



WALTER REED HEALTH CARE SYSTEM STRATEGIC PLAN FOR FY 2001-2003

CONTENTS

Introduction	2
Leadership in Clinical Readiness	5
Outcomes Management	8
Clinical Center of Gravity for Army Medicine	11
Primary and Specialty Care Integration	15
Partnering with Other Services and Agencies	18
Information Management and Technology	21

INTRODUCTION

The Walter Reed Health Care System

The Walter Reed Health Care System (WRHCS) is the largest, most complex, most capable, and most challenging health care entity in Army medicine below the level of a Regional Medical Command. As a major subordinate unit of the North Atlantic Regional Medical Command, it includes under one command the medical treatment facilities of Walter Reed Army Medical Center, Dewitt Army Community Hospital, Kimbrough Ambulatory Care Center, and the subordinate units of these organizations. The WRHCS is located within Region 1 of the TRICARE program of the Department of Defense. The WRHCS meets the medical needs of 150,000 beneficiaries of the military health system, including 120,000 enrolled in the TRICARE program, and others who are presently ineligible for TRICARE enrollment because of their age 65 or older. As a worldwide referral center, Walter Reed's workload for complex specialty care includes both patients from the 3 state geographic range of the WRHCS and patients referred from around the world.

The Imperative for Integration

The initial period of existence for the WRHCS, between 1996 and 2000, was a time of changing concepts, emphasis, and organization. One constant unrealized goal over these years has been that a functionally integrated system of Army primary and specialty care for the National Capital Area would best serve the interests of patient welfare, readiness and education. Study of the outcomes of integrated health care shows that the whole is greater than the sum of its parts: integrated systems perform better than stand-alone primary and specialty centers. True integration of Army health care in the WRHCS would also best support the ability of the Army to effectively partner with and contribute to higher level integration of the care provided by Navy, Air Force, and other federal facilities in the area.

Vision and Mission Development

In August 2000 the Commanders of the WRHCS, Dewitt Army Community Hospital, and Kimbrough Ambulatory Care Center agreed on vision and mission statements for the WRHCS to support its potential for fully integrated function. The new statements reflect the intent of the current vision and mission documents of the Army, of the Defense Health Program, the U.S. Army Medical Command and the North Atlantic Regional Medical Command:

Walter Reed Health Care System Vision

Provides the Nation's most effective population-based primary and specialty military health care for soldiers, other service members, families and retirees in the National Capital area. Serves as the pre-eminent Federal medical center for worldwide referral care, clinical education and clinical research.

Walter Reed Health Care System Mission

- 1. Develop leadership in clinical readiness for combat and contingency missions.***
- 2. Exploit advances in wellness, prevention and disease outcomes management for maximum quality of life and health.***
- 3. Serve as the Army's center of gravity for complex care, clinical education and clinical research.***
- 4. Become the national leader in outcomes-focused integration of primary and specialty care.***
- 5. Partner with other services and agencies to promote excellence in military health care with prudent stewardship of resources.***

Strategic Plan Development

During September 2000, teams of WRHCS leaders prepared a draft Strategic Plan to execute the newly articulated mission. The resulting plan includes five sections keyed to the elements of the mission statement, and a sixth section focused on information management and technology. The leadership came together on 21 September 2000, collectively endorsed the new vision and mission statements, and discussed each section of the draft strategic plan with its team of authors. The resulting consensus product is intended to convey WRHCS-level guidance to its component medical facilities for the direction of the System over a three year planning horizon, from Fiscal Years 2001 to 2003. For each mission element, the plan considers background information, and provides an analysis of the current strengths and weaknesses of the WRHCS, as well as

the potential external opportunities and threats that may affect mission accomplishment. Sections conclude with broadly stated goals and objectives, which are subject to modification as new opportunities develop over the period of the plan's execution. This strategic plan now forms the basis for the development of implementing plans for each of the three major medical treatment facilities of the WRHCS. The facility plans will specify the timelines and metrics that commanders will follow in order to realize the goals of the WRHCS.

