under arduous conditions. What better place to see our success in partnering to save lives than in the Global War on Terrorism where 90 percent of our wounded warriors live … and more than 50 percent were able to return to duty in three days or less.

The leading edge of our system of care is our combat medics who continue to deploy with advanced trauma skills and emergency medical training. These skills keep soldiers alive, but it is the heart and soul of the medic that consistently displays how heroic and brave these young men and women are on a day-to-day basis.

Our commitment to all of our customers—soldiers, families and retirees—remains stronger than ever.

Surgeon General of the Navy
VADM (Dr.) Donald C. Arthur, Jr.

Partnerships are an extension of Navy medicine's ability to care for patients. Now more than ever partnerships are critically important to military medicine. There are examples of partnerships across the spectrum of military medical operations around the world.

The recent humanitarian mission to Southeast Asia completed by the USNS MERCY, (T-AH 19) is an excellent example of partnerships. MERCY provided direct aid to more than 87,000 people in Indonesia, Bangladesh and the Philippines. MERCY's team included non-governmental organizations, US Army and US Air Force medical personnel, naval construction forces and medical personnel from Canada, India, Malaysia, Australia and Singapore.

In 2006 the Joint Forces Command (JFCOM) tasked the Navy with providing medical staffing in support of the Army's Landstuhl Regional Medical Center (LMRC) Germany, for one year beginning November 2006. Upon arriving, this group of more than 300 Navy medical reservists and 30 active duty personnel became part of the LRMC team and are providing superior medical, surgical and preventive health care to wounded warfighters.

Navy medicine is also exploring new relationships such as the one established with the Balboa Career Transition Center. The Navy Medical Center, San Diego, recently entered into an agreement with the US Department of Labor, the US Department of Veterans Affairs (VA) and the California Employment Development Department to provide quality VA benefit information and claims intake assistance, vocational rehabilitative services, career guidance, and employment assistance to wounded and injured service members and their families.

Navy medicine's alliance with Veterans Administration medical facilities is also evolving into mutually beneficial partnership. The close monitoring and coordinating of care for sailors and Marines who transfer to or are receiving care from a VA facility ensures their needs are met and that their families are availed the services they need.

Navy medicine will continue to reshape and transform, as has been our tradition, so that we can continue to rapidly steam to assist … anytime, anywhere.

Surgeon General of the Air Force
Lt Gen (Dr.) James G. Roudebush

The Air Force Medical Service is committed to providing the best resources possible to support joint warfighters as well as the Air Force's top priorities: supporting the Global War on Terror, caring for Airmen and their families, and recapitalizing our assets.

We provide the same quality of care—and access to care—for all of our nearly 3 million beneficiaries. In doing so, we provide quality, world-class health care and health service support anywhere in the world at anytime, ensuring that active duty and Reserve component personnel are healthy and fit before they deploy, while deployed, and when they return home.

As part of a joint team, we now have more than 800 medics in 10 deployed locations including Iraq and Afghanistan. Every day, Air Force medics save the lives of Soldiers, Marines, Airmen and civilians; Americans, Coalition, Afghani and Iraqi; friend and foe alike.

Whether stabilizing a casualty, preparing a casualty for transport, providing continual care at stops along the way, or the actual patient movement phase itself, what matters most is providing the most robust enroute care system possible to every injured warfighter.

In Iraq, once the helicopter takes off, no casualty is more than 25 minutes away from a surgeon. After casualties receive additional stabilization and essential care, they are prepared for the next phase of enroute care. That phase, aeromedical evacuation, is distinctly Air Force.

Our modern aeromedical evacuation teams, coupled with our innovative Critical Care Air Transport Teams, set up flying intensive care units in the back of any aircraft. They safely fly even the most severely injured thousands of miles to definitive care in Germany or stateside. With their families present, they begin the recovery and rehabilitative process.

Delivering this remarkable medical care takes trained, clinically current physicians, nurses and technicians. We concentrate on medical education programs and developed clinical training platforms providing surgical and trauma care experience. That, plus our readiness training platforms, ensures our medics are the best-trained AF medical force in history.

Coast Guard Health and Safety Director
Rear Adm. Paul Higgins

During 2006, the Coast Guard has been challenged to complete its diverse core missions, especially in supporting America's War Against Terrorism, strengthening U.S. port security, and continuing disaster relief efforts. As always, our ability to respond to the call has depended upon maintenance of optimum deployable readiness by all active and reserve personnel.

The reduction of accidental injury and occupational illness is the primary focus of the Coast Guard safety program. This focus not only increases our units' readiness posture, but it also helps to reduce health care costs. Both benefits are maximized by the Coast Guard's unique organizational structure that places health and safety within the same functional program.

The Coast Guard is implementing a new Deployable Operational Group that necessitates an entirely new breed of Coastguardsman. No longer is medical treatment completely the purview of the Corpsman. Boatswains Mates, Mechanics and Marine Safety Technicians are learning to provide Advanced Emergency medical training.

Providing the best tools to our health care team means that our medical information technology, including AHLTA and telemedicine, is moving forward.

Finally, we recognize that members of Team Coast Guard are better able to be mission ready if they are confident that their family's needs are being met. An example of this kind of attention to Coast Guard families is reflected in the expansion of a General Services Administration (GSA) agreement that provides increased access to, and subsidized rates for, GSA-owned child development centers nationwide.

Operational Medicine Continues to Save, Rebuild Lives

War is a terrible but effective laboratory for trauma medicine, say military physicians. Many doctors working in American emergency rooms (ERs) describe civilian gunshot wounds as "recreational." Combat wounds, however, are often far more damaging, caused by high-velocity bullets, rocket-propelled grenades and razor-sharp flying shrapnel. Today, the number of deaths due to combat injury is approximately half what it was in Vietnam. The credit goes in part to improved body armor, far-forward surgical teams and the critical-care air transport provided by flying intensive care units. Just as important, though, are the lessons learned by military physicians. They adapt tried-and-true techniques to treat complex battle wounds as they innovate and improvise to save lives.

