

# COMMUNICATIONS PLAN MILITARY HEALTH SYSTEM (MHS) REVIEW: REPORT AND RECOMMENDATIONS

30 September 2014 (v14)





**MHS MILITARY HEALTH SYSTEM**

health.mil

# **COMMUNICATIONS PLAN**

## **MILITARY HEALTH SYSTEM REVIEW AND REPORT**

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## Background

On May 28, 2014, the Secretary of Defense ordered a comprehensive review of the Military Health System (MHS). The review was directed to assess whether: 1) access to medical care in the MHS meets defined access standards; 2) the quality of health care in the MHS meets or exceeds defined benchmarks; and 3) the MHS has created a culture of safety with effective processes for ensuring safe and reliable care of beneficiaries. This is the first time the MHS has taken an enterprise view of such scope in these areas.

Based on information analyzed during the review, the MHS provides good quality care that is safe and timely, and is comparable to that found in the civilian sector. However, the MHS demonstrates wide performance variability with some areas better than civilian counterparts and other areas below national benchmarks.

Together, the review's results and the professional inputs from six external experts indicate clear opportunities to improve health care delivery. By implementing effective strategies used by other high-performing organizations, the MHS can create an optimal health care environment that focuses on continuous quality improvement where every patient receives safe, high-quality care at all times.

The major recommendations in this report are directed at system enhancements to address areas of concern and to drive change that will foster creation of a high reliability health system. High reliability organizations, in general, are those where harm prevention and quality improvement are second nature to all in the organization. Such organizations recognize the risk of over simplification in complex systems: thus, implementation of the proposed recommendations should not be expected to result in immediate change. MHS governance can support performance improvement with better analytics, greater clarity in policy, and aligned training and education programs. However, improving outcomes is about decreasing performance variance at the individual facility level, which requires consistent leadership vigilance, with the goal of making the MHS a top-tier health care system.

## Goals/Objectives of Communications Plan

- **Educate** senior leaders, external stakeholders, partners, and beneficiaries on the findings, recommendations, and conclusions of the MHS Review.
- **Inform** internal and external stakeholders about specific actions being taken to address identified challenges in access, safety and quality
- **Engage** outside experts and stakeholders to review their recommendations and suggestions for improvement.

## Target Audiences

***DoD Senior Political and Military Leadership*** - Senior political, civilian, military line and military medical leadership within the Department of Defense.

***MHS Personnel*** - Internal Health Affairs, Service medical, and Defense Health Agency military, civilian, and contract staff.

***MSO/VSO Groups*** – Military Service Organizations and Veteran Service Organizations. Associations and non-profit organizations focused on promoting beneficiary priorities, interests, and concerns (ex. Military Officers Association of America, National Military Family Association).

***Beneficiaries*** – Active duty, family members, and retired beneficiaries who have received or are eligible to receive care within the MHS.

***Congress*** - Members and staff on the Senate Armed Services Committee (SASC), House Armed Services Committee (HASC), Senate Appropriations Committee – Defense (SAC-D) and House Appropriations Committee – Defense (HAC-D). General messages to other interested members of Congress will fall into the same categories as the more targeted messages to committee members.

***White House*** - Administration liaisons for DoD issues, health care issues, and budget issues.

***TRICARE Contractors*** – Managed Care Support Contractors and other industry partners who work with the Department of Defense and Military Health System to provide care to beneficiaries.

***Civilian Medical Leadership*** – Leaders of civilian partner institutions and associations, including leading health facilities, professional organizations, and accreditation bodies (ex. AMSUS, ACS, NSQIP)

***Press/Media*** – Members of the press, with particular focus to major national publications (New York Times, Washington Post, Wall Street Journal) and established military-focused publications (ex. Military Times, Stars & Stripes).

***General Public*** – All remaining members of the general public.

## Key Messages

*"The report provided no evidence of substantive deficiencies in the safety, quality, and access to care at MHS that would warrant broad and urgent changes" Dr. Peter Pronovost, M.D. Ph.D., FCCM -- John Hopkins Medicine Senior Vice President for Patient Safety and Quality Director of the Armstrong Institute for Patient Safety and Quality.*

- Nothing is more important than the health and well-being of our people. The Department is committed to quality and safety in every aspect of our health care system.
- Over the past 13 years of war the Military Health System (MHS) has demonstrated excellence in many things, including battlefield trauma care, medical evacuation, and post-combat rehabilitative care.

- The Secretary of Defense directed the 90-Day review of the Military Health System (MHS) to provide an assessment of how the MHS is performing in three vital areas: access to care, quality of care, safety of care.
- The assessment was expected to provide a baseline for how the MHS is performing today, and – where performance was not meeting either internal or external standards – provide specific recommendations for improvement for the MHS to be viewed as a leading health system in the United States.
- This review found that the MHS delivers safe, timely, and quality care that is comparable to civilian systems. However, the MHS demonstrates wide performance variability with some areas better than civilian counterparts and other areas below national benchmark.
- DoD's health care medical professionals and providers are second to none in their commitment to achieve more accountable and quality health care for all of our people. But we can and must do better.

## Talking Points

### About the Review:

- The review looked at hundreds of measures. The system itself covers 9.6 million beneficiaries, with over 50 inpatient facilities and over 600 clinics in the direct care system and hundreds of thousands of providers and hospitals that are affiliated with DoD through its private sector network.
- For this review, DoD worked with three premier health organizations in the country – Geisinger Health System, Intermountain Health, and Kaiser Permanente. Of the measures used by these organizations, there was not a single set that was directly comparable across all four systems of care. This finding, however, does highlight the value and importance of comparing DoD to itself, *over time*, as much as comparing to other institutions.
- Six leading medical experts external to the MHS reviewed both the methodology and outcomes of the review. The external experts largely validated the findings, recommendations, and conclusions of the report, as well as suggested additional actions. Their full comments are included in the report.
- Given the short timeframe for this review, the team largely used information already collected by the MHS.
- Caution is needed when assessing how the MHS compares to healthcare in the U.S. in general, or how it compares to particular systems. The report used national benchmarks for specific measures where available, and other standards when a national benchmark could not be found.