Participants

This strategic planning process was conducted by COL Michael Dunn, WRHCS Commander; COL Eileen Malone, Dewitt Army Community Hospital Commander, COL Lairie Stabler, Kimbrough Ambulatory Care Center Commander, and COL Brian Foley, WRHCS Chief of Staff, under the guidance of MG Harold Timboe, Commander of the North Atlantic Regional Medical Command and Walter Reed Army Medical Center. COL Jane McCullough, Commander of the 48th Combat Support Hospital, participated in the discussions. Planning was facilitated by Mr. Richard Stacey, with the assistance of MAJ Manester Bruno and CPT Peter Murdock. The Leadership in Readiness team, led by COL Larry Bolton, included COL Quigg Davis, LTC Jerome Penner, CSM George Martinez and MSG Jackie Horton. The Outcomes team, led by COL Jill Phillips, included COL Thierno Diallo, COL Robin Hightower, COL William Duncan and MSG Theodis Butler. The Clinical Center of Gravity team, led by COL Dale Block, included COL James Geiling, COL Stephen Gibbs and COL John Kugler. The Primary-Specialty Care Integration team, led by LTC David Jones, included COL Debbie Lomax-Franklin, Ms. Sandra Hersh, Ms. Kathie McCracken and Ms. Catherine Whelan. The Partnering team, led by LTC Michael Krukar, included COL Carol Jones, COL Walter Egerton, and LTC Gregory Winn. The Informatics team, led by LTC Vaseal Lewis, included COL Ronald Poropatich, MAJ Paul Duch and CSM Steven Brooks.

MISSION ELEMENT 1: DEVELOP LEADERSHIP IN CLINICAL READINESS FOR COMBAT AND CONTINGENCY MISSIONS.

Background

The concept of readiness includes multiple individual and collective components. The individual readiness of physicians, nurses and enlisted medical specialists to perform patient care in combat requires continued performance of challenging, high complexity care in peacetime—the concept of an adequate load of clinical decision making under pressure. Clinical training programs in the WRHCS also incorporate a military-unique curriculum that emphasizes those aspects of a clinical specialty that are critical for medical readiness, for example, the medical management of chemical casualties involving the airway is highlighted in anesthesiology, pulmonary-critical care, and ENT training. Individual readiness also includes such elements as common task training (CTT) and nuclear, chemical and biological (NBC) training. Individual Professional Filler System (PROFIS) standards must be met to achieve the operational and tactical focus of readiness. Collective readiness tasks, including unit Emergency Preparedness Preparation (EPP) planning, and the functions of Specialized Medical Augmentation Readiness Teams (SMART teams), must also be considered. Placing the responsibility for readiness operations under the Medical Center Brigade Commander and building an effective human resources engine are two initiatives that will result in better coordination and synchronization of training and tasking, so as to maximize readiness and minimize the interruption of patient care. Three assumptions underlie this strategic plan section: (1) Readiness will be integrated into overall strategy development for the WRHCS; (2) There will be no net gain in AMEDD military human resource requirements and authorizations; and (3) Readiness resources will not be reduced in the out years.

Assessment

Strengths

The WRHCS has a strong Individual Readiness Training (IRT) program. The clinical challenge level related to readiness is as strong or stronger here than in any other patient care network in the Department of Defense. Additionally, the WRHCS has the makings of a robust SMART team program. These teams are force multipliers not first responders, are MACOM assets, and are capable of executing required missions within required timelines. Policies and plans for resources, training and equipment have been addressed to a variable extent. To ensure that team personnel are available for missions, they are not assigned to resource PROFIS requirements. There is consideration of designating team OICs as commanders to increase their documented leadership experience as well as the effectiveness of these teams in actual operations.

Weaknesses

Inadequate retention of soldiers and civilians, incomplete implementation and execution of a Walter Reed Health Care Operations System, incomplete PROFIS training, lack of integrated emergency preparedness planning and implementation, and lack of a WRHCS military Human Resource Management System are key areas of weakness. Our current EPP Structure is limited to WRAMC. We must integrate WRAMC's EPP with WRHCS, the District of Columbia government, and the surrounding community. Our current human resources management system is also limited to WRAMC and must integrate throughout the WRHCS. The need to look into training back-up personnel is great because of human resources management issues, emergency preparedness, and the absence of a WRHCS Operations System. All are weaknesses related to clinical readiness for combat and contingency operations. These weaknesses exist in an atmosphere of increased operational tempo and unexpected contingency operations that affect the availability of providers for continuing patient care operations. There is a significant problem with recruiting, retaining, and selection of soldiers, NCOs, officers and civilians in the WRHCS. While these problems are not unique to the WRHCS they are a weakness that affects not only readiness, but also the daily delivery of patient care. Another human resources issue is the difficulty in getting PROFIS personnel trained and ready to deploy any place at any time. The requirements for PROFIS personnel are constantly increasing.

Opportunities

We have major new readiness opportunities involving field training and human resource management with the 48th CSH. In addition, we can capitalize on training with our War Trace units and exploit an increased interest in supporting our contingency mission to support Site R. Implementing and executing a Walter Reed Health Care Military Human Resources Management System will help remedy human resources management issues by optimizing personnel distribution. This management system should allow us to substantially improve in the areas of accountability, PROFIS, awards, evaluations and personnel actions.

Threats

A strong economy with a negative impact on retention, high OPTEMPO and PERSTEMPO, potential reductions of readiness dollars, attrition of noncombat military end strength by the Army transformation process, and unforeseen and

non-mission essential taskings all pose threats to the readiness posture of the WRHCS. Any loss of significant care complexity, challenge level or volume by

loss of our patient base or care capacity would limit the capability of providers to perform the same functions with high efficacy in combat.