- Scoop and transport: Though damage-control surgery is available near the firefight, surgeons and medics do just enough to repair critical wounds, and then transport patients to facilities with more capabilities. It's a new approach to surgery that calls for stopping hemorrhage or contamination and then moving the patient out to the next higher echelon of care facility.

- Knowledge moves quickly: The hard-won knowledge gained by military physicians treating complex wounds—called polytrauma or multitrauma—shows up in published papers or ER seminars to educate trauma surgeons back home, and this knowledge can have an almost immediate effect on standard medical practice.

- Experience counts: Downrange surgeons gain invaluable experience treating many patients with the same type of injury. From relentless opportunities to repair torn flesh, they become ever more adept, for example, at identifying what tissue is viable and can be saved, and what must be cut away to prevent infection.

- Creativity counts: Military physicians may improvise on the spot, pushing concepts beyond known boundaries, by turning the hospital staff into a walking, real-time, body-temperature blood bank; using less-invasive pediatric tubes and scopes; and injecting a manmade blood-clotting protein, intended for hemophiliacs, to stop blood loss.

- Techniques are refined: Refinements to traditional techniques may mean making more cuts or cutting sooner to release pressure inside a damaged limb, or rethinking the standard philosophy about when to close a wound. For example, physicians may choose to use external devices to stabilize fractures without covering open wounds—the choice decreases movement and reduces infection and loss of bone and tissue.

- Procedures count: Formal trauma systems allow for improved coordination among the physicians who work together on a patient, sharing knowledge and techniques. Real-time information sharing means physicians are able to examine recent data and make system-wide policy changes right away.

What's Better Than Morphine?

It's better than morphine, say the experts, of a military-wide program focused on swift pain relief. Pioneered by Lieutenant Colonel Trip Buckenmaier, an anesthesiologist at Walter Reed Army Medical Center, the use of localized nerve blockers on patients taking long medevac flights now helps control pain. The technique is especially effective when treating wounds to the extremities and gunshot wounds to the chest. Until recently, morphine had been the textbook pain control choice, but administering the drug was problematic because of its ability to depress the respiratory system and the subsequent need for constant monitoring—particularly difficult on dark, noisy medevac flights. After the nerve block techniques debuted at the 10th Combat Support Hospital in Baghdad last year, the shift away from morphine rapidly gained favor, because patients stayed comfortable, but conscious.

At the same time, improvements have been made in pain-medication delivery systems—the pain pump once was a bulky electrical machine, and now it's hand-held, patient-administered, plastic, portable, durable and designed for one-time use. The Director of the Pain Management Clinic at Bethesda Naval Medical Center, anesthesiologist Dr. Zachary Kitchen, describes the changes in pain treatment as moving from a carpet-bomb to smart-bomb approach. Currently it is possible to choose a refined combination of pain pumps, localized nerve blockers, heavy-duty opiates, over the counter pain medications and anti-convulsive meds to provide a tailored response to manage each individual's pain.

Sports Rehab Works for Today's Wounded Warrior

Most military amputees, and other severely wounded service members who require extensive rehabilitation, are treated at Walter Reed Army Medical Center or the new Intrepid Center at Brooke Army Medical Center in San Antonio. The facilities are equipped with the latest technologies such as running gait analysis units, dual-force plate treadmills, uneven terrain modelers and a 30-foot climbing and rappelling wall at the Intrepid Center. However, whether in Texas or Washington, DC, the military's rehabilitation specialists are encouraging wounded soldiers to take up horseback riding, skiing, mountain biking, rock climbing, hunting and fishing not only to strengthen their bodies, but also to buoy their spirits. Sports therapy advocates see downhill racing amputees regain confidence in their physical abilities, even if they are missing an arm or leg. For their part, therapists have gained insight into this new generation of physically well-toned war wounded who survive potentially fatal wounds with their athletic spirit intact. Despite frequent combinations of grievous injuries, including amputated limbs, blindness, severe burns or head trauma, young warriors have impressed their doctors, nurses and therapists with their grit, determination and resilience. Sports rehab meets their physical training needs, while providing a welcome psychological boost and an opportunity for the soldier to be competitive again. While military medicine is dedicated to the fullest possible recovery for soldiers, a still larger goal, say Army officials, is to retain seriously injured soldiers who love their jobs and want to return to active duty.

The Bionic Arm Is Not Science Fiction

New lower-arm and hand prostheses are now being fashioned from plastic, metal, a computer chip, electrical wiring and a skin-like silicone "glove" for a natural-looking, life-like hand. The cosmetic hand, a silicon glove that fits over a prosthesis, reproduces tiny creases on the fingers, darker tones on the knuckles and functional fingernails, recreating the wearer's own hand down to hand-painted freckles. The artists who work at Walter Reed Army Medical Center (one a sculptor, another a former Hollywood makeup artist) paint the glove with painstaking care; they are so dedicated to recreating a soldier's lost hand that they'll recreate childhood scars and sometimes shave a patient's arm hair and glue it to the glove. A single "skin" for a replacement hand can require 60 hours of work.

During war or peacetime, there are fewer upper-limb losses than leg amputations, which explains in part why arm and hand prosthetics technology has advanced little since World War II. It's also true that upper limbs are harder to duplicate—particularly when you consider how many different functions the hand performs. But with the increased incidence of arm/hand injury in Iraq and Afghanistan, the Department of Defense has funded a two-year research program to create a better-functioning artificial arm and, within four years, a brain-controlled robotic version arm and hand that will nearly duplicate, in looks and function, the lost limb.