- There are no national standards or benchmarks for perinatal and obstetric care. In the absence of national standards, DoD elected to participate in a voluntary program of data collection and reporting with 85 participating hospitals that have high volumes of perinatal care. Thus, DoD benchmark data is compared to this limited number of institutions. The data provides DoD with a sense of how we are performing against these other hospitals, but it does not represent a national standard.
- DoD's voluntary participation in the National Surgical Quality Improvement Program (NSQIP) is also an attempt to compare ourselves against a subset of US hospitals in the area of surgical quality. But, it is not a national benchmark.
- The MHS Review made five overarching recommendations, focusing on standardization, process improvement, and transparency. In addition, there were 77 specific recommendations for action to address issues identified in the review.

#### MTF Outliers:

- A significant number of the measures evaluated in the review have been available to the public through either DoD websites or through the Joint Commission website:
  - These measures, however, were not necessarily easy to find nor were they displayed in an understandable manner
  - One recommendation emerging from the review is the need to further improve MHS transparency – and this review is the first step
  - We will improve our web products, and work with other organizations (such as Hospital Compare, operated by the Center for Medicare and Medicaid Services (CMS)) to further publicize our information.
- In some areas of health care quality and safety, we have fallen short of our own standards and expectations:
  - There is variation in performance. This is true within the same MTF for select services, within the Military Departments, and across the MHS; however, we have seen improved performance, over time, on a number of key quality and safety measures
  - We are targeting the contributing factors for this variation, both positive and negative, and any potential impact it may have on patient care
- We are investing in improved analytic measures and tools to improve across our enterprise:
  - The recommendations that will come forth from the Secretary include system-wide reforms
  - We are confident that these comprehensive reforms will provide local commanders with the resources and tools that they need to aggressively implement local solutions

- We will be establishing an educational and outreach campaign with military and veteran service organizations to help inform our beneficiaries about the measures we collect and monitor in order to improve, and help them ask the right questions within their local communities

Five Overarching Report Recommendations:

1. The MHS should develop a performance management system by adopting a core set of jointly defined access, quality, and patient safety metrics; further develop MHS dashboards with system-wide performance measures; and conduct quarterly formal performance reviews of the entire MHS, with the DHA monitoring performance and supporting MHS governance bodies in those reviews.
2. The MHS should develop an enterprise-wide quality and patient safety data analytics infrastructure, supported by appropriate health information technology, data management tools, and trained personnel. This will require close collaboration between the DHA's analytic capabilities, which monitors the MHS overall, and the Service- level analytic assets.
3. The MHS should create transparency of information in both the direct and purchased care components, with visibility internally, externally, and to DoD beneficiaries. Greater alignment of measures of the purchased care component with those of the direct care component should be incorporated in TRICARE regional contracts.
4. Health Affairs, with the support of the Services and the DHA, should develop policy which will drive the MHS culture of safety and quality, with the Services and the DHA executing policy based on a common understanding of the principles of a high reliability organization.
5. The MHS should continue to develop, where it makes sense either fiscally or from a quality of care perspective, common standards and processes across the enterprise with the goal of improved outcomes in the areas of patient safety, quality, and access.

Conclusions from the MHS Review Report:

- Conclusions Regarding Access to Care: On average, the MHS provides ready access to medical care as defined by access standards in policies and guidance of Health Affairs, the Military Medical Departments, and in TRICARE contract specifications (although current TRICARE regional contracts do not specify the level of detail which DoD regulations require for the direct care component).
- Conclusions Regarding Quality of Care: The MHS is substantially in compliance with national quality benchmarks across a wide range of measures for inpatient and outpatient care where data were available for comparison. However, there are opportunities for improvement in specific clinical areas as well as in the areas of policy, performance monitoring and compliance, and training and education.

- **Conclusions Regarding Patient Safety:** While there are ongoing efforts within the DHA and MTFs to continuously improve patient safety at all levels, the review identified opportunities for improvement across the system that, addressed through a standardized and common approach, would further advance the existing culture of safety as well as improve safety within the MHS.

*MHS Goals Moving Forward:*

- The MHS will continue to mature as an integrated health system, improving alignment among the Services and between the direct care and purchased care components, placing particular emphasis on improving transparency related to access, quality of care, and patient safety.
- The MHS will implement the principles of a high reliability organization through leadership engagement, a culture of quality and safety, and robust process improvement through regular performance reviews.

*Secretary Hagel's Action Plan:*

- **Access to Care:** Within 30 days, all MTFs identified in the review as outliers with respect to access standards will have action plans to improve performance. Additionally, a 12-month study will be conducted to review purchased care access for all TRICARE enrollees.
- **Quality and Safety of Care:** Within 45 days, all MTFs identified in the review as outliers with respect to the quality and safety measures used in the review will have action plans to improve performance. Also, within 90 days, the DHA will provide a plan for a more comprehensive assessment of quality and safety within purchased care. Lastly, within 90 days, the DHA will establish a MHS performance management system to support the Services as they manage and monitor MTF performance.
- **Transparency and Patient Engagement:** Within 30 days, the MHS will have a plan to provide all currently available aggregate statistical access, quality, and safety information available on health.mil. Additionally, within 30 days, the MHS will develop a mechanism through which patients and stakeholders are engaged for ongoing and enduring input.
- **High Reliability Organization:** Within 90 days, the ASD(HA) will lead the development of a specific plan to implement the necessary changes to move to a top performing health system and address all recommendations in the MHS review report.

Public Affairs Guidance

1. **Purpose:** To provide Public Affairs Guidance (PAG) and strategy concerning Secretary Hagel's publication of the recommendations and results from the 90-day "Military Health System (MHS) Review" for patient access, quality and safety.

- 2. Background:** On May 28, 2014, the Secretary of Defense ordered a comprehensive review of the Military Health System (MHS). The review was directed to assess whether: 1) access to medical care in the MHS meets defined access standards; 2) the quality of health care in the MHS meets or exceeds defined benchmarks; and 3) the MHS has created a culture of safety with effective processes for ensuring safe and reliable care of beneficiaries. This is the first time the MHS has taken an enterprise view of such scope in these areas.

The review is scheduled for release on October 1, 2014. Based on information analyzed during the review, the MHS provides good quality care that is safe and timely, and is comparable to that found in the civilian sector. However, the MHS demonstrates wide performance variability with some areas better than civilian counterparts and other areas below national benchmarks.

Together, the review's results and the professional inputs from six external experts indicate clear opportunities to improve health care delivery. By implementing effective strategies used by other high-performing organizations, the MHS can create an optimal health care environment that focuses on continuous quality improvement where every patient receives safe, high-quality care at all times.

The major recommendations in this report are directed at system enhancements to address areas of concern and to drive change that will foster creation of a high reliability health system. High reliability organizations, in general, are those where harm prevention and quality improvement are second nature to all in the organization. Such organizations recognize the risk of over simplification in complex systems: thus, implementation of the proposed recommendations should not be expected to result in immediate change. MHS governance can support performance improvement with better analytics, greater clarity in policy, and aligned training and education programs. However, improving outcomes is about decreasing performance variance at the individual facility level, which requires consistent leadership vigilance, with the goal of making the MHS a top-tier health care system.

### **3. Communications Goal:**

- ***Internal:*** Prepare spokespersons and SMEs to communicate the findings, outcomes, recommendations, and action plans for the way ahead coming from the MHS Review. This includes Service and local subject matter experts responsible for responding to Service- and/or MTF-specific queries.
- ***External:*** Prepare for interviews and respond to external queries. Provide external stakeholders with information on the outcome of the review; the performance of the MHS; and how the Department will continue to work towards providing access to care, patient safety, and the highest quality of care.

4. **Department Posture:** Secretary Hagel is committed to providing the highest quality of care to all beneficiaries. OSD PA will serve as the central spokesperson and release authority on all media queries related to the outcomes of the review. Everyone, except OSD PA, will be in a response to query posture. Coordination between OSD PA and all other public affairs professionals and offices throughout the Department will be absolutely essential throughout the process.
5. **PA/Communication Planning Instructions and Command Relationships:** All queries from external media related to the MHS Review should be referred to MAJ James Brindle ([james.b.brindle.mil@mail.mil](mailto:james.b.brindle.mil@mail.mil)) or LCDR Courtney Hillson ([courtney.l.hillson.mil@mail.mil](mailto:courtney.l.hillson.mil@mail.mil)). Any questions regarding public affairs activities or guidance should be referred to the office of MHS Strategic Communications (Mr. Richard Breen, [Richard.Breen@dha.mil](mailto:Richard.Breen@dha.mil), his or his deputy, Ms. Karen Roberts [Karen.Roberts@dha.mil](mailto:Karen.Roberts@dha.mil) or their Chief, Media Relations, Mr. Kevin Dwyer, [Kevin.Dwyer@dha.mil](mailto:Kevin.Dwyer@dha.mil)). MTF PAOs who receive queries on local aspects of the review should take the query, draft a response, send the response to the service medical PAO for review. The service medical PAO will review the response and coordinate final approval with their respective service public affairs office (OCPA, CHINFO, **SAF/PA**).

Sample questions that should be directed to OSD PA:

- What were the findings of the MHS review?
- What recommendations does the report make?
- How soon will the recommendations be implemented?

Sample questions that should be directed to MHS Strategic Communications:

- Who in the DHA will be responsible for the implementation of recommendations?
- How will the DHA implement/enforce new policies?
- How will the DHA make information from the review results and action plans public?

Sample questions that should be directed to Service Public Affairs:

- May my Commander conduct a town hall with beneficiaries?
- May my Commander conduct a proactive interview with a member of the media?

Sample questions that should be answered by the MTFs:

- What did the MHS review find about your specific MTF?
- What are the metrics for your MTF regarding access, patient safety and quality?
- The report says this facility is an outlier in XXX metric, what does that mean? Are you doing anything to address it?

## 6. POCs

### Service PAOs:

#### Army:

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### OSD PA Deputy Secretary Work's PAO

LCDR Courtney Hillson, 703-697-5131, [courtney.l.hillson.mil@mail.mil](mailto:courtney.l.hillson.mil@mail.mil)

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## Strategies/Tactics and Channels for Delivery

Tactic	Date Completed	Product	Owner	Audience
Secretary Hagel's Front Office Receives MHS Review Report	29 August	EXSUM/Report/Roll-out Matrix/SD Draft Action Memo	DSD FO/SD FO	<b>Internal:</b> SD
NSC/WH Notification	3 Sept.	EXSUM/Report	DSD FO/SD FO	<b>External:</b> NSC/WH
MTF Notification of Individual Facility's Results from the MHR Review Report	3 Sept.	MTF Individual Report Cards	HA/DHA	<b>Internal:</b> DHA/Services
Secretary Hagel MHS Review Report Brief	22 Sept.	EXSUM/Report/Roll-out Matrix/SD Draft Action Memo	DSD FO/SD FO	<b>Internal:</b> SD
DoD Conf. Call with External Experts (Prepare for MHS Review Report Release)	23 Sept.	EXSUM/Report/Comm Plan/SD Action Memo	DHA OGC OSD/PA OSD/LA	<b>External:</b> Review External Experts
Prep Session with Dr. Woodson + SG's Pentagon Briefing Room 2E973	29 Sept. 1300	Murder board and prep session for NYTs interview, MSO/VSO engagement and press conference	OSD/PA MHS Comms Services	<b>Internal:</b> DHA Leadership
Embargoed Interview with the New York Times (Sharon LaFraniere + Andy Lehren) Pentagon 3E1070	30 Sept. 1300	Embargoed on-the-record interview. Embargo to lift at 1315 on 24 September	DHA OSD/PA MHS Comms	<b>External:</b> New York Times
Prep Session with DSD, Dr. Junor, Dr. Woodson + SGs Pentagon 3E928	30 Sept. 1500	Prep session and murder board for MSO/VSO engagement and press conference	OSD/PA MHS Comms Services	<b>Internal:</b> DSD, P&R, DHA representatives
DoD Senior Leader Notification (Services, Joint Staff, Medical Commands, MTFs)	1 Oct. 0800	EXSUM/Report/PAG/Fact Sheet/SD Action Memo	P&R	<b>Internal:</b> DoD Senior Leaders

