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COOPERATIVE EFFORTS WITHIN THE US MILITARY HEALTH SERVICES SYSTEM

BY

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medical system. Medical readiness has been improved in the areas of intelligence, research and development, and logistics. While progress in readiness has occurred in plans, operations and training, there is need for improvement. Peacetime health services have also experienced the emphasis on joint operations. Regionalization, while holding great potential for sharing, has fallen short of original expectations and needs revitalization. The Joint Interservice Resource Study Group process offers additional opportunities to review medical functions and services. Quality assurance has benefited from the joint efforts of the Tri-Service Committee on Quality Assurance and the Interservice Training Review Organization. Common credentialing criteria, however, will require standardization of the professional training base which can only occur after joint functional reviews of specialty training. The major recommendation made by the study was that Department of Defense direct a system-wide analysis of medical functions, requirements, programs, and resources to determine the best military medical organization for both wartime and peacetime.

USAWC MILITARY STUDIES PROGRAM PAPER

COOPERATIVE EFFORTS WITHIN THE US MILITARY HEALTH SERVICES SYSTEM

A GROUP STUDY PROJECT

by

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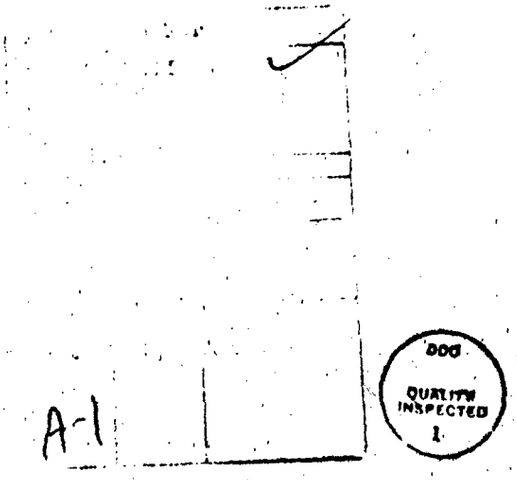
1 May 1985



ABSTRACT

AUTHOR(S): Matthew J. Barlow, Jr., COL, MC
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CHAPTER I

INTRODUCTION

BACKGROUND

Within the United States, health care costs continue to escalate. (See Figure 1.1). In 1982, the $332.4 billion spent for health care in the United States amounted to 10.5 percent of the Gross National Product (GNP).[1] During 1982, medical costs for the Department of Defense (DoD) reached $7 billion.[2] Projected DoD medical appropriations for Fiscal Year (FY) 1986 approach $10 billion (See Figure 1.2).[3]

The Military Health Services System (MHSS) is charged with two missions:

Support military operations, both in peace and war, and

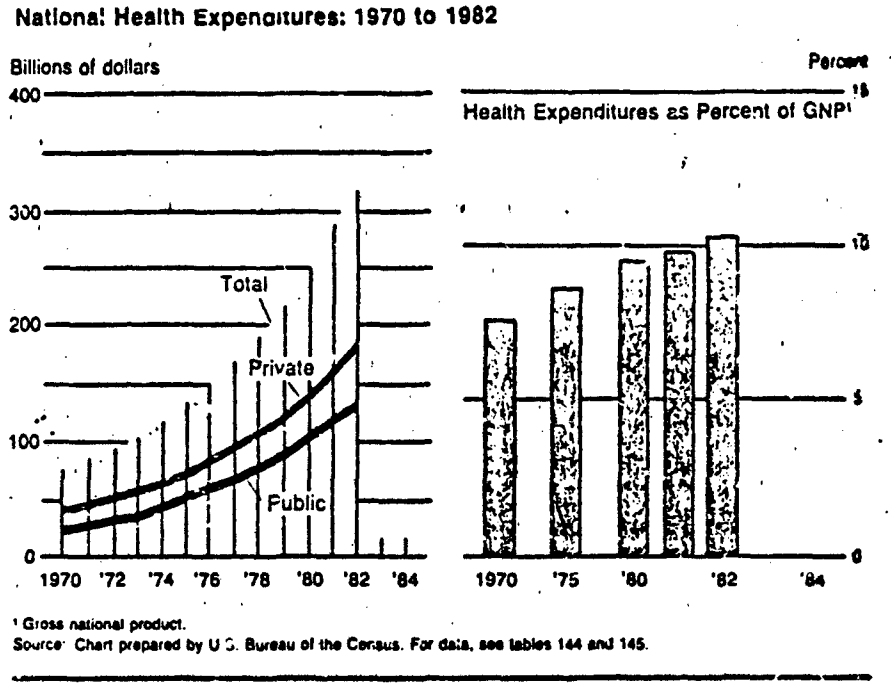
Provide day-to-day health services for eligible beneficiaries.[4]

It is the support of military operations, both in peace and war that distinguishes military medicine from civilian medicine. At times these two missions compete for scarce resources.

