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 231 military treatment facilities (MTFs), and the MHS/TRICARE system provides coverage for 9.7 million beneficiaries, including active duty personnel, retirees and their dependents. In addition, the VHA provides care for 8.5 million enrollees through 152 hospitals and 802 community-based outpatient clinics.

This report card for government services does not use the same methodology as was used for the states. 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 Veterans Health Administration. During these interviews, we discussed the major issues affecting their systems in the areas of access, public health and injury prevention, quality and patient safety, and disaster preparedness. (The area of 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 general, beneficiaries of the MHS and VHA have the advantage of universal health insurance and consistent access to care. All of the military branches and the VHA are focusing on the development of Patient Centered Medical Homes (or, within the VHA, Patient-Aligned Care Teams) for all beneficiaries, to assure access to coordinated primary care. Access to specific specialty providers is still somewhat limited, particularly in the area of mental health services, and patients are referred to the civilian system (although in some cases, such as pediatric mental health services, providers may still be difficult to find) when there is a need. The demand for mental health services within the MHS continues to increase among both active duty enrollees and family members, causing further strain on the behavioral health care system.

In addition, the deployment of providers still presents a barrier to access for MHS beneficiaries. While the Army has seen a steep decline in deployments since the withdrawal from Iraq, the Navy and Air Force are still experiencing high levels of deployments, particularly of orthopedists and emergency physicians, to Afghanistan. While diversion is not unheard of, it is rare, because admission rates are low and boarding is not a problem.

Quality and Patient Safety. Within the MHS, all branches participate in the Healthcare Effectiveness Data and Information Set (HEDIS), report indicators to The Joint Commission, and conduct patient satisfaction surveys. The various branches are also pursuing their own quality monitoring efforts; for example, the Air Force is looking closely at process improvement indicators for emergency departments, including door-to-doctor time, door-to-floor time, and the percentage of patients in the ED for more than 6 hours. This has led to significant improvements in patient flow. The Navy is focusing on the development and implementation of clinical practice guidelines, focusing first on low back pain, post-traumatic stress disorder (PTSD), and women’s preventive health. The MHS as a whole is focusing on the monitoring and improvement of evidence-based practices such as administration of antibiotics within one hour of surgery, screening for low-density lipoprotein (LDL) among patients with cardiovascular disease, and screening for Hemoglobin A1c in diabetics. The system is also monitoring access to primary care, satisfaction with various aspects of care, and primary care continuity.

The VHA has long been a leader in quality measurement and monitoring. Since 2008, the agency has published an annual facility-level report on quality and patient safety, including indicators of staffing levels, utilization volume, patient safety, health equity, quality, mortality, and timeliness of care.

The use of electronic health records is inconsistent across the MHS and VHA. The VHA has had electronic medical records in place since the 1970s, and uses one system across the agency nationwide. An integrated system within the emergency department has been in place for only a few years, however. Within the MHS, the use of EHRs is inconsistent; the Air Force only uses an electronic system for lab orders and prescriptions; while the Navy has an electronic system, they are considering replacing it; and the Army reports that they have a number of systems in place but no system that was specifically designed for use in the ED.

Public Health and Injury Prevention. The population enrolled in the MHS is, as a whole, healthier than the general U.S. population; the VHA, on the other hand, serves a riskier population, with high levels of smoking and diabetes. However, both the MHS and the VHA face specific health risks within their populations and are working to address these issues.

Injury is an ever-present risk among active duty MHS enrollees. Military bases strictly enforce safety regulations such as bicycle helmet requirements, a ban on cell phone use while driving on the base, motorcycle safety training requirements, and random breathalyzers. The Navy conducts an annual General Military Training for all members each year, focusing on the root causes and prevention of injury.

Physical fitness is also of utmost importance to the military. The MHS also implements “individual medical readiness” continued on page 122
assessments, a part of the Army Comprehensive Soldier Fitness program, which is being expanded to include family members. The MHS tracks obesity levels within its enrollees, and has found that active duty members are less likely to be obese than the general population (although obesity rates among new recruits appear to be increasing), while retired members are more likely to be obese. The rate of smoking is higher among active duty enrollees than other enrollees, and nearly one-third of service members aged 18-24 use tobacco in some form. The Army Surgeon General is currently conducting a major campaign on sleep, nutrition, and exercise.

Throughout the MHS there is an emphasis on recognizing, diagnosing, and intervening for mental illness and suicide prevention. The MHS tracks referrals for PTSD, which increased from 2009-2010 and declined a bit in 2011, to a level higher than that found in 2005; this is attributed to physicians' increasing willingness to recognize and refer. The system has also instituted a comprehensive program to identify and treat PTSD, leading to improved treatment response.

The VHA is seeing a change in the health profile of its beneficiaries. The influx of younger vets, along with the decline in the population of World War II vets, has shifted the primary risks from chronic physical illness to mental illness.

The military branches vary in their approach to the abuse of painkillers, which is becoming an increasing problem among wounded warriors. The Army has a central database for all prescriptions, and a Controlled Substance Advisory Group tracks heavy users and identifies a single provider to monitor them. The Navy has instituted a comprehensive pain management program at the hospital level to treat patients and educate providers on issues such as non-narcotic alternative medications, complementary and alternative medicine, prescription drug abuse, and measures of effectiveness. Teams are being trained now for implementation of this program during this fiscal year.

Disaster Preparedness. All of the military branches are dedicated to their role in disaster preparedness both domestically and worldwide. They conduct regular tabletop or simulation drills, have all-hazards plans in place, and coordinate with local plans and systems in the states in which their bases are located. The Air Force, for example, conducts drills at least quarterly, the Army does so twice a year, and the Navy conducts mass casualty drills annually and radiation drills quarterly. Larger exercises will also involve civilian partners, such as an Air Force drill involving a scenario at an air show, and the Navy involves the local communities in its radiation drills.

All members are trained regularly in mass casualty response. The Air Force requires a training every year; the Navy conducts both online and in-person trainings, and a chemical and biological weapons response course is required for all. The Navy has also created a new fellowship in Emergency Preparedness and Disaster Response, consisting of a year of clinical training and the coursework for an MPH degree.

The branches have their own real-time notification systems through their own chains of command, and are included in civilian systems as well. The military hospitals all monitor their own surge capacities.

Within the VHA, emergency response is handled through an emergency management department, with offices on the regional and national levels. They too conduct regular drills, cooperate with their communities on their drills, and have an emergency manager in each facility.

Overall Assessment. The MHS and the VHA continue to provide a model for the civilian health care system in access to primary care, disaster preparedness, and injury prevention, and their approach to quality monitoring appears to have improved in recent years. However, these systems face particular challenges in the mental health arena and in the consistent use of electronic health records.