

**DEPARTMENT OF THE AIR FORCE**

**PRESENTATION TO THE COMMITTEE ON ARMED SERVICES**

**SUBCOMMITTEE ON PERSONNEL**

**UNITED STATES SENATE**

**SUBJECT: Health Care**

**STATEMENT OF: Lieutenant General Paul K. Carlton, Jr.  
Air Force Surgeon General**

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Mr. Chairman and members of the committee, thank you for this opportunity to address the goals and accomplishments of the Air Force Medical Service (AFMS). I consider it a privilege to appear before this committee who has worked so hard on our behalf.

As I begin my tenure as the Air Force Surgeon General, I am honored to lead the finest young health care professionals in the world into the 21<sup>st</sup> Century. The Air Force Medical Service (AFMS) will continue to execute our successful “Parthenon” strategy, centered on medical readiness, employing TRICARE, tailoring the force, building healthy communities, and customer satisfaction. However, we will expand the horizons of the strategy to focus on population-based health care and global support of the Expeditionary Aerospace Force.

### ***Reengineering Medical Readiness***

The AFMS is well positioned to support our new Expeditionary Aerospace Force doctrine. We must be able to respond to major theater wars with a power projection force, while also being able to support small-scale contingency operations. Our nation’s commitment to global engagement has meant unprecedented peacekeeping, humanitarian and civic action deployments since the Persian Gulf War. The AFMS has made significant strides in ensuring the 21<sup>st</sup> Century aerospace warrior will have new, modular, and flexible medical readiness capabilities to support these operations.

The AFMS operational support capability must address three major functional areas: war-winning, disaster relief, and support for humanitarian operations. Each of these functional areas is critical to supporting our National Security Strategy. I have directed my staff to optimize operational health support to provide this full spectrum

support. We are working with the Air National Guard to optimize and enable their forces to provide military support to civil authorities. I have also directed my staff, in conjunction with regional CINCs, DoD, and the Department of State, to develop a comprehensive AFMS medical theater engagement support plan. Our reengineering efforts will be vital to achieving these operational goals.

By the end of this fiscal year, we will have replaced our contingency hospitals with Air Force Theater Hospitals (AFTHs), which provide a modular, incrementally deployable capability to provide essential care. They use existing Air Transportable Hospital (ATH) and specialty teams, along with pre-positioned (buildings) and deployable (tents) AFTHs. Future force commanders will dial up or dial down Air Force clinical and technical capability, easily permitting the deployment of hospitals from 10- to 114-bed capability. The Form, Fit, and Function Follow-on Test conducted last February at Nellis AFB proved that our concepts of operations, manpower force listings and allowance standards will meet operational requirements.

Also in Fiscal Year 2000, we will begin fielding our new Expeditionary Medical Support/Air Force Theater Hospital (EMEDS/AFTH), which will replace the ATH. We will have a very clinically capable, light, flexible, modular package that leverages man-portable assets such as the Mobile Field Surgical Team, Critical Care Air Transport Team, Squadron Medical Element and our specialty sets. The increments are EMEDS Basic, EMEDS + 10-bed AFTH, and EMEDS + 25-bed AFTH. The beauty of this new capability is that we can append specialty sets and wards at the 25-bed level, thereby sustaining up to the 114-bed AFTH, should we require this capability. More importantly, we have reduced the lift profile three-fold (from 55 to an estimated 18 pallets for 25-bed

AFTHs). This new field hospital package can provide the theater commander exactly the level and mix of medical services he or she requires in as little as 12 hours post-arrival for the basic increment.

To support EMEDS/AFTH, we are planning field training using clinical, technical and readiness field experts to develop bold and decisive medical leadership to respond to the rigors of Air Expeditionary Forces (AEF) deployments. Beginning in February, and ramping up over two years, training will include all team members and will be prioritized based on the AEF rotation schedule.

The AFMS has answered the call of the CINCs in one other vital area. The Air Force now has a well proven capability to care and manage the critical care patient in the Aeromedical Evacuation (AE) System. Through the use of Critical Care Air Transport Teams – or CCATTs – we augment AE crews to evacuate newly stabilized patients to CONUS for definitive care. We have trained more than 151 CCATTs and have 51 equipment sets on hand, with plans to field 25 sets in Fiscal Year 2000.

