2012

MHS STAKEHOLDERS' REPORT

The MHS: Healthcare to Health

Table of Contents

1.0 Leadership Views
- 1.1 Assistant Secretary of Defense for Health Affairs 1
- 1.2 Surgeon General of the Air Force 2
- 1.3 Surgeon General of the Navy's Bureau of Medicine and Surgery 3
- 1.4 Surgeon General/Commander, U.S. Army Medical Command 4
- 1.5 Commander, Joint Task Force National Capital Region Medical 5
- 1.6 Coast Guard Director of Health, Safety and Work-Life 6

2.0 What We Did: A Snapshot of a Dynamic Organization in 2011 7

3.0 What We Face: Operating In Challenging Times 8
- 3.1 The Changing Nature of Supply and Demand 9
- 3.2 Escalating Costs 12

4.0 How We're Doing: Assessing Progress in Achieving our Strategic Goals 14
- 4.1 Readiness 15
- 4.2 Population Health 19
- 4.3 Experience of Care 23
- 4.4 Per Capita Cost 29

5.0 Where We're Going: An Integrated Military Health Delivery System that Consistently Delivers Quadruple Aim Performance 33
- 5.1 Bringing Care Back to our Military Treatment Facilities 34
- 5.2 Transforming from Healthcare to Health 36
- 5.3 Performing the Role of the Integrator 37
- 5.4 Partnering to Achieve the Quadruple Aim 38

6.0 Turning Strategy to Action: Our 2012 MHS Strategic Initiatives 39

1.1

Assistant Secretary of Defense for Health Affairs

The United States military produces leaders for American society like no other organization in the world. The Military Health System is a unique microcosm of this world.

This leadership is developed in a very special culture forged from core values of duty, honor and commitment to our nation. A leadership which promotes an ethos of teamwork and loyalty to mission and members of our team—no one gets left behind. A culture which is self-critical and invites criticism and acts to improve. And, we are a culture that reflects the best values of the military and medical professions. Values that begin with an ethic of healing and extend to the highest values of personal courage and sacrifice for a larger purpose.

In this 2012 Stakeholders' Report, we provide a window into how military medicine has performed over the last several years—where we have succeeded and where we have fallen short. What we have learned and where we are headed.

After ten years of war, we have learned a great deal, and we have substantively contributed to the advancement of medicine worldwide. Yet, our combat experience continues; thousands of wounded, injured and ill service members and their families continue to rely on us every day for their care. Millions more rely on us to keep them well.

In 2012, our challenges extend from the battlefield to the budget. Simple, and simplistic, cost-cutting exercises will not suffice. Our readiness mission has always required that we maintain a fit and healthy fighting force. Now, we are focused on maintaining fitness and health for all 9.7 million people we serve.

We are an organization on the move – from healthcare to health.

Dr. Jonathan Woodson

"We are an organization on the move—from healthcare to health."

1.2

Surgeon General of the Air Force

Readiness: "Trusted Care Anywhere" is the AFMS mantra. Readiness remains our number one priority. We know our patients and embrace our heritage of innovation to optimize health and improve care at home and deployed. It all starts with RAPPORT – being trustworthy.

Access: Continuity of care is our promise to beneficiaries. We strive to always be available to enrolled patients and to recapture care to our hospital systems. One million patients in patient-centered medical homes in 2012. Our clear focus is to activate patients as full partners in enhancing their health.

Partners: Shared ideas and services are instrumental to building and sustaining health systems. Our affiliations with civilian institutions, Veteran's Affairs, joint and coalition partners promise sustained currency, better health, better care and best value for all our beneficiaries.

Precision: Leveraging data leads to a culture of visible outcomes for our beneficiaries. Medical informatics transforms data to decision quality information for patients and healthcare teams. Decision support accelerates change in practice patterns and behavior. We create the setting for "right" behaviors by measuring and rewarding outcomes to inspire trust and confidence within our system.

Organized: We are now able to fit a highly capable, modular hospital with sustainable operating support into two C-17 aircraft. Upon arrival, we provide patient care capabilities within 30 minutes and full surgical/intensive care within three hours.

Respect: Research creates knowledge. Continuous improvement in global air evacuation over 10 years safely returned >92,000 patients from theaters of operation. We protect privacy and ensure medical information is safe as we generate new health literacy and improve efficiency and effectiveness of care.

Trust: The foundation of our military health system. Execution of the Quadruple Aim ensures world class care for our beneficiaries. "Trusted Care Anywhere" requires RAPPORT with patients and partners to let them know we will always be there to guarantee their success.

Lt. Gen. Charles B. Green

"Execution of the Quadruple Aim ensures world class care for our beneficiaries."

1.3

Surgeon General of the Navy's Bureau of Medicine and Surgery

Vice Adm. Matthew L. Nathan

Navy Medicine is a thriving, global health care network of 63,000 Navy Medical personnel around the world who provide high quality health care to more than one million eligible beneficiaries. Navy Medicine personnel deploy with Sailors and Marines worldwide, providing critical mission support aboard ship, in the air, under the sea and on the battlefield. I am proud to report that the current state of Navy Medicine is strong, but numerous challenges abound in the future of military medicine and health care in our nation as a whole.

Recently I laid out my strategic objectives for my tenure as the 37th Surgeon General of the Navy to meet these challenges head on. They include continuing to provide support to the warfighter, a focus on readiness and a consistent level of global engagement across the Navy Medicine spectrum. There are three more objectives though that I believe warrant further discussion as they apply to all of military medicine and arguably all health care providers. As we move forward in this new year and beyond, we must look at several key areas.

First is ensuring we are looking intently at the value of what we provide to our beneficiaries. It is imperative that we consider value in all strategic and tactical decision making.

We must also enhance our healthcare informatics capability. We will not make true headway on the cost or access to health care without continued leverage of information management and information technology at all levels of care.

I am also committed to working with my fellow Surgeons General in the spirit of jointness. The synergy of creating efficiencies, removing redundancies and allowing transparency will elevate care and reduce costs. Joint command-and-control cannot happen overnight and must grow from the deck plates with coordinated efforts from the services and those best informed to provide input so that more light than heat is generated.

I am excited about the future! I am encouraged by the opportunities and the shaping that will occur as we find our equilibrium in a dynamic and evolving environment.

"The synergy of creating efficiencies, removing redundancies and allowing transparency will elevate care and reduce costs."

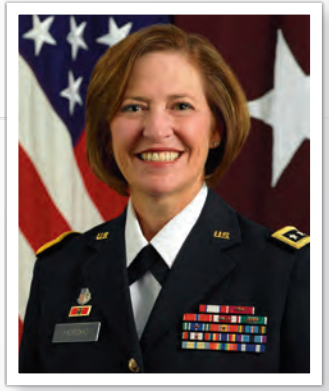
1.4 Surgeon General/Commander U.S. Army Medical Command

Army Medicine is comprised of a vast network of diverse professionals focused on the current war, the readiness of the joint force, national security, and the immediate and future health of our beneficiaries. Every member of our team, from clinical specialists to administrative support personnel, strives to perfect the patient experience—independent of location or conditions. We are an integrated health enterprise—a system of interdependent systems supporting soldiers and families in all aspects of life. Through innovation, superior training and an unmistakable "Warrior Spirit," Army medics have saved thousands of lives in combat while simultaneously promoting medical readiness and health across hundreds of camps, posts and stations in the United States and abroad.

We are a learning organization with an unwavering commitment to perpetual improvement and a collaborative partner focused on collective health. Army Medicine is a responsible steward of our treasured resources and will earnestly face fiscal realities by reducing variation and increasing efficiency while maintaining our documented effectiveness. We believe in the unity of command as a proven Principle of War and will diligently promote the Military Health System through transparency, common performance objectives and measures, standardized business and clinical practices, robust analytics, and the ability to synchronize across time and distance.

Despite unparalleled success over the past decade, we have a significant amount of work ahead to meet the demands of the future—known and unknown. Success is dependent upon the continued service and perseverance of the entire team in a highly coordinated fashion. We are proud of our role within the Military Health System and we are leading change in the era of possibilities.

Army Medicine: Serving To Heal...Honored To Serve



LTG Patricia D. Horoho

"We are an integrated health enterprise—a system of interdependent systems supporting soldiers and families in all aspects of life."

1.5 Commander Joint Task Force National Capital Region Medical

Vice Adm. John M. Mateczun

The National Capital Region (NCR) provides the world's best care and rehabilitation for our nation's most severely injured Warriors leveraging the Military's first Integrated Health Care System. Our number one priority is care for our Wounded Warriors and their family members. It is our sacred trust. With new and enhanced infrastructure, new technologies, and best clinical and business practices, we will meet the congressional mandate for world-class care in the MHS.

The Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) have over three million square feet of new and renovated medical and administrative space. In addition, both campuses have Warrior Complexes with double-occupancy suites that can accommodate up to 594 Wounded Warriors and non-medical attendants. These enhanced medical and support facilities represent a new beginning for health care delivery in the NCR. The NCR Integrated Delivery System (IDS) provides DoD the unique opportunity to achieve an integrated system that supports patients and families while meeting service readiness requirements. The NCR IDS is based on a patient-centric model that brings together the best of Army, Navy and Air Force clinical practices and cultures. By integrating practices, capabilities, technologies and resources, health care services in the NCR are able to be greater than the sum of their parts and further expand already world-class services.

The NCR has achieved significant advances in support services for amputees, traumatic brain injuries and post-traumatic stress disorders. The National Intrepid Center of Excellence, located on the Bethesda campus, provides the most advanced services for diagnostics, inter disciplinary treatment planning and family education and support services for Warriors with traumatic brain injuries, and/or complex psychological health issues. The Military Advanced Training Center helps Warriors with orthopedic trauma build their strength, skills and confidence.