Combat Stress Responds to a Variety of Efforts

Military mental health experts have adopted a cautious approach to labeling military personnel (sailor, soldier, airman or Marine) as being at risk for post traumatic stress disorder (PTSD). A supportive environment, time, and monitoring may be more clinically effective ways of treating stress symptoms, which deployment health experts describe as often the predictable reintegration and readjustment problems of veterans returning from Operation Iraqi Freedom and Operation Enduring Freedom. The goal of this "watchful waiting" is to avoid pathologizing transient emotional problems that are, fundamentally, very normal reactions to abnormal experiences. In fact, because stress symptoms may well dissipate over time and respond to lower-level kinds of support, the experts say it may be inappropriate and even harmful to label early symptoms of combat stress as mental health dysfunction.

To avoid that leap and gain a clearer understanding of the life cycle of combat stress, the Post Deployment Health Reassessment (PDHRA), fully implemented last year, is administered three to six months after a veteran's return home. Service members still participate in the Post Deployment Health Assessment, the health screening that occurs at the time of return, but the PDHRA aims to identify problems that surface after soldiers have spent some time at home and returned to a more normal life: They might find that a backache or rash they thought would just go away continues to be a problem, or that painful memories intrude upon daily life. Thus, the PHDRA identifies deployment-related health problems, both mental and physical, that persist after redeployment or that emerge only after the soldier has been home for a while, and it provides for the follow-on health care needed.

"Gaming" Treats Severe Symptoms

When military health professionals identify service members at risk for symptoms of severe combat stress or post-traumatic stress disorder, a full range of treatment options is available to help, and new treatment vehicles continually are being explored. For example, at the Naval Medical Center in San Diego, a two-year, $4 million study offers virtual reality as an alternative to more traditional talk therapy for Marines suffering combat stress-related symptoms that are severe enough to warrant treatment. Wearing simulator helmets, wired with biofeedback sensors, and monitored by clinicians, patients re-experience the sights, sounds, and sometimes even the smells of the battlefield—and learn to manage the fear that results. However, the jolting images and sounds, based on the Full Spectrum Warrior training simulator, are more than mere video games. Because the 12-session virtual reality treatment can be anxiety provoking, it is conducted in a supportive and highly controlled environment, where the game player's heart rate and breathing are closely monitored. Virtual reality gaming is an innovative leap in "exposure" therapy, which seeks to help relieve a patient's stress by desensitizing him to the stimuli of painful memories. A similar treatment trial is underway at Tripler Army Medical Center in Hawaii.

DoD Boosts Outreach Efforts to Identify and Treat Stressed Veterans

The Department of Defense (DoD) is aggressively pursuing new ways to identify and treat service members suffering symptoms of combat stress or other behavioral health problems. In addition to traditional referrals to mental health specialists, the DoD supports numerous non-medical outreach efforts, such as services offered by family support groups and chaplains. The Military Health System integrates the work of its primary care providers across the full spectrum of community support services, to include several confidential, online resources and education and marketing campaigns that familiarize veterans and families with contact information and available treatment options.

- A series of fact sheets, developed by a psychological-health education team at the Uniformed Services University of the Health Sciences, helps returning Service members reintegrate into their families. "Courage to Care" products are available to any service member, family member or health care provider.

- An innovative treatment trial at Walter Reed Army Medical Center compares the effectiveness of two different kinds of early treatment—stress inoculation training and supportive counseling. Supportive counseling allows a person to vent, identify feelings and have his or her experiences validated. Inoculation training aims to teach a person the skills needed to deal with an anticipated exposure to a problem. The Web-based study will assess—confidentially—delivering treatment before a diagnosable problem emerges.

- Last spring, to augment helping agencies already working on base, Pacific Air Force bases fielded a new team of licensed, professional stress counselors who are just a phone call away if an airman experiences a problem or just feels the need to talk to a professional. There is no fee for an appointment. Just as important, the civilian counselors, social workers and psychologists do not report a service member's visit to the chain of command (except mandatory reporting for homicidal or suicidal tendencies or criminal activity). The program, Military and Family Life Consultants, was offered to all services by the Office of the Secretary of Defense, and each service is fielding its own version. The goal of the program is to provide early intervention for service members experiencing stress. The counselors are "early" listeners—the people who may hear grumblings first—and they can help resolve a member's short-term problem that is not serious enough to require therapy or warrant a mental health diagnosis.

- Navy hospitals have created a series of online videos to explain post-traumatic stress disorder (PTSD) symptoms and provide contact information. Produced by Navy LifeLines, the videos feature Navy psychiatrist Captain Jennifer Berg (now Captain Jennifer Morse, USN (Ret.)) interviewing a medic, a Marine commander and family members about the problems service members experience after returning from combat. Because some segments are designed specifically for family members, the videos were widely distributed and advertised in local newspapers around naval bases to make families aware of available counseling programs. The videos have been so successful that the Army and Air Force are using them to encourage their families to seek help.

- Sponsored by the DoD, a confidential mental health screening tool is available online for service and family members. Viewers complete a self-assessment checklist and then receive tailored information about other resources, such as counseling or treatment options, if needed. https://www.militarymentalhealth.org/welcome.asp.

- The DoD shares information and concerns with the Department of Veterans Affairs (VA), which provides readjustment counseling at more than 200 community-based veterans centers. An additional 44 returning Vets Outreach and Care programs were established last year and 40 more are scheduled to open in the future. In addition, military and VA physicians are more sensitive to the possible link between physical and mental illness, because research shows that physical symptoms (like backaches or nausea) are far more likely to occur in patients suffering combat stress symptoms than in veterans without other symptoms. Indeed, a stressed patient might initiate a doctor visit for a physical complaint, such as headache or indigestion. Thus, at VA hospitals across the country, every vet who registers for care, whether for a rash or a sprained ankle, is screened for mental health concerns, including PTSD, depression and substance abuse.