PURPOSE

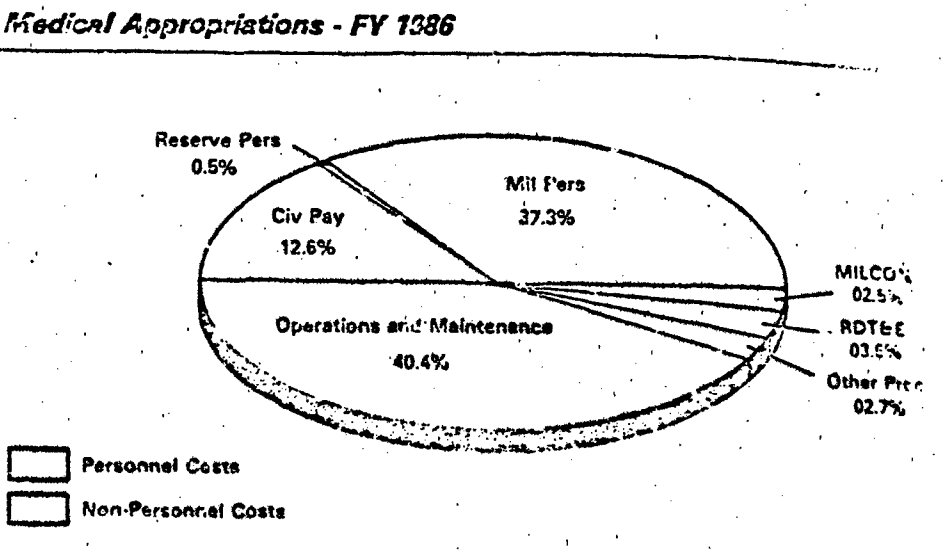
Quality health services for the military are vital for the survival of the United States. However, serious deficiencies in medical readiness were characterized as "war stoppers" by the Joint Chiefs of Staff during a 1983 worldwide mobilization exercise."[5] Also, the competing missions of providing peacetime and wartime health services in a constrained resource environment require close

Figure 1.1 National Health Expenditures: 1970 to 1982



Source: US Department of Commerce, National Data Book and Guide to Source Statistical Abstract of the United States, 104th Edition, p. 100.

Figure 1.2 DOD Medical Appropriations FY 1986



Source: Caspar Weinberger, Report of the Secretary of Defense to the Congress on the FY 1985 Budget, FY 1987 Authorization Request and FY 1986-90 Defense Programs, p. 286.

cooperation among the Military Medical Departments. The purpose of this group study project is to describe and discuss the current level of cooperation within the Military Health Services System (MHSS) and to identify areas where additional cooperation may enhance military health care delivery.

INVESTIGATIVE PROCEDURES

The primary method used for investigation was personal interviews with Department of Defense medical officials. The subject of current cooperative efforts was examined in the areas of medical readiness, peacetime health services, and quality assurance. This study did not attempt to examine every cooperative medical effort within the military. The authors made an extensive review of literature, and relied on their professional judgment and experience for selection of interviews, literature search, and subsequent conclusions and recommendations.

ORGANIZATION OF THE PAPER

This paper is organized into five chapters which address the cooperative efforts within the United States Military Health Services System (MHSS). Chapter I provides the background, purpose, investigative procedures and evolution of MHSS. Additionally, a sampling of the allied military medical organizations of Canada and the Federal Republic of Germany were studied to gain insight into their cooperative efforts. Medical readiness is addressed in Chapter II. Of particular interest is the examination of cooperative medical readiness in the United States European Command, a joint command, because this command is forward deployed. Peacetime health services are discussed in Chapter III. Chapter IV is concerned with quality assurance which has significant impact on all areas of health care delivery. Conclusions and recommendations are related in Chapter V.

EVOLUTION OF MILITARY HEALTH SERVICES SYSTEM

Since World War II, numerous organizational studies (See Figure 1.3) have examined ways for improving medical readiness, insuring quality care, minimizing personnel requirements, eliminating duplicate facilities, and standardizing training. The findings in these studies have been mixed; some stated that military medicine should be unified, while others suggested closer coordination and cooperation in order to better utilize scarce resources. Opponents of unification of health services argue that unification would create loss of command and control of military medical resources by the operational combat commander. Opponents of simply closer cooperation and coordination suggest that the component service medical department will do no more than necessary, but maintain a parochial view, thus decreasing the likelihood of an efficient and effective Military Health Services System (MHSS). Unification has not occurred; however, changes within the MHSS have evolved. "The Office of the Assistant Secretary of Defense (Health and Medical) (which later became Health Affairs) [ASD(HA)] was established in 1953. The purpose of this office was "to plan and direct the development of efficient programs for the maintenance of high health standards among personnel of the Armed Forces and for the effective management of hospitals and other medical installations."[6]

In 1973, the concept of regionalization was approved by the Deputy Secretary of Defense.[7] Currently the regionalization plan requires military medical activities of each Service located within a designated area to meet quarterly in order to share discussions on health-related matters. (Further discussion of regionalization will take place in Chapter III). In order to develop further