Patients in the NCR benefit from the new capabilities, technologies and practices made possible by integrating services. Benefits include a centralized appointment and referral process that eliminates redundancies and matches patients quickly with a primary and/or specialty care provider. NCR hospitals incorporate evidence-based design principles to decrease patient stress, increase social support, provide ample light, improve privacy and improve sleep and rest. The WRNMMC Comprehensive Cancer Center is the only peer-partner-in-care center with the National Cancer Institute, in addition to becoming an NCI designated Cancer Center. This Center provides patients with the most effective approaches to cancer prevention, diagnosis and treatment. It includes new and enhanced services including gynecological, prostate, breast, medical and surgical oncology.

> "Our number one priority is care for our Wounded Warriors and their family members."

1.6 Coast Guard Director of Health, Safety and Work-Life

RADM Maura Dollymore

"When gales blow and others seek safe harbor, Coast Guard crews get underway to save lives; our cutter, aviation and deployable forces interdict smugglers on the high seas; our marine inspectors crawl through hot, filthy ballast tanks to ensure commercial ships safety; our boarding teams climb aboard wave-lashed trawlers to protect our marine resource from foreign encroachment and depletion. We stand with U.S and allied services in defense of freedom." This quote from the USCG Commandant's Direction forms the trackline for the professionals of the USCG Health, Safety, Work-Life/Family Service (HSWL) Directorate. The HSWL program serves as the health, safety and family service resource for CG beneficiaries through its delivery of primary care, family services, hazard prevention, and its partnership with the Military Health System and TRICARE.

The Commandant's guiding principles provide clarity regarding how we will move forward in 2012:

- Steady the Service – ongoing focused commitment to the Quadruple Aim and the National Prevention Strategy as the strategic compass to guide all HSWL programs toward success. Implementation of Patient-Centered Wellness Home is key.
- Honor our profession – Strive for professional excellence. Implementation of our Integrated Health Information System will provide us a critical tool.
- Strengthen partnerships – Integration of our HSWL mission sets internally and a continued focus on external partnerships are vital to supporting our mission. Our joint participation in the Military Health System represents a vital strategic partnership for the Coast Guard.
- Respect our shipmates – Be passionate about preventing, protecting, and providing HSWL services while also creating a richly diverse and continual learning-focused technical workforce.

Successful implementation of our key initiatives will serve us well as we enter an austere budget environment that will challenge the Coast Guard to prioritize and focus on those activities that are clearly best practices and evidence-based.

Our program envisions a healthy, safe and thriving total Coast Guard force that is Always Ready.

We prevent, we protect and we provide.

We are the Health, Safety and Work-Life/Family Service team professionals of the United States Coast Guard.

This is what we do.

"Our program envisions a healthy, safe and thriving total Coast Guard force that is *Always Ready.*"

2.0 What We Did: A Snapshot of a Dynamic Organization in 2011

The Military Health System (MHS) is a complex organization with a $52B budget that provides health services to 9.7 million beneficiaries across a range of care venues, from the forward edge of the battlefield to traditional hospitals and clinics at fixed locations. To get a better sense of the size, complexity and services delivered by the MHS, we offer the following:

Readiness

321,751 - Service Members Deployed

17,476 - Medical personnel deployed

589,573 - Medical encounters in theater

6,943 - Medical Evacuations

221 - Number of amputees with major limb amputations from OEF/OIF

16,270 - Service members currently in the Integrated Disability Evaluation System

Healthcare

1,169,003 - Inpatient admissions

129,152,879 - Outpatient visits

124,729 - Births

142,126,856 - Prescriptions

Health

2,281,669 - Beneficiaries getting care from a patient-centered medical home

2,938 - Enrolled in Train2Quit smoking cessation program

235,304 - Post-Deployment Health Assessment and Post-Deployment Health Reassessments through third quarter of 2011

669,149 - Service members who used the Global Assessment Tool to increase resilience

Learning & Growth

24,000 - Medical Education and Training Campus (METC) graduates

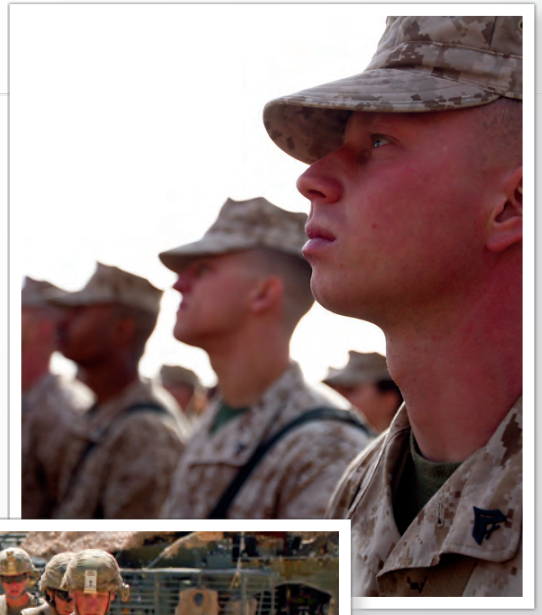
3,600 - Active Research Protocols

233 - Accredited military graduate medical education programs

731 - Lean Six Sigma and Continuous Process Improvement Projects

3.0

What We Face: Operating In Challenging Times



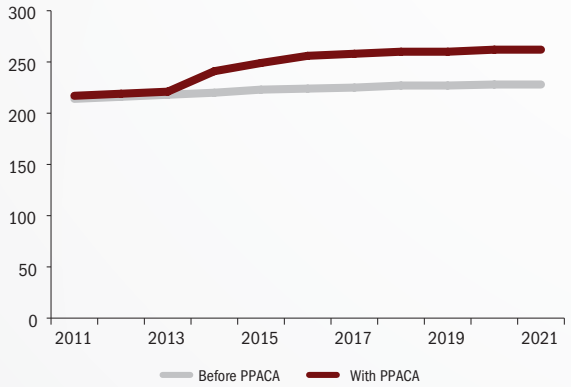
We live in challenging times. The unprecedented length of two wars has tested our resilience in providing operational medical support and caring for returning wounded warriors with complex, long-term health care needs. The slow recovery from a severe global recession coupled with a growing number of seniors beginning to receive promised entitlements has created a daunting federal fiscal challenge that will impact both the military and health care. Military medicine will undergo major changes in the years to come, possibly having to respond to reduced end strength, closure of some medical facilities, budget constraints, changes to the health benefit, and new missions and medical threats. There will be more emphasis on healthy living to reduce the chronic disease burden and there will be changes in the delivery of care, emphasizing teamwork, continuity and accountability for producing value. Successfully navigating these challenges will require flexibility in our thinking and organization, and a culture of innovation.

3.1 The Changing Nature of Supply and Demand

Increasing Demand for Primary Care Physicians

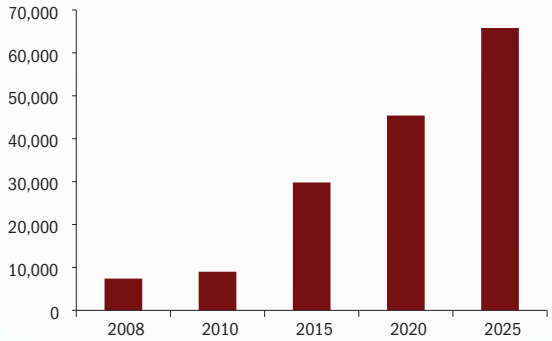
The Patient Protection and Affordable Care Act (PPACA) will ensure that many more Americans will have access to health insurance beginning in 2014. All of these newly insured people will be seeking a primary care provider at a time when there will be a growing shortage of physicians. In addition, the number of MHS enrollees using private sector care is rising. In order to ensure that all of our beneficiaries have access, we will need to expand primary care and continue to explore new models of care delivery.

Insured Americans Under 65



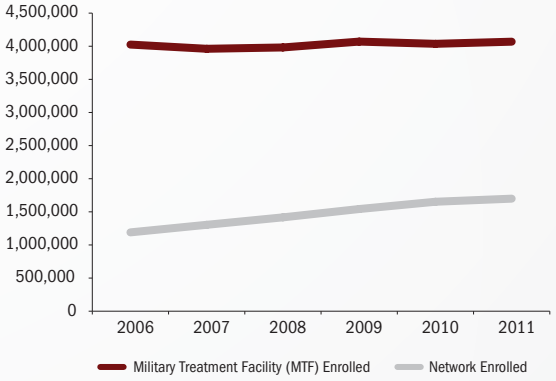
Beginning in 2014, over 30 million additional people will have access to health insurance.

Expected U.S. Primary Care Physician Shortage



The country will face an increasing shortage of both primary and specialty physicians.

MHS Enrollees



Over the past five years, 500,000 more people have enrolled in TRICARE Prime with almost all of the increase occurring in network care.

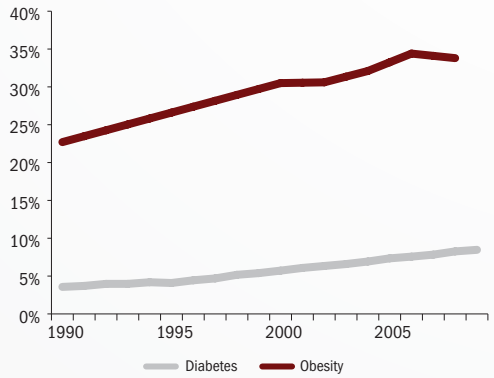
Source: Congressional Budget Office 2011, Association of American Medical Colleges Center for Workforce Studies, June 2010 Analysis

3.1 The Changing Nature of Supply and Demand

Increased Individual Demand Due to Increased Illness Burden

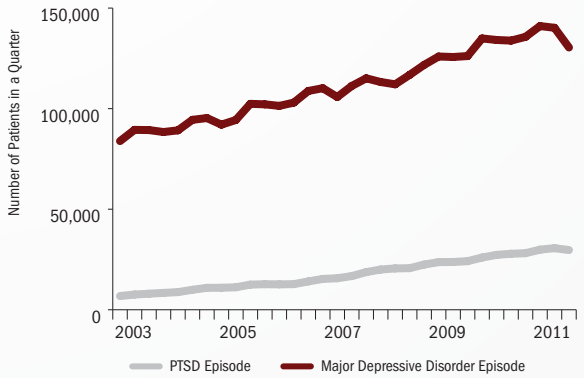
The country has experienced an epidemic of obesity that has been accompanied by a rise in chronic illnesses like diabetes. This will put a strain on the health system for years to come. In addition to this challenge, the MHS has had to adapt to a rise in depression and other mental illness that may be related to the effects of ten years of war.

U.S. Prevalence of Diabetes and Obesity



Over the past 20 years, the proportion of obese Americans has increased by nearly 50%. The prevalence of diabetes has increased in a similar fashion.

MHS Prevalence of Diagnosed Depression and PTSD in Adult Beneficiaries



Over the past six years the diagnosis of depression and post traumatic stress disorder has increased by nearly 100% in the total MHS beneficiary population. Part of this may be attributed to increased awareness and reduced stigma.

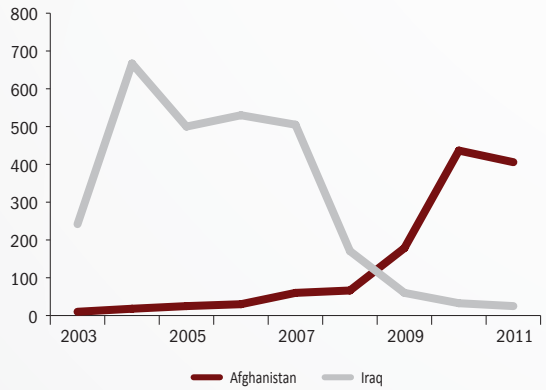
Source: Centers for Disease Control 2010

3.1 The Changing Nature of Supply and Demand

The Enduring Medical Effects of Ten Years of War

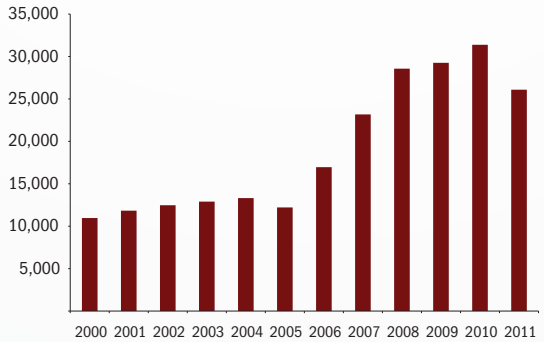
In addition to the growing prevalence of chronic disease that we confront in the U.S., we face increased and unique demands from the casualties of war. Although combat operations have ended in Iraq and have leveled off in Afghanistan, ten years at war may have a long-term impact on demands for health services in the MHS, particularly in mental health.

Average Number Wounded in Action Per Month



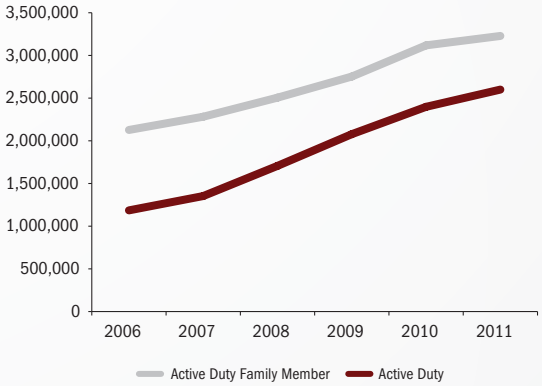
We are fighting one less war, but the MHS continues to see significant numbers of combat trauma cases.

Diagnosed Cases of TBI



The diagnosis of Traumatic Brain Injury began to decline in 2011 but still accounted for approximately 25,000 new cases.

Behavioral Health Outpatient Encounters



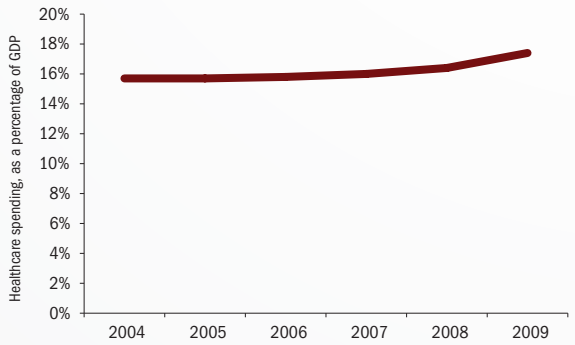
The cumulative effects of ten years of war, as well as successful anti-stigma campaigns, have driven demand for behavioral health services to new highs for active duty service members and their families.

3.2 Escalating Costs

Healthcare Cost Inflation is Unsustainable

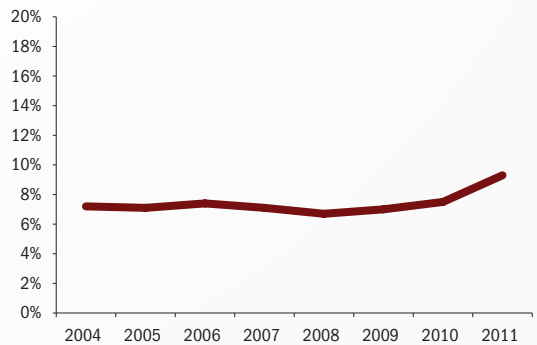
The slow but inexorable growth in health care costs in the United States and in the Department of Defense (DoD) continues. Recent upticks in the percentage of health care costs relative to GDP and the DoD budget reflect overall economic conditions and slowdowns in federal spending, rather than recent spikes in health spending. Yet, these external circumstances further highlight the trade-offs between health spending and other national …and national security…priorities.

U.S. Spending on Healthcare, as a Percentage of GDP



Since 2004, the cost of healthcare as a percentage of GDP has risen from less than 16% to nearly 18%.

Unified Medical Program as a Percentage of DoD Budget



In 2004, the cost of healthcare was approximately 7% of the total DoD budget. It is now nearly 10%, a rate of growth that is unsustainable.

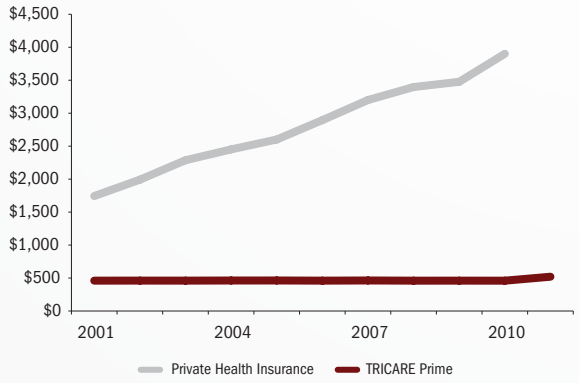
Source: Organization for Economic Cooperation and Development 2011, TRICARE Publication FY2011 Report to Congress

3.2 Escalating Costs

More MHS Beneficiaries are Relying on TRICARE for Their Health Care

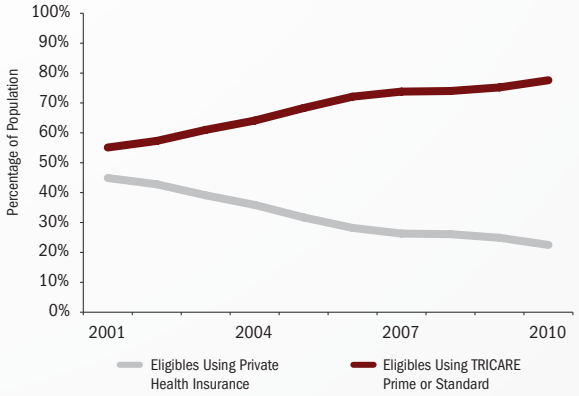
As the costs for private sector health insurance continue to grow, most employers have shifted a significant amount of the cost burden to employees. In 2011, DoD introduced very modest increases in TRICARE Prime enrollment fees for retirees and their families—but the increases were well below the private insurance cost growth. The trend of the last ten years—in which retirees drop their private insurance and return to TRICARE as their primary insurance—is likely to continue.

Private Insurance Premiums Vs. TRICARE Enrollment Fee (Family)



Over the past ten years, private insurance premiums have increased by over 100%; TRICARE fees remained unchanged until a modest increase was implemented in 2011.

Retiree (<65) Health Insurance Coverage



Since 2001, more and more eligible beneficiaries have decided to rely on TRICARE for their health needs, contributing to escalating costs for the DoD.

Source: TRICARE Publication FY2011 Report to Congress

4.0 How We're Doing: Assessing Progress in Achieving our Strategic Goals

MHS Leadership is committed to delivering value to all we serve. The Quadruple Aim represents our strategic goals and value proposition: improved readiness, better care, better health and responsibly managed costs.

The MHS Quadruple Aim:

Readiness

Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.

Population Health

Reducing the generators of ill health by encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.

Experience of Care

Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.

Per Capita Cost

Creating value by focusing on quality, eliminating waste and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

Measuring Performance:

Over the next few pages we will describe our strategic goals and show some of the indicators that we use to determine our success in achieving the Quadruple Aim.

4.1 How We're Doing: Readiness

We maintain an agile, fully deployable medical force and health care delivery system so that we can provide state-of-the-art health services anytime, anywhere. We use this medical capability to treat casualties and restore function, and to support humanitarian assistance and disaster relief around the world.

We partner with commanders and individual service members to create a healthy, fit, resilient and medically-prepared fighting force.

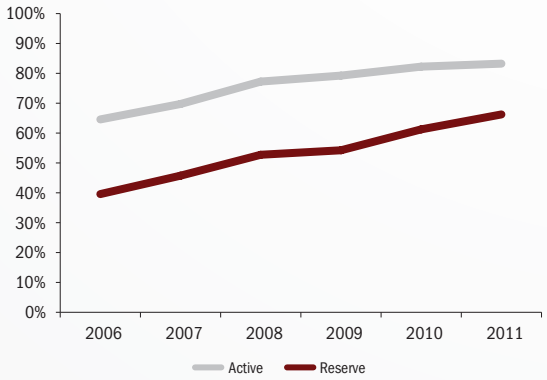
We support the larger DoD effort to ensure that families and the military community are resilient and prepared for the stress of deployment.

4.1 How We're Doing: Readiness

Improving Individual and Family Readiness and Resilience

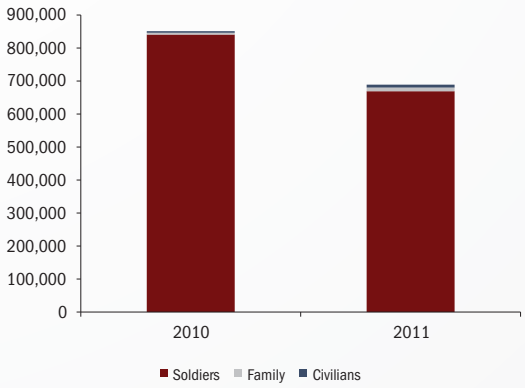
Despite the extraordinary demands of supporting two wars over the past decade, a partnership between line commanders and the medical community has resulted in a steady increase in the rate of individual medical readiness, but there is still room for improvement, particularly in the reserve and guard community. The recognition that many service members and their families will face repeated deployments resulted in the unprecedented development of resilience programs such as Comprehensive Soldier Fitness. These programs are building the capacity of the Force and families to thrive in the face of the stress of military life.

Individual Medical Readiness (IMR)



Recent efforts to increase periodic health assessments and dental readiness have increased overall rates of individual medical readiness, particularly in the guard and reserve.

Resiliency Assessments for Active Duty, Families and Civilians



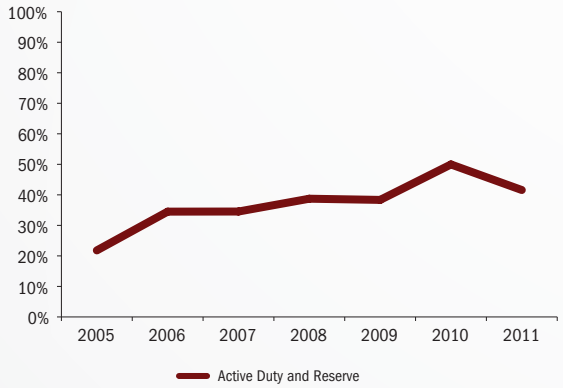
The Global Assessment Tool (GAT) is administered as part of the Army Comprehensive Soldier Fitness program and helps individuals track and improve emotional, social, spiritual and family strength. The program is now being expanded to include family members.

4.1 How We're Doing: Readiness

Assessing and Improving Psychological Health

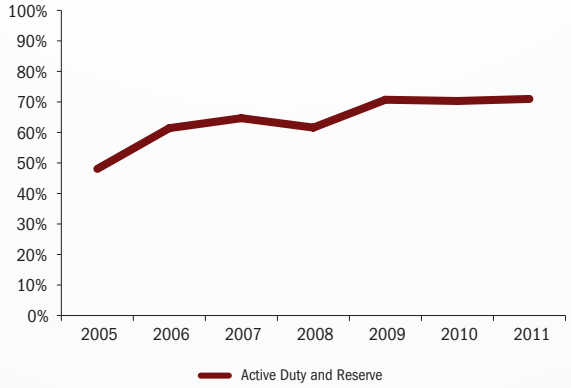
Combat operations can result in psychological trauma. The DoD has addressed this risk through a comprehensive program of screening, early detection and improved access to psychological health services. We have also implemented innovative programs to address psychological health issues in primary care settings. Despite this effort, we continue to face a growing demand for services and a recognition that service members will be contending with the psychological consequences of war for years to come. The MHS is committed to meeting these long-term needs.

Post Traumatic Stress Disorder Referral Rate



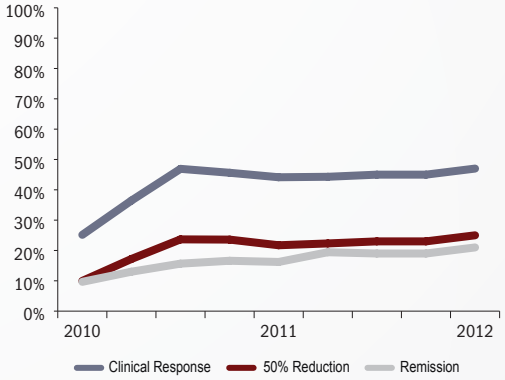
If a service member screens positive indicating a risk for PTSD, they are now referred for further evaluation about 50% of the time. Early in the war the rate was significantly lower possibly due to a lack of provider awareness or willingness to refer.

Post Traumatic Stress Disorder Engagement Rate



We have observed a steady increase in the rate at which service members follow through with a recommendation to seek mental health services. This may represent success in overcoming stigma.

Post Traumatic Stress Disorder Remission Rate



A number of primary care sites have implemented a comprehensive program to identify and treat Post Traumatic Stress Disorder. These sites are achieving improved rates of treatment response over time.

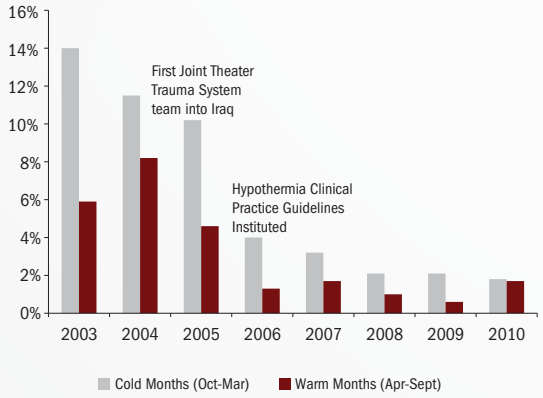
Source: RESPECT.MIL

4.1 How We're Doing: Readiness

Casualty Care is Achieving Superior Outcomes at all Stages of Care

The changing nature of combat operations required the MHS to function as an agile learning organization. Early in the war, the care team recognized that if patients arrived with hypothermia, they were less likely to survive. Rapid implementation of clinical protocols resulted in a reduction of hypothermia. This, along with many other improvements, has allowed battlefield care to save close to 100% of those who make it to a treatment team. Once care is initiated, it never stops; our shared goal is the restoration of maximal function.

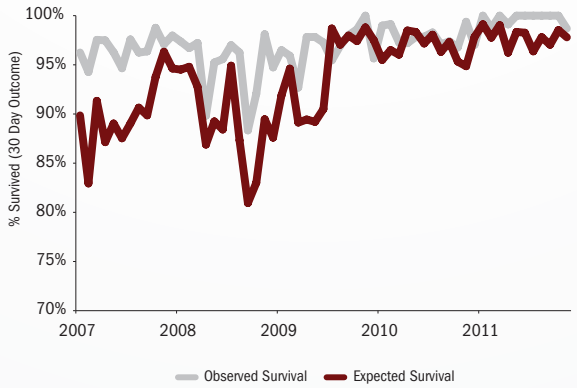
Percentage of Patients Admitted Hypothermic Iraq 2003-2010



The rate at which combat casualties experience hypothermia has dropped by over 80% since 2003.

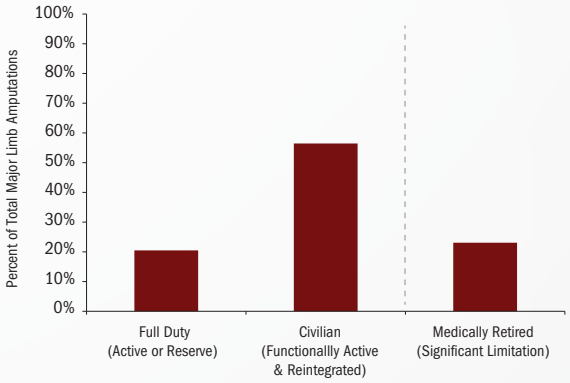
Observed vs. Predicted Survival Rate

(Battle Wounds in Operations Enduring Freedom and Iraqi Freedom)



Since 2007, the actual survival of combat casualties in Iraq and Afghanistan has exceeded results obtained in the leading trauma centers in the U.S.

Amputee Functional Reintegration 2002-2011



Two years after injury, nearly 80% of total limb amputees are either still on Active Duty or are functioning as a full time student or parent.

4.2 How We're Doing: Population Health

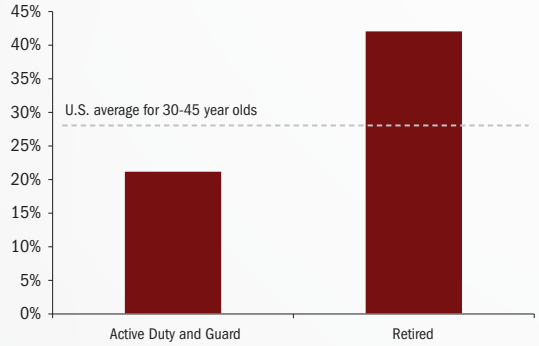
Improved health is the result of an effective partnership between a health system and a person. Healthy behaviors improve quality of life; alternatively, unhealthy behaviors, such as smoking, over-eating, a sedentary lifestyle, alcohol abuse and family violence reduce well-being and readiness. The MHS strives to engage with all beneficiaries and enable them to take control of their health, so that together we create a more robust and resilient military community.

4.2 How We're Doing: Population Health

Encouraging Healthy Behavior – Curbing Obesity

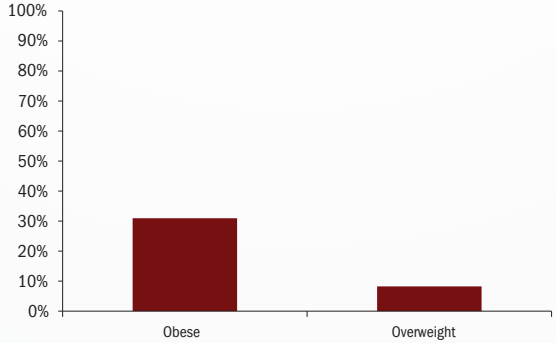
The MHS—similar to the U.S. health system—faces challenges with obesity that require a combination of health system interventions, behavioral changes and policy innovations. While we are now able to monitor levels of obesity in our beneficiary population, we do not have a comprehensive program to work with our patients and help them make the changes needed to achieve a healthy weight. This is a high priority issue for the coming year.

Prevalence of Obesity in MHS Beneficiaries (Ages 40-49)



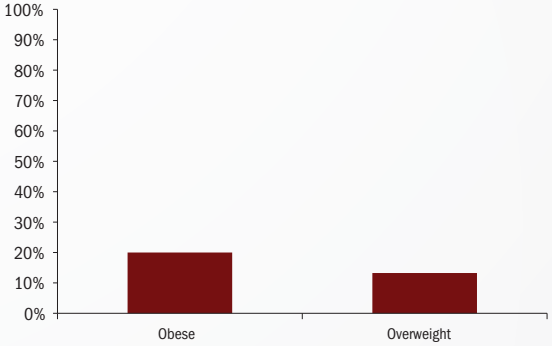
The rate of obesity in active duty service members is significantly lower compared to retirees of the same age. There may be an opportunity to intervene to prevent waistline growth with retirement.

Diagnosis Rate of Obese/Overweight Beneficiaries, FY2011



Less than a third of obese patients and less than 10% of overweight patients have a weight condition documented in their medical record.

Counseling Rate of Beneficiaries Diagnosed as Obese/Overweight, FY2011



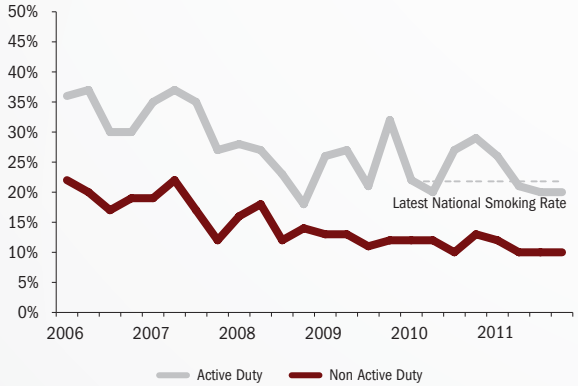
Of those beneficiaries diagnosed as being overweight or obese, only 10% and 20%, respectively, are counseled on ways to manage their weight.

4.2 How We're Doing: Population Health

Encouraging Healthy Behavior – Tobacco Cessation

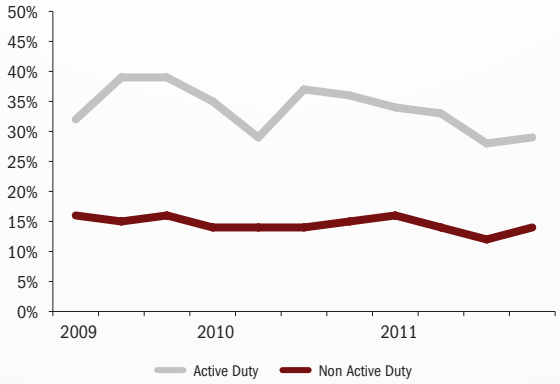
In support of the National Prevention Strategy, one key focus is tobacco cessation among our beneficiaries. Our efforts have shown a decrease in smoking rates but we still have room for improvement in reducing the use of all tobacco products. It is important to reach out and educate beneficiaries early in life to reduce and eliminate unhealthy behaviors down the road. Our younger Service members are using tobacco at higher rates than their peers not in Service. We need to change that.

Smoking Rate
18-24 Year Olds



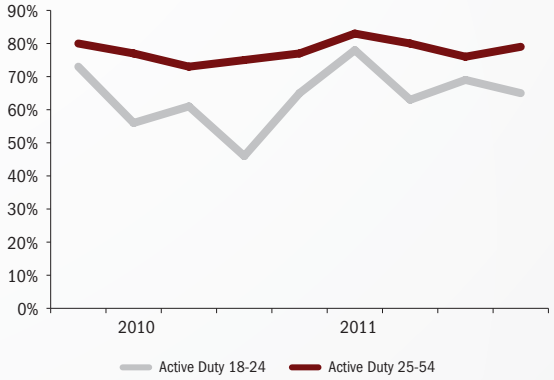
Historically the smoking rate of active duty service members has been one and a half times higher than their non active duty peers. Over the last five years, the MHS has seen a decrease in the rate of smoking in both populations.

Tobacco Use Rate,
18-24 Year Olds



Recently we have expanded our measurement to consider all types of tobacco use. Nearly one third of young service members report that they use some form of tobacco product.

Tobacco Cessation Counseling Rate
Active Duty



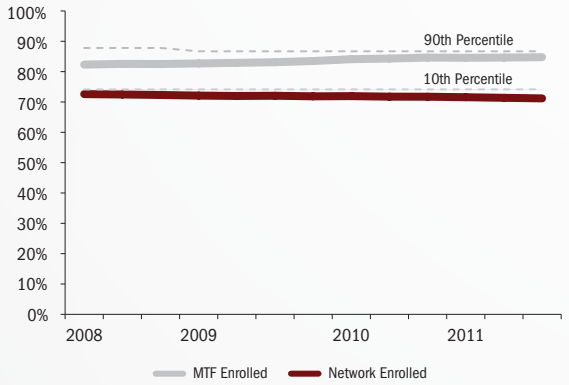
18-24 year-old active duty members are less likely to be counseled to quit smoking than older active duty members; this is a pattern we are looking to change.

4.2 How We're Doing: Population Health

Ensuring that our Beneficiaries Have Wellness and Prevention Services

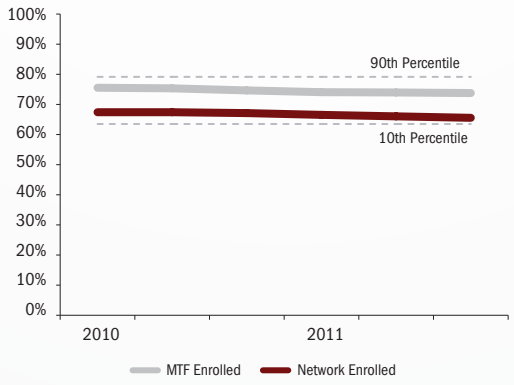
For the past several years, we have been focusing our efforts on ensuring that our enrollees receive optimal preventive services. We have performed better than 90% of U.S. health systems on colorectal cancer screening, but we still have room to improve on cervical and breast cancer screening. In addition, we are aiming to improve adherence to guidelines for early childhood health visits.

Cervical Cancer Screening Rate



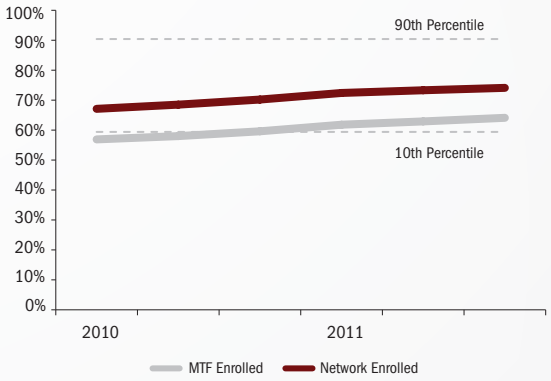
Women are more likely to have a documented cervical cancer screening if they are enrolled in one of our military treatment facilities.

Breast Cancer Screening Rate



The rate of screening for breast cancer is higher for women enrolled to an MTF compared to network enrollees.

Children with Six Well-Child Visits in First 15 Months



We recently added this measure of well-child visits; early data suggest steady improvement for enrollees to both MTFs and the TRICARE network.

4.3

How We're Doing: Experience of Care

Our beneficiaries deserve an excellent experience of care across all six dimensions identified by the Institute of Medicine. Care must be: safe, effective, patient-centered, timely, efficient and equitable.

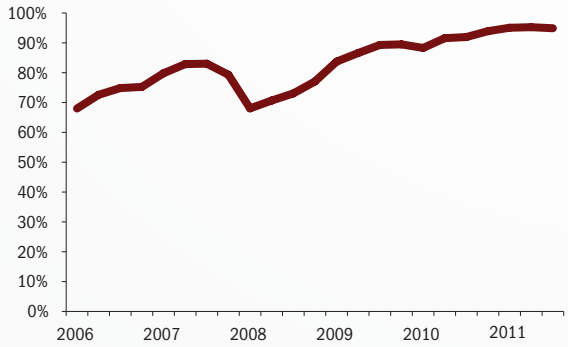
We strive to see the care experience through the eyes of our beneficiaries in order to design our systems to meet their expectations. We must demonstrate that our quality compares favorably with the best of civilian health care.

4.3 How We're Doing: Experience of Care

Employing Evidence-Based Practices to Improve Safety

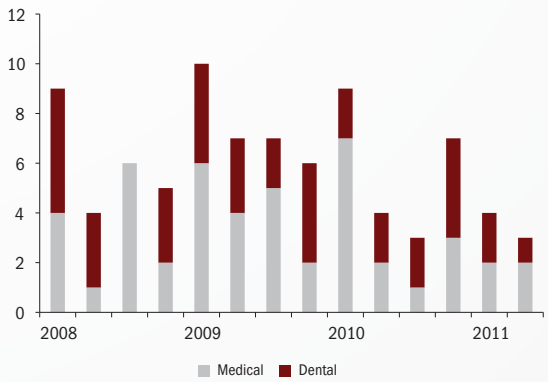
One of the keys to improving safety is the consistent use of evidence-based practices. We are beginning to see major benefits from this approach; over the past several years we have instituted guidelines to reduce post-surgical infections by ensuring that patients receive antibiotics before surgery when warranted. In addition, we are expanding use of protocols or bundles to reduce harm events in hospitals like wrong site surgery, ventilator-associated pneumonia and pressure ulcers. Our goal is a 40 percent reduction in hospital-acquired infections by the end of 2013.

Antibiotics Administered Within One Hour of Surgical Procedure



In 2006, patients received prophylactic antibiotics 60 minutes before surgery only 70% of the time; now it is over 93%.

Number of Wrong Site Surgeries



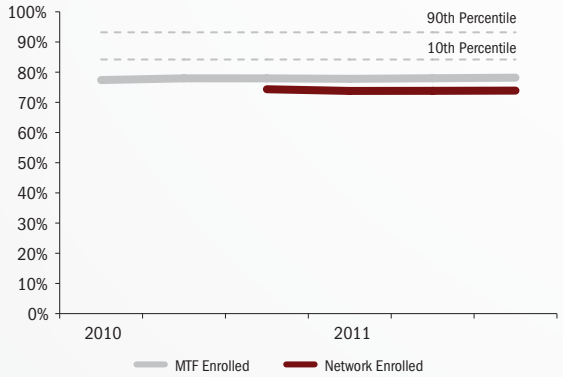
Across the entire MHS there are approximately 14 wrong site surgeries per year along with a similar number of dental procedures.

4.3 How We're Doing: Experience of Care

Improving Adherence to Evidence-Based Treatment Guidelines

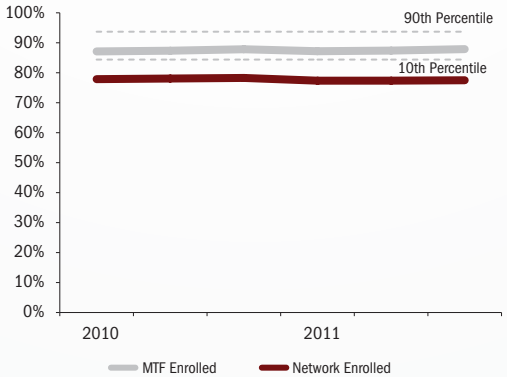
We know that our patients will have better health outcomes if they receive the appropriate evidence-based interventions for chronic illnesses like diabetes and cardiovascular disease. We also know that patients fail to get recommended treatment when there are faulty "handoffs" between providers. In some cases this can even lead to a readmission. By integrating care across time and space, we intend to improve adherence to guidelines and reduce errors.

Screening Rates for Low Density Lipoprotein (LDL) in Patients with Cardiovascular Disease (CVD)



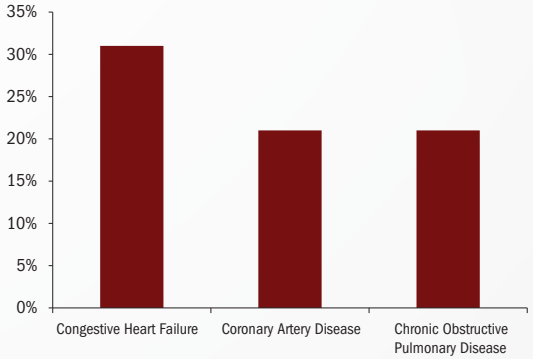
About 80% of enrollees with CVD receive recommended monitoring of their lipids. We strive to increase both the level of screening and the appropriate management of lipids to prevent the progression of illness.

Screening Rates for Hemoglobin A1c (HbA1c) in Diabetics



The HbA1c test checks the long-term control of blood glucose levels in people with diabetes. This screening test is more likely to be documented for enrollees to an MTF as compared with Network enrollees.

Conditions with Highest Direct Care Hospital Readmission Rates



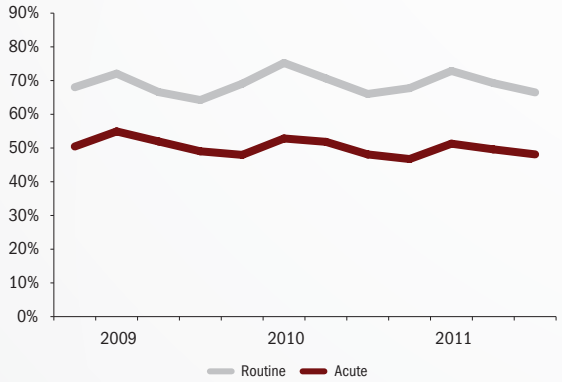
The MHS has joined the National Partnership for Patients. As part of this effort, we will focus on reducing hospital readmissions by improving care transitions.

4.3 How We're Doing: Experience of Care

Improving Access and Reducing Waiting Time

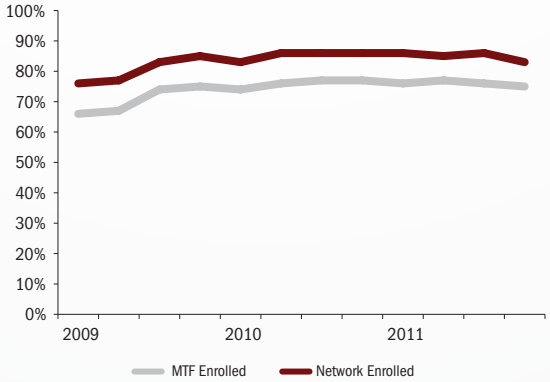
Patients should not have to face lengthy waits for primary care. And once patients have entered care, they should be offered a rapid evaluation and efficient treatment so they can return to health and to their normal routine. One area where it has been particularly challenging to coordinate care and reduce waiting times has been disability evaluation for wounded, ill and injured Service members.

Third Available Primary Care Appointments



At over 50% of MTF primary care clinics, if a beneficiary calls for an acute appointment they will be offered at least three options within 24 hours. Two-thirds of patient-centered medical home teams are meeting this same standard.

Satisfaction with Getting Timely Care



Overall satisfaction with healthcare has remained relatively flat for the last year, but we are seeing improved satisfaction in patient-centered medical home settings.

Medical Evaluation Boards (MEBs) Completed Within 35 Days

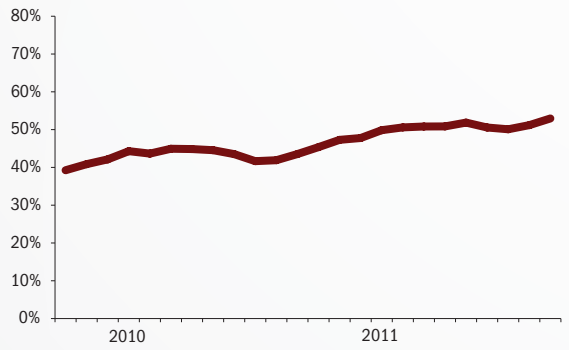
Less than half of the time, MEB processing meets our timeliness standard of 35 days. Delays in the disability process can lead to dissatisfaction.

4.3 How We're Doing: Experience of Care

Improving Continuity of Care and Patient Centeredness

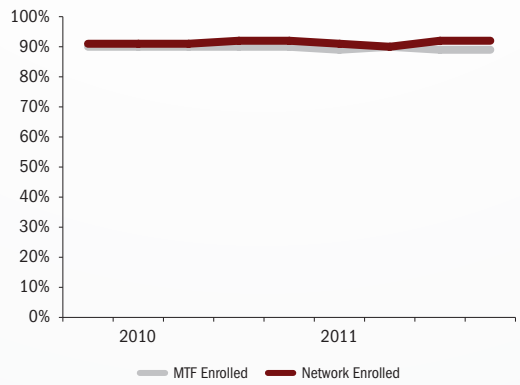
The MHS is in the process of implementing the patient-centered medical home, ensuring that every enrollee has access to a primary care manager and care team. We have placed much greater emphasis on linking patients with their doctor and we are seeing objective evidence of success. Over time, we predict that improved continuity will result in improved satisfaction and better outcomes.

Primary Care Manager (PCM) Continuity



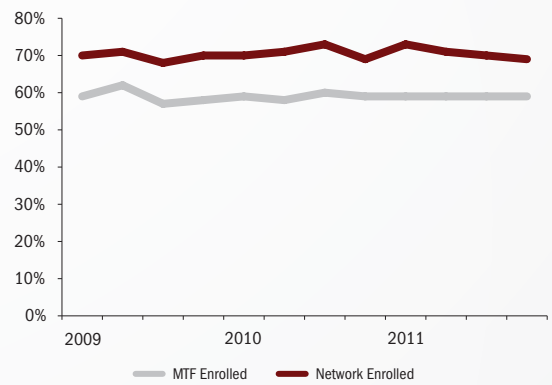
On average, enrollees to military treatment facilities see their assigned primary care manager just over half of the time, but many MHS patient-centered medical homes are achieving rates above 65%.

Satisfaction with Provider Communication



One of the strongest drivers of overall satisfaction with healthcare is provider communication. Over the past two years, this measure has not changed and remains at 90%.

Satisfaction with Healthcare



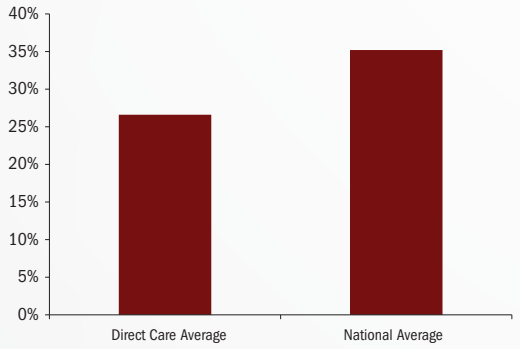
Patients enrolled to TRICARE network providers report higher satisfaction with health care. With the continued expansion of patient-centered medical homes within MTFs, we expect to see this gap narrow.