Goals and Objectives for FY 2001-2003

A key collective readiness goal for SMART team capability is the capacity to deploy complete, well-trained and equipped teams to any location at any time. A challenge is the fact that many specialists assigned to positions on these teams are only one deep. To meet the goal rapidly, we will review and update plans and resource requirements by 31 December 2000. All SMART teams will be resourced by 1 March 2001, and team exercises will commence by 1 May 2001.

A key individual readiness goal is to have 100% of all PROFIS personnel trained and ready. This will be accomplished by establishing an effective WRHCS PROFIS training program, that ensures that WRHCS PROFIS requirements are 100% filled at all times, that there is optimal synchronization between personnel and operations, and that we maximize training opportunities such as those afforded by the 48th CSH, 2290th USAH and other war-trace units. WRHCS assets must be leveraged to ensure that every training opportunity is maximized. To build on the readiness strengths of the WRHCS, our goal is 100% individual readiness training, to be accomplished by adopting fully effective plans, policies and procedures for readiness training by January 2001.

Maximizing retention of all qualified military and civilian personnel within the WRHCS is a readiness goal. It must be met by engaging leaders at every level in military and civilian retention efforts, supporting quality of life issues such as on-post day care, and developing viable marketing strategies aimed at recruiting skilled civilian professionals and technicians, as well as improving civilian personnel management practices for those in place.

The Site R contingency mission goal is to reach 100% mission capability. The site will undergo a complete renovation beginning in the first quarter of FY 2001. Individual teams that would man the site need to remain trained at all times. Teams will become fully exercise and mission capable by the third quarter of FY 2001.

We will integrate and exercise an Emergency Preparedness Plan throughout the WRHCS, recognizing the threat profile to the National Capital Area. To accomplish this goal, plans, policies, and procedures must be developed that will capitalize on system-wide resources for responding to potential contingencies.

MISSION ELEMENT 2: EXPLOIT ADVANCES IN WELLNESS, PREVENTION AND DISEASE OUTCOMES MANAGEMENT FOR MAXIMUM QUALITY OF LIFE AND HEALTH.

Background

Disease outcomes management is the most effective way to assess and benefit patients with chronic diseases. Management strategies that focus on patient perceptions of their health status and social issues and on their relationship with providers can strongly influence improved outcomes. The formation of a working partnership among patients, primary care providers and specialists is made possible by unity of purpose supported by improved information sharing and data systems. Disease outcomes management applies the tools of population wellness and prevention to groups of persons with chronic disease states. Adequacy of resources and staff support is a key restraint. Recent advances have provided tools to measure outcomes; for example, a usable outcomes database has moved from vision to reality quickly. Disease outcomes management focuses on measurable processes of care, e.g., the frequency of hemoglobin A1C measurement for diabetic patients. Interventions that improve such processes within well conceived clinical practice guidelines can reduce the frequency and severity of exacerbations of chronic illness, reduce the level of high intensity ambulatory care, and reduce hospital admissions and readmissions. Our focus is to define and meet the clinical, functional, and educational needs associated with successful treatment of a chronic condition. Under Background of the Outcomes section, Our Outcomes Management initiative focuses not only on the processes of care, but outcomes from the patient's perspective to include functional status social support systems, satisfaction with care, and educational needs.

Analysis

Strengths

The WRHCS has a \$10 million congressional appropriation for FY01 for the demonstration of outcomes management, as well as strong command support. The program is seen as the right thing to do for patients, and as a unifying concept for DoD's largest integrated primary care patient base with its most robust specialty care center. Primary care providers and specialists are committed to a departure from an emphasis on workload-driven counting or dollar-driven savings per enrolled patient to a new outcomes-driven standard. VHA/DoD national clinical practice guidelines have been approved for several

chronic disease states, and effective patient education materials in printed and electronic form are available. The staffs of the U.S. Army Medical Command and the U.S. Army Center for Health Promotion and Preventive Medicine are engaged as active participants in the effort, with an intent to help report, exploit and proliferate outcomes management gains throughout the military health

system as they are demonstrated in the WRHCS. New specialty data modules that have the capacity to integrate with primary care are now available.

Weaknesses

The WRHCS at present lacks a fully integrated care delivery system and lacks an integrated information system at local and system levels, both of which must be built within a constrained time frame (12 months) in order to succeed in a funded demonstration of measurably improved outcomes. There are potentially problematic issues with TRICARE enrollment policies, in that success in outcomes management may attract additional patients who are not now dependent on the WRHCS for care and for whom the WRHCS is not now resourced. There is a lack of infrastructure for information technology, especially reliability and capacity (e.g., LAN failures, lack of broadband capacity, lack of flexibility to connect PCs to different areas in a facility). A shortfall of primary care providers system-wide diminishes the population base to which we can provide a continuum of care.