- Newly formed last year, the DoD Task Force on Mental Health is conducting a wide-ranging examination of the department's mental health assessment and treatment programs, featuring "town hall" style meetings in military communities across the country. Composed half-and-half of military personnel and civilian appointees, including medical experts, the task force will provide an independent review of the military's efforts to identify and treat soldiers suffering symptoms of combat stress and PTSD. Within a year, task force members will report their findings and propose new ways to educate service members about mental health issues.

The MHS Looks to the Future

Electronic Health Records Can Track Disease Patterns

The military's electronic health record, AHLTA, has been deployed to all military hospitals, 411 medical clinics and 417 dental clinics, including deployed field units. AHLTA—now globally accessible—leads the nation in achieving the President's stated goal of providing electronic health records for most Americans by 2014. For the Military Health System and TRICARE beneficiaries, the goal is to see all phases of AHLTA implemented by 2011.

AHLTA gives providers instant access to a patient's history (medical condition, prescriptions, results of diagnostic lab tests). This means doctors will not needlessly duplicate costly tests, scans and labs. The legible, comprehensive patient information can provide potentially life-saving information when minutes matter. Future plans for AHLTA include computerized "tablets" for providers to enter notes as they continue to face and talk with patients. Combat medics and corpsmen have already field-tested portable, hand-held medical data-collector devices, which accept a service member's dog-tag-sized electronic information chip.

Perhaps the most significant benefit of the electronic health record will emerge from the large, long-term medical studies that AHLTA will facilitate, by allowing researchers to track and document disease patterns. More immediately, bio-medical surveillance units will monitor disease trends to isolate outbreaks and provide targeted, early intervention.

Realistic "Wounds" Train Combat Lifesavers

Medical drills and mass casualty training events often present "patients" with ailments written on paper and pinned to their jackets: "head trauma," "severed arm," or "chest wound." Now, war-gaming computer simulation, which has a long history in military operational training scenarios, introduces medics and corpsmen to every kind of wound or injury imaginable. The highly realistic training prepares combat lifesavers to deal with some of the horrific wounds they may see when deployed overseas with Army and Marine Corps units.

Deployment-Related Health Studies Are Posted Online

Launched last spring, a new Department of Defense Web site offers a searchable inventory of research studies and outcomes for all government-funded scientific studies on deployment-related physical and mental health issues. DeployMed ResearchLINK debuted with reports of medical research emerging from the1990-91 Gulf War. The online library now includes data gathered from subsequent deployments, including current operations in Afghanistan and Iraq. As new studies are completed, the results are added to the site. Merging two older sites, Medsearch and DeployMed, DeployMed ResearchLINK provides service members, veterans, families, health care providers, researchers and the public a source for information about federally-funded deployment-related medical research.

Battlefield Surgeons Benefit from Joint Training

The Combat Trauma Surgical Committee (CTSC) was formed after the Gulf War at Fort Sam Houston more than 10 years ago to oversee trauma surgical training. Today they not only coordinate newer, more numerous and more innovative training programs, but they also recommend tri-service trauma surgery policy changes to the Department of Defense in the delivery of military trauma medicine. With members from all services, the CTSC improves training by maintaining a sharp focus on the wounded soldier, sailor, airman or Marine. Committee members created the Emergency War Surgery Handbook, which is used in the Emergency War Surgery Course—the now-standard text and class for battlefield surgeons is continually refined by an upcoming generation of surgeon-instructors whose experiences in Iraq and Afghanistan add to the handbook's archive of knowledge.

Partnerships with Civilian ERs Provide Training

Because the emergency room (ER) of a metropolitan hospital treats traumatic injuries in volumes not seen outside combat, it can provide invaluable training for military medical personnel. At the three service trauma training centers (the Navy in Los Angeles, the Army in Miami and the Air Force in Baltimore), the curriculum is the same for every student, and the student seats are interchangeable among the services, whether for surgeons, corpsmen, or nurses. But, real-world experience for the military centers' students comes from partnering with civilian trauma centers, where ER physicians may see gunshot wounds mimicking those of the battlefield. A similar training effort at King's County Hospital in Brooklyn prepares Reserve medics for battlefield medicine by exposing them to the trauma and tempo of a busy urban ER.

Hidden Wounds Are Identified and Treated

Car accidents and fistfights once accounted for most traumatic brain injuries. However, military doctors are now treating an increased number of Iraq veterans for this "hidden wound"—so-called because the explosive force of a bomb can set up shock waves that rock the brain, causing closed head injuries that are hard to detect. Previously, people with brain injuries often went undiagnosed—many were labeled mentally ill or mistaken for being inebriated. Today, working with the Department of Veterans Affairs, the Department of Defense is treating soldiers with traumatic brain injuries in therapy centers around the country, where occupational and speech therapy are combined in a daily work environment to help the patients regain the memory skills needed to lead a normal life.

Meeting the Challenges

Medical Reorganization

As 2006 came to a close, the Deputy Secretary of Defense issued a concept paper, outlining the "way ahead" for reorganized Department of Defense medical assets. The conceptual framework stopped short of a Unified Medical Command, but sought to establish a process that will increase joint operations and reduce duplication of work where appropriate. Significant efforts will unfold in 2007, as the MHS moves from conceptual framework to implementing guidance. The following elements capture the principal activities for the coming year:

- A Joint Senior Flag Officer will have command responsibility in the National Capital Area and in San Antonio (under BRAC) with local military treatment facility commanders reporting to this joint authority. Following these efforts, work will begin to migrate to joint markets in other multi-service areas including: Tidewater, Hawaii, San Diego, Colorado Springs, Puget Sound, Anchorage, Fairbanks, Bragg/Pope, Charleston, Ft. Jackson-Shaw, Gulf Coast (Biloxi-Gulfport).
- A Joint Medical Education and Training Center will be established in San Antonio.
- Site selection and accelerated efforts to co-locate Health Affairs, the TRICARE Management Activity (TMA) and Army, Navy and Air Force medical headquarters in the National Capital Area.
- Work will begin to identify areas where the TMA and the services may consolidate common support activities, and begin merging appropriate headquarters staffs and functions.
- All Medical Research and Development assets and programs will be combined under the Army Medical Research and Material Command.
- A Joint Military Health Services Directorate under a Joint Senior Flag Officer reporting to the Assistant Secretary of Defense for Health Affairs will be created to consolidate key shared services and functions at the MHS corporate level (Human Capital Management, Finance, IMIT, Support and Logistics Services and Force Health Operations). Concurrently, the TMA will be re-chartered as the TRICARE Health Plan Agency, with a focus on insurance, network, benefit and beneficiary issues.