4.3 How We're Doing: Experience of Care

Improving the Birth Experience

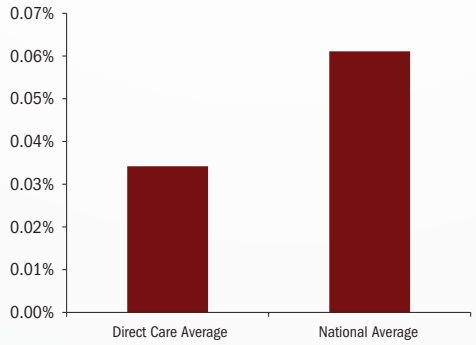
Approximately 40% of the inpatient care we provide in military treatment facilities is related to childbirth. MTF quality outcomes compare favorably to national norms, but enrollees' satisfaction with the birth experience in military hospitals is 10% to 15% below the civilian hospital rate. We must address the entire experience of care as we seek to be provider of choice.

Cesarean Delivery Rate, 2010



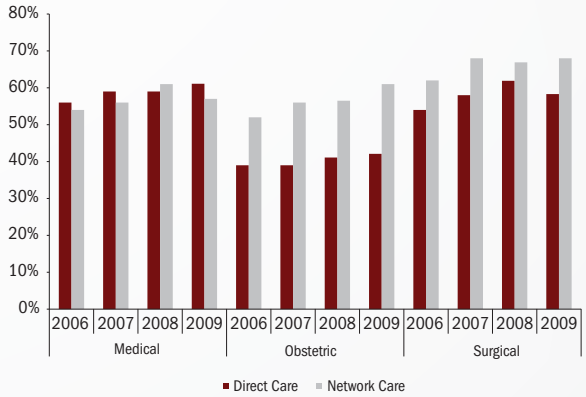
The rate of Cesarean delivery in MTFs is significantly less than the national average.

Major Complication Rate of Newborns Born in the Hospital, 2010



The rate of major complications during childbirth in MTFs is about one half of the national average.

Satisfaction with Inpatient Care
(Overall Hospital Rating)



Patients receiving obstetrical care at TRICARE network hospitals report higher satisfaction with health care.

4.4 How We're Doing: Per Capita Cost

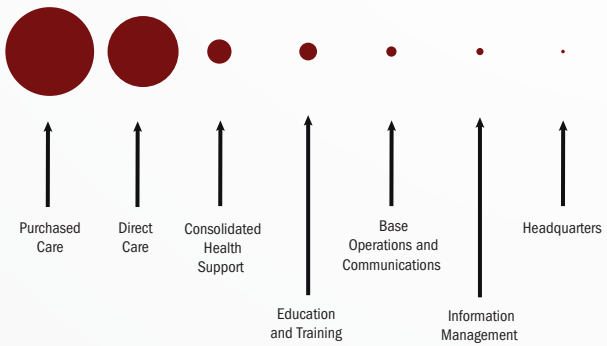
We create value by enhancing readiness, improving population health and enhancing the experience of care. We reduce the total cost of health services by optimizing our investments in health promotion, prevention and the development of resilience, ensuring access to full spectrum primary care, focusing on quality, and reducing unwarranted variation.

4.4 How We're Doing: Per Capita Cost

Understanding Our Costs

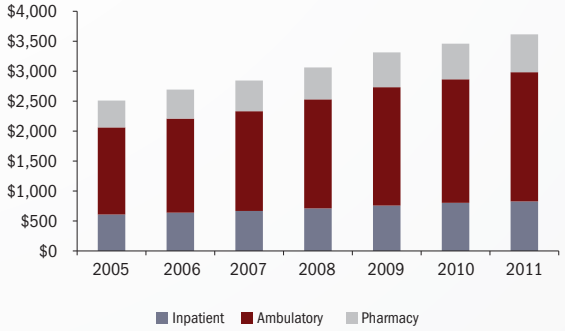
The overwhelming majority of MHS resources are used to deliver care. The cost of delivering care to an MHS enrollee has risen from $2,500 per year in 2005 to just over $3,500 in 2011. The increase in cost is being driven both by an increase in the cost of individual health services and in the rate of utilization of services. Three significant contributors to rising costs include increased demand for emergency services, mental health care and care for musculoskeletal injuries.

MHS Budget by Budget Activity Group



The MHS has a total operating budget of just over $52B, most of which is used to provide care through military treatment facilities and the TRICARE Network.

Enrollee Per Year Costs

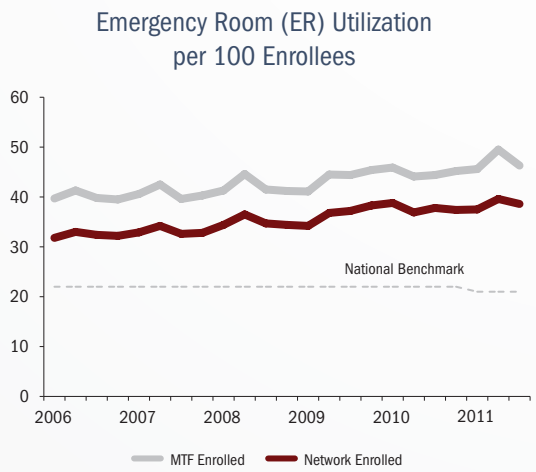


The annual cost of providing care for an average MHS enrollee is just over $3,500, almost two-thirds of which is for ambulatory services including laboratory and radiologic procedures.

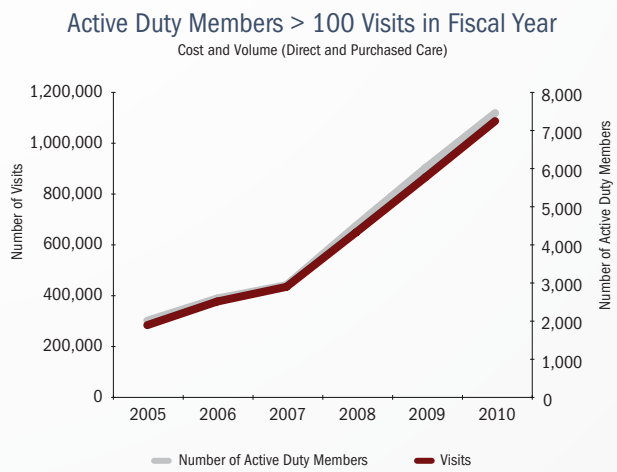
4.4 How We're Doing: Per Capita Cost

Focusing on the Drivers of Increased Costs

Reducing emergency room (ER) use and improving care management represent two ways to reduce costs while improving outcomes. As we implement enhanced access and patient-centered medical homes, we are confident that we will be able to reduce ER visits and provide more comprehensive care management for those with complex needs.



Emergency room utilization for Prime enrollees continues to climb and ismore than double the rate of insured individuals in the United States.



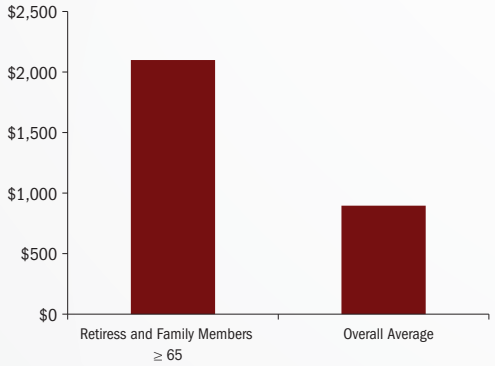
The number of active duty members with greater than 100 visits in a year has more than tripled over the last five years; care associated with those patients now accounts for more than one million visits per year.

4.4 How We're Doing: Per Capita Cost

Encouraging Pharmacy Home Delivery to Improve Quality While Reducing Cost

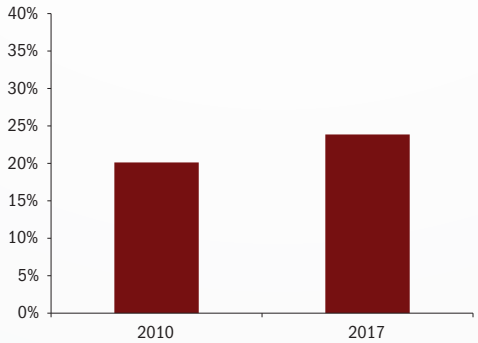
MHS pharmacy costs were close to $7B in 2011. Much of that was for beneficiaries over the age of 65 who require more medicines, often for chronic conditions. As our population ages, this cost pressure will increase. One way for us to reduce costs and improve quality is to encourage beneficiaries to use home delivery. When patients get their medications in the mail, they are more likely to take them regularly and the government is able to benefit from discounted prices.

Average Annual Prescription Costs Per Beneficiary



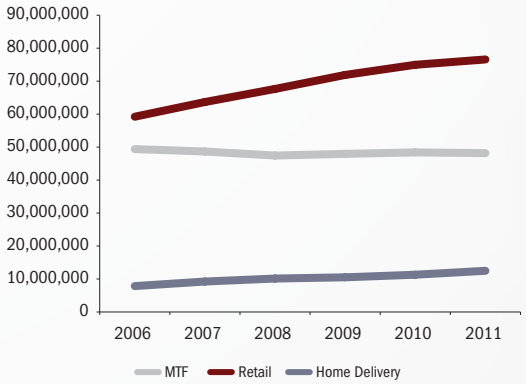
The MHS spends over $2,000 per year per Medicare-eligible DoD beneficiary.

Projected Growth in the MHS Over 65 Population



Currently one in five MHS beneficiaries is over the age of 65; by 2020 that number could be one in four.