Opportunities

Development of a system-wide primary care provider information network would enhance communication and care delivery. To enhance patient-provider relationships, use of the Point of View Survey tool can pinpoint the key problems we face with delivering service to our clients. Analysis of functional status information for our disease management populations can define specific opportunities to improve quality of life. Improving the functionality of the WRHCS web site for patient education, appointing and medication refilling will win back confidence in a system that is now problematic in the ease of making appointments. Improved communication between primary care and specialty providers can result from the application of practice guidelines with specialty referral triggers and enhanced ease of specialty appointing supported by the new outcomes database. There is an opportunity to position the WRHCS for additional Congressional funding for FY 02 if we show measurable success with our FY01 resources. Success in disease outcomes management will also strongly position the WRHCS for the advent of TRICARE Senior Prime.

Threats

The potential threats include: the lack of continued congressional funding; raised patient expectations are not satisfied over time; generation of an increased volume in the primary care base without a concomitant increase in capacity of the specialty base; objections from DoD(HA) and TMA regarding TRICARE access policies; and the potential for deficient data quality and quantity that would frustrate analysis.

Goals and Objectives for FY 2001-2003

We must formally integrate the use of outcomes and other performance measures into the health care delivery process of the WRHCS. Sub-goals are to improve the quality of the patient-provider relationship, to improve the quality of care for specific disease entities, and to support further integration of primary and specialty care.

We will establish disease outcomes management a partnership of patients, primary care providers and specialists designed to provide the right care at the right time in the right way for serious chronic diseases. This system-wide strategic approach includes measures to assess clinical performance, health status, satisfaction, administrative and financial functions for the following 6 disease states within the WRHCS:

1. Hypertension/ diabetes/dyslipidemia
2. Congestive heart failure
3. Chronic obstructive pulmonary disease
4. Childhood asthma
5. Breast cancer
6. Chronic hepatitis C.

We will endeavor to optimize four core elements: patient identification, patient education, compliance tracking, and clinical management.

Based on population data and estimates of disease prevalence from queries of our Composite Health Care System (CHCS) database, we expect to enroll approximately 20,000 WRHCS beneficiaries in outcomes management projects to improve care of these 6 disease states.

MISSION ELEMENT 3: SERVE AS THE ARMY'S CENTER OF GRAVITY FOR COMPLEX CARE, CLINICAL EDUCATION AND CLINICAL RESEARCH.

Background:

The WRHCS includes the most advanced specialty care facility in the Department of Defense, as well as a network of Army military treatment facilities that provide primary care for 150,000 beneficiaries in the National Capital Area. The WRHCS includes Walter Reed Army Medical Center (WRAMC), the major undergraduate medical student teaching resource of the Uniformed Services University of the Health Sciences (USUHS). WRAMC trains 60 percent of the Army's clinical subspecialists, and is the Army's largest center for clinical education, operating 50 graduate medical education programs and the Army's most productive clinical research program. The density, volume and complexity of its teaching case mix makes the WRHCS a unique and valuable combat readiness platform because it trains and sustains the high order skills that doctors, nurses and enlisted medical specialists must apply under combat conditions. In its volume and intensity of complex care, the WRHCS stands alone in its capacity to contribute clinical readiness to the nation's warfighting capability. Its rich mix of complex clinical effort gives the WRHCS its essential character as the clinical center of gravity for military medicine. About half of WRAMC's workload of patients with serious, complex diseases comes from within the WRHCS. The other half is referred from military facilities around the world. The strategic challenge facing the WRHCS as center of gravity is to maximize referrals for complex high teaching value cases to WRAMC while ensuring complete support of the primary care missions of its other facilities.

Analysis

Strengths

Walter Reed has a worldwide reputation and "brand name" recognition for clinical excellence. Its medical, nursing, and support staff includes many of the most capable providers, researchers and clinical leaders in military medicine. Its depth within specialties and its breadth of specialty coverage is unique for a Federal medical center. It has a loyal, dedicated core patient base within the National Capital Area. Its programs in graduate medical education generally attract the strongest Army trainees, who achieve a pass rate on specialty board examinations of over 96 percent. Graduates of these training programs serve at military medical facilities worldwide and help to maintain communication and facilitate patient referrals. Many senior military and civilian Department of Defense leaders, as well as members of Congress, receive care at WRAMC and support its continuation as a center of clinical excellence. Clinical research is robust, involving over 1000 active research protocols and over \$55 million in

annual funding. WRAMC's position as the principal undergraduate teaching medical center for the USUHS brings it the continued intellectual stimulation of students and teaching faculty.