These changes will accelerate the existing path toward greater interoperability, joint operations and shared services that have been underway for over a decade. In the combat theaters in Iraq and Afghanistan, in medical centers such as Landstuhl Regional Medical Center in Germany, in graduate medical education programs and at our military medical university, Uniformed Services University of the Health Sciences, the MHS has been changing and adapting to better meet the needs of our service members, our line leaders and our beneficiaries. These actions will enhance our operational effectiveness and lead to greater efficiency.

Seamless Transition for Injured Veterans

The Joint Seamless Transition Program is a collaborative effort between the Services and the Department of Veterans Affairs (VA) to coordinate a more timely receipt of benefits for severely injured service members while they are on active duty. To launch the program, the VA teamed with the National Naval Medical Center in Bethesda to provide benefits information and counseling for injured service members who leave acute care at the military treatment facility (MTF) and seek follow-up care at VA hospitals. Teams of caseworkers and discharge planners serve as a central point of contact for veterans and their families, to ensure individual patient needs are met. Arrangements are also made for service members on convalescent leave who wish to continue rehabilitation at their hometown VA facility. As the Seamless Transition program grew, the VA's liaison coordinators expanded to the Naval Medical Center Balboa in San Diego, and the MTF at Camp Pendleton. Now there are VA social workers and counselors assigned at eight MTFs, including Walter Reed Army Medical Center.

Guardsmen Team with VA to Assist Veterans

The Department of Veterans Affairs (VA) has teamed up with the National Guard Bureau to create State Benefits Advisors (SBAs) to help coordinate benefits at the state level for guardsmen returning from active duty deployments. The 54 new National Guard SBAs, who are recently returned veterans, have received specialty training in VA and TRICARE benefits to provide information and resources to guardsmen returning to civilian life.

Workshop Teams Army and VA Therapists

The Brooke Army Medical Center at Fort Sam Houston hosted nearly 100 rehabilitation team members from 15 Department of Veterans Affairs (VA) hospitals to share knowledge about assisting amputees with adjusting to prosthetics and learning new skills to lead a full life. The VA therapists credited the military with taking recovery to a higher level of care seldom encountered in traditional rehabilitation programs. For their part, military therapists were eager to share information about their patients' high-functioning skills and athleticism. At the workshop, patients demonstrated their high-tech prosthetics, the increased performance capabilities the prosthetics allow, and the exercises needed to continually advance their mobility—all of which the VA therapists will now incorporate into their own treatment programs.

DoD and VA Share Resources and Patients

The Department of Defense (DoD) and the Department of Veterans Affairs (VA) will jointly create and operate the North Central Federal Clinic in San Antonio, where about 10,000 veterans and eligible family members will receive outpatient health care services. The new facility, with four VA and four Air Force providers will explore ways for the agencies to share resources and work better together. Another example of DoD/VA resource sharing involves the Great Lakes Naval Station military treatment facility—an aging facility with excess capacity—which is being folded into the new state-of-the-art outpatient facility at the North Chicago VA Medical Center.

Information Flows Both Ways

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) are considered leaders in cross-agency medical-records sharing—this is what interoperability should look like, say the experts. The cooperation between the DoD and VA may provide the basis for a secure national system for sharing medical data. Information sharing between the departments began in the 1990s and accelerated when VA doctors gained access to the military's post-deployment health assessment (PDHA) data for returning veterans. The "bidirectional" sharing of health data steadily increased in 2006 as more than two dozen military treatment facilities shared clinical information with all VA hospitals and clinics. Ultimately, both departments will have access to each other's patient data, to ensure continuity of care and patient safety. The sharing of clinical and demographic information will also make it possible for military researchers to conduct valuable studies in the future. The largest data-sharing project to date is a multi-million dollar effort to exchange medical records led by the VA's Puget Sound Health Care System and the Army's Madigan Medical Center, both in Washington state. Similarly, the South Texas Veterans Health Care System has launched a pilot program to share images (X-rays, MRIs) and other patient data with two DoD facilities in Texas, Wilford Hall and Brooke Army Medical Centers.

TRICARE Accomplishments

TRICARE Team Helps Madi Weiss Walk

Three-year-old Madeline Weiss needed surgery that would allow her to walk. And she needed it soon—during a window of opportunity when the nerves in her toddler legs could be repaired, her motor skills retrained and developmental delays recaptured.

Madeline's family faced the additional pressures and uncertainties of life in the military. Madi lived in Fort Hood, Texas with her parents, CWO2 Rodney and Brenda Weiss, and three brothers, Creedance (7), Jaden (5) and Lincoln (7 months). As her parents made decisions about Madi's treatment, they also faced the news of Dad's upcoming deployment, just a few months away.

Born prematurely, Madi spent the first five weeks of life in the neonatal intensive care unit. She was diagnosed in her first year with cerebral palsy (CP), a group of chronic disorders that impact the body's ability to control movement. Most significantly for Madi, the nerve endings in the backs of her legs had not formed properly, so that, as she grew, Madi experienced tight spastic (tensed) muscles, difficulty walking and problems with fine motor skills. She could walk on tiptoe, but optimum mobility required the aid of a toddler-seated walker.

Like many CP children whose attention is focused on making their limbs work properly, Madi experienced developmental delays that affected speech and learning. She began occupational therapy at eight months old, physical therapy at one, and speech therapy at three—all traditional treatments for CP children. But the prognosis was that Madi would be wheelchair bound as she grew older.

Then the Weisses found a lesser-known surgical option—selective dorsal rhizotomy (SDR)—that might offer Madi a future of walking on her own.

When Madi's doctors mentioned this option, Rodney and Brenda logged on to the internet in Texas and found what they were looking for in Missouri: Dr. T.S. Park, a nationally recognized pediatric neurosurgeon at St. Louis Children's Hospital, specialized in treating CP spastic children. SDR involves removing a portion of the patient's vertebrae and then dividing nerve bundles in the spine. One at a time, segments of nerves are tested: If the nerves test spastic, they are severed; if they test normal, they're left alone. The best outcome is a normal supply of nerves controlling the leg muscles. For Madi, that could mean normal or near-normal mobility, perhaps relying only on the use of a cane.

The Weiss family was enrolled in TRICARE Prime in the South region, yet Dr. Park and St. Louis Children's Hospital were network providers in the West region. Madi's referral would require authorization from the managed care support contractor for an out-of-region provider.

A team of family, friends and military medical staff came together to ensure Madi's surgery was authorized in a coordinated and timely manner. The team: Madi's grandfather, Retired Army Master Sergeant Ron Weiss; a colleague and former Health Benefits Advisor, Bill Walters;

Kevin Brown, a 30-year Air Force retiree and TRICARE Champion; and Lola Ross, a case manager at Fort Hood's Darnall Army Medical Center.

Ross contacted Madi's parents; researched the SDR procedure from a clinical and TRICARE benefit coverage perspective. Ross educated the civilian provider's office on the referral and authorization process, assisted the doctor's staff in preparing a referral request and provided the Humana Military Healthcare Services staff with advance notice. The preparation paid off – and the authorization was quickly granted.

When Madi's parents first saw their sleeping daughter after surgery, they pulled the sheets back and marveled at the change in her legs. "We could tell right away" about the success of the surgery, says Brenda. "Her legs were lying flat, loose, not flexed. We hadn't seen her legs relaxed since she was three months old. It was like she had brand new legs." Mom and Dad cried tears of joy as they envisioned a new future for their child.

The improvement was immediate and will get better over time, adds Grandpa Ron Weiss, concluding, "I'm just so glad TRICARE is there."

"Great!" and "Wonderful!" were the universal responses from Military Health System staff when the family passed along Madi's exciting news and their thanks.

"It was really just a matter of facilitating communication," says Ross, "and making sure the right people had all the necessary information." Coordination—connecting the dots—never seemed more satisfying for the people who do it every day. It was a high-five moment for the team of advocates who worked together to help a little girl walk.

TRICARE Tracks Your Cough from Maine to California

Military beneficiaries routinely move…from New Jersey to Japan, from Germany to Georgia. Too often, frequent moving meant that service or family members never quite got on top of a chronic illness like asthma because treatment plans seldom survived a move intact. An asthmatic child might thrive under an active asthma-management program in one region, and then move to another region where no similar program exists. Another patient might leave behind a doctor who emphasized a medication regimen and limited cardiovascular stress, and then find himself in a new location with a new provider who encourages walking every day.

Last year, the TRICARE Management Activity (TMA) brought consistency to treatment plans for beneficiaries dealing with chronic diseases across the country. In September 2006, the three TRICARE regional contractors implemented standardized disease management programs for high-risk asthma and congestive heart failure (CHF) patients. This year, the program will add similar standards for monitoring diabetes patients. Patients participating in the programs are identified by the TMA and then managed by the contractors.

Disease management provides a standardized approach to communicating with patients whose own self-care efforts play a central role in managing their disease. One-on-one or in group sessions, the provider teaches patients about positive behaviors—like reducing stress and moderating alcohol use—that the patient can actively choose to improve his health. Research shows, for example, that a CHF patient will do better over time if he is educated about the impact of weight gain on his disease, about how to monitor his own health at home and about when to seek care. Clinic staff members also support a patient's compliance with his treatment plan by offering routine feedback on the results of good self-management—a nurse might call to discuss recent lab tests and remind a patient about taking his prescriptions properly, or a dietician might initiate a discussion of healthy eating choices. This consistent attention to detail empowers the patient to participate fully in his plan of care—to view his health as the result of a partnership between himself and his providers.

In addition to encouraging the partnership between practitioner and patient, the management program tracks the patient's status in concrete, measurable ways, and it focuses on proven, effective treatment options. The TMA sets the standards for the best clinical practices that have proven to yield positive results, but the contractors retain some flexibility in implementing the guidelines to better fit their patient population and provider network. All parties share a focus on evidence-based practices. For example, the Department of Defense and the Department of Veterans Affairs practice guidelines show that certain kinds of inhalers are better for certain asthma patients. And the guidelines demonstrate the effectiveness of pneumonia vaccinations for CHF patients. The TMA now tracks the clinical outcomes and monitors the progress for CHF and asthma patients across the country.

Pharmacy News Includes Cost-Saving Opportunities

In the pharmacy marketplace, generic drugs are edging out their brand-name counterparts, reflecting a trend that promises to slow prescription-drug spending and save millions of dollars for U.S. consumers and health plan administrators. Commercial pharmacy benefit managers, like Express Scripts, Inc. (ESI), are helping save money for their clients and the beneficiaries they serve by designing plans that promote the use of generic medications. The increased use of generics helps stretch already thin resources to ensure the Department of Defense continues to provide a high-quality prescription benefit.

The long-term effect on overall health care costs of a nationwide shift to generic drugs is hard to estimate because prescription-drug spending is only part of the bigger picture for medical care expenses. For a sobering perspective, consider that the Centers for Medicare and Medicaid Services estimated that total health expenditures for 2006 were $2.16 trillion, and that amount is expected to grow to more than $4 trillion by 2015. Nevertheless, at least in the short term, pharmacy cost increases are slowed by consumers shifting to generics, and the role of generics is undoubtedly a bright spot on the bleaker health-care-costs horizon. Nationwide, the Congressional Budget Office estimates that generics save consumers an estimated $8 to $10 billion dollars a year at retail pharmacies.

Because the Food and Drug Administration vouches for the safety, efficacy, purity, and equivalency of generics approved for marketing in the U.S., brand-name manufacturers no longer try to discourage use of generic copycats by calling them inferior to innovator drugs. Instead, big pharmaceutical companies now are competing for a piece of the generics market, partly because several very popular, top-earning brand-name drugs are scheduled to lose patent protection in the next few years. After that, less-pricey generic equivalents will be produced for eager consumers.

With TRICARE's 9.1 million beneficiaries as customers, ESI ranks among the top three pharmacy benefits managers in the country. Department of Defense regulations require ESI to fill prescriptions with generics whenever possible, and TRICARE beneficiaries reap the savings: They pay $3.00 for a 30-day supply of generic drugs at a retail pharmacy, compared to $9.00 for brand-name drugs. When beneficiaries order medications through the TRICARE Mail Order Pharmacy (TMOP), they save even more—they receive up to a 90-day supply of generics for $3.00. Last year, Congress was poised to consider eliminating entirely the co-payment for generics ordered through the TMOP program. Cost for a 90-day supply then? $ 0.

Rx for Saving Money, Time, Effort—Go TMOP

Last year, the number of unique users of the TRICARE Mail Order Pharmacy (TMOP) program increased by more than 36,000—in the month of August, alone, users jumped by 9,000. That's because the good news about TMOP is spreading: If beneficiaries take prescription drugs for a long-term, on-going condition, TMOP can save them time and money. Administered by Express Scripts, Inc., one of the nation's top pharmacy benefit managers, TMOP allows beneficiaries to get up to 90-days-worth of drugs, brand-name or generic, for the same price one would pay at the local drugstore for a 30-day supply; it's a savings of 66%. And, beneficiaries can be sure of their prescription's safety and accuracy—each TMOP order is verified twice by registered pharmacists who are available for questions 24 hours a day, 7 days a week.

Five things to know about TMOP:

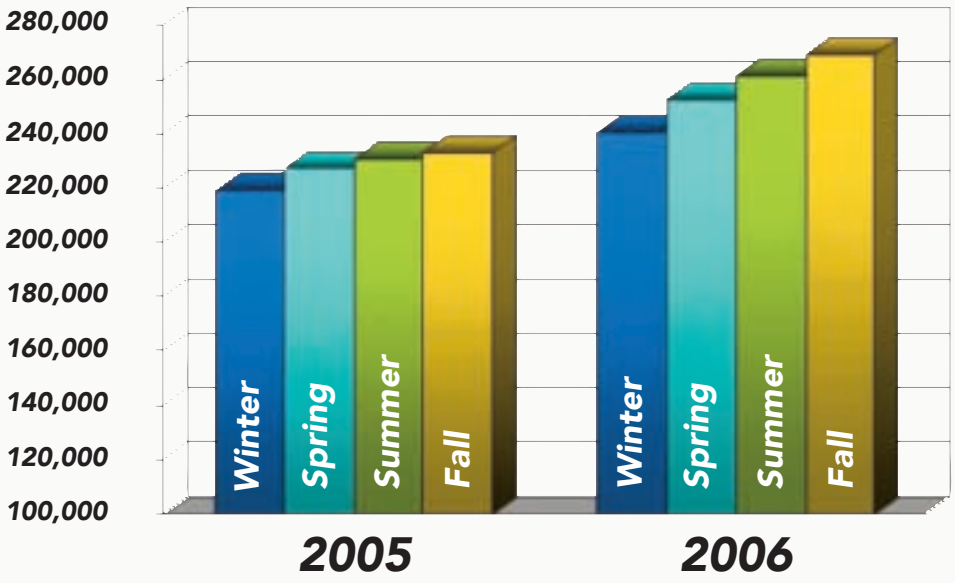
- Beneficiaries can choose which medications go to TMOP—it is specifically designed for drugs taken on a regular basis. A short-term medication need (for immediate pain control or an antibiotic) can be filled at a military treatment facility pharmacy or local retail pharmacy.
- Contact information must be current in the Defense Enrollment Eligibility Reporting System.
- Shipped in plain, weather-resistant pouches, prescriptions arrive directly at beneficiaries' homes, with no shipping or handling fees.
- Refills can be ordered by mail, phone, fax, or online. Beneficiaries pay by check or credit card for phone and online orders. (Note: Active duty service members never pay a cost share.) Order status and forms can be found at Express-Scripts.com.
- TMOP can't be used by beneficiaries who have other health insurance (OHI) with a prescription drug benefit unless the medication is not covered by the OHI or the dollar limit for the other coverage has been reached.

Find out more on the TRICARE Web site, at www.tricare.osd.mil/pharmacy/tmop.cfm.

Rx Fills Just Got Easier

A helpful new feature, called "online coordination of benefits (COB)," was rolled out last year to TRICARE's network of 58,000 retail pharmacies to make prescription-filling an easier transaction for beneficiaries with other health insurance (OHI). If a patient has OHI with a prescription drug benefit, by law the OHI pays first and TRICARE pays second. Often in the past, that meant the beneficiary would pay their OHI cost share at the pharmacy and then file a paper claim to TRICARE for reimbursement. With online COB in place, however, the pharmacy staff can immediately verify what costs the OHI and TRICARE cover and the patient leaves the pharmacy with a better understanding of actual costs and often, owing nothing. The online COB improvement will be appreciated by about half a million TRICARE beneficiaries who have OHI and fill prescriptions at TRICARE retail pharmacies every month.

TRICARE Mail Order Pharmacy Total Users



TRICARE by the Numbers

The Basic Facts of TRICARE

Mission

To enhance the Department of Defense and our nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care

Vision

A world-class health care system that supports the military mission by fostering, protecting, sustaining, and restoring health

What is TRICARE

A health care plan using military health care as the main delivery system

- Augmented by a civilian network of providers and facilities
- Serving our uniformed services, their families, retired military, and their families worldwide

TRICARE Figures

9.1 million
TRICARE Eligible Beneficiaries

- 5.0 million
  TRICARE Prime Enrollees
- 1.6 million
  TRICARE For Life
- 169,000
  TRICARE Plus
- 94,000
  US Family Health Plan
- 34,200
  TRICARE Reserve Select
- 2.2 million
  Non-enrolled Users
- 62,000
  Age 65 & older
  (not TRICARE For Life)

TRICARE Dental Coverage

- 1.7 million
  Active Duty
- 1.8 million
  Active Duty Family Members
- 975,000 Retirees

MHS Direct Care Facilities

- 65 Military Hospitals
- 412 Medical Clinics
- 414 Dental Clinics

132,700 MHS Personnel

- 86,400 Military
- 46,300 Civilian

39.32 billion FY06 Budget
(Unified Medical Program)

- $28.16 billion
  Defense Health
  Program
- $11.16 billion
  Medicare Eligible
  Retiree Accrual Fund

A Week in The Life

19,600
Inpatient Admissions

- 5,000 Direct Care
- 14,600 Purchased Care

Outpatient Workload
(Direct care only)

- 642,400 Professional
  Outpatient Encounters
- 102,900 Dental Seatings

2,100 Births

- 1,000 Direct Care
- 1,100 Purchased Care

2.22 million Prescriptions

- 1.12 million Retail Pharmacies
- 948,000 Direct Care
- 150,000 Mail Order

3.5 million Claims Processed

$754 million Weekly Bill

2006 Benefit Updates

Overseas Eligibility: Command Sponsorship

Active duty service members with overseas orders are required to obtain command sponsorship for accompanying family members so the family can enroll in TRICARE Overseas Program (TOP) Prime and TRICARE Global Remote Overseas (TGRO). The overseas family members must also reside with their sponsor to be eligible for enrollment into TOP Prime. If command-sponsored families enrolled in TOP Prime or TGRO have a newborn or adopt a child while overseas, they must enroll the child to receive TOP Prime or TGRO benefits.

If service families move overseas without command sponsorship, they are only covered under TRICARE Standard. Under Standard, family members must pay an annual deductible and cost shares for covered service received outside of the military treatment facility (MTF) and may have to pay the entire bill at the time of service and then file a claim for reimbursement. They may be able to enroll in TRICARE Plus or receive care at an MTF on a space available basis.

Medicare Opt Out Providers

If a beneficiary enters into a private contract with a provider or supplier who does not offer services through the Medicare program (the provider or supplier chooses to opt out of the Medicare program), TRICARE will process the claim as if TRICARE were second payer after Medicare, as long as the service or supply is a benefit under TRICARE, and the provider or supplier is TRICARE-authorized.

Change in TAMP

Guardsmen and reservists comprise the majority of service members recalled to active duty during their Transitional Assistance Management Program (TAMP) period—the 180 days of TRICARE coverage immediately following release from active duty. The change from TAMP to active duty requires that the member and family members automatically be disenrolled from TRICARE Prime under TAMP. Of course, Prime coverage can continue—if family members want it—but they must re-enroll under the sponsor's new active duty status. Often in the past, families failed to complete the required paperwork for TRICARE Prime enrollment; thus, they were automatically converted to TRICARE Standard; and they discovered what they should have done only after they began receiving doctors' bills for Standard cost shares. Starting in 2006, family members have a 30-day period to submit a TRICARE Prime enrollment form to the regional contractor under the sponsor's new active duty status: They will be retroactively enrolled to the effective date of the sponsor's recent activation, and they will experience no gap in Prime coverage.

Colorectal Screening

Colonoscopies in support of colorectal cancer screening for beneficiaries age 50 and older who are at normal risk will be reimbursed by TRICARE. Screening is covered every 10 years or more often if a beneficiary is determined to be at risk for colon cancer.

TRS—What's New

The opportunity to purchase TRICARE Reserve Select (TRS), in one of three premium tiers, was extended to all qualifying members of the National Guard and Reserves. Members may now return to civilian life for about three months before deciding whether or not to purchase TRS coverage, rather than having to make the decision before separation from active duty. And if the TRS member is recalled to active duty for more than 30 days, his TRS coverage and premium payments are suspended while he is on active duty—they resume after active duty, with no loss to him of TRS coverage days.

Bariatric Surgery

Gastric bypass, gastric stapling or gastroplasty, including vertical banded gastroplasty is covered by TRICARE when a beneficiary is 100 pounds over the ideal weight for height and bone structure and has an associated medical condition; is 200% or more of the ideal weight for height and bone structure; or had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery. Laparoscopic surgical procedures for gastric bypass and gastric stapling (gastroplasty), including vertical banded gastroplasty are now covered by TRICARE.

TRICARE

To comment on the 2007 TRICARE Stakeholders' Report, e-mail: comments@tma.osd.mil, or write to: TRICARE Management Activity, Office of Communications & Customer Service, 5111 Leesburg Pike, Skyline Five, Suite 810, Falls Church, VA 22041-3206

The report is available online at www.tricare.mil/stakeholders