Home Delivery Trend



Savings from home delivery prescriptions have been significant, and the use of this venue for delivery continues to increase.

Source: TRICARE Publication FY2011 Report to Congress

5.0 Where We're Going: An Integrated Military Health Delivery System that Consistently Delivers Quadruple Aim Performance

Although it is generally accepted that rising health care costs pose a threat to the economy, to national security and to the personal pocketbook, we have not agreed as a country on an effective strategy to combat this very real challenge.

MHS leadership believes that effective and integrated care coordination, greater patient engagement and awareness, and timely dissemination of best practices represent the long-term strategies needed to bend the cost curve while increasing quality and health outcomes.

Where We Are Going

- We will operate our MTFs at full capacity to support readiness and the backbone of our clinical systems – our GME programs.
- Shifting our focus from healthcare to health will deliver value to our Force and to our system.
- A relentless focus on process improvement will decrease variation, decrease waste and increase productivity in our care system.
- A shifted focus on population health is the keystone to the rest of the Aims. In previous years, the MHS has worked to improve patients' Experience of Care. This year, it will focus energy and resources on maintaining a healthy population—the key to the other three Aims.

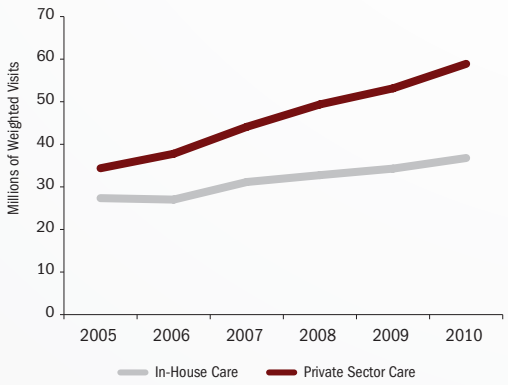
This is not a change of direction, but rather a new focus on our journey to a healthier, more resilient military force.

5.1 Bringing Care Back into our MTFs

Optimizing the Use of Our Hospitals and Clinics to Support both Readiness and Graduate Medical Education (GME)

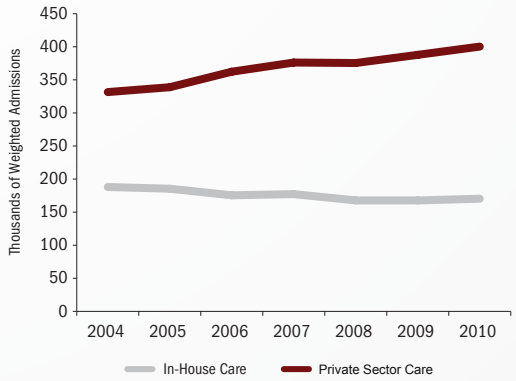
Over the past five years, the amount of care provided to DoD beneficiaries has continued to increase, but the majority of that increase has occurred in the private sector. There is an opportunity to pull some of that additional workload back into military treatment facilities so that our providers can remain current in the skills they need for readiness and so that our trainees can have a rich clinical experience.

Outpatient Weighted Workload



Between 2005 and 2010 the proportion of total ambulatory care provided by our MTFs declined from 44% to 38%.

Inpatient Weighted Workload



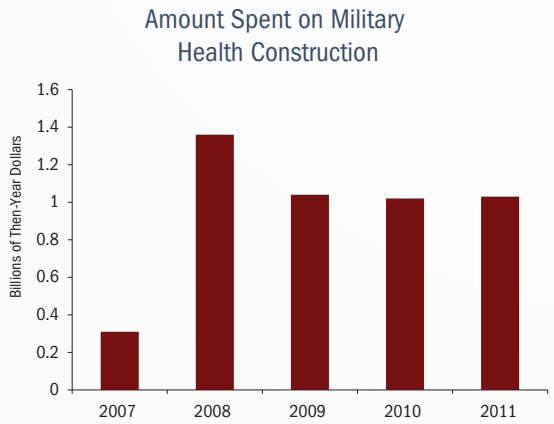
Between 2005 and 2010 the proportion of total inpatient care provided by our MTFs declined from 36% to 30%.

Source: TRICARE Publication FY2011 Report to Congress

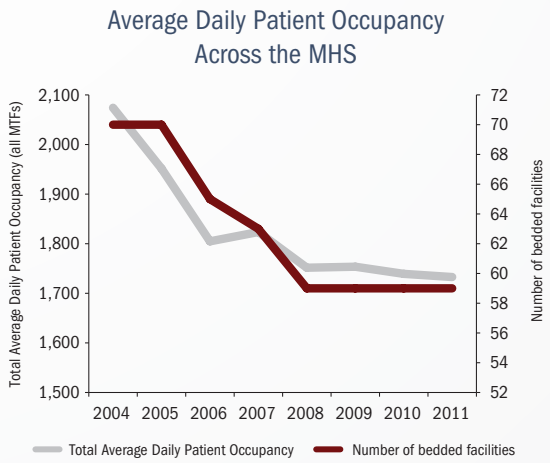
5.1 Bringing Care Back into our MTFs

Operating Our World Class Facilities at Full Capacity

Over the past four years we have seen unprecedented investment in medical facilities for the MHS, but we have also seen a reduction in the occupancy of our hospitals. We intend to reverse that trend and operate at full capacity in support of both graduate medical education and the readiness of our healthcare team.



Prior to 2008, the DoD invested approximately $300 million in military medical construction per year. From 2008-2011 that investment increased to over $1 billion per year. As a result, the MHS now has an increased number of truly state-of-the-art hospitals and clinics.

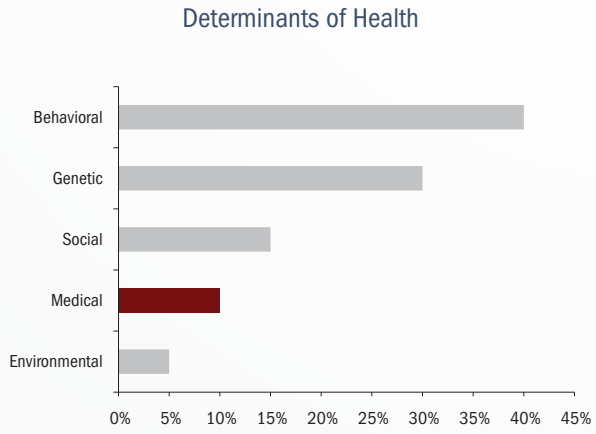


Since 2004, the average number of patients per day in all MHS hospitals has gone from nearly 2,100 to about 1,700. During this same period we closed over ten hospitals as part of base realignment and closure.

Source: TRICARE Publication FY2011 Report to Congress

5.2 Transforming from Healthcare to Health

Focusing on the Major Contributors to Health Outcomes



The actual causes of illness and death in the United States often relate to personal behaviors that the health care system fails to address. To achieve our transformation from healthcare to health, we will have to learn better ways to help people adopt a healthier lifestyle. In the near term, we will focus on ways to reduce obesity and reduce tobacco use.

Source: Schroeder, Steven A., We Can Do Better -- Improving the Health of the American People, N Engl J Med 2007 357: 1221-1228

5.3 Performing the Role of the Integrator

There are 9.7 million Americans who rely on us to ensure their health care needs are met – whether through delivery of care, coordination of care with the civilian sector or coverage of care through an exceptional health insurance product.

Regardless of who delivers the care, the MHS has to tie the pieces together. We are the integrator.

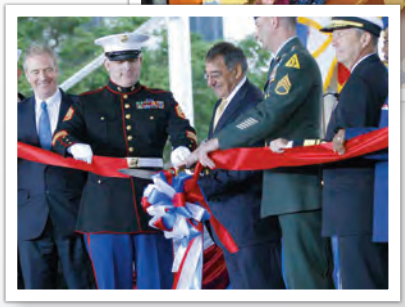
Here are the five elements of integration in which every world-class health system must excel, and which we will place added emphasis on in 2012:

- Making patients and families part of the care team
- Re-designing how primary care is delivered
- Ensuring population health management
- Aligning financial systems and incentives across the MHS
- Integrating systems of care – and information systems – into an enterprise-wide model

5.4 Partnering to Achieve the Quadruple Aim

The MHS is a learning – and teaching – organization. We are going to engage with federal health partners and thought leaders in the private sector in a targeted and disciplined manner to create more opportunities for interaction, sharing and collaboration. These are just a few examples now underway:

- Closer integration and sharing with the Department of Veterans Affairs
- Formal engagement with the High Value Health Collaborative – led by Dartmouth and joined by six other leading health organizations in the United States, we will securely share our data to collaboratively understand existing care delivery models and export best practices across our system
- Participation as a member in the Innovation Learning Network – led by Kaiser and joined by 16 other health systems, we will engage with these institutions to share system-wide improvements that advance military and civilian medicine



6.0 Turning Strategy to Action: Our 2012 MHS Strategic Initiatives

Readiness

- Operate our MTFs at full capacity to support readiness and graduate medical education
- Implement policies, procedures and partnerships to meet individual medical readiness goals
- Integrate and optimize psychological health programs to improve outcomes and enhance value
- Implement DoD/VA joint strategic plan for mental health to improve coordination

Population Health

- Improve the measurement and management of population health to accelerate the shift from healthcare to health

Experience of Care

- Implement evidence-based practices across the MHS to improve quality and safety
- Implement patient-centered medical homes to transform and improve primary care
- Optimize pharmacy practices to improve quality and reduce costs
- Create alternative strategy for purchasing care to improve Quadruple Aim performance

Per Capita Cost

- Implement alternative payment mechanisms to pay for value

Learning & Growth

- Implement modernized EHR to improve outcomes and enhance interoperability
- Improve governance to achieve better Quadruple Aim performance
- Improve enterprise clinical intelligence to improve quality and reduce waste
- Promote a culture of innovation to achieve breakthrough performance

The MHS: Healthcare to Health