

Government Services

This section addresses the emergency medicine services provided by the Military Health System (MHS) and the Veterans Health Administration (VHA). The MHS maintains 63 military hospitals and 413 medical clinics, and the MHS/TRICARE system provides coverage for 9.2 million beneficiaries, including active duty personnel, retirees, and their dependents. In addition, the VHA provides care for 3.5 million enrollees through 153 hospitals and more than 1,000 community-based outpatient clinics.

This assessment of government services does not use the same methodology applied to the 50 states and DC. The data available for the military and veterans' health systems and the different context of the services provided do not allow for the collection of the same measures or a direct comparison with the states. Rather, this report card is based on the available data and on detailed interviews with experts in the field, including representatives of the Army, Navy, and Air Force medical systems and the VHA. During these interviews, we discussed the major issues affecting their systems in the areas of *Access to Emergency Care*, *Public Health and Injury Prevention*, the *Quality and Patient Safety Environment*, and *Disaster Preparedness*. (The area of medical liability is not directly relevant in these systems, because, as government employees, MHS and VHA physicians do not face personal liability lawsuits.) The findings of these interviews are summarized below.

Access to Emergency Care. In contrast to the civilian population, beneficiaries of the MHS and VHA have the advantage of universal health insurance, greatly enhancing their access to primary, specialty, and emergency care. Nonetheless, gaps in ac-

cess can occur, especially when physicians in highly sought-after specialties, including emergency medicine, are frequently deployed. Therefore, while access to primary care is generally good, there can be a shortage of providers for routine appointments in some services, and the saturation of the civilian system can exacerbate the strain on the military system. As in many states, access to on-call physicians in certain specialties, such as neurosurgery, invasive cardiology, and gastroenterology, may be limited, and the supply of these specialists may be further strained by deployments. In addition, not all specialties are available at all military hospitals, resulting in transfer of acute and routine specialty care to the civilian network. Thus, military emergency departments' access to on-call services is reflective of the challenges of each base's local community.

Emergency physicians are among the physicians most often deployed in the MHS, but all services maintain a system of contract support through civilian emergency staffing companies (and the contracted staff are required to be board-certified or -eligible, as are those within the MHS). Boarding in the emergency department is not described as a problem in any of the military services; beds are generally available or patients can be transferred to the civilian system. Likewise, diversion is extremely uncommon in MHS hospitals; Air Force and Navy hospitals do not generally accept patients diverted from the civilian system, but Army hospitals do, and they are more likely to be the recipients of diverted patients than to be on diversion themselves. Thus, representatives of all three services assessed *Access to Emergency Care* within the MHS as better than in the civilian system. The same is true of the VHA: an unpublished survey of VHA hospitals found that they

were on diversion 18 percent of the time, but because of the excess capacity of the hospitals, boarding is rarely an issue.

The major barrier to access within the MHS is the deployment of needed physicians. Moreover, recruitment and retention of physicians are hampered by the pay scale within the MHS (which is about two-thirds of the civilian standard for an emergency physician), although the MHS is attempting to address this with incentives such as loan repayment programs and proposed reform of specialty pay levels. The major advantage of the MHS in the area of access is, of course, the guarantee of health care to its beneficiaries.

Public Health and Injury Prevention. The military services all go to great lengths to promote safety and prevent injuries among their personnel and their families. Injury prevention efforts within the MHS include suicide awareness trainings, motorcycle helmet laws, strictly enforced seat belt and child safety seat requirements, and random breathalyzer checks to prevent driving while intoxicated. The MHS also allows victims of sexual assault to seek confidential treatment. Within the Air Force, every fatality among active duty personnel is researched and briefed, and the Navy Safety Center tracks both fatal and non-fatal injuries among Navy personnel.

Within both the MHS and the VHA, a number of prevention programs are available as well, including smoking cessation programs, access to gyms, and mental health screening and treatment. Mental health is a major priority throughout the military; for example, the Air Force has annual suicide awareness trainings, and all branches conduct mental health screenings before and after each deployment. Similarly, the VHA has recently established a suicide prevention hotline and has hired suicide prevention counselors at each of its medical centers. The VHA also monitors preventive health efforts such as annual

continued on page 122

The MHS and VHA can provide an example for the civilian health care system in many areas.

Government Services, continued

flu immunizations and smoking cessation counseling, and reminders pop up in the system's electronic health record to assure that preventive health topics are being addressed.

Physical fitness is clearly valued within the military, and active duty personnel must meet standards for fitness. Overall, while the MHS serves a disproportionately young, male population that is at high risk for injury, this risk is balanced by dedicated efforts toward injury prevention.

Quality and Patient Safety Environment. Facilities within the MHS and the VHA report on HEDIS measures and other measures of quality and patient safety, including waiting times, medical errors, hospital-acquired infections, and patient satisfaction. According to the VHA's 2008 report to Congress on these measures, the VHA's scores on HEDIS measures are superior to those of the commercial, Medicare, and Medicaid sectors on every measure for which scores are comparable. (The most recent summary of MHS quality measures is from Federal Fiscal Year 2005, so a similar comparison for the MHS is not available.)

The VHA maintains a system of electronic medical records that includes emergency departments and that follows enrollees wherever they go for care within the VHA system. The MHS, on the other hand, has an electronic medical record system, but it does not include emergency departments. The MHS system has been described as cumbersome and slow, and its

lack of a patient tracking module for the emergency system presents a patient safety concern. Both systems have computerized order entry for prescriptions and lab orders (although the system used in the MHS's emergency departments is described as outdated), along with systems to prevent medication errors by alerting providers to potential drug interactions or other safety risks. The Department of Defense's Patient Safety Center monitors medical errors as well.

Overall, while both the MHS and the VHA monitor a wide range of quality indicators, the MHS would benefit from standard emergency care measures that are centrally reported, tracked, and compared to civilian systems that serve similar populations.

Disaster Preparedness. Preparation for disasters and other emergency situations (known as "operational readiness training") is an integral part of the training and routine operations of MHS and VHA providers. While the disaster plans for military hospitals are more advanced than their civilian counterparts, significant work remains to make them robust and functional. Drills for chemical and biological threats are conducted regularly within both systems, and real-time notification systems, tied to the analogous civilian systems, are in place to contact all personnel at any time. Drills are also coordinated with the states and communities in which MHS and VHA hospitals are located. For example, all Air Force bases maintain "all-hazards response plans" which are integrated into the community's disaster response plans. They participate in

community and regional drills for responding to emergencies such as earthquakes or radiation leaks. Surge capacity is calculated for each hospital, and while MHS and VHA hospitals meet capacity criteria of The Joint Commission, their capacity is generally not included in their community's calculation of surge capacity.

The VHA and the MHS can provide an essential element in states' and communities' abilities to respond to a wide range of events and hazards, and these systems can provide a valuable resource to their communities. Therefore, while government-run systems' efforts in this area are promising, there may be room for improvement both within the MHS system and in the integration of these preparedness efforts with those of their states and communities.

Overall Assessment. While they experience particular challenges, the MHS and VHA can provide an example for the civilian health care system in many areas. Specifically, their *Disaster Preparedness* efforts are thorough, and both the MHS and the VHA are leaders in *Public Health and Injury Prevention*. In the area of quality, while the data show high levels of quality within the VHA, the MHS does not have similar data available, making comparisons difficult. While deployments and the challenges associated with recruitment and retention remain barriers, access to primary, specialty, and emergency care are improving and may be superior to access among civilians.