As part of Mirror Force, the AFMS initiative to bring together active duty, Guard and Reserve components into a seamless force, Air Education and Training Command developed the Aeromedical Evacuation Contingency Operations Course to provide critical training for Total Force ground-based AE units. This course became operational in May 1999. In addition, we developed the Top Sustainment Training to Advance Readiness (TopSTAR) course to regionalize refresher training for all components. The first TopSTAR site became operational at the 59<sup>th</sup> Medical Wing, Lackland AFB, Texas, in February 1998.

Force health protection continues to be on the forefront of our efforts. Though far from completion, we are accomplishing a great deal in response to Weapons of Mass Destruction (WMD) requirements. The Air Force Medical NBC Defense program achievements over the past year have been in identifying requirements, codifying doctrine, approving equipment, and executing training. To support requirements, we added medical-related items as high leverage in the Air Force Counterproliferation Roadmap. To support doctrine, we participated on the team that produced the first-ever joint publication on the care and treatment of biological warfare casualties, and this team is now working on a similar publication on medical operations in an NBC environment, to be completed this year. We also helped to develop a “Response Guide for Commanders and First Responders,” which addresses biological, incendiary, chemical, and explosives threats on Air Force installations.

The rapidly expanding potential for NBC warfare makes necessary the capability to continue medical operations even in toxic environments. The objective of the Chemically Hardened Air Transportable Hospital (CHATH) program is to provide the equipment necessary for such a capability. Our medics at Air Combat Command worked in the true spirit of “jointness” with the Army on this system, and both Army and Air Force requirements are incorporated in the Joint Operational Requirements Document for a CHATH/Chemically Protected Deployable Medical System. The CHATH completed Initial Operational Test and Evaluation in December 1997. The Milestone III production decision was achieved in March 1998, and initial operational capability was declared in October 1998. Fielding should be completed in September. The CHATH represents the

culmination of an approximate 10-year joint effort to provide collective protection capability for patients treated in the field in a chemical warfare environment.

To support the warfighters, we recently finalized the Biological Augmentation Team contingency operations (CONOPs), which provides diagnostic identification capability for naturally occurring or induced biologic agents at a deployed location. With this new team, we can now analyze samples and interpret results using complementary microbiological techniques, primarily a nucleic acid-based testing platform. The team deploys based on threat assessments and will usually deploy with the EMEDS/AFTH. We will field several teams in this year.

Further, Air Combat Command's development of "Project Yorktown" will change the way we respond to terrorism forever. Project Yorktown was developed as an integrated suite of early warning and identification capabilities for biological and chemical attack. It is composed of a clinical encounter system that collects standardized medical signs, symptoms, diagnoses and procedures. These are encapsulated and sent immediately to a location in the United States where they are electronically analyzed for abnormalities. If something suspicious is indicated, laboratory identification systems pre-positioned at high threat areas are utilized to determine if a biological or chemical agent was present that may have been covertly introduced to members at the location through food or environmental vectors. Should an incident be confirmed, Yorktown is linked with a sophisticated network of command and control agencies to help mitigate the effects.

Our medics in Europe have also aggressively prepared for WMD. To meet in-place force health protection requirements, United States Air Forces, Europe (USAFE),

medical personnel developed a new in-place patient decontamination team for each of their five bases. This team is a non-deployable organic medical asset for patient decon at USAFE medical treatment facilities (MTFs). The approved CONOPs includes capability to decontaminate patients outside the MTF. Fielding will be completed this fiscal year.

Finally, our WMD training focus has been through distance learning. During this past year, 8,000 Air Force medics, including active duty, Guard and Reserve, participated in the NBC Satellite Broadcast Training.

Despite these serious efforts to protect the force, we are not yet fully prepared to counter WMD, specifically chemical and biological weapons, on the battlefield. In all likelihood, our foes will not meet us force on force -- asymmetrical attacks, including those on the homeland, represent huge challenges in which the AFMS can be expected to play a crucial role. With the support of our sister services, DoD and our leadership at all levels, the AFMS is committed to helping our nation prepare for this very real and lethal threat.

### ***Employing TRICARE***

Another way we protect the troops is by reassuring them that their families are well cared for while they are deployed. TRICARE has been fully operational for more than a year now, and we have come a long way toward resolving problematic issues, such as improving access to care and payment of claims. We recognize that access continues to be a problem, and that, once in the door, our patients are, for the most part, highly satisfied customers.

We are committed to achieving five metrics across the AFMS that will ensure improved patient access to primary care: (1) measured progress toward maximum allowable enrollment; (2) 1,500 patients enrolled per primary care manager (PCM); (3) 25 patients per day per provider (4) 3.5/1 support staff/provider ratio; and (5) two exam rooms per provider. We are closely monitoring how our facilities are meeting these metrics and holding them accountable. Our ultimate goals are that every patient will know his PCM by name and enjoy guaranteed access standards for primary care.

Certainly, a key factor in the success of these five metrics is educating our PCMs to understand, accept, and deliver the expectations of leading edge primary care and population-based health care. We are developing an aggressive, exciting education program to optimize AFMS primary care. The program's objectives are to prepare our primary care teams to deliver the health care benefit effectively and efficiently; develop programs that execute the population health improvement policy; and develop criteria that will assist in the effective distribution of resources. We are implementing the "Quickstart" phase of the program in early 2000, with follow-on sustainment activities through the next year. In the long term, we are seeking a culture change through a primary care course and other formal education programs.

One of our greatest remaining TRICARE challenges across the AFMS is to provide care to those who are not being fully served. For example, we are on the threshold of programs that will provide TRICARE to our geographically separated units, and we're working on solutions for their family members as well.

We are also trying very hard to fulfill the promise made to our older retirees that they would have health care for life. I am happy to say that our participation in the

TRICARE Senior Prime demonstrations for the over-65 retiree has been well received. However, the unique needs of this population place some very stringent demands on the Military Health System, such as benefits mandated by Medicare that differ from those provided by DoD. And to put it simply, our older beneficiaries require more health care. We will continue to address those issues.

The good news is that utilization rates and customer satisfaction are high. And with access to the National Mail Order Pharmacy, TRICARE Senior Prime enrollees have better prescription coverage than ever before. This year, we will embark on the Federal Employees Health Benefits Program (FEHBP)-65 demonstrations, giving us insight into another possible means of meeting our beneficiaries' health care needs.

Another way we are working to create viable alternatives for our beneficiaries is through sharing arrangements with the Department of Veterans Affairs (DVA). Today we have more than 100 agreements with the DVA, sharing more than 270 services. Our new \$164 million joint venture facility in Alaska at Elmendorf AFB opened in May 1999. The DVA staffs and operates the intensive care unit, saving the Air Force \$1.4 million annually in referrals to downtown facilities. The Air Force staffs and operates the multi-service medical/surgical unit. Both organizations staff the emergency room, internal medicine, and surgery sections. Our other two joint ventures continue successfully at Albuquerque, New Mexico, and Las Vegas, Nevada.

We're also pursuing numerous joint initiatives with the DVA to improve mutual efficiencies. For example,

- Clinical guidelines improving the standards of care are being shared across the Services and DVA, enhancing continuity and outcomes

- Discharge physicals are now “one-stop shopping” through one organization
- One computerized patient record for both organizations will be beta tested at the new joint venture facility in Alaska this spring, allowing one computerized record that could be used during and after active duty service
- DVA representatives are participating on the DoD pharmacy redesign working group to establish standardization between agencies where feasible
- Combined purchasing of pharmaceuticals is saving \$57 million for both DoD and DVA

The AFMS is also seeking to improve health care for our beneficiaries by better educating our own. As a large employer providing health care services for their employees, the Air Force has stressed the involvement of line leadership. At our Chief of Staff’s urging, we have developed a program we call “Command Champion” that takes TRICARE to the unit commanders, providing tools to help them ensure their people are receiving the best possible care. Personal involvement by senior staff at our MTFs and Major Commands offers clear guidance on how TRICARE works at the local level and where assistance is available. I am delighted with the returns on this effort! Senior MTF representatives met initially with 2,400 commanders; made 1,258 follow-up visits; and hosted more than 1,600 commanders at a culminating Hot Wash. Program success is perhaps best summarized by the 60<sup>th</sup> Medical Group, who said, “Virtually 100 percent of the commanders expressed appreciation for the caring way in which the medical group presented Operation Command Champion and the outreach provided to them.” One commander stated, “The growing pains are over; we’re going the right way and getting a good news story.” Further, we are pleased that the Army and Navy have adopted our

program in educating their own leadership. Our proposed sustainment program is anticipated to begin in May.

We are also encouraged by the efforts of the Defense Medical Oversight Committee (DMOC), which has been formed to ensure optimum Service participation in the military health care agenda. This board consists of the Under Secretary of Defense (Personnel & Readiness), Service undersecretaries, Service vice chiefs, and the Assistant Secretary of Defense (Health Affairs) as voting members. The Service surgeons general participate, but are non-voting members. The main purpose of this board is to define the medical benefits and establish budget priorities.

#### *Tailoring the Force*

The focal point of our system remains the military MTF. We're stressing that the care provided in our MTFs be the best available and the most efficiently provided. Toward that end, we are emphasizing performance and optimization of our system. We are sizing our MTF staffs to specifically meet the needs of the local population, including our over-65 beneficiaries. I have asked the MAJCOM surgeons to meet specific staffing levels and arrangements to optimize the health care delivery process.

Our vision of population-based health care management is driving the methods used to plan for and allocate resources to our MTFs, and is therefore vital to our Tailoring the Force pillar. The primary objective of Tailoring the Force is to develop a long-term resourcing process that will optimize overall force size, increase MTF productivity and effectively manage patient care through a focus on health awareness and prevention. We are developing and implementing various tools to properly size and resource our MTFs to meet mission requirements and population health care needs.

One of these tools, Stratified Enrollment-Based Capitation (EBC), allocates funds to each MTF based on the direct health care cost of an enrolled population. We are using EBC as a metric for MTF commanders to build an awareness of all resources used in providing service to TRICARE Prime enrollees. Ultimately, this data will ensure future MTF commanders have the data to know who their TRICARE Prime patients are and the cost of caring for these patients.

Another tool is the Enrollment-Based Reengineering Model (EBRM). The traditional method of using historical workload of an unenrolled population to determine staffing requirements is outmoded. The EBRM determines manpower requirements for a managed care delivery system with an enrolled population. Consistent with changes in the civilian sector's delivery of health care, the model shows more primary care physicians are required than specialists. It also suggests the "ideal" provider/support staff ratios. EBRM is akin to what our line counterparts call "Primary Aircraft Authorized" – PAA -- meaning there is consistency in the numbers and specialties of personnel manning comparable units. Unless there is an extenuating requirement, Air Force MTFs with similar patient populations should have the same manning profile.

The ultimate outcome of a system reengineered in these ways is a system in which the MTF's enrolled population drives money and manpower. As noted previously, we have put metrics into place that measure our progress toward this goal, and we're reviewing our progress monthly, base by base. The majority of health services will be delivered through prevention programs and well supported primary care managers. SEBC and EBRM encourage MTF commanders to enroll their beneficiaries and retain

them as satisfied customers while emphasizing preventive and primary care as the preferred delivery setting.

### *Building Healthy Communities*

The prevention paradigm of our fourth pillar, Building Healthy Communities, is the cornerstone of the population-based health care management system. Previously we concentrated on individual prevention initiatives through clinical intervention, but now we are using the community-approach, population-based initiatives. The community approach has already been tested and proven by the Air Force. For example, in response to a community problem, suicide, we established an Integrated Product Team (IPT), comprised of members from various functional specialties – such as chaplains, security police, family advocacy, legal services, and mental health – and chaired by the AFMS. As a result of the efforts of the IPT, suicide rates have declined from 16 per 100,000 to 5.6 per 100,000 within the Air Force during the past five years. The suicide prevention program has been applauded as a benchmark for both the public and private sector.

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

The concepts of a healthy community involve more than just medical interventions. They include local environmental quality and hazards; quality of housing,

education and transportation; spiritual, cultural and recreational opportunities; social support services; diversity and stability of employment opportunities; and effective local government. Impacting these elements requires long-term, dedicated planning and cooperation between local Air Force commanders and civilian community leaders.

Three major areas we have initially targeted at the community level are decreases in tobacco use, alcohol abuse, and injuries. The Under Secretary of Defense for Personnel and Readiness chartered the Prevention, Safety and Health Promotion Council (PSHPC), with the Air Force as executive agent, to address these and other areas. We have now developed additional committees to focus on Putting Prevention Into Practice, which provides tools and training to providers to ensure they use each encounter with a patient as an opportunity for preventive interventions; Joint Preventive Medicine Policy Group; self-reporting tools, such as the Health Enrollment Assessment Review; and Sexually Transmitted Disease Prevention. These efforts are critical, when we consider that more than 70 percent of preventable deaths are due to life-style factors.

We are also stressing prevention at the individual level – readiness begins with each individual, each human weapons system. Our tool to assure individual readiness for any contingency is the Preventive Health Assessment (PHA). The PHA changes the way the Air Force performs periodic physical examinations from a system based on intervention to a system that stresses prevention. The goal is to identify risk factors from a person's life-style – such as whether a person smokes, how frequently he exercises, and his diet – as well as his genetic background, individual health history and occupational exposure. Then, through proper prevention practices, we assist the member to moderate those risks.

PHA data, along with data on medically related lost duty days, immunizations status, dental readiness and fitness status, are available to the unit commander to provide vital information about the readiness of his or her unit. Our line commanders have reported high satisfaction with the PHA, and were especially pleased when their units were prepared to go to the field for deployment exercises without any medical discrepancies.

To support our goals in population health, the Air Force Medical Operations Agency stood up our Population Health Support Office (PHSO) in May 1999. The PHSO will focus on three primary activities. First, they will provide a centralized help desk and resource center, accessible through a toll-free number (1-800-298-0230), e-mail (phso-helpdesk@brooks.af.mil), and a web site (www.phso.brooks.af.mil). Second, they will offer program management assistance for our various prevention programs, such as the HEAR, the PHA, and Put Prevention Into Practice. They will also be available to assist in areas such as condition management, clinical reengineering, patient education, and metrics. Third, the PHSO will be responsible for health data identification, analysis and reporting. We are excited about the PHSO and all our efforts to make population-based health care a reality in the Air Force.

### ***Customer Satisfaction***

These are all examples of how we are striving to meet our customers needs, and thus achieve Customer Satisfaction, the capstone of our Parthenon strategy. It all comes down to satisfying our customers. Whether our customers are active duty, family members or retirees, our AFMS stands ready to provide world-class deployed and home-station medical support.

We recognize that, as the AFMS evolves into a worldwide competitive health plan, it is essential that all AFMS personnel adopt a total customer service philosophy that transcends our current business practices. To do this, we have implemented a strategy to create a climate and culture where customer focus and service permeates the AFMS, leading to customer satisfaction and loyalty. Our competitors know that customer satisfaction is the key to retaining and recapturing patients – we know it too. Our customer satisfaction task force, known as the “Skunkworks,” has completed its first two phases of development and deployment, and is now well on its way to executing the third phase, sustainment and partnering.

In 1999, we completed five customer satisfaction model site visits, conducted eight deployment roll-outs for all AFMS organizations and higher headquarters, and began the sustainment/partnering phase for AFMS organizations in collaboration with the MAJCOMs through five sustainment summit meetings. We are also working to actively involve our reserve components in the customer satisfaction strategy as a part of our Mirror Force endeavors to achieve a seamless, ready Air Force health service.

This year, we will continue ongoing sustainment and partnering endeavors with the Major Commands, our AFMS organizations and the reserve components. In addition, we will be inserting customer satisfaction priorities in the TRICARE 3.0 contracts to help ensure contractors are held to the same standard as our AFMS personnel. To monitor and measure our sustainment success, we will use “report card” data and the AFMS customer satisfaction metrics that are part of the AFMS Performance Measurement Tool (PMT).

Quality care continues to be our hallmark. With all of our facilities surveyed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Air

Force continues to meet or exceed civilian scores. The average Air Force clinic accreditation score has risen from 97.0 percent in 1998 to 97.4 in 1999, with an impressive 73 percent accredited with Commendation.

Many of our facilities continue to participate in the Maryland Hospital Association (MHA) Quality Indicator Project. Air Force performance has been commendable and is consistently better than the overall MHA national average for several indicators. Our total cesarean section rate has been approximately 20 percent less than the national rate. Air Force rates for returns to the Operating Room and Intensive Care Unit are continually less than the national rate. Also, our mortality rates for overall inpatient, as well as neonates and perioperative patients, are far below the national norm. These rates indicate a sustained quality of care for these areas in AF inpatient facilities.

Air Force personnel are also participating in the Quality Interagency Coordination Task Force's Patient Safety Working Group to improve health care through the prevention of medical errors and enhancement of patient safety. The Air Force is promoting its Medical Incident Investigation review process where an external professional investigation team reviews medical incidents for causes and identified lessons learned for prevention of future similar incidents. The lessons learned are then widely disseminated throughout the medical community as NOTAMs (notes to airmen). The Air Force is also using the Composite Health Care System (CHCS) electronic order entry of prescriptions to eliminate illegibility' as a cause of medication errors. In addition, we are piloting pharmacy robotic technology with excellent initial reports on decreasing dispensing errors. These are all ways we are striving to put our patients first.

## ***Conclusion***

The “Parthenon” has been and continues to be an effective strategy for moving the AFMS to a population-based health care system. Our outstanding PMT metrics will continue to monitor successful implementation of necessary changes and ensure we satisfy our customers to the best of our ability. The ultimate goal of our strategy is a healthy, fit fighting force that can effectively support the greatest Expeditionary Aerospace Force in the world.