Weaknesses

The most urgent problem facing the WRHCS in recent years has been lack of resources coupled with turbulence in policy and direction of military health care in the National Capital Area. From Fiscal Year 1997 to Fiscal Year 1999, operating resources, facility maintenance support, resources to modernize major equipment, and numbers of clinical support staff were in negative real growth. WRAMC, for example, lacked the human and dollar resources in early 1999 to safely and consistently care for more than 150 inpatients, and routinely diverted patients with complex problems elsewhere, with a decline in its case mix index to below that expected for a teaching medical center. Turbulence during this period was manifested by frequently rotating leadership of the TRICARE program in the National Capital Area, conflicting plans to consolidate care and facilities of the three Services in the area, and severe problems with access to care and patient appointing conducted by a new managed care support contractor. Resource constraints during this period fell most heavily on specialty care in military medical centers, because national attention, as well as available resources, were concentrated on dealing with widespread dissatisfaction with access to primary care. While resourcing, direction, staff support, clinical workload and complexity have all substantially improved during Fiscal Year 2000, the improvements are incomplete, and there is significant concern that the gains will prove to be only transitory. Retention of mid-level and senior military clinicians in several key services has been poor, driven in part by the above problems. Continuing weaknesses include widespread lack of attention to cultivating the physician referral base with inadequate communication to referring providers, lack of responsiveness of our mechanisms for hiring, advancing, rewarding and disciplining civilian staff, and lack of a consistent, universal culture of courtesy and support for patients.

Opportunities

The greatest new opportunity for ensuring a strong level of complex care in the WRHCS is the expected advent of legislative authority to provide continued care for beneficiaries aged 65 and over, in the TRICARE Senior Prime program. Depending on the specifics of the implementing legislation and policy, we can anticipate that about 30,000 eligible beneficiaries in the WRHCS may be attracted to the program. Development of a common spirit within the WRHCS, coupled with the proliferation of appropriate provider-friendly information systems, offers an opportunity to establish solid, timely clinical feedback to referring providers. Measuring clinical productivity and assessing the value added of specialty care will become critically important in future resource

decisions. Metrics to assess specialty care productivity are not yet defined within the Department of Defense, offering an opportunity for WRHCS clinical experts to collaborate in their definition on terms that will fairly represent the value of our care. Our new specialty clinical review and analysis process, conducted in concert with the U.S. Army Medical Command staff, is a promising vehicle for such definition. Finally, there is growing evidence that the best outcomes in such specialties as cardiac surgery, interventional cardiology, and neurosurgery take place in high volume centers. As policy drives the concentration of care in such centers based on quality, outcomes and patient safety, it will be a critically important opportunity and imperative for the WRHCS, especially WRAMC, to meet the expected volume-outcomes requirements for the complex care it provides, either as a stand-alone center or as part of a carefully consolidated operation with one or more other centers, following the pattern already in place for our consolidation of neurosurgery with the National Naval Medical Center, or solid organ transplantation with the National Institutes of Health and university programs.

Threats

The three major threats to continued predominance of the WRHCS as a clinical center of gravity are the potential diversion of our patient base, the potential diversion of resources to alternate sources of care, and the potential for loss of productive collaboration with other institutions on which our future strength will increasingly depend. The viability of our family member and retiree patient base within the WRHCS depends not only on ease of access and patient satisfaction, but very importantly on the relative costs to patients of alternative care. For example, an unattractive or excessive TRICARE Prime or Senior Prime copayment requirement, set against changes that might make a low cost FEHBP or USFHP benefit more appealing, could drive care elsewhere. Increasing expense and inconvenience of travel and lodging for worldwide referral patients, coupled with development of cost-attractive subsidized civilian alternatives, have already greatly impacted our worldwide referral base and may further diminish this important patient population. Civilian academic medical centers in our area are under severe financial strains as their own resources and patient bases decline. The threat of potential changes in law and policy that would assist these centers at our expense by channeling our patients and resources to them will likely intensify over this period. A key driver of this threat is the potential diminished appreciation by policymakers of the importance of strong military specialty care for combat readiness. As the most recent needs for robust specialty care in combat recede in history, our sustainment as a clinical center of gravity may lose support. Finally, our future as a center of complex care is increasingly linked with that of our collaborating centers. Future threats to the strength of clinical care at the Navy, Air Force, other federal, and civilian centers that are linked with our education and specialty programs, and any threats to the continuation of a strong USUHS, represent major potential problems for the WRHCS.

Goals and Objectives for FY 2001-2003

The WRHCS will carefully prepare for, market, and vigorously execute TRICARE Senior Prime with a goal of enrolling 30,000 beneficiaries in our area. We will position the necessary primary and specialty care capacities to meet the projected care needs of this population within access standards, either in our own facilities or when necessary in civilian network facilities.

We will commit to set the standard for the utmost respect and courtesy to all patients at all times by all staff members. We will expect total adherence to this standard as a condition for service in any capacity.

We will establish a new standard of timely, formal, written communication to all referring providers, both within the WRHCS and worldwide, of the key findings and outcomes of every significant episode of specialty care. The communication will specify an easily accessible specialist physician point of contact for more information and for facilitating future referrals.

We will develop and implement reliable measurements for clinical productivity in specialty care. The measures will take into account research productivity, teaching commitments, and military-unique functions including readiness training, deployments and other duties. We will propose adoption of the productivity measures throughout Army medicine as a basis for specialty care resource management.

We will seek to conduct a sufficient volume of high complexity care to ensure best outcomes when volume-outcomes relationships are defined for a specific procedure or form of care. We will combine our efforts with those of other centers when necessary and appropriate to ensure best outcomes, or, if we are unable to ensure best outcomes in our hands, we will arrange care where patients' best interests are served.

We will support expansion and strengthening of our clinical research programs, both in-house and in collaboration with other centers and USUHS. We will strongly encourage and reward publication of research by staff and graduate trainees in national peer-reviewed journals.

MISSION ELEMENT 4: Become the national leader in outcomes-focused integration of primary and specialty care.

Background

A well functioning integrated health care system provides appropriate, efficient primary and specialty care that meets well defined access and quality standards for its enrolled beneficiaries. Physicians, nurses, and other providers of primary and specialty care communicate freely and coordinate their efforts. An initial Army concept, Gateway to Care, was followed by the Department of Defense's current TRICARE program, both of which sought to define a clear, assured health benefit for all persons enrolled in a military health maintenance plan, in contrast to our historical practice of offering space-available care for non-active duty beneficiaries when circumstances allowed. Good management of a military health plan first requires definition of the expected wellness, prevention, and disease treatment needs of an enrolled population, followed by the definition and provision of human and material resources to best meet the needs. The greatest challenges in military health plan management have proven to be the integration of the right mix of primary care with specialty care in military facilities, and the provision of appropriate contracted civilian care when access to the right military care is lacking. The WRHCS must integrate the efforts of primary and specialty care staffs in dispersed locations, must ensure timely information transfer among all elements of care, and must ensure that patients are appointed in a manner that puts them in the right place at the right time with the right data to ensure the right care with minimal inconvenience. The standard for measuring the success of integrated health plan management in the WRHCS will be the outcomes of the care we provide for our most challenging common disease states, as discussed above.

Analysis

Strengths

The system has a large number of well qualified physicians and other providers in nearly all required specialty areas, and a relatively large network of primary care providers located in proximity to our major concentrations of patients. We have the basics for information management and data transfer with the CHCS and CIS clinical data systems, Outlook electronic mail, and reasonably effective telephonic appointing and pharmacy call-in systems. Our military providers and patients share a common military culture and value system of caring, loyalty to concepts beyond self interest, and accountability. Clinical decision making is influenced primarily by what is best for the patient rather than fee-for-service profitability or expediency.

Weaknesses

Up till now, specialists at WRAMC and primary care providers in the rest of the WRHCS have not considered themselves as members of the same team. Geographic dispersion, rarity of face-to-face contacts, dependence on poorly functioning data systems for communication, poorly defined command relationships among major system elements, and above all, constant win-lose competitions for a diminishing pool of resources have largely prevented development of a team spirit. The location of the bulk of specialty care capability at WRAMC makes its access by much of the enrolled population difficult. The mix of military specialists and primary care physicians available within the WRHCS is driven by an officer distribution plan predicated on operational and training requirements rather than the health care needs of the enrolled population. For example, there is inadequate capacity for military specialty care in such key areas as orthopedics, dermatology, gastroenterology and mental health to meet the needs of the enrolled primary care base. Access to contracted civilian specialty care for these needs has been problematic both in volume and quality. Attempts to support appointing and access through our TRICARE support contractor are frustrated by resourcing, experience and appointing software communication problems, as well as by existence of overlapping Army, Navy and Air Force care capabilities that lack coordination.

Opportunities

The WRHCS now has a unified command structure, as well as a collective leadership that has an unprecedented opportunity to plan and execute adequately resourced primary and specialty care keyed to defined population needs. The continuation of adequate resources to support population-based care now appears likely, given the will of Congress to support improved military health care. An earlier regional planning effort using a Regional Uniform Benefit Model (RUBM), was well conceived but failed to gain wide acceptance in part because deficient total resources set up win-lose competitions for the redistribution of inadequate assets, a situation that we now have the opportunity to learn from and overcome. Over the next three years we can expect deployment of improved information systems to support integration, as discussed in the final section of this plan. Return of specialty appointing functions from the support contractor to military facilities offers a new opportunity to improve their responsiveness. The collaboration between primary and specialty providers involved in disease outcomes management, as discussed earlier, offers an attractive intellectual opportunity for providers to generate and report measurable improvements in care resulting from primary-specialty integration. Finally, implementing TRICARE Senior Prime will require substantial increments in specialty care availability for its elderly enrollees, with expanded requirements for careful care integration for maximum benefit.

Threats

The principal threats to successful care integration now appear to be time, space and resources. Federal health care redirections are difficult to conduct in a timely manner, because they depend on multiple time-sensitive components. In the case of primary-specialty care integration in the WRHCS, assessment of population-based needs must be followed by such actions as hiring of civilian physicians, support staff, nurse practitioners and case managers, reassignments of officers, redirection of dollars, generation of new contracts, and execution of potential resource support and resource sharing agreements with our support contractor. If TRICARE Senior Prime is implemented in October 2001, adequate advance care integration will be a major challenge. Space challenges involve both patients and providers. Travel distances for patients to seek frequently needed specialty care must be minimized, at the same time that specialty provider travel to primary care sites is conducted for maximum efficiency. Resource shortfalls at critical points are a final threat that could defeat care integration. For example, lack of follow-on funding beyond Fiscal Year 2001 for our disease outcomes management program could severely compromise the entire integration process that depends on an outcomes management focus.

Goals and Objectives for FY 2001-2003

We will conduct a population based assessment of the anticipated health needs of our primary care base in order to determine requirements for primary and specialty care. The assessment will include definition of the needs of our expected TRICARE Senior Prime enrollees.

We will use the best combination of military, government civilian, direct contracted, and resource sharing/resource support staff to meet defined primary and specialty care needs. We will form effective teams of primary and specialty physicians, nurses and other providers as appropriate, and provide them with the necessary support staff, resources and appointing and information support to ensure their success.

We will implement effective military health plan management across the WRHCS with tight coordination among the managed care staffs of all its elements, improved collaboration with our managed care support contractor, and enhanced communication with Navy and Air Force facilities.

We will assess and report the effectiveness of our disease outcomes management programs to demonstrate the benefits of disease targeted primary-specialty care integration.

Mission Element 5: Partner with other services and agencies to promote excellence in military health care with prudent stewardship of resources.

Background

Partnering is the sharing and integration of human and material resources with other organizations and agencies to efficiently treat our beneficiary population, maintain and improve individual and collective readiness, and support educational and training opportunities. Elements of the WRHCS are engaged in numerous partnering relationships with organizations of other Services, such as the National Naval Medical Center and Malcolm Grow Air Force Medical Center, with other Army units such as our Reserve Component war trace units, active TO&E units, and the US Army Medical Research and Materiel Command, and with Department of Defense agencies such as USUHS and the Armed Forces Institute of Pathology. We collaborate with other government agencies such as the Veterans Administration, the National Institutes of Health, the Office of the Attending Physician to Congress, and the White House Physician's Office, as well as with multiple public and private hospitals and universities and with the agencies of allied governments. The success of nearly all missions of the WRHCS depends in a significant way on collaboration with other organizations. Our relationship with our TRICARE managed care support contractor and with other commercial service providers involves the provision of contracted services to the WRHCS in settings that require our staff to work in concert with the contractors' employees. These commercial relationships, as well as our partnership efforts with labor unions that represent many of our civilian staff, are governed by law, policy and contract provisions.

Analysis

Strengths

In any partnering relationship, the WRHCS offers multiple capabilities and depth in primary and specialty care, education, research, and support services. Many of its most important partnerships have a record of decades of successful implementation. The Congress and the Department of Defense are generally supportive of well-conceived partnership efforts that can be shown to avoid duplication of functions and to save resources.

Weaknesses

Members of organizations that attempt to work in partnership must often overcome cultural and operational differences that may seem to be greater among agencies of our own government than between foreign countries.

Differences in basic goals, planning horizons, workload and resource tracking systems, incompatible clinical information systems, and different patient and provider preferences, practices and expectations can frustrate our capacity to work together. When shortfalls occur in elements that partners view as essential for their own functioning, such as specific patient populations, workloads of index surgical cases, numbers of approved graduate medical training positions, or resources, win-lose competition for such elements makes continued partnering difficult.

Opportunities

Partnering can create new and powerful coalitions of the supporters of the collaborating partners. For example, a new alliance of the congressional supporters of military readiness and benefits with the legislative supporters of more effective health care delivery has provided the WRHCS with the resources and opportunity to show the potential effectiveness of disease outcomes management. The new emphasis on patient safety, care quality and best outcomes for complex care provided in high volume centers offers the opportunity to form the necessary partnerships that will ensure high case volumes. The concentration of government and private health care facilities in the National Capital Area presents rich opportunities for effective clinical partnerships. Partnerships that can reduce duplicative services and save resources may provide us with an opportunity for access to new technology and new resource streams.

Threats

At any time, several of the major partners of the WRHCS can be expected to be dealing with external threats that compromise their effectiveness. Shifting patient populations, new reimbursement formulas by payers, and shifting patterns of care that have marginalized a number of large inpatient-focused institutions are examples of the threats that have severely affected some of our partners. In graduate medical education in the National Capital Area, our web of partnerships makes us dependent on the viability of USUHS, the National Naval Medical Center, and Malcolm Grow. In readiness, our posture now depends on the resources and operational tempo provided to our partner active and reserve component TO&E units. In every aspect of our operations, a serious threat to our partners is now a threat to the WRHCS.

Goals and Objectives for FY 2001-2003

We will identify, for each of our facilities, the major partnerships that help to sustain our core missions. We will assess our relative contributions to each such partnership in order to define what return we receive on our investment of human and dollar resources in the partnering effort.

Walter Reed Health Care System Strategic Plan for FY 2001 to 2003

We will identify any major partnerships in which the future ability of our partners to continue participation appears to be in question, and will determine how best to support the continuation of those mission-essential efforts that appear to be under threat.

We will continually assess the potential for beginning new partnering efforts, especially with facilities of other Services and other federal health organizations, when there are mutual benefits that appear to justify a specific effort.

Supporting Mission Element: Provide accessible, reliable, and accurate information systems that respond to the needs of the Walter Reed Health Care System.

Background

Information integration measures the extent to which the new integrated WRHCS has the information infrastructure, communications, and applications to support clinical integration. The attributes include the abilities to identify each member or patient across care settings, to update patient clinical and administrative information once and make it available to all authorized users, to maintain an integrated patient problem list, to coordinate the scheduling of visits across care facilities and settings, to enable care providers to communicate seamlessly across settings, and to analyze outcomes of care across settings.

Analysis

Strengths

Geographic location is an asset because the WRHCS is co-located with the Pentagon, Congress and other federal agencies. We enjoy high visibility to top decision makers as well as a strong reputation as a center of excellence in medical knowledge. We have the most well developed, highest quality military medical information infrastructure in the national capital area. The WRHCS is a trail blazer in the area of strategies for integrated health care data systems. We are proactive in the areas of customer support and command investments in Information Management and Information Technology. Our clinical staff includes many respected providers who have a facility for information systems and a strong commitment to helping improve our information posture.

Weaknesses

Incompatibility of existing systems and lack of database standardization severely impairs the ability to fully realize our medical informatics potential. Lack of redundancy in infrastructure, insufficient infrastructure monitoring tools, and inadequate bandwidth to support recognized future requirements have compromised our ability to innovate and lead in an environment of ever changing technology. The lack of centralized management of distance learning, web development, and videoconferencing with insufficient network accessibility limits our ability to communicate with other sites that might assist us or to help others who need our assistance. Inadequate security tools, low throughput in our current automated call distribution system, and high turnover in personnel to correct these problems all compromise productivity.

Opportunities

The lack of information connectivity among the medical facilities of the three Services in the National Capital area is a well known obstacle to true tri-Service care coordination or integration. The building sense of urgency on this issue represents a unique opportunity to correct multiple potential medical information technology problems in the National Capital Area in a unified, cost-efficient manner. Our patient population now has a high degree of facility and experience with home internet use, which has raised their anticipation and expectations for facilitating their care via internet access to the WRHCS.

Threats

The most serious threats to effective development of good information support for the WRHCS appear to be the potential for continued fragmentation of information requirements from different echelons of leadership within the Army and Department of Defense, lack of full compatibility of new systems being considered for purchase, and the danger that rapid reactions to attempt to solve urgent problems may leave us with suboptimal, less than cost-effective solutions for the long term.

Goals and Objectives for FY 2001-2003

We will assess current and future informatics needs and mission objectives over this period in order to define the resources needed to best satisfy them.

We will develop a fully functional WRHCS web site that provides a portal for patients to all WRHCS treatment facilities and patient-friendly clinical functions for appointing, pharmacy refills, wellness and prevention education, self-assessment, and non-urgent communication with providers.

We will work toward informatics integration of all military health facilities in the National Capital Area with a single CHCS host, integrated appointing and procedure scheduling, and complete access to all needed clinical data from any care site in the National Capital Area.

We will provide state-of-the art support for clinicians and trainees engaged in care, such as personal digital assistant devices with capable software packages, automated access to professional journals and databases, and automated scheduling and workload capture tools that require no or minimal clinician time to operate.

We will provide a new, integrated personnel, readiness, and training data system to support management of these functions throughout the WRHCS.