Congressional Notification to Members and Staff on the SASC, HASC, SAC-D + HAC-D	1 Oct. 1000	EXSUM/Report/SD Action Memo/Fact Sheet	OSD/LA	<b>External:</b> Congress
MSO/VSO Engagement (Conference Call) Pentagon 3E928	1 Oct. 1000	Agenda: <ul style="list-style-type: none"> <li>DSD and Dr. Junor make remarks.</li> <li>Dr. Woodson and SG's answer questions.</li> </ul> (EXSUM/Report/SD Action Memo/Fact Sheet)	DHA OSD/PA MHS Comms	<b>External:</b> MSOs/VSOs
Provide Pentagon Press Corps all Products Embargoed for 1315	1 Oct. 1115	EXSUM/Report/SD Action Memo/Fact Sheet	OSD/PA	<b>External:</b> Pentagon Press Corps
Post Products to DoD Website (health.mil)	1 Oct. 1315	EXSUM/Report/SD Action Memo/Fact Sheet	OSD/PA MHS Comms	<b>External:</b> Public
Press Conference (On-The-Record Briefing) Pentagon Briefing Room 2E973	1 Oct. 1315	Agenda: <ul style="list-style-type: none"> <li>SD, DSD and Dr. Junor make remarks.</li> <li>Dr. Woodson and SG's answer questions.</li> </ul> (EXSUM/Report/SD Action Memo/Fact Sheet)	OSD/PA	<b>External:</b> Pentagon Press Corps
Internal Message	1 Oct. 1315	Internal e-mail to MHS staff from ASD (HA)/SGs/DHA Director discussing report, findings, and way ahead.	MHS Comms	<b>Internal:</b> MHS Staff
Additional Stakeholder Engagement	1 Oct. 1330	Email notification to stakeholders about MHS Review outcomes and way ahead	ASD(HA)	<b>External:</b> Beneficiaries, MCSC, MSO/VSO
Staff + Beneficiaries Engagement	1 / 2 Oct.	MTFs will be allowed to host town halls and engage staff and beneficiaries.	MTFs	<b>External:</b> Staff + Beneficiaries

### ACCESS

- 1. There is an acknowledged disconnect between reported satisfaction with access and the rate with which access standards are met. Why do you think this disconnect exists – if access is so good, shouldn't that be reflected in the patient's level of satisfaction with access?**

A: We identified this disconnect, and agree that our internal access measures and patient satisfaction with access seem to conflict. The MHS will conduct a deeper dive on this issue with close engagement with our beneficiary population to ensure we identify and address the cause or causes of this disconnect.

- 2. There are numerous reports of beneficiaries calling to schedule an appointment and being told to call back because nothing is available. How are those individuals tracked? Are you monitoring whether their access standards are being met if they are told to call back?**

A: This question is directly related to the work we have now undertaken to address the previous question. We are studying appointment processes across our system and will be recommending changes to ensure we are capturing all patient requests for appointments. The Department will implement any changes necessary to further improve the comprehensiveness of its data collection processes.

- 3. Does DoD have the same access problems that were reported at the VA medical facilities?**

A: No. The review looked at the methodology and actual reporting of access to care standards. There was no evidence, for instance, that separate appointing records were being kept in order to meet access standards. The existence, and communication, of access to care standards provides beneficiaries with the right to request referrals to civilian sources of care when access standards cannot be met. However, the comparison to the VA is not the important finding. Instead, we need to ensure our processes for accessing care are convenient and timely for our patients.

- 4. What is the process by which customer input and complaints are captured and addressed? Who aggregates and analyzes the data?**

A: The MHS conducts a number of beneficiary surveys and provides multiple avenues for beneficiaries to provide feedback – both locally and at the enterprise level. The enterprise level data is captured, analyzed and used to identify where services or communications can be improved or targeted in a more effective way. This survey data is broken down by Service and MTFs, and share with them for management oversight and improvement efforts when needed.

The implementation of the Patient-Centered Medical Home is one example where the MHS has seen improvement in patient satisfaction scores along with improved access to care and delivery of preventive service measures.

## QUALITY

### **5. What are you doing to address outliers on risk-adjusted, all-cause mortality?**

A: The risk-adjusted, all-cause mortality rate that was presented in the report is the first time that risk-adjusted, all-cause mortality has been presented – both internally to MTF commanders and externally to the public. The MHS leadership and clinical experts worked on establishing this common measure over the last year and used the report as an opportunity to conduct a complete analysis of the data. We are sharing this information with all of our MTFs – both those within expected levels and the small number of outliers – to better understand the reasons behind the results. We are cautious about over-interpreting this data, as the medical literature is also cautious about the value of this metric in assessing quality.

Most medical experts recommend that greater focus be placed on cause-specific mortality measures (e.g., surgical mortality, infant mortality). We are pleased that these more granular mortality measures reflect very well on MHS quality and have been in place for a number of years. All of our high-volume surgical hospitals are within expected mortality rates for surgical outcomes and infant mortality at our MTFs are either within expected levels or better than other hospitals participating in NPIC.

### **6. Some military treatment facilities fall in the bottom 10% to 25% of the nation among a number of factors concerning their performance. What is being done about improvement plans for these facilities?**

A: The report points out that we have higher degrees of variation in our performance than we should. On some measures, we are in the top 10% in the country, and in other areas, we are near the bottom. Most MTFs had both positive and negative outliers. It is important to recognize that being a negative outlier does not necessarily mean bad care. It provides an opportunity to investigate the circumstances. This was pointed out clearly by the methodology reviewer, Dr. Brent James, from Intermountain Healthcare. In all areas where we are performing below national benchmarks or our own standards, we have implemented action plans for improvement.

A core set of metrics is being reviewed by MHS leadership to track progress at the highest level and ensure alignment and effective performance reviews at all levels of the MHS.

- 7. The MHS recently launched a campaign requiring TRICARE PRIME enrollees with civilian Primary Care Managers (PCMs) to change their PCM and return to certain military facilities for their primary care needs. Some of these facilities (e.g., Madigan Army Medical Center) are shown to be statistically significant outliers on quality measures for surgical morbidity, infant harm, and postpartum hemorrhage rates. Why are you forcing people to go back to what this report identifies as an unsafe facility?**

A: The identification of an MTF as an outlier on select measures does not mean a facility is unsafe. All TRICARE Prime enrollees residing near DoD MTFs, regardless of their PCM location, are required to use the MTF for specialty care or hospitalizations if the capacity and medical capability exists. For specialty care, beneficiaries would still need to seek a referral to go to other civilian sources, even if they were not enrolled to the MTF. Patients are encouraged to ask about our quality and safety performance at all of our MTFs. The initiative to recapture primary care within MTFs is focused on ensuring our military providers have an active clinical practice and retain their clinical skills. In certain locations, we are offering patients the option to change their PCM from civilian to military. In a small number of locations where MTF capacity for additional primary care patients is particularly high, certain MTFs “directed” patients to change their PCM from civilian to military – although waiver processes are available when continuity of care is an issue.

TRICARE Prime is our preferred choice for patients who live near a military medical facility. We want to serve them. Beneficiaries, however do have choices – and can select TRICARE Extra or TRICARE Standard and seek care exclusively from civilian health care providers.

- 8. Much of the quality and safety information addressed in the report is not readily available to beneficiaries and the public. Many other systems, including the VA, put their data online in an easy to understand format. What are your plans to make this access, safety, and quality data available to beneficiaries?**

A: The MHS currently makes public our HEDIS (outpatient) and our ORYX (inpatient) performance measures at <https://www.mhs-cqm.info/index.aspx>. Nonetheless, we are undertaking several initiatives to increase transparency of our information. We are also working with the Center for Medicare and Medicaid Services to include DoD MTFs on “Hospital Compare” – a national, public website that reports quality and safety information, and allows patients to compare performance against several facilities in their geographic area. Finally, we will make our existing, public information on quality measures easier to find, understand, and use.

- 9. For perinatal data, you state that you identified data coding issues in 2005, saying that only 22% of administrative files were coded correctly. What have you done to fix it since then?**

A: The MHS Perinatal Advisory Board, in coordination with the Services, has continued to examine data collection and provide continuous training to perinatal practitioners to improve data coding and collection quality. The MHS is currently in the process of doing

another internal audit to examine perinatal data integrity to ensure we are more accurately capturing the care delivered in our facilities.

**10. How are you addressing issues with specific mortality measures at low-volume facilities in the MHS Review?**

A: We looked at risk-adjusted, all cause mortality in all of our hospitals as part of the review. We did not find that low-volume facilities were outliers in mortality rates. In addition, in both our surgical quality and perinatal quality assessments, mortality rates are statistically as good as, or better than, national mortality rates at every military hospital in our system.

SAFETY

**11. Why did you only start addressing Hospital Acquired Conditions (HAC) a few years ago? Why are MHS rates on some HAC measures almost double the national rate?**

A: The MHS has been addressing quality and safety issues for decades. The Partnership for Patients (PfP) initiative is a collaborative public-private partnership, initiated by the Centers for Medicare and Medicaid Services (CMS) several years ago – and which DoD joined in 2010. The specific HAC measures that we now track are part of this recent initiative. The entire purpose of the PfP is to provide participating health organizations with common measures and the ability to compare performance – both against other participating organizations and against your own organization over time. We are seeing the benefits of this program, and – in many cases – are seeing substantive improvement over the last three years from our initial baseline. In some areas we are exceeding national averages and benchmarks. The measures also provide us with some indication of where we need to focus even more effort.

OVERALL LEADERSHIP ISSUES

**12. Has the Department cut staffing at MTFs in ways that jeopardize health and safety?**

A: No. Throughout the last several years of sequestration, the government shutdown, and short-term furloughs of government personnel, the Department leadership emphasized to both our local medical leaders and our patients that patient safety and quality would not be compromised. If local commanders believed that budget reductions might compromise safety, they were authorized to request supplemental funds or refer patients to civilian facilities for care.

**13. How does this review affect the MHS modernization study undertaken by DoD in 2013 and 2014? Are facilities being identified for downsizing because of access, safety, or quality issues?**

A: The Modernization Study is not related to this review or to issues related to quality at any of our MTFs – except that both studies are focused on making the MHS a better,

stronger health system for the future. The MHS Modernization Study is focused on identifying the appropriate medical infrastructure and personnel requirements to sustain both a medically ready force and ready medical forces.