Figure 1.3 Military Medical Reorganization Studies

Study/Plan	Date	Recommendation	Results
Eisenhower (a)	1947	. Unified medical service	. Not Implemented
Kirk Plan (b)	1947	. Unification: Armed Forces Medical Director General	. Not Implemented
Joint Chief of Staff (a)	1949	. Unified and amalgmated (single) Medical Service	. Not Implemented
1st Hoover Commission (d)	1949	. Unified Medical Administration (UMC) . Separate Military Department Teaching Hospital . Consolidation of most large-scale Federal Medical Activities	. Not Implemented
Hawley Committee (a)	1948	. Coordinated Problem Solving Mechanism . Medical organization among National Military Establishment . Armed Forces Medical Council	. Separate Military Medical Organization . OSD Medical Staff Agency
Secretart of Air Force (Symington) (a)	1949	. Separate Air Force Medical Service	. Air Force Medical Ser
Cooper Committee (a)	1949	. Civilian Director of Medical Service [later became Assistant Secretary of Defense for Health Affairs (ASD(HA)]	ASD(HA)
2nd Hoover Commission (a)	1955	. Separate Military Medical Services . Health quasi-insurance program	, CHAMPUS
Ross Plan (c)	1963	. Intergrated Medical Service Agency - Maintenance of Medical elements organization combat units	. Not Implemented
Wilbur Plan (b)	1973	. Regionalization of Health Care delivery centers	. Regionalization in CONUS
OBM, DOD, DHEW Study (a) (Military Health Care Study)	1975	. Central entity for coordinating planning, resourc programming based on capital oversight for operations assigned to regional authority	. Defense Health Council (DHC) regional coordination . Uniformed Chart of Accounts

Figure 1.3 (Continued)

Rice Plan (Defense Resources Management Study) (a)	1979	. Integration CHAMPUS and direct care function of military medical readiness and benefit mission	. Standardizing of existing system
Air Force SAC/SG Study (d)	1979	. Unification	. Not Implemented
Grace Commission (a)	1982	. Centralized Health Agency under ASD(HA)	. Not Implemented
		. Abolish Uniformed Services University of Health Services	. Not Implemented
		Change CHAMPUS reimbursements for cost containment	. CHAMPUS Reimbursements changed
Senate Armed Service Committee Report (a)	1982	. Enhance Mobilization Readiness Cost Containment and Medical care	. On going
Defense Health Agency (DHA) (a)	1982	. DHA feasibility established (All peacetime medical care under one manager)	. DHA not implemented; however, ASD(HA) program manager for DOD Health

* CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)

Sources:

(a) DHA Study, pp. 2-1 - 14.

(b) Richard Ginn, "Of Purple Suits and Other Things: An Army Officer Looks at Unification of the Department of Defense Medical Service," Military Medicine, Vol 143, 1, January, 1978,

(c) Richard Ross, COL, A Single Department of Defense Medical Service (U), pp. 41-2

(d) US Air Force, HQ SAC/SG, Unification of the Military Medical Services, January, 1979, p. 11.

cooperation among the Military Medical Departments, the Defense Health Council (DHC) was established in 1976,[8] and is chartered under DOD Directive 5136.8, dated 8 July 1982 (under revision).[9] Currently membership consists of the following: ASD(HA), chairman; Surgeon General from each Military Department; representative from Office of Joint Chiefs of Staff (OJCS); representative from the Uniformed Services University of the Health Sciences (USUHS). The Surgeon General, US Public Health Service and the Chief, Medical Director, Veterans Administration serve as ex-officio members. There are two sub-councils of the DHC: the Dental Chiefs Council and the Medical Readiness Policy Advisory Committee. The DHC serves "to advise the Assistant Secretary of Defense (Health Affairs) on DoD health matters by providing a forum for consultation, discussion, and advice on DoD health plans, policies, and related issues, and by facilitating coordination among the organizations represented by the DHC members."[10]

The Report for the Secretary of Defense On The Feasibility and Benefits to Be Gained From Creating The Defense Health Agency (the DHA study), dated 26 August 1983, offered functional comparisons of the Offices of the Surgeons General, Army, Navy, Air Force, and a proposed Defense Health Agency (DHA) (See Figure 1.4). The study proposed the formation of a DHA which would be the single manager for all fixed facilities while the Surgeons General would focus attention on mobilization needs. Medical personnel would remain with their respective medical component service.[11] This DHA proposal has not been adopted. However, on 5 October 1984, Deputy Secretary of Defense, William H. Taft, IV, signed a new and expanded charter for the Assistant Secretary of Defense (Health Affairs) which states:

> Subject to the direction of the Secretary of Defense, the ASD(Health Affairs) shall exercise oversight of all DoD health resources.[12]

Figure 1.4 Functional Comparisons Offices of the Surgeons General Army, Navy, Air Force, and Defense Health Agency (DHA)

ARMY MEDICAL DEPARTMENT

OTSG

Surgeon General

- Deputy Surgeons General
- Dental Services Chief
- Chief Veterinarian Corps
- Chief Medical Corps Affairs
- Health Facility Planning
- R & D
- Medical Services Corps
- Nurse Corps
- Medical Specialist Corps
- Personnel
- Health Care Operations
- Professional Services
- Resources Management
- Automation Management
- Administrative Office

HEALTH SERVICES COMMAND

Office of the Commander

- Deputy Commander Dental Services
- Dental Services
- Veterinarian Services
- Inspector General
- Judge Advocate
- Equal Opportunity Office
- Personnel
- Operations
- Logistics
- Comptroller
- Professional Activities
- Headquarters Company
- Management Information Systems
- Security
- Public Affairs
- Chaplain
- Adjutant General
- Telecommunications

NAVY MEDICAL DEPARTMENT

OFFICE OF THE DIRECTOR OF NAVAL MEDICINE AND OTSG

Director, Naval Medicine and Surgeon General

- Director, Naval Medicine and Surgeons General
- Deputy Director, Marine Corps Medical Matters
- Special Assitant for Reserves
- Resources Division
- Plans and Policy Division
- Government and Non-Government Offices
- Health Care Operations Division
- Education and Training Division

NAVAL MEDICAL COMMAND

Commander, Naval Medical Command

- Vice Commander
- Inspector General
- Force Master Chief
- Equal Employment
- Equal Opportunity
- Legal Support
- Public Affairs
- Headquarters Administration
- Financial Management Directorate
- Fleet Readiness and Support Directorate
- Health Care Operations Directorate
- Readiness and Logistics Directorate
- Personnel Management Directorate

BASELINE ORGANIZATION

NAVAL GEOGRAPHIC MEDICAL COMMANDS

Commander, Naval Medical Command

- Deputy Commander, Chief of Staff
- Assistant Chief of Staff for Resource Management
- Assistant Chief of Staff for Logistics
- Assistant Chief of Staff for Plans and Operations
- Assistant Chief of Staff for Dental

AIR FORCE MEDICAL DEPARTMENT

OTSC

Surgeon General

- Dental Services
- Executive/Administrative Services
- Coordinator for Professional Affairs
- Assistant for Medical Research and Bioenvironmental
- Chief, Nurse Corps
- Assistant for Quality Assurance and Risk Management
- Director, Medical Plans and Resources
- Health Affairs and Plans
- Financial Management
- Manpower Division
- Health Policy and Programs
- Medical Readiness
- Facilities Liaison of AFMSC

MEDICAL SERVICES CENTER

Commander, AFMSC

- Chief, Medical Services Corps
- Chief, Biomedical Sciences Corps
- Executive/Administrative Services
- Aerospace Medical Consultants
- Consumer Health Education
- Director, Health Care Support
- Biometrics Division
- Medical Systems
- Health Facilities
- Medical Logistics

DEFENSE HEALTH AGENCY

Director, DHA

- Deputy Director, DHA
- Executive Officer
- Secretariats (Public Information, Chaplain, etc.)
- Inspector General
- DHA Counsel
- Health Care Evaluation
- Associate Director for Operations (Includes CHAMPUS)
- Associate Director for Mobilization and Readiness Support
- Assistant Director, Administration
- Assistant Director, MIS
- Assistant Director, Facilities, Logistics and Material
- Assistant Director, R&D
- Comptroller

DEFENSE HEALTH AGENCY REGIONS

Regional Commander

- Chief of Staff
- Direct Support
- Fixed Site Facilities Commander Officer
- Operations
- Administration
- MIS
- Facilities, Logistics and Material
- Manpower
- Financial Management
- Mobilization and Readiness Support

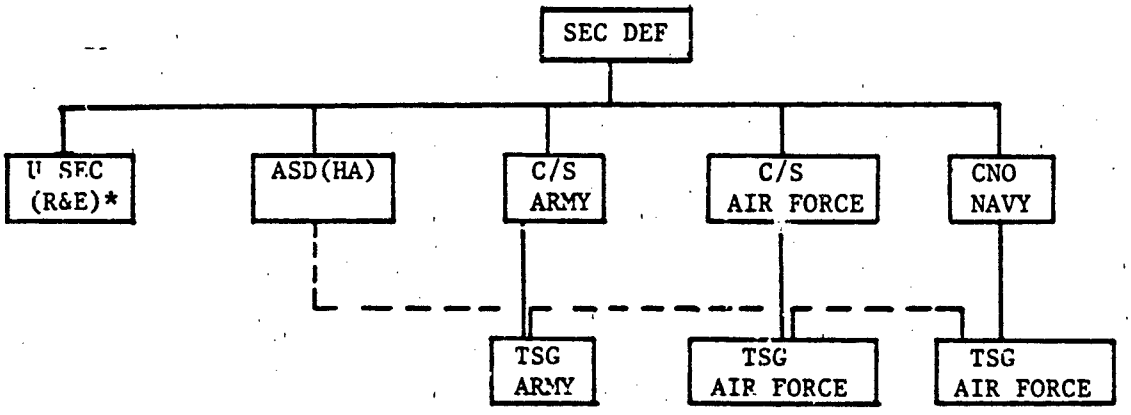
Source: DHA Study, Figure 5-5

The DoD Directive 5136.1 (See Appendix 1) designates the ASD (HA) the program manager for all DoD health and medical resources. Dr. William Mayer, the current ASD(HA) has established a Defense Medical Resources Advisory Board (DMRAB), (Appendix 2) designed to serve as the forum for discussion of major issues confronting the MHSS and to aid in the resolution of those issues that do not require the attention of the Defense Resources Board (DRB), the Deputy Secretary of Defense, or the Secretary of Defense.[13]

As of 1982, the MHSS was potentially responsible for nearly 10 million beneficiaries. There were "150,000 people, 18 major centers, 143 other military hospitals, and 310 other fixed site medical facilities of the Medical Departments of the Army, Navy, and Air Force, the Office of the Assistant Secretary of Defense for Health Affairs (ASD(HA)), and the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS)."[14] However, these figures are not all inclusive, since they only show resources in fixed medical facilities, not operational (field) medical units.

The current organization of medical activities within DoD are depicted in Figure 1.5. The organization charts of the Department of Defense and Office of the Secretary of Defense are located in Appendices 3 and 4, respectively. At this time each Military Medical Department is organized differently (See Figure 1.4). The Army Medical Department is organized functionally. In 1973, the U.S. Army Health Services Command was created to operate fixed medical facilities in the Continental United States, Alaska, Hawaii, and Panama.[15] Army combat organizations also have medical units organic to them. Air Force medical services are an integral part of all field activities of the Air Force. Recently the Navy has reorganized functionally by forming the Office of the Director of Naval Medicine and Office of The

Figure 1.5 DoD Medical Activities



DoD - Department of Defense
SEC DEF - Secretary of Defense
U SEC (R&E) - Under Secretary (Research and Engineering)
ASD(HA) - Assistant Secretary of Defense (Health Affairs)
C/S - Chief of Staff
CNO - Chief of Naval Operations
TSG - The Surgeon General
_____ Direct Control
---------- Statuatory responsibility for overall supervision of DoD health affairs.

* Responsible for functional area of increasing the effectiveness and performance of people as integral parts of weapons and protecting people from hazards of the combat and natural environment (DoD Directive 5136.1, Subj. "Assistant Secretary of Defense (Health Affairs)."

Surgeon General and the Naval Medical Command. The Naval Medical Command provides medical and dental services through the formation of geographic and mission specific commands.[16] Fleet medical services remain under the direct control of fleet naval forces, but receive professional and technical medical and dental services from Naval Medical Command. Additionally, Navy medical authorities are responsible for assuring health services for the Marine Corps.

ALLIED MILITARY MEDICAL SERVICES

Military medical organizations should reflect the national strategy of the nation. Therefore, military medical services of foreign armed forces are organized in a variety of ways to meet special national needs. The allied armed forces of Canada and the Federal Republic of Germany (FRG), give the reader insight into different organizational approaches which seek cooperation and intergration within their respective military medical systems.

Canadian Forces Medical Services

In 1959, the Canadian Forces Medical Services (CFMS) were unified in order to "provide the most flexible efficient and economical medical service for the Armed Forces"[17] which was approximately 280,000 strong. Today, the Canadian Armed Forces has approximately 80,000 servicemembers who receive medical services from 380-400 physicians and an equal number of nurses. Care is provided for active duty military only, except in isolated areas where family members also receive medical care.[18] Medical regionalization did not take place until 1963 because operational commanders were reluctant to give up their medical personnel and units.[19] In the late 1960's, the entire Canadian Armed Forces was unified. This unification weakened The Surgeon General's control over medical assets because

functional/regional commanders again assumed responsibility for medical services.[20] However, in past emergency situations, the Surgeon General has redirected the personnel resources of the CFMS. At other times the Surgeon General must mitigate his use of CFMS resources who, for the most part, come under control of the non-medical, functional/regional commanders.[21] In July 1985, the Canadian Armed Forces will again wear distinct Army, Navy, and Air Force Uniforms.[22] The large size of the United States military, (2,138,000 active duty; 1,096,000 Reserve Components as of 1984),[23] the enormous population cared for by the US MHSS, forward deployment of military, the capability of power projection, and the existence of separate Army, Navy, and Air Force Departments make comparisons of United States military medical efforts with the Canadian unification process wrought with danger.

Bundeswehr Medical and Health Services

Since the formation of the Bundeswehr in 1956, in the Federal Republic of Germany (FRG), the Surgeon General, Federal Armed Forces has had equal status with the Chiefs of Staffs of the Army, Navy, and Air Forces. (See Appendix 5). He reports directly to the Minister of Defense and four state secretaries. The Surgeon General's mission is to provide effective and efficient operation of all health services of the Bundeswehr (See Appendix 6). He has overall technical responsibility for field medical services in the three services (See Appendix 7).[24] There are 3000 medical officers (2000 are physicians; 1000 are pharmacists who must take care of all medical supplies). There are no nurses in the active military, but in times of war will come from the reserves and civilian community. Medical officers wear the uniform of the service with which they are associated. Twelve Bundeswehr station hospital are jointly staffed. The Federal Armed Forces

Medical Office continually controls the station hospital, medical laboratories, medical training for medical officers and advanced medical training for non-commissioned officers.[25] The Field Medical Service is integrated into the unit commands of the Army, Air Force, and Navy.[26] There is the potential for conflict between The Surgeon General's technical supervision and the operational commander's direct control of these medical units. In some ways, the organization of the Bundeswehr Medical and Health Services is similar to the proposed United States Defense Health Agency (DHA). The military missions of the United States and Federal Republic of Germany differ. Therefore, one must be careful when comparing medical military organizations. For example FRG's military are not forward deployed; they must defend their homeland on their own turf, and they are smaller in size than the U.S. Maintaining lines of communication, establishing evacuation policies, and re-supplying hospitals and other medical units may have different solutions for different countries.

ENDNOTES

1. US Department of Commerce, National Data Book and Guide to Source Statistical Abstract of the United States 1984, 104th Edition, 1984, p. 100.

2. US Department of Defense, Feasibility and Benefits to be Gained from Creating the Defense Health Agency (DHA), 26 August 1983, p. ES1 (Hereafter referred to as the DHA Study).

3. Caspar Weinberger, Report of the Secretary of Defense to the Congress on the FY 1986 Budget, FY 1987 Authorization Request and FY 1986-90 Defense Programs, p. 286.

4. DHA Study, p. ES 1.

5. "Interview Between the Surgeon General of the Army Medical Department Lt Gen Bernhard T. Mittemeyer and the Editor of the Medical Bulletin," Medical Bulletin of the US Army Europe, Vol 41, No. 9 September 1984, p. 3.

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7. US Department of Defense, Deputy Secretary of Defense Memorandum. Regionalization of Peacetime Military Health Services Support, 5 September 1973.

8. Source: Rumsfield, Donald. Memorandum, DOD Health Council (DHC). Washington, D.C.; Office of the Secretary of Defense, December 18, 1976. (cited in Ginn, p. 24).

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13. US Department of Defense, Assistant Secretary of Defense Memorandum: Establishment of a Defense Medical Resources Advisory Board (DMRAB), 17 October 1984.

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16. US Department of the Navy, Navy Medical Command Organization Manual, 5430.1, 5 April 1984, p. 00-1.

17. J.W.B. Barr, A Story of the Canadian Forces Medical Services as told by the Colonel Commandant on the Occasion of the 25th Anniversary, December 1983, p. 2.

18. In-person discussion with Chester Brown, L.COL, DO, DFMS, Canadian Medical Liaison Officer to the U.S. Army, 26 November, 1984.

19. Barr, p. 6.

20. Ibid., p. 7.

21. Ibid., p. 8.

22. In-person discussion with COL Douglas A. Fraser, Canadian International Fellow, Army War College, 22 March 1985.

23. Weinberger, p. 300.

24. Federal Armed Forces Directorate of Health and Medical Services, Briefing: Mission and Organization of the Bundeswehr Medical and Health Services, 21 February, 1985. pp. 1-2.

25. In-person discussion with Dr. Borkowski, COL, Federal Armed Forces Directorate of Health and Medical Services, FRG, 21 February 1985.

26. Federal Armed Forces Directorate of Health and Medical Services, p. 6.

CHAPTER II

MEDICAL READINESS

> The art of war teaches us to rely not on the likelihood of the enemy not coming but on our own readiness to receive him; not on the chance of him not attacking but rather on the fact that we have made our position unassailable.
> - Sun Tzu 500 BC

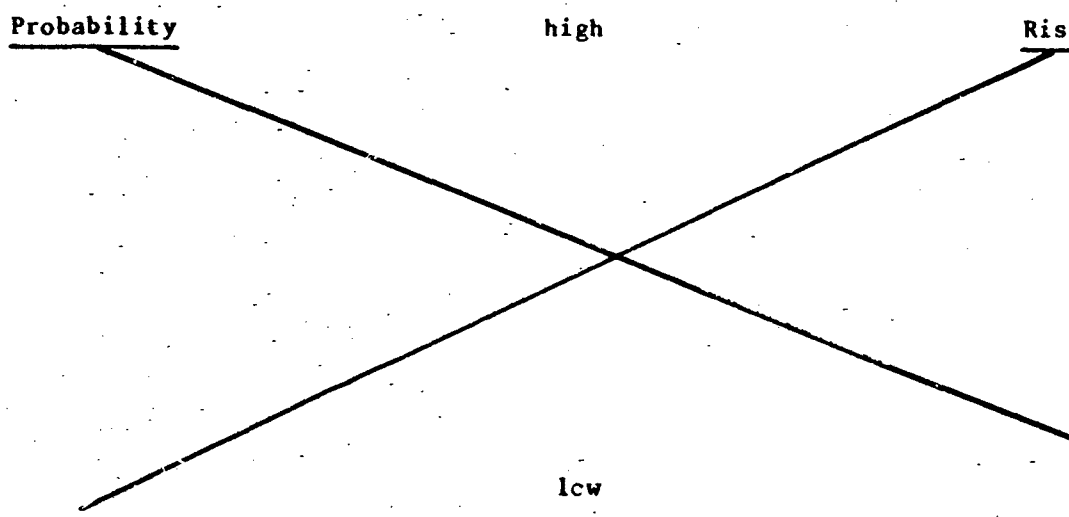
BACKGROUND

One cannot help but have been made aware lately of the perceived reduced level of readiness of the Military Health Services System (MHSS). Hardly a week goes by without being, once again, reminded of our inability to provide optimal care for the expected thousands of casualties our armed forces would suffer in some yet-to-be-fought, distant large-scale war. One needs to be aware, though, of where on the spectrum of conflict and under what circumstances these deficiencies are most apparent (see Figures 2.1 and 2.2).

As distances lengthen and warning times shorten the ability to provide optimal medical care is degraded. The leadership of the Department of Defense (DoD) and the three Military Departments are aware of this shortfall and are working to remedy it.[1] They are not only increasing the budget spent on medical readiness but also attempting to get more out of what they are allocated by reducing the waste of triplication of time, effort and resources spent to solve a common problem.

There is no question that future wars will involve all the Services of the DoD. Even an unconventional war will see soldiers, sailors, airmen and marines, on foreign soil, with resultant battle and non-battle injury or disease. What constitutes readiness to provide medical care for these servicemembers? In a 8 February 1982 memorandum from the Director of the Joint Staff, Office of the Joint Chiefs of Staff, readiness was defined as "the ability of forces, units, weapons systems or equipment to deliver the outputs for which they were

Figure 2.1 Spectrum of Conflict



Terrorism	Unconventional Warfare	Minor Conventional Warfare	Major Conventional Warfare	Theater Nuclear Warfare	Strategic Nuclear Warfare

Figure 2.2 Spectrum of Medical Vulnerability

Close Site (Central America)

or Long Warning (30 days)

Medical Vulnerability

Distant Site (SW Asia)

or Short Warning (3 days)

Terrorism	Unconventional Warfare	Minor Conventional Warfare	Major Conventional Warfare	Theater Nuclear Warfare	Strategic Nuclear Warfare

designed, including the ability to deploy and employ without unacceptable delays." More specifically, in the Fiscal Year 1986 Annual Report to the Congress medical readiness meant:

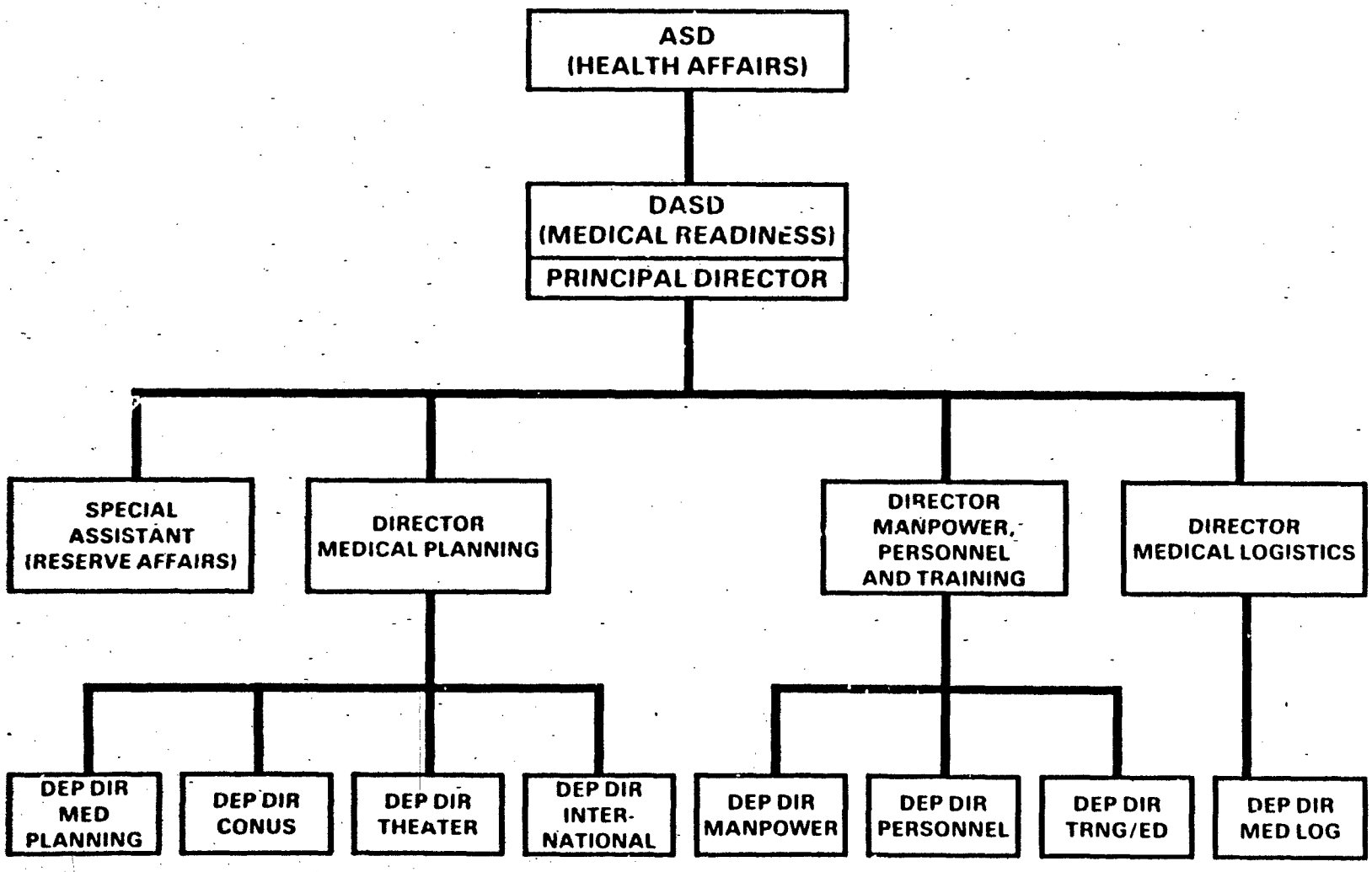
> the ability to treat casualties and return them to duty as soon as possible; to provide life saving care, including surgery, to US casualties in the event of war or terrorist attack, within the first few hours of injury; and to evacuate casualties requiring more definitive medical care.[2]

ASD(HA) has, since 1979, had a deputy and staff specifically charged with forming medical readiness policy and informing the ASD(HA) on the status of medical readiness (Fig. 2.3). In addition, at the DoD level, the Defense Health Council has its own sub-council to identify readiness issues and recommend solutions to problems in medical readiness, mobilization deployment and crisis management. This Medical Readiness Policy Advisory Committee is chaired by the Deputy Assistant Secretary of Defense for Medical Readiness who also advises the ASD(HA).

Historically, the Army has been most dependent on smooth-running joint operations. The Army, unlike other Services, cannot get to the battle site, be reinforced or supplied without the other Services' planes or ships. There is increasing awareness that the next war may be lost unless the operations of US forces are skillfully synchronized. With persistent congressional and taxpayer concern about the product produced for the billions of dollars spent annually for defense, all the Services are paying joint operations far more attention. General Maxwell Thurman, the Army Vice Chief of Staff, stated during a lecture, 7 February 1985, at the Army War College, that among the nine Army thrusts, for Fiscal Year 86 and beyond, the sixth thrust was to "enhance joint Service cooperation." This thrust might have been motivated in part by the realization that in a low intensity conflict, one most likely to occur, the burden of fighting may temporarily shift to a single Service and those not engaged will be required to provide support. In such a conflict Army and/or Marine elements

Figure 2.3

OFFICE OF THE DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR MEDICAL READINESS



would sustain a disproportionate number of casualties compared to the Navy and Air Force. It is, therefore, conceivable that underutilized assets would be called upon to provide backup or surge support in significant quantities. Support might consist of entire medical units or perhaps only compatible, standardized equipment and crosstrained personnel familiar with the medical operations of the other Services. In a discussion at the Army War College on 27 November 1984, LTG Bernhard T. Mittemeyer, the then Army Surgeon General, stressed the need for consolidation, cooperation and crosstraining among the Medical Services.

There has been a noticeable shift in sentiment in favor of joint operations effected by the complex interaction of congressional and military medical leadership.

This chapter will systematically examine joint efforts in those areas which directly affect the ability of the Medical Services to produce the output for which they were designed -- the conservation of the fighting strength. Specifically, medical personnel and training, intelligence, operations and planning, research and development, and logistics will be addressed.

MEDICAL PERSONNEL AND TRAINING

Each Medical Service manages its recruiting independently; the Army Medical Corps through the US Army Medical Department Personnel Support Agency, the Navy and Air Force through their Recruiting Commands. There is sharing of information at a semi-annual joint recruiting conference. The Services claim that their programs, assignment policies and needs are so dissimilar as to warrant three separate recruiting efforts. They are looking for qualified personnel to fill both their peacetime and wartime needs. Wartime requirements are based on force structure and casualty estimations compiled by the Services' personnel sections. Unfortunately, the Services do not use standardized methods to estimate casualties in a mutually shared area such as a Communications Zone nor do

they use standardized methods to determine wartime requirements for medical personnel. This deficiency is driving development of standardized models for force structure of units deployed overseas, thus creating a basis on which to estimate what common effect an enemy threat will cause.[3]

About 60 percent of the Army and Air Force medical wartime requirements will be met by their Reserve Components.[4] The Navy/Marines rely less on Reserves than their sister Services do. As a result of a study conducted by the Strategic Studies Institute, US Army War College, in 1979 each Service was urged to implement policies which would enhance higher levels of Reserve Component accessibility upon mobilization. By 1983, some improvement was made but there still existed a significant shortfall.[5] (Table 2.1)

Table 2.1

% Medical Personnel Accessible on Mobilization Day

	Physicians	Nurses	Oral Surgeons
Selected Ready Reserve	88%	85%	89%
Individual Ready Reserve	80%	79%	82%
Retirees	62%	65%	60%

In addition to the Selected and Individual Ready Reserves and Retirees, there exist Standby Reserves. Standby Reserves include personnel who once were active duty or ready reserve but have subsequently dropped their affiliation. Until recently there was considerable difference among the Services on the management of the Standby Reserve. The Army was alone in not counting on them in time of war because of very doubtful availability; whereas the Navy and Air Force included over 5000 Standby Reserve physicians in their availability figures. Since the MAXIMUS Study on wartime availability was released in April 1984, the Navy and Air Force have also removed physicians from their Standby Reserve rolls.[6]

The Services also have different policies relating to mobilization of physicians enrolled in civilian graduate medical education.[7] ASD(HA), in January 1983, attempted to standardize training policy among the Services by issuing DoD Directive 1215.4, Medical Training in Reserve Components. The programs covered in this directive have been implemented wholeheartedly by the Navy, to a lesser degree by the Army and even less by the Air Force.[8]

The Army's Academy of Health Sciences (AHS) sponