THE ASSISTANT SECRETARY OF DEFENSE

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HEALTH AFFAIRS

OCT 16 2007

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

As required by Section 733 of the National Defense Authorization Act for Fiscal Year 2007, this report provides data on the performance of the health care system in meeting the access standards to health care services for wounded, injured, or ill Service members returning to the United States from a combat zone.

The Department of Defense's (DoD) tracking system uses five data sources to identify individuals who return from deployment with an injury, illness, or wound, and draws from the Post-deployment Health Reassessments, medical treatment facility and civilian claims data, and Active Duty referral data. The attached report provides many results from our access-to-care analysis of a cadre of individuals who returned from deployment. Across all referrals that could be compared with the standards, about 85 percent met DoD's access-to-care standards for time between the referral and the initial appointment.

I am committed to ensuring that our Service members receive the care they need and deserve. Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

Report on the

Department of Defense
Performance of the Military Health Care System in Meeting Standards For Access to Health Care
July 2007

In Response to the

John Warner National Defense Authorization Act for Fiscal Year 2007 (Section 733)

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REPORT TO CONGRESS ON THE PERFORMANCE OF THE MILITARY HEALTH CARE SYSTEM IN MEETING STANDARDS FOR ACCESS TO HEALTH CARE

Introduction

Section 733 of the National Defense Authorization Act for Fiscal Year 2007 requires the Department of Defense (DoD) to establish a uniform system for tracking the performance of the Military Health System (MHS) in meeting DoD's requirements for access to health care for the ill, injured, or wounded members of the Armed Forces in the United States following their return from a combat zone. In March of this year, DoD provided a report to Congress on the access standards (as required under Section 733(a)). In June, DoD provided a report that described the new tracking system established to monitor the access standards for these Service members (also required under Section 733(e)). This report describes the performance of the MHS in meeting these access standards (as required by Section 733(e)).

Ensuring that ill, injured, or wounded Service members are receiving high-quality health care is an extremely high priority of DoD. Part of receiving high-quality health care is prompt access to care, so DoD has established access standards for different types of care for its beneficiaries (e.g., urgent care and referral to specialists). This new tracking system will help DoD meet its commitment to the ill, injured, or wounded Service members by tracking whether these members are receiving care within DoD's access standards.

Identifying the Ill, Injured, or Wounded

The tracking system identifies the ill, injured, or wounded members of the Armed Forces who have returned from deployment to a combat zone. DoD maintains a list of all members who return from overseas deployments through its Defense Eligibility Enrollment Reporting System (DEERS) Contingency Tracking System (CTS). Starting with that list, DoD identifies ill, injured, or wounded members in five primary ways:

1. Identify Service members who have been evacuated from theater for illnesses, injuries, or war wounds.
2. Identify ill, injured, or wounded members by screening members who return from deployments outside the United States about their medical care needs through the Post-Deployment Health Assessment (PDHA), documented on the DD Form 2796. The PDHA contains questions that allow the identification of ill, injured, or wounded members.[1]
3. Because some members who return to the United States may not have symptoms of their illness at the time of their return (when they complete the PDHA), DoD uses a third method to identify the ill, injured, or wounded: the Post-Deployment Health Reassessment (PDHRA documented on the DD Form 2900). The PDHRA is administered to members who returned from deployment 90–180 days previously and is designed to assess the medical

[1] Returning members can be identified as having a need for referral for the following types of care: audiology, cardiac, combat stress, dental, dermatolology, Ear, Nose and Throat, eye, family problems, fatigue, gastrointestinal, urology, gynecology, mental health, neurology, orthopedic, or pulmonary. The PDHA form also has a pregnancy referral and "other" referral, but the tracking system excludes pregnancy and other referrals when identifying the ill, injured, or wounded.

status of returning members and their need for services. Like the PDHA, the PDHRA identifies returning members who need a referral to a medical care provider for evaluation and follow up.

4. Because some Service members may not complete a PDHA (and have not had sufficient time to complete the PDHRA), DoD's tracking system identifies any returning members who subsequently received care at a civilian or military medical treatment facility (MTF) with a diagnosis of post-traumatic stress disorder (PTSD), other psychological health care, concussion, burns, or amputation.
5. Active Duty patients referred to the Department of Veterans Affairs (VA) for care also are identified.

DoD's tracking system uses all five of these sources (medical evacuations, PDHA, PDHRA, MTF and civilian claims data, and active duty referrals to the VA) to identify the ill, injured, or wounded who have returned from a combat zone to the United States. Because Service members return to the United States in different ways (medical evacuation or other) and because some symptoms are not evident at the time a member returns to the United States, no one method is sufficient. DoD has cast a wide net to identify as many of the ill, injured, or wounded as possible. Appendix A contains the criteria to identify the ill, injured, or wounded Service members to track.

This initial report measures the access-to-care results for individuals who returned to the United States during the July to September 2006 quarter and who met one or more of

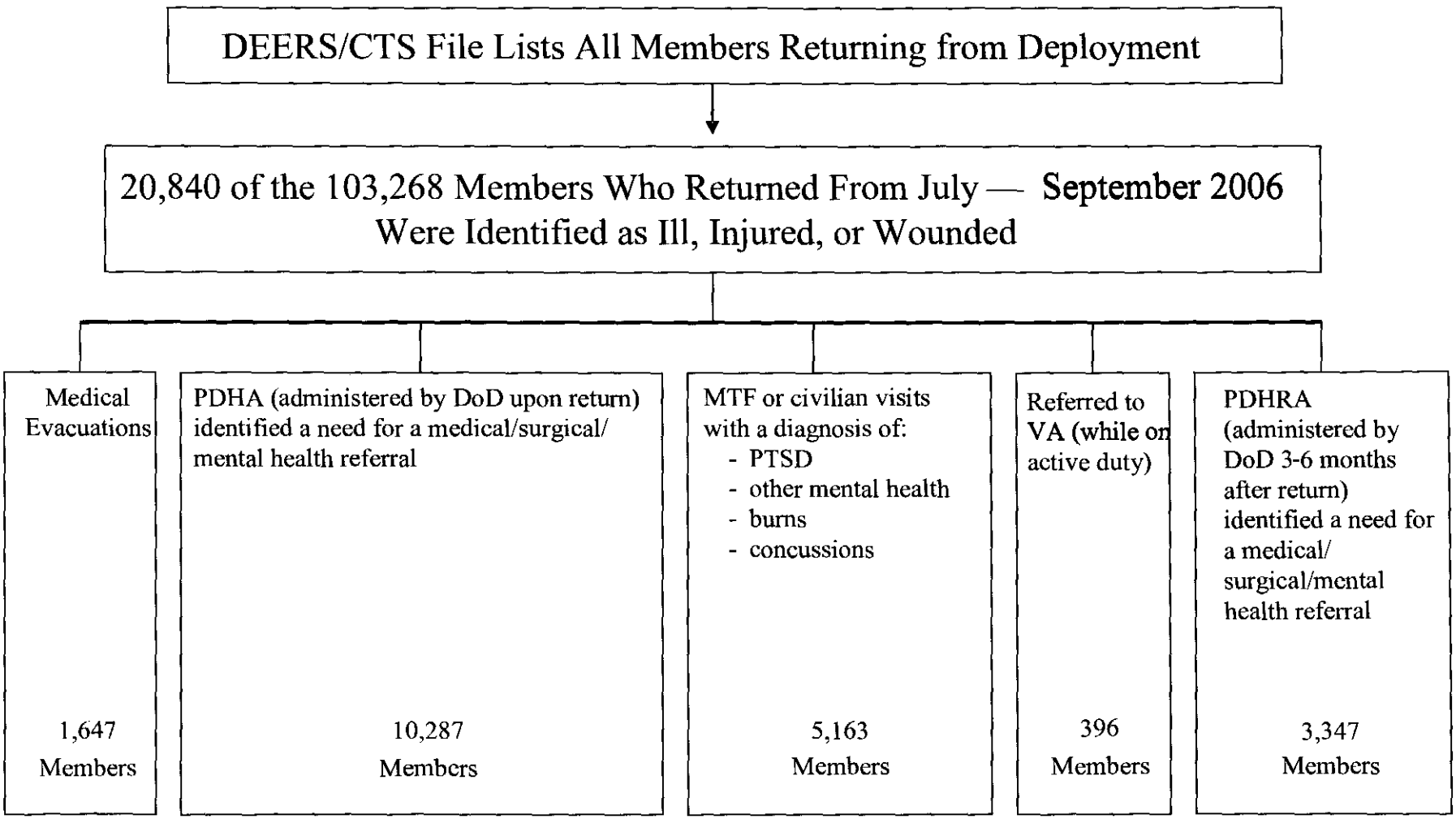
the five criteria described above as ill, injured, or wounded.[2] Using this time frame of Service members returning to the United States at least 9 to 12 months ago allows sufficient time to pass to assess access to care. Using the data sources described above, the DoD's tracking system identified 20,840 unique Service members who have returned from deployment during the July–September 2006 period and who were identified as ill, injured, or wounded (see Figure 1).[3] About eight percent of these 20,840 Service members were medically evacuated because of serious illness, injuries, or wounds. A second group, comprising about one-half of the ill, injured, or wounded members in this cohort was identified because the PDHA, which is completed typically at the time the member returns from a deployment, indicated a need for a referral for care.

[2] During this period, about 103,000 Service members returned to the United States from a deployment to a combat zone.

[3] DoD is capable of tracking individuals who were identified as ill, injured, or wounded more recently, and many of the more actionable reports that will be generated using this tracking system will focus on individuals who were more recently identified as ill, injured, or wounded returnees. These additional capabilities are described later in this report.

Figure 1

Identifying Members Returning from Overseas Who Are Ill, Injured, or Wounded



The tracking system uses three other sources of data to help identify the ill, injured, or wounded. About one-quarter of the ill, injured, or wounded in the cohort were identified because they had MTF or civilian care with a diagnosis of a concussion, burns, PTSD, other mental health condition (the most common diagnosis among these members was a mental health condition), or a Standard North Atlantic Treaty Organization (NATO) Agreement injury code for a battle injury. An additional 16 percent of the ill, injured, or wounded cohort was identified because their PDHRAs, which are administered three–six months after returning from deployment, indicated that they needed to be referred for care. The PDHRA would undoubtedly have identified more members who were ill, injured, or wounded if the tracking system had not already identified returning members with MTF or civilian care with certain diagnoses. Finally, about 2 percent of the ill, injured, or wounded were identified because they were referred to the VA for care (some of these referrals are for traumatic brain injury).

More than half of the 20, 840 persons identified as ill, injured, or wounded had a mental health condition (see Table 1). About one out of six of the returning members had an orthopedic problem, about 1 out of 16 had a neurological condition, about 1 out of 11 had a dental condition, and about one out of three had some other condition (cardiac, dermatology, pulmonary, etc.). Because some of the returning Service members had multiple conditions, the percentages shown in Table 1 sum to greater than 100 percent.

Table 1

Common Conditions among the Ill, Injured, or Wounded Who Returned from July to September 2006

Condition	Percentage with this Condition
Mental Health	55%
Orthopedic	16%
Neurology	6%
Dental	9%
Other	34%

Note: percentages sum to more than 100 percent because some returning Service members have multiple conditions.

DoD's Access Standards

Once the ill, injured, or wounded members have been identified, the tracking system determines whether DoD's access standards have been met. The "Code of Federal Regulations" (CFR), 32 CFR 199.17, and the Assistant Secretary of Defense for Health Affairs Policy 06-007, February 21, 2006, "TRICARE Policy for Access to Care and Prime Service Area Standards," define standards for access to care.

The standards are:

- All military health care beneficiaries have the right to access ***emergency*** services when and where the need arises.
- For an ***urgent*** medical condition, care is to be provided within 24 hours.
- Waiting time for treatment of a ***routine*** condition must not exceed one week.

- Waiting time for access to ***specialty*** care including surgical, medical, mental health, and rehabilitative services and ***wellness*** care will not exceed four weeks after receiving a referral.

Policy 06-007 provides that Active Duty Service members who cannot be accommodated in the direct care MTF system within the established access to care standards must be offered a referral for care within the civilian network or authorization to seek care outside the network.

Approaches to Analyzing Performance in Meeting Access Standards

Identifying the length of time required to receive medical care is difficult to track for any health care system because potential medical problems must first be identified by a beneficiary or provider and brought to the attention of the system. Often, this requires a beneficiary to make an appointment with a provider who can determine whether the beneficiary actually has a medical condition requiring attention and, if so, whether it is an urgent or routine need or whether it requires referral to a specialist.

Tracking the performance of the MHS in meeting the access standards is complicated for the following reasons. First, identifying a patient's medical need, whether for emergency, urgent, routine, or specialty care, is not always straightforward. For example, physicians may have different views of whether a patient needs routine care or referral to a specialist. Second, some patients decide to leave the system and get care from a civilian plan (if they have employer health insurance as many Guard and Reserve members do) or from a VA facility. Third, some patients may choose not to get care in a timely manner. For example, although offered an appointment for care within the

standard time, a patient may choose to defer it to a time more convenient for the patient. To deal with these variations, many civilian health plans ask their members if they were satisfied with the length of time they had to wait to get care (DoD also does this through its quarterly Health Care Survey of DoD Beneficiaries). This approach, although widely used, is limited in that individuals may not recall their waiting times accurately.

Because of these issues, DoD's tracking system uses two approaches to measuring the performance of the MHS in meeting DoD's access standards: administrative data and survey data. These two approaches allow assessment of the performance of the MHS from different perspectives. Although neither approach can provide a comprehensive assessment of access, the two taken together are likely to be more accurate than either one in isolation.

Administrative Data Analysis

Approach—This approach measures the length of time between the date a member receives a referral for care and the date of the appointment. Administrative data maintained by DoD record the dates of referral, the type of care required (urgent, routine, or specialty), and the date of appointments that are kept if the referral is made in an MTF. For some care that does not need a referral (e.g., visits to a patient's Primary Care Manager), administrative data can track the time elapsed from when an appointment was made to when the visit occurred. Although tracking the waiting times for care provides important information about the access to care, there are a number of shortcomings to using administrative data. First, many types of care are not addressed specifically by the access standards (e.g., walk-in visits and follow-up visits after an initial referral

appointment). Second, for care that does not need a referral (e.g., primary care) measuring the time from booking the appointment to the visit does not include the time it may have taken to schedule the appointment. Third, some patients who get an appointment do not keep that appointment because the member chooses not to keep the appointment, is unable to keep the appointment, or because the problem no longer needs medical attention. While these problems confound the measurement of the system's performance when using administrative data, taken in aggregate the administrative data provide valuable information about access.

Results—The analyses of access in this report focus on a subset of the 20,840 Service members who were ill, injured, or wounded. Specifically, they exclude the 1,035 Service members who only had dental conditions and focused on the 19,805 Service members who had a medical condition.[4]

One capability of DoD's tracking system is to determine how quickly a Service member had the **first** continental United States (CONUS) medical encounter after the health care provider identified that the individual was ill, injured, or wounded and where the visit occurred.[5] More than three-quarters of the 19,805 members identified as ill, injured, or wounded with a medical condition who returned during the July–September 2006 period had the first CONUS medical encounter in the MTF and another eight percent had the first medical encounter with a civilian provider (see Figure 2). About 60 percent of the initial medical encounters occurred within seven days and about 75 percent

[4] 832 of these 19,805 Service members had both a medical and dental condition.

[5] The time of the first encounter is not the DoD's access standard. However, these data allow DoD to measure how many persons have received care (or not received care) and the site of that care.

occurred within the first 28 days. We were unable to track the length of time it took for the first CONUS medical encounter for about 13 percent (2,606 members) of this ill, injured, or wounded cohort because the Service members lost their eligibility for MHS care by May 2007 (966 members), received the care at an overseas MTF (780 members), or we have no data on their care (because they either did not receive care or they only received care outside the MHS, such as at the VA (860 members)).

The DoD's tracking system can analyze the extent to which the access-to-care standards were met for 15,718 (79 percent) of the 19,805 ill, injured, or wounded who had at least one CONUS MTF visit by June 2007. This report cannot address the access standards for the remaining 4,087 members who had only civilian care (1,481) or for whom there is no available CONUS data (2,606). Of the 15,718 with CONUS MTF care, 9,759 of these individuals had MTF care requiring a referral, and 15,484 had MTF care that did not require a referral (see Figure 3). For MTF care requiring a referral, DoD's tracking system measures the time elapsed from the referral date to the initial appointment covered by that referral (to determine if the access-to-care standards were met for that referral). For MTF care that does not require a referral, the tracking system can measure the time elapsed from the date the appointment was scheduled to the date the appointment occurred (to determine if the access-to-care standards were met for that appointment).

The 9,759 individuals who had ***MTF care requiring a referral*** received a total of 40,476 unique referrals for care (about 4.1 referrals per person).[6] Of these 40,476 unique referrals, we were able to compare 38,056 against DoD's access-to-care standards.[7] Across all referrals that could be compared with the standards, about 85 percent met DoD's access-to-care standards for time between the referral and the initial appointment. This percentage varied widely by type of referral. For example, 62 percent of the 876 initial referral appointments for urgent care met DoD's one-day standard and 73 percent of the 350 referrals for routine care met DoD's seven-day standard. On the other hand, out of 36,669 initial referral appointments for specialty care, 85 percent met DoD's 28-day standard and 99 percent of the 161 referrals for wellness care met DoD's 28-day standard.

We also analyzed the degree to which the access standards were met for the 15,484 individuals who had ***MTF care that did not require a referral***. These 15,484 ill, injured, or wounded members had on average 13 appointments that did not require a referral. Of the 203,032 MTF appointments that did not require a referral, we were able to compare 42,608 of these appointments against DoD's access–to–care standards that measure the time between the date the appointment was scheduled and when it occurred.[8] About 84 percent of these visits met DoD's access-to-care standards. Meeting standards

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[6] As discussed below, these 9,759 ill, injured, or wounded members not only had an average of 4.1 referrals per person, but also about 13 other MTF visits not requiring a referral.

[7] These access standard tabulations exclude from both the numerator and the denominator 2,420 referrals for which the standards cannot be measured, including referrals for civilian care, and referrals for future care (e.g., recent referrals for which the appointments have not been scheduled).

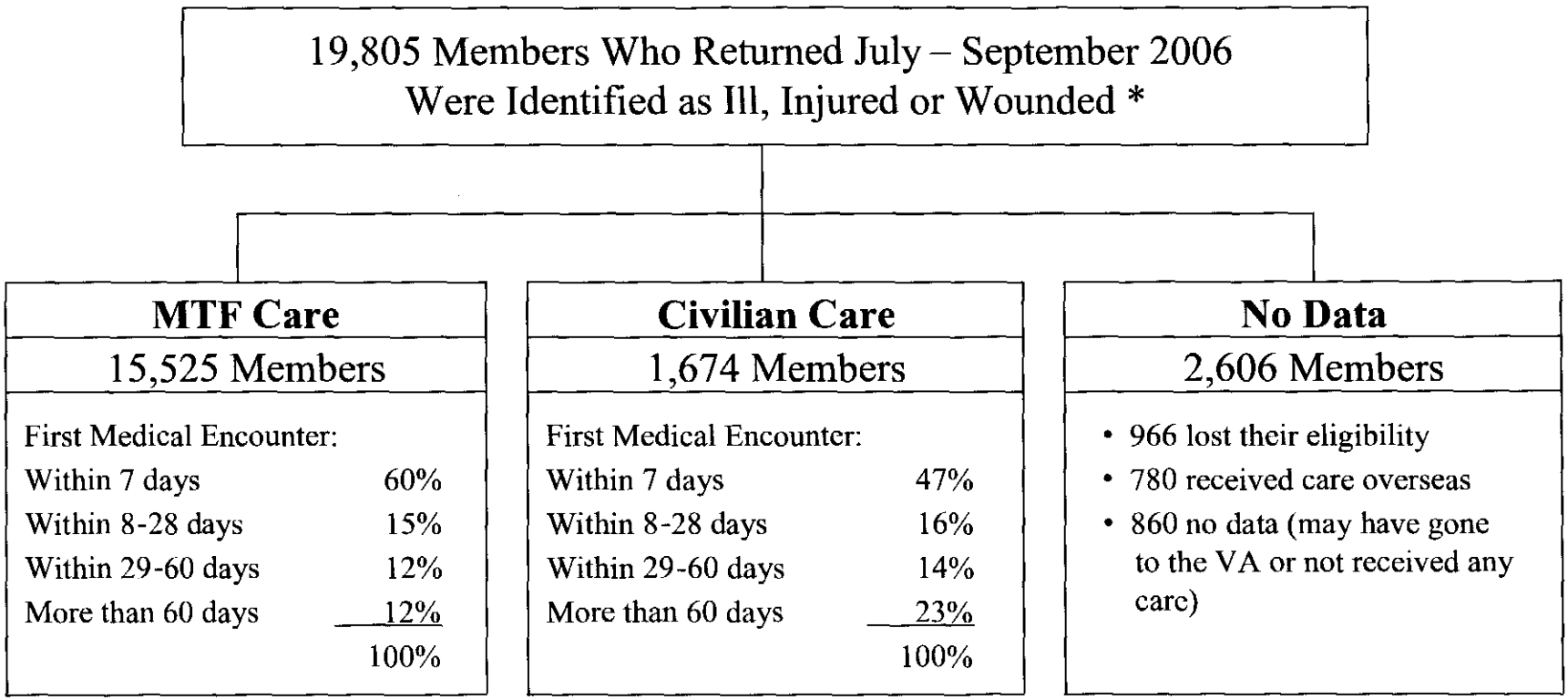
[8] These access standard tabulations exclude from both the numerator and the denominator 90,464 walk-in and sick-call visits as well as 69,780 appointments for other services for which the access standards cannot be applied (e.g., radiology, future visits, etc.).

ranged from 64 percent for routine care to 90 percent for wellness care. The most common type of appointment was for specialty care; 86 percent of these appointments were completed within DoD's 28-day standard.

For both types of appointments combined, we found that DoD's access-to-care standards were met in 84 percent of the cases for these ill, injured, or wounded members receiving MTF care (see Table 2). For urgent care, specialty care, and wellness care referrals and appointments in the MTF, the percentage of referrals and appointments that met DoD's access-to-care standards ranges from 85 to 91 percent. Routine referrals and appointments met DoD's seven-day standard about 65 percent of the time for this ill, injured, or wounded cohort.

Figure 2

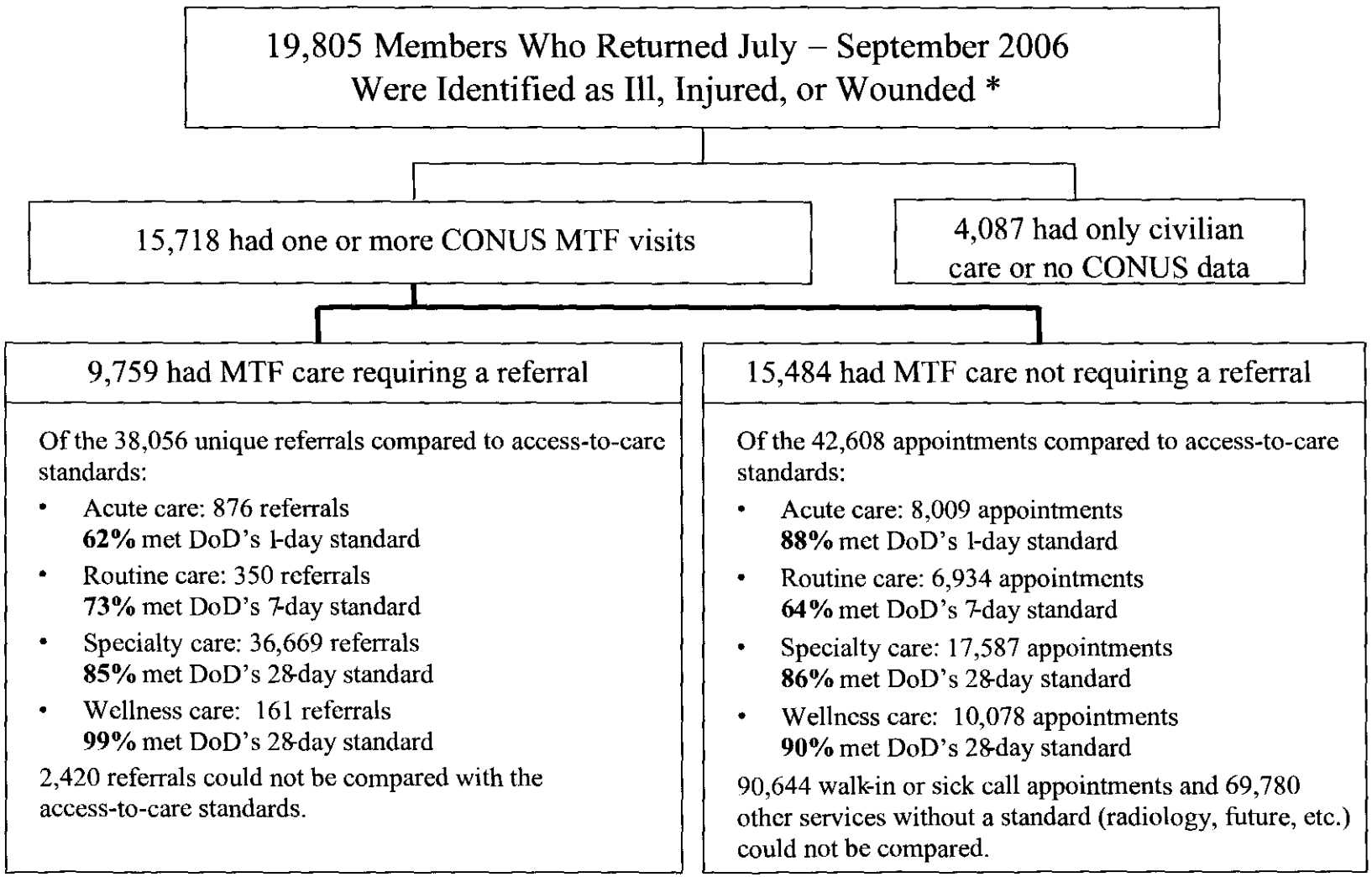
How Quickly Did the Ill, Injured, or Wounded Have Their First Medical Encounters?



* This analysis excludes 1,035 Service members whose only referral was for a dental condition.

Figure 3

84% of MTF Referrals and Non-Referral Appointments Met DoD's Access Standards



* This analysis excludes 1,035 Service members whose only referral was for a dental condition.

Table 2

Percentage of MTF Care Meeting DoD's Access-to-Care Standards for the Ill, Injured, or Wounded

Type of Care (Access-to-Care Standard)	Referral Appointments	Non-Referral Appointments	Total
Urgent/Acute (1 day)	62%	88%	85%
Routine (7 days)	73%	64%	65%
Specialty (28 days)	85%	86%	85%
Wellness (28 days)	99%	90%	91%
Total	85%	84%	84%

Note: Data are shown for 15,718 of the 19,805 ill, injured, or wounded identified for the July–September 2006 period who had MTF care through June 2007. Referrals include 40,476 unique referrals. 2,420 referrals were excluded because the referrals were sent downtown (1,045), were for care without a standard (such as future care) (196) or other reasons (1,179). Non-referral appointments include 42,608 appointments. 160,424 appointments were excluded because they were walk-in or sick-call visits (90,644) or other appointments without a standard (such as radiology or future visits) (69,780).

Survey Approach

A second approach used by DoD's tracking system is to measure whether the access standards have been met through surveys of ill, injured, or wounded Service members. As part of the tracking system, a sample of the returnees identified as ill, injured, or wounded will be surveyed and asked about the length of time it took to be seen for their medical problem for two types of care: 1) care that needed attention right away, and 2) care that did not need attention right away. This approach is used currently in the quarterly Health Care Survey of DoD Beneficiaries, and is used by many private sector health plans. The survey approach has the advantage that it can obtain data about emergency care as well as urgent, routine, and specialty care. It also can serve as a check on the access to care reported from administrative data. On the other hand, it relies on

the member's recall of the time it took to be seen by a provider. Because patient recall is not always accurate, this may introduce some inaccuracies into the measurement process. In addition, this survey requires members to state whether their problem was one that required attention right away or whether it was one that did not need immediate attention. Again, the patient's recall may not be accurate.

The DoD is conducting surveys of the ill, injured, or wounded and hopes to provide results in its next quarterly report.

Future Improvements

DoD will continue analyzing access-to-care performance each quarter. Upcoming analyses should present a more comprehensive picture of the performance of the MHS in meeting DoD's access-to-case standards for five reasons:

1. In recent years, a higher percentage of returning Service members have completed the PDHA and PDHRA. This trend should continue, so a higher percentage of members returning from overseas will have completed the PDHRA, which will mean a more comprehensive list of the ill, injured, or wounded.
2. Many PDHAs done for the Navy and Marines are done on paper and then entered into a database. The Navy and Marines are automating this process, which will provide more current and accurate data and will submit all of the PDHAs electronically. This would increase the comprehensiveness of the list of ill, injured, or wounded and allow these returning members to be identified more quickly.

3. The access data for this report were based upon data from 75 of the 86 Composite Health Care System host sites in CONUS (including all the medical centers); DoD expects data from all 86 CONUS sites for the future analyses.
4. DoD is adding a flag to its data systems to identify any returning Service member who is in case management, and will include any of these individuals in its definition of the ill, injured, or wounded (although they should be counted already by the PDHA, PDHRA, or MTF/civilian encounters with current diagnoses).
5. Results will be available from the survey described above.

Extending the Tracking System to Provide More Actionable Information

To provide more information that is actionable to MTF Commanders and the Services, DoD is adding a set of flags associated with the ill, injured, or wounded Service members to the MHS Management Analysis and Reporting Tool (M2), which is used by local MTFs and the Services.[9] This will allow the M2 system to generate actionable data reports on this population specifically for MTF Commanders, the Services, or the TRICARE Management Activity staff. For example, one report will include the number of visits per person, and a second one will report the number of ill, injured, or wounded without any visits in a month or quarter. Another will list PDHA and PDHRA referral needs. These types of reports will allow MTF Commanders and the Services to follow up on their Service members. Individual M2 users also will be able to run their own ad hoc

[9] This capability should be available by October 2007.

reports.[10] As discussed above, DoD also will implement electronic data reporting on MTF case management services (by collecting Standard Ambulatory Data Records (SADRs), for case management services). In this way, DoD will capture consistent electronic information on who is case-managed in the MTF to facilitate reporting and analysis of case management for ill, injured, or wounded Service members.

Summary

DoD's tracking system uses five data sources to identify whether a member who has returned from a combat zone is ill, injured, or wounded. It identifies not only individuals who return with an injury, illness, or wound, but also those whose symptoms are identified three–six months later through the PDHRA process, and draws from MTF and civilian claims data and active duty referrals to the VA. For each of the Service members identified as ill, injured, or wounded, DoD uses two broad approaches to assess its performance in meeting its access standards. First, using administrative data for individuals who received MTF care, DoD measures the length of time between a referral for care and the date of the appointment (or, for MTF care that does not need a referral, the length of time from when the appointment was scheduled to when it occurred). Second, for a sample of all returning members, DoD will conduct a survey of the self-reported length of time it took to get medical care. When combined, these two approaches allow an assessment of the performance of the MHS in meeting DoD's access-to-care standards.

[10] M2 is also set up to allow restricted access to patient-identifiable information, so that only authorized users would be able to see privacy-protected information (e.g., if patient identifiers are included).

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(SEPARATES THE REPORT AND APPENDIX A)

Appendix A

Identifying the Ill, injured, or wounded Members of the Armed Forces

The DoD tracking system identifies the ill, injured, or wounded Service members who are listed in the Defense Eligibility Enrollment Reporting System Contingency Tracking System as having returned to CONUS from an Operation Iraqi Freedom or Operation Enduring Freedom deployment and who meet the following criteria:

- Returned via medical evacuation as identified in United States Transportation Command's Regulating And Command And Control Evacuation System (TRAC2ES) for reasons other than pregnancy, or
- Had a PDHA or PDHRA indicating a need for a medical care referral for reasons other than pregnancy or referrals to a chaplain or One Source, or
- Diagnosed with post-traumatic stress disorder (using diagnosis codes 309.81 or 308), a concussion (using diagnosis codes 850.0–850.9 or 310.2), a psychological health condition (MDC 19), or burns (MDC 22), or amputation (DRG 113, 114, 213, or 285), or
- Listed in a Standard Inpatient Data Record (SIDR) (or Standard Ambulatory Data Record (SADR) when the field becomes available) with a Standard NATO Agreement injury code indicating battlefield injury, or
- Had a referral to the Department of Veterans Affairs while on active duty.