## OTHER

**14. One of the external experts identifies a “culture of mediocrity” in the MHS. Is there a plan to address this finding?**

A: The external experts provided a number of observations and comments concerning the data and other information collected for the MHS Review. The context of this specific quote focuses on the point internal reviewers identified as well – that the MHS has to deliver focused improvements to be considered a top-tier health care organization. The same external expert, Dr. Peter Pronovost, notes that he did not identify any deficiencies that require urgent changes. This feedback assists with our own, internal findings and helps inform the action plans designed to address these issues.

**15. One of the external experts identified concerns about a “culture of retaliation and fear” among some staff in the MHS. Where in the report is the action plan to address this culture of retaliation and fear?**

A: Comments concerning potential examples of retaliation against whistleblowers are deeply concerning to the Secretary. These issues are taken very seriously and in any situation in which such a concern is voiced, the Services have been directed to investigate these comments and report back to their senior Service leaders.

**16. Why has OSD permitted the identified variability in Service compliance with OSD policy, especially in the areas of safety and quality reporting?**

A: We are a learning organization. We recognize that in some locations where compliance with OSD policy was low, the lack of adherence to policy may have been due to misinterpretation. As part of our corrective action plan, we will clarify access, quality and safety policies in order to reduce or eliminate this variation.

**17. How does the MHS factor malpractice claims and lawsuits into its determination of quality or safe care? This was not addressed in the report.**

A: Risk management is a distinct part of the MHS quality review process. Not all litigation is related to adverse safety or quality outcomes and these issues. All litigation related payments over \$500,000 receive mandatory quality assurance reviews, regardless of the underlying cause for litigation. Additionally, quality management experts do meet with risk management personnel and discuss cases in order to meet.

**18. How do military hospitals or clinics manage beneficiary complaints? Who’s ultimately responsible?**

A: Every military hospital and clinic has a process for patients to provide feedback and / or register complaints, to include issues regarding access, quality, safety, customer service, administrative processes or covered benefits. There are also processes to appeal decisions or raise issues to a higher level of command as circumstances warrant. Patient feedback is used to improve processes throughout our system of care.

**19. When do we expect recommendations will be implemented?**

A: The Military Health System is an organization committed to continuous quality improvement. We track a number of measures closely, and have seen many trends that are moving in the right direction. The specific recommendations in this report will begin implementation immediately, and each action will have a specific timeline associated with its implementation. There will be regular reporting to the Secretary on all actions until they are completed.

**20. How many people worked on this report and how much did it cost the Department?**

A: 118 FTE's full and part time worked on this report. The report cost the Department approximately 2.5 million.

## FACT SHEET:

### The Department of Defense's 90-Day Review of the Military Health System

The Military Health System (MHS) serves 9.6 million Americans entitled to health care coverage through the Department of Defense (DoD) – active duty service members, military retirees, and their families, to include survivors of service members who died on active duty. In FY 2013, the MHS included a direct care system with over 50 hospitals and over 600 clinics staffed by almost 150,000 military and civilian personnel, along with a private sector network of care encompassing hundreds of thousands of providers.

On May 28, 2014, the Secretary of Defense ordered a comprehensive review of the MHS. The review was to assess whether: 1) Access to medical care in the MHS meets defined standards; 2) The quality of health care in the MHS meets or exceeds defined benchmarks; and 3) The MHS has created a culture of safety with effective processes for ensuring safe and reliable care of beneficiaries. This is the first time the MHS has taken an enterprise view of such scope in these areas.

Overall, the MHS Review team found that the MHS provides safe, timely, and quality care. However, the MHS does demonstrate performance variability compared to civilian counterparts and national benchmarks, outperforming in some areas and under performing in others.

The MHS Review included industry standard measure sets with hundreds of sub-measures across safety, quality, and access for the direct care system, as well as measures used for assessing the care provided by our private sector network. Metrics included externally established and reported measures, along with internal MHS metrics and benchmarks.

In addition to the DoD and Service subject matter experts, the review team included six, independent and esteemed external experts in patient safety and quality who reviewed both the methodology for assessing access, safety and quality and the actual performance of the MHS. All external reviewers acknowledged the challenge of comparing performance across health systems and noted that many of the challenges facing the MHS are similar to challenges inherent throughout U.S. health care.

The external experts validated that the review was conducted appropriately and that the MHS is using measures consistent with other health organizations. They confirmed that greater focus and improvement is required for the MHS to become a top-tier health system in all facets of our delivery system.

The MHS is committed to full performance transparency, and will highlight both the positive performance indicators and areas where the MHS is performing below standards. Below is a summary of each area, along with many of the key recommendations. The full report is available at [http://www.defense.gov/home/features/2014/0614\\_healthreview/](http://www.defense.gov/home/features/2014/0614_healthreview/)

## Access

### **Key Findings:**

- The majority of MTFs meet established access standards for TRICARE Prime beneficiaries. For example, the average number of days for TRICARE Prime patients to obtain an appointment to a specialty care provider in an MTF is 12.4 days, well below the 28 days required by regulation.
- There was a notable difference between access standards being met and the satisfaction of patients with the ability to receive timely access to care. This observation requires greater examination by MHS leaders.
- Access measures for beneficiaries who get their care from purchased sector providers are limited, and the reviewers were unable to compare how access to military providers compared to those in purchased care.

### **Key Recommendations:**

- The Department will improve business processes for access to care to include: standardize rules for specialty care access; implement a Joint Service survey tool; standardize access reporting from TRICARE Regional Offices and purchased care; and standardize customer service training across the MTFs.
- In addition, the MHS will conduct a study to better understand TRICARE patients' access to private sector care, with a specific focus on patient satisfaction in both our direct care system and purchased care.

## Safety

### **Key Findings:**

- The MHS would benefit from communicating that patient safety and quality is the top priority.
- Using a nationally standardized survey, the MHS culture of safety, is comparable to that found in the civilian sector.
- By implementing the Partnership for Patients program, the MHS has improved on many hospital acquired condition measures. Select safety measures, however, are below national standards.
- Despite a long-standing policy requirement that all root-cause analyses (RCAs) be reported to the Patient Safety Analysis Center (PSAC), not all RCAs performed by the Services are submitted. The execution and content of RCAs are not standard across the Services. In addition, there is variability across the MHS on how specific actions stemming from RCAs are implemented to correct identified issues.
- The review identified potential issues with staffs' participation in reporting of patient safety events. Consequently, the reviewers found that the Patient Safety Reporting System (PSRS) may not provide an accurate indication of the MHS' level of harm rate.

### **Key Recommendations:**

- The Department will implement the principles of a high reliability organization, focused on leadership, culture and robust process improvement; MHS leadership will set safety culture expectations and conduct follow-on monitoring; and the MHS will expand transparency of patient safety information.

### **Quality**

#### **Key Findings:**

- Health Employer Data Information Set (HEDIS) measures (which capture preventive services and select health outcomes) showed high variation among MTFs. Of the 18 HEDIS measures monitored by the MHS, eight were above the 50<sup>th</sup> percentile (i.e., above national averages), seven were between the 25<sup>th</sup> and 50<sup>th</sup> percentile, and three measures were below the 25<sup>th</sup> percentile. In 2013, 10 of the 18 measures showed statistically significant improvement while six of the 18 measures showed statistically significant decline.
- Perinatal care shows the MHS overall is performing better on infant mortality than the National Perinatal Information Center (NPIC) averages. NPIC's benchmark is comprised of 85 high volume obstetric care hospitals. However, on several specific measures (to include postpartum hemorrhage and undefined neonatal trauma), the MHS is performing below the NPIC benchmarks.
- Surgical mortality rates (death rates) are within expected rates at all 17 DoD MTFs that participate in the National Surgical Quality Improvement Program (NSQIP). The surgical morbidity (surgical complications) rate was statistically significantly below average in eight of 17 participating MTFs in 2013. For three other MTFs, below average performance has persisted for several years. Three of 17 MTFs in the most recent reporting period are performing at the top tier nationally.
- Clinical quality and outcome data for care rendered in the purchased care sector is less than what is collected for direct care.
- There are gaps in the ability of ASD(HA) to validate and ensure Service compliance with HA Quality and Safety Policy.

#### **Key Recommendations:**

- The Department will expand its collaboration with external health care organizations to improve as a learning organization; develop and implement a process to manage and track Service and DHA compliance with applicable DoD policies and directives. The Services and the DHA will implement procedures to effect improvement with oversight from the ASD(HA) with respect to all performance metrics. The DHA will evaluate alternative methods of incentivizing contractors and / or providers to improve the provision of clinical preventive services.

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## FACT SHEET:

### Overview of the Department of Defense's Military Health System

The Military Health System (MHS) is the global health system of the Department of Defense (DoD) with the principal mission of readiness: maintaining a medically ready fighting force, and a ready medical system that is prepared to respond to the full spectrum of military operations. The MHS is comprised of medical personnel, infrastructure and resources from the Army, Navy, Air Force, Defense Health Agency and Office of the Assistant Secretary of Defense (Health Affairs). One of the largest health systems in the United States, the MHS budget exceeds \$50 billion.

The MHS mission is accomplished through a diverse set of activities. The MHS provides an integrated combat-ready system in support of battlefield medical requirements that includes deployable hospitals, shipboard medical capabilities, an aeromedical evacuation system, and global medical surveillance services.

Currently, the MHS operates a worldwide health care delivery system that includes care delivered in over 50 military hospitals and over 600 clinics, as well as a supporting network of private sector providers offered under its health insurance system known as Tricare. This system provides health services to approximately 9.6 million beneficiaries – active duty service members, military retirees, their eligible family members and survivors.

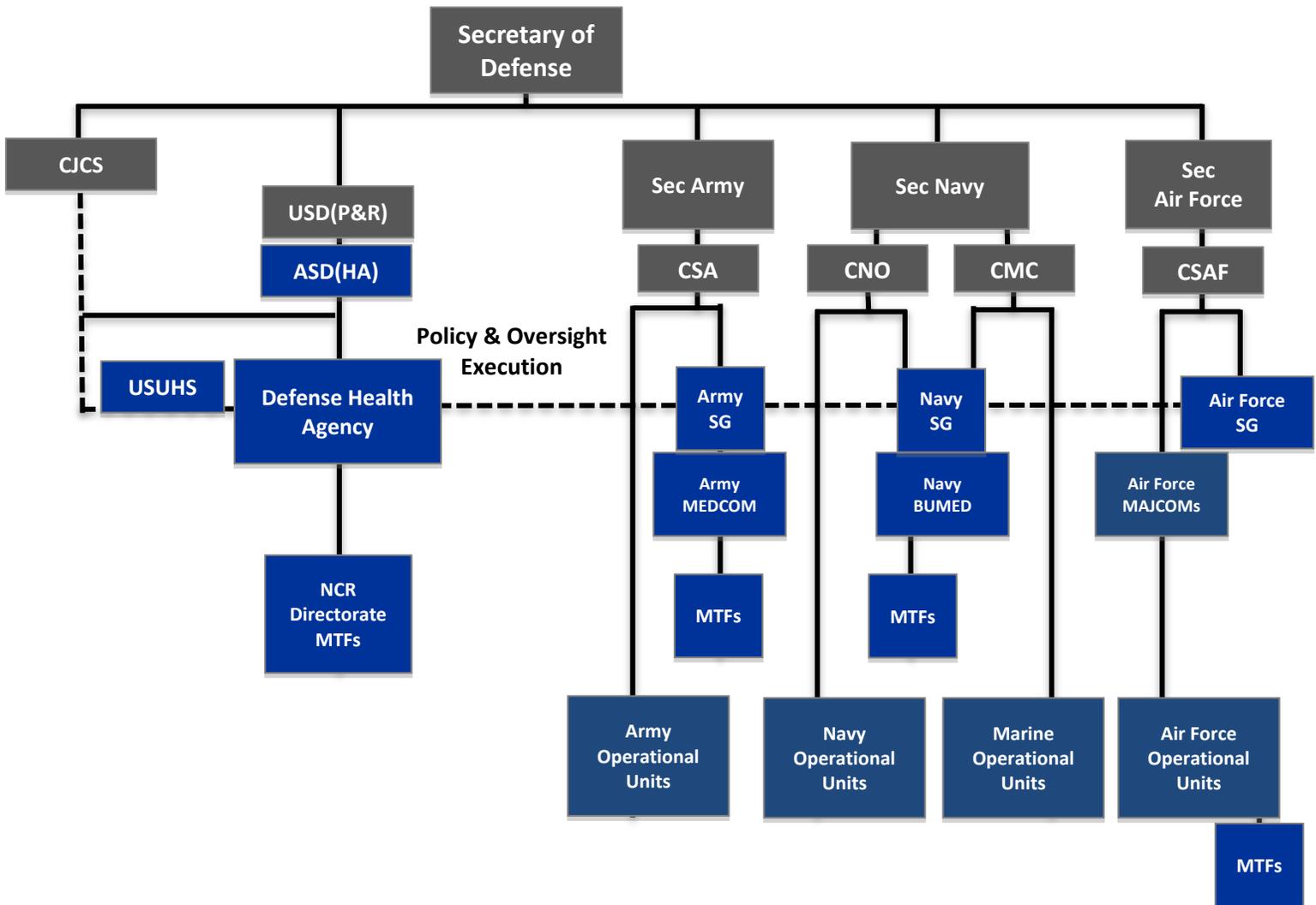
The MHS system manages a comprehensive medical research and development program that works closely with academia and private research organizations. The MHS delivers public health services that include community health services, environmental surveillance and monitoring.

This system is supported by diverse medical education and training programs, including a fully accredited medical school, graduate medical education and training programs, and enlisted and officer training platforms that collectively produce more than 27,000 graduates each year.

#### **Leadership:**

The MHS leadership includes the Assistant Secretary of Defense for Health Affairs (ASD(HA)), the Surgeons General for the Army, Navy and Air Force, and the Director, Defense Health Agency (DHA). The ASD(HA) is the senior medical advisor to the Secretary of Defense, and establishes health policy for the Department, and is responsible for oversight of the MHS. The Director, DHA reports to the ASD(HA). The Service Medical Department Surgeons General report to their respective Service Chiefs of Staff and Service Secretaries. The organizational relationships between the Surgeons General and military medical treatment facilities varies by Service.

The chart below provides a high-level overview of these reporting relationships:



**The Defense Health Agency (DHA):**

The Defense Health Agency (DHA) was established on October 1, 2013, as a Combat Support Agency, supporting the military services in their delivery of integrated, high quality, and affordable health services. Led by its Director, Lt. Gen. (Dr.) Douglas Robb, the DHA is responsible for the execution of policy as issued by the ASD(HA). The DHA is responsible for management of ten shared services that support Service Medical Department missions, and include: the TRICARE Health Plan; pharmacy operations; health information technology; medical logistics; health facilities; medical education and training; public health; research; development and acquisition; budget and resource management, and procurement. Finally, the DHA exercises authority, direction, and control over the inpatient facilities and the subordinate clinics assigned to the DHA in the National Capital Region, to include Walter Reed National Military Medical Center and Ft. Belvoir Community Hospital.

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**\*\* ALL MTF STAKEHOLDER ENGAGEMENT SHOULD USE SIMILAR LANGUAGE \*\***

**DRAFT EMAIL FROM DR. WOODSON & SURGEONS GENERAL TO MHS STAFF**

We want to thank the Secretary of Defense for directing this review, and Deputy Secretary Bob Work, and Under Secretary of Defense for Personnel and Readiness Jessica Wright for their stewardship and deep engagement in the review at every step of the way.

The review team, led by senior officers from all three Services and assisted by six independent, civilian health experts, conducted an impressive, comprehensive review of access, safety, and quality in the Military Health System.

Both our beneficiaries and the American public expect that the quality of healthcare provided to those who serve today, who have previously served, and their families, is second to none.

The Military Health System is unique in its scope and complexity as a world-wide health system, operating in every type of operational environment. This report focused in our hospitals and clinics, identifying many things the Military Health System is doing well. The report also identifies a number of areas for improvement. Our performance - and our challenges - reflect what is found throughout American medicine. We can do better, and we will.

This review, the recommendations, and the Secretary's direction allow us to renew our pursuit of excellence in every facet of our operations. The Military Health System is an organization committed to continuous learning and improvement.

As a public institution — accountable to the military and civilian leaders in the Department, to our beneficiaries, and to the taxpayers who fund us — we will be fully transparent in what we need to do. We begin that transparency now by posting the full MHS Review online at [health.mil](http://health.mil) for all to see. We will also engage our patients to ensure that the information we provide to them is useful as they make important health care decisions.

We will expand our strategic partnerships with leading, external institutions, adopt best practices wherever they are found, and leverage the exceptional talent we have within the MHS to make these improvements in our system.

We are grateful for your service and your commitment to excellence in healthcare for those we are privileged to serve.

Jonathan Woodson, M.D., Assistant Secretary of Defense (Health Affairs)  
Lieutenant General Patricia D. Horoho, Surgeon General, United States Army  
Vice Admiral Matthew Nathan, Surgeon General, United States Navy  
Lieutenant General Thomas W. Travis, Surgeon General, United States Air Force  
Lieutenant General Douglas J. Robb, Director, Defense Health Agency