CHAPTER 2

Military Healthcare System

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The Military Healthcare System (MHS)

The Defense Health Agency (DHA) provides an integrated healthcare delivery system of medical treatment facilities (MTF), including hospitals, medical centers, and clinics, all with a particular emphasis on population health and medical readiness. The overreaching mission of the DHA is to provide necessary medical support to military operations, service members, and their families. In 2017 Congress directed the Department of Defense (DoD) to consolidate all DoD military treatment facilities of the Army, Navy (including the Marine Corps), and Air Force under the DHA. Each branch of service has the responsibility of managing medical operations for their respective soldiers, airmen, sailors, and marines (Adirim, 2019) (**Figure 2-1**).

Battlefield Medicine and Transition of Care for Wounded Warriors

Healthcare delivery in the battlefield setting sets the DHA mission apart from that of the civilian healthcare system in significant ways. During wartime, the military has the responsibility to develop, communicate, and operationalize strategies to deliver needed health care in very austere and unpredictable circumstances on the battlefield, while still caring for those back home. The cost of not meeting the demand of this mission is directly measured in decreased operational mission readiness, insufficient care to dependents, and (most significantly) loss of our valuable assets—or service members (SMs). The military has executed this mission with exceptional success for many years. In fact, many lifesaving

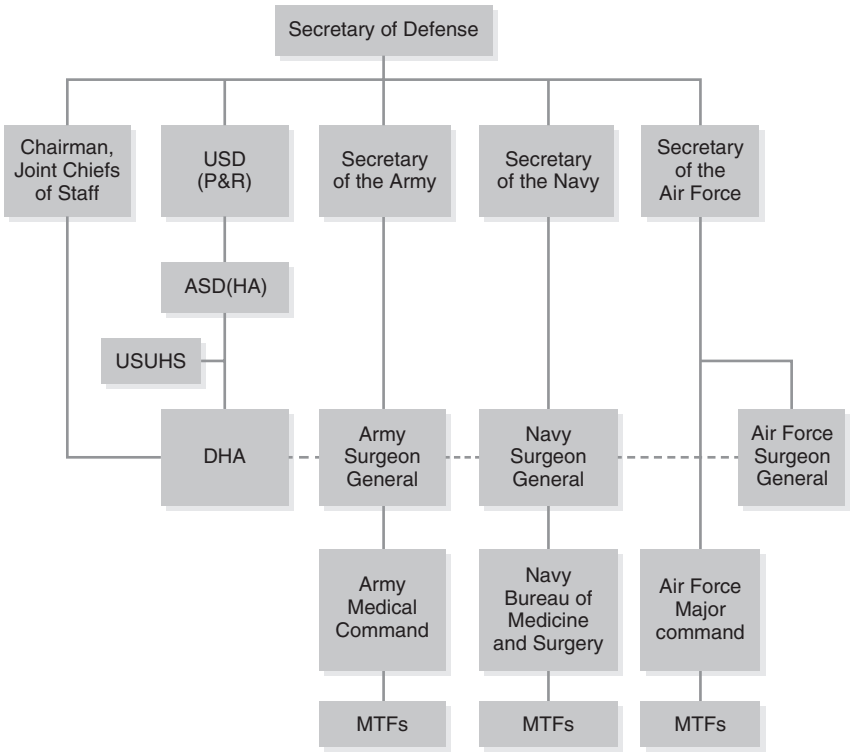


Figure 2-1 Integrated healthcare delivery system.

Modified from Department of Defense. (2014). Overview of the Department of Defense's military health system. https://archive.defense.gov/home/features/2014/0614_healthreview/docs/Fact_Sheet_Overview.PDF

antibiotics, surgical procedures, and general medical practices can be linked directly to battlefield medicine (Cubano, 2018). The mission is not only to deliver health care in these unique situations, but also to do so while maintaining a standard of care that is commensurate with non-battlefield settings. This feat requires extensive training and preparation of the military medical personnel on the front lines of the healthcare delivery system.

Another critical component of battlefield medicine is patient transport and transfer. The DHA coordinates military and logistical assets to facilitate the seamless transfer of sick and injured SMs from the battle zone to the appropriate level of care facility. While it may seem simplistic, this often requires procurement of a complex combination of point-of-injury ground assets, medical air evacuation support, unique naval capabilities, and military fires to protect medical personnel and transportation assets during execution of the movement. These unique challenges represent just a fraction of the no-fail mission sets taken on by the military medical delivery network.

The Role of the Military Healthcare System in OCONUS and CONUS as well as during Peacetime and War

Role 1 - 4

Field Manual (FM) 4–02 (2013) lays out the roles or echelons of care for active beneficiaries,

which spans from the unit level to general hospitals. Level I is unit level care (e.g., buddy aid, combat stress support, and evacuations support), level II is care provided by medical battalions or medical companies (e.g., level I care with the addition of surgical, dental, and radiological support), level III care is conducted in the MTF (Evacuation Hospitals or Combat Support Hospitals) (e.g., conduct surgery, recover for return to duty, stabilize for evacuation), and level IV care is conduct in Field or General Hospitals away from the combat zone (e.g., rehabilitation, orthopedics, OB/GYN, dental, and optometry).

The DHA must tailor healthcare delivery to many different locations, operational missions, and patient populations. During wartime, this mission spans from the front lines of the battle to the long-term rehabilitation complex, and every step in between. The configuration of MTFs along the continuum of care must encompass a wide range of capabilities, and the DHA must ensure provider competency in all required specialties. There is a large network of educational and training organizations within the DHA that play an invaluable role in this regard. Considering that the United States has existed in a steady state of wartime operations for decades, the DHA has become extremely resourceful and resilient at operationalizing the delivery of its healthcare products.

Moreover, recent years have seen an escalation of tensions at the demilitarized zone between North and South Korea where many SMs and their families live and work. SMs stationed in Japan also are in danger of the increasing ability of North Korea to strike Japan with deadly force. In addition to traditional military treats, infectious diseases have threatened the readiness of our troops and the well-being of their families worldwide. Depending on where SMs work, imminent threat of war, vectorborne illness, pandemic infectious disease, water/food security, among other issues must be mitigated to ensure operational readiness.

Military public health personnel work tirelessly to provide sound and effective preventive medical plans to minimize the impact of infectious disease and trauma, manage behavioral health treats, and overcome other risks to SMs and their families. Prevention protocols are also specific to location of military operations, population, and other factors. Preventive measures are arguably the efforts across the force healthcare delivery network that pay the highest dividends and have the longest history in the U.S. military, which dates to World War 1 (Fox et al., 2010).

Examine the Role of the Medical Home within the MHS

The patient-centered medical home (PCMH) concept was introduced in the United States in 1967 to combat rising medical costs, optimize resources, and address increased demand for care, poor health outcomes, and unacceptable patient satisfaction. A council of leading medical professional agencies endorsed the PCMH model in 2002, with a focus on seven core principles to be implemented within the primary care setting (**Table 2-1**) (Marshall et al., 2011).

Within the MHS, the PCMH is physically located within military treatment facilities and provides high-quality care to SMs and their families. The PCMH minimizes disruption of care and decreases the time active duty (AD) civilians, SMs, retirees, and their beneficiaries are out of the workplace for medical appointments. PCMHs offer a patient empowerment model, which actively involves patients in their own care and places them at the center of the care plan where they are encouraged to have an active role. The PCMH model focuses on the patients' health goals in locations where they work, play, and live. Medical homes offer primary care and other ancillary services such as laboratory, pharmacy, and radiology services. The PCMH model can provide

Table 2-1 Patient-Centered Medical Home (PCHM) Principles

Types of Care	Definition
Personal Physician	Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.
Physician-Directed Medical Practice	The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
Whole-Person Orientation	The personal physician is responsible for providing all the patient's healthcare needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventive services, and end-of-life care.
Coordinated and/or Integrated Care	Care is coordinated and/or integrated across all elements of the complex healthcare system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to ensure that patients get the indicated care in a culturally and linguistically appropriate manner when and where they need it.
Quality and Safety	Quality and safety are hallmarks of the medical home. Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family. ■ Evidence-based medicine and clinical decision support tools guide decision making. ■ Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. ■ Patients actively participate in decision making, and feedback is sought to ensure patient expectations are being met. ■ Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication. ■ Practices go through a voluntary recognition process by an appropriate nongovernmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model. ■ Patients and families participate in quality improvement activities at the practice level.
Enhanced Access	Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.
Payment Reform	Payment appropriately recognizes the added value provided to patients who have a PCMH. The payment structure should: ■ Reflect the value of physician and nonphysician staff of patient-centered care management that falls outside of the face-to-face visit.

Types of Care	Definition
	■ Pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. ■ Support adoption and use of health information technology for quality improvement. ■ Support provision of enhanced communication access such as secure email and telephone consultation. ■ Recognize the value of physician work associated with remote monitoring of clinical data using technology. ■ Allow for separate fee-for-service payments for face-to-face visits. Payments for care management services that fall outside of the face-to-face visit, as described earlier, should not result in a reduction in the payments for face-to-face visits. ■ Recognize case mix differences in the patient population being treated within the practice. ■ Allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. ■ Allow for additional payments for achieving measurable and continuous quality improvements.

Table was created based on extracted definitions provided in the MHSPCMH guide (MHSPCMH, 2011).

shorter times away from military units, work, or home, and the centralized team structure improves readiness by decreasing emergency room (ER) visits (Marshall et al., 2011).

The military has three distinct populations that include SMs, retirees, and their family members. Caring for these unique populations must focus on the end-state of "readiness." Overall, the medical home in the MHS focuses on combat medical readiness for SMs, family readiness for the beneficiaries, and readiness for all retirees and AD civilians who support the warfighter. To ensure that all beneficiaries receive adequate care, the MHS deployed two platforms to enhance access to care. Soldier-centered medical homes (SCMHs) and family-centered medical homes (FCMHs) were operationalized to increase access to care and to leverage embedded medical assets. SCMHs are housed on the military installation near brigade level units where much of the SM population lives, while FCMHs are strategically placed in local communities to facilitate easy accessibility for beneficiaries. By creating these two new clinical platforms of integrated care for SMs and their families, the MHS effectively increased access to care, improved patient satisfaction and readiness, decreased cost, and improved the quality of care (Army Medicine, n.d.).

Mission of the MHS and Mission Readiness

The complex mission of the DHA includes ensuring the health and well-being of millions of AD and reserve SMs and their families. SMs must be trained, retrained, and ready to provide the highest level of medical care in support of operational missions across the globe.

Moreover, the United States has maintained a military presence in many countries with whom they have historically been at war. With SMs and their families living and working in countries and cities worldwide,

military medical assets must also follow to ensure continuity of medical readiness. The DHA has intensely invested resources, and the DoD has heavily budgeted for seamless access to care of all SMs, no matter where they are asked to serve. Alongside access to care for SMs and their families, quality and safety are of great concern to the DHA. With large medical centers, community hospitals, and clinics spanning the globe, DHA MTF safety is consistently rated as comparable to that found in the civilian sector based on averages from nationally standardized surveys of employee perceptions and patient response rates (Secretary of Defense, 2019).

Healthcare Missions between the Services

For all branches of the military, the goal is to provide high-quality healthcare products to SMs. Due to the differences in missions, vehicle platforms, and several other key factors, there are significant differences in the way that healthcare delivery is managed across the DoD footprint. Navy, Air Force, and Army providers must have mission-specific training, which makes for some differences in patient management across the Armed Forces. In many cases, there is no single set of metrics that can be monitored to assess performance of healthcare delivery, quality, safety, access, and other parameters across the enterprise. Additionally, purchased care that occurs outside of the DHA network of MTFs carry their own set of metrics, medical records systems, and providers, which compound the problem of tracking and comparing healthcare delivery across the entire DoD footprint (Washington et al., 2018).

Scope and Allocations of Care

The MHS provides care for some 9.5 million beneficiaries: AD, retirees, their qualified family members, and survivors (Tricare, n.d.). The MHS provides the same preventive care and every type of medical/surgical service as healthcare systems in the private sector and is managed by Tricare, a state-of-the-art comprehensive military health maintenance organization (HMO). The level of access to care at military treatment facilities is based on the beneficiary category, of which there are two major groups:

1. AD, retired, and guard/reserve members
2. Dependents (spouses and children under age 23 who are registered in the medical record database)

A beneficiary's category determines the enrollment qualification and the subsequent coverage group. Tricare Prime, Tricare Prime Remote, Tricare Prime Overseas, Tricare Prime Remote Overseas, Tricare Select, Tricare Select Overseas, Tricare Young Adult, Tricare For Life, Tricare Reserve Select, Tricare Retired Reserves, and U.S. Family Health Plan are the different programs being offered (Tricare, n.d.). While enrollment can seem overwhelming, Tricare services offer assistance for determining which option is best for each beneficiary.

AD and their families are top priority in the provider portfolio in military treatment facilities. This group is front-loaded for all medical and surgical appointments within available provider profiles. Many AD SMs and their families are enrolled in one of the Tricare Prime options, which have no associated co-pays or monthly costs. Generally, there are no out-of-pocket expenses, even if the beneficiary is seen in the private sector. Additionally, travel reimbursement for specialty care not provided within the local MTF is available to offset any costs the beneficiary may incur.

Retirees are prioritized second in military MTF. In most instances, retirees are in what is called space available (SPACE A) categories for appointments. This means that any empty appointments after the demand from the AD group has been satisfied can be scheduled for a retiree. Dependent children may be seen under certain circumstances depending on the

SM's marital status during the time of service. Unfortunately, Reservists and National Guard members cannot be serviced at the military MTF on a regular basis. This group is only entitled to medical care at the MTFs when they are on AD orders, in which case they are considered first priority just like other AD SMs and their families.

Access to Care for Military Members and Families: Private Sector Partnerships and Department of Veteran Affairs (VA) Partnerships

Not all installations have the same level of military treatment facility coverage. Depending on the size of the military community, location, and the missions, different levels of military emergency facilities, military medical centers, community hospitals, or clinics may vary. Beneficiaries will move from one state or country to another when changing duty stations, so their type of enrollment may change (e.g., a move from the United States to Germany requires an enrollment change from Tricare Prime to Tricare Prime Overseas). To facilitate continuity of care, military electronic health records (EHR) are uniform across all states and continents.

Special assignments such as training with industry partners, long-term health education and training, or recruitment are other times when the beneficiary's type of enrollment may change. If there is no nearby MTF, the plan will change from Tricare Prime to Tricare Prime Remote, or U.S. Family Health Plan, which gives coverage to contracted private sector providers at no cost, including medications. The Assistant Secretary of Defense (ASD) of Health Affairs oversees Tricare, but it is managed by the military and private sector partnerships. There are several types of private sector partnerships (**Table 2-2**) that require registration as a network or nonnetwork entity (Smith et al., 2017).

Military members with over 20 years of service, or those who have qualifying medical injuries, may leave AD and become a retiree. All others who separate are considered veterans. The VA healthcare system does not service AD SMs but is the primary source of access to health care for retirees. Since the VA does not see AD SMs, no record sharing routinely occurs between the two populations. For years, the MHS and VA have been working toward developing a method of record sharing

Table 2-2 Provider Types

Professional providers (other than applied behavior analysis [ABA]) include medical doctors and doctors of osteopathy (MDs/DOs), physician assistants (PAs), nurse practitioners (NPs), urgent care providers, psychiatrists, psychologists, masters-level mental health providers, and physical, speech, and occupational therapists (PTs, STs, OTs).	**ABA providers** include Tricare-authorized Board-Certified Behavior Analysts® (BCBAs), BCBA doctorals (BCBA-Ds), licensed behavior analysts (LBAs), or other qualified Tricare-authorized independent providers with a scope of practice for independent practice of ABA.
Facilities and ancillary type providers include hospitals, ambulatory surgical centers, hospices, skilled nursing facilities, psychiatric facilities, home health agencies, and durable medical equipment and medical supply companies.	To enroll: www.tricare.mil

TRICARE. (n.d.). *Become a Tricare provider*. https://www.tricare-west.com/content/hnfs/home/tw/prov/become-a-provider.html

between VA healthcare facilities and MTFs. The Virtual Lifetime Electronic Record (VLER) Health Initiative and eHealth Exchange (a network of exchange partners who securely share clinical information across the United States) are data management platforms that allow participating medical organizations to share medical records. Several VA facilities in the United States are leveraging the VLER and are sharing military EHRs between the military MTF, VA, and participating civilian healthcare partners to provide continuity of care and reduce errors and redundancies (Tricare, n.d.).

Tricare Insurance

The DHA delivers health care to millions of SMs and their dependents. To accomplish this, the system relies on both MTFs and purchased care, which is used when MTFs are over capacity. The purchased care option employs assets from civilian network hospitals to augment the reach and capacity of DHA assets. The military healthcare delivery network is managed through Tricare, which handles over 9.5 million beneficiaries (Tricare, n.d.). Also, compared to civilian healthcare delivery systems, the DHA generally covers a younger, healthier, and more compliant patient population. The systems, too, within the DHA tend to be more integrated and easier to access for SMs and their families (Army Medicine, n.d.).

Education and Training Requirements of the MHS Team

To augment healthcare delivery, the ASD of Health Affairs places a high value on medical education and training of healthcare providers through several outlets across the country. The Uniformed Services University of the Health Sciences (USUHS) is, perhaps, the flagship of the medical education efforts across the DHA, but there are many other medical military training programs throughout the country as well. Additionally, the DHA has prominent research and development operations that are active in production of vaccines, medications, and other healthcare knowledge products, materials, and services.

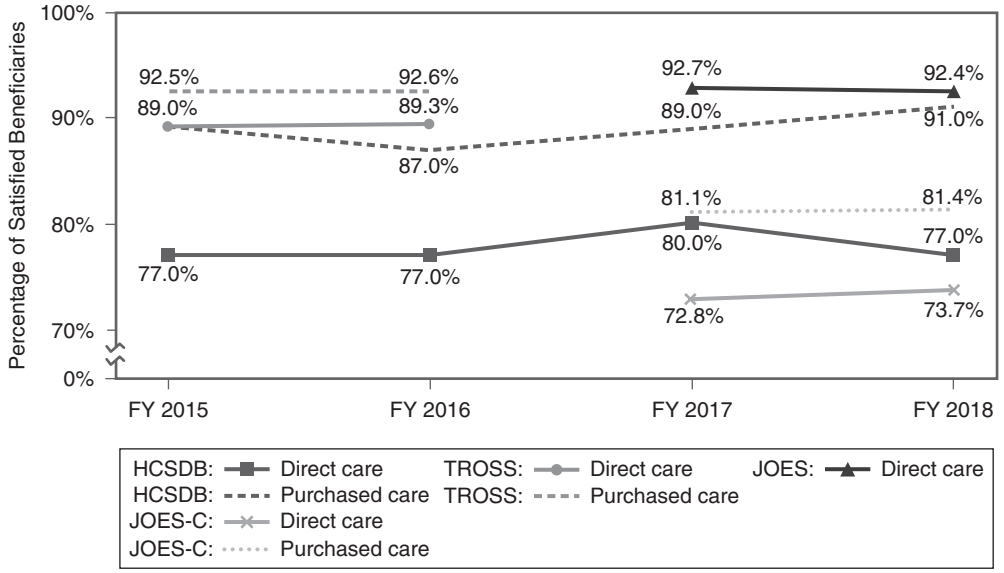
The USUHS trains a significant number of healthcare professionals annually, but to meet the demand of the DHA, private civilian training programs are employed as well. Physicians, nurses, behavioral health providers, and many other medical professionals are routinely recruited from the private sector to become medical officers in the DoD. Several incentive programs are available to civilian-trained healthcare professionals through the DHA that function to expand the capabilities and proficiency of the DHA provider force. Additionally, programs to certify providers, nurses, veterinarians, medics, and other healthcare professionals are provided across the force to ensure that providers remain up to date with new medical developments and are consistently provided DHA beneficiaries with cutting-edge medical care (Army Medicine, n.d.).

Patient Satisfaction and Loyalty in the MHS

Healthcare outcomes are the measure for quality of all healthcare systems, and the MHS system is no exception. The personal expectation in contrast to the experience is what will determine the quality of care that the MHS is delivering. Research on the MHS discovers that many military beneficiaries were less than pleased with the care received and suggested improvement to decrease the gap between beneficiaries' expectations and their experience (Jennings & Loan, 1999; Jennings et al., 2005). As the DoD evaluates medical systems for the military, the National Defense Authorization Act (NDAA, 1992) mandated the establishment of an annual survey program that is benchmarked against healthcare norms.

MHS healthcare scientists gather data to analyze beneficiary satisfaction and to support strategic marketing and planning. Data scientists also work to increase access to and quality of care, and to maintain a proactive posture for responding to changing needs of the DoD. The needed information is extracted from a series of surveys, including the Health Care Survey of DoD Beneficiaries (HCSDB), Tricare Inpatient Satisfaction Survey (TRISS), and Joint Outpatient Experience Survey (JOES). HCSDB is conducted annually for system improvement and assesses how efficiently the system administers benefits to Tricare members. The TRISS and JOES are based on individual encounters both inpatient and outpatient, respectively. Every visit with a provider within the MHS will trigger a survey depending on the type of encounter (Army Medicine, n.d.). The MHS generates annual reports to assess results of the surveys, and these reports are shared with senior leaders and NDAA. Reports can be obtained through the MHS Army Medicine website.

Figure 2-2 is a snapshot from the DHA survey evaluating satisfaction with care.



Notes:

– Results for each survey above are weighted to appropriately represent the composition of the MHS population.

– TROSS results for FY 2016 continue from October 2015 to May 2016 for direct care, and from October 2015 to April 2016 for purchased care.

– Results for HCSDB are for Prime enrollees only. "HCSDB Purchased Care" is defined as those who are assigned to an MCSC. "Satisfaction With Care is worded very similarly in each survey as the following statement: "Overall, I am satisfied with the health care I received on this visit" The five-point scale for this question ranges from "Strongly Disagree" to "Strongly Agree." The results provided above are for those beneficiaries who reported either "Somewhat Agree" or "Strongly Agree."

– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration, respective to the JOES and JOES-C surveys.

– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

Figure 2-2 HCSDB, TRISS, JOES, and JOES-C ratings of satisfaction with care, FYs 2015–2018.

DHA/SP&FI (J-5)/Decision Support, HCSDB, TROSS, and JOES, compiled May 12, 2018.

Several recent studies regarding quality of and access to care for retirees and veterans reveal that many private sector providers lack the needed level of familiarity with the healthcare needs of military beneficiaries (Dyhouse, 2018). This disconnect provides barriers to care for many military families. The military has a specific culture, comradery, environment, and community that must be considered by civilian medical systems. Military beneficiaries can develop a sense of loss and undue stress if these variables are not considered (Daniels, 2017; Elnitsky & Kilmer, 2017). Providers within the MHS are colleagues, neighbors, brothers and sisters in arms with the people they serve. The convenience and a sense of familiarity with this system make it easy for the beneficiaries to remain loyal. Additionally, the MHS is staffed largely by veterans and AD professionals who have firsthand experience with the nuances of military life.

Conclusion

Every healthcare system is expected to provide the best care possible, and there are no exemptions for the MHS. We have reviewed the missions, operations, populations, and partnerships of this complex system. Hopefully, we have shed light on some to the unique situations associated with caring for our SMs who defend the United States and its allies. In addition to maintaining the highest standards, the MHS is responsible for the medical readiness of the fighting Armed Forces of our nation (Kellermann, 2017). For more information on the MHS, refer to the resource list at the end of this chapter.

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Useful Websites

1. Tricare: https://tricare.mil/
2. Defense Health Agency (DHA): https://www.health.mil/About-MHS/OASDHA/Defense-Health-Agency
3. Surgeon Generals—Army, Navy, Air Force
4. Military and Veteran Benefits: http://www.Military.com
5. Military Healthcare System Review http://archive.defense.gov/pubs/140930_MHS_Review_Final_Report_Main_Body.pdf
6. Uniformed Services University of the Health Sciences (USUHS): https://www.usuhs.edu/home
7. Health: https://health.mil/About-MHS
8. Army Medicine: https://armymedicine.health.mil/Patient-Centered-Medical-Home
9. Uniformed Service Academy of Family Physicians: http://www.usafp.org/Patient-Centered-Medical-Home-Page.html
10. Patient Centered Primary Care Collaborative: http://www.pcpcc.net/
11. American College of Physicians PCMH Resource Site: http://www.acponline.org/running_practice/pcmh/understanding/
12. NCQA Recognition Website: http://www.ncqa.org/tabid/631/default.aspx
13. American Academy of Pediatrics Center for Medical Home Implementation: http://www.medicalhomeinfo.org/how/care_delivery/pediatric_subspecialists.aspx
14. AHRQ PCMH Resource Center: http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483
15. American College of Physicians PCMH Website: http://www.acponline.org/running_practice/pcmh/
16. American Academy of Family Physicians PCMH Checklist: http://www.usafp.org/PCMH-Files/AAFP-Files/PCMHChecklist.pdf
17. American Academy of Family Physicians: http://www.aafp.org/online/en/home/membership/initiatives/futurefamilymed.html
18. Patient-Centered Primary Care Collaborative: http://www.pcpcc.net3
19. American College of Physicians: http://www.acponline.org/running_practice/pcmh/demonstrations/jointprinc_05_17.pdf
20. Become a Tricare Provider: https://www.tricare-west.com/content/hnfs/home/tw/prov/become-a-provider.html
21. U.S. Department of Veterans Affairs: www.va.gov
22. Overview of the Department of Defense's Military Health System: https://archive.defense.gov/home/features/2014/0614_healthreview/docs/Fact_Sheet_Overview.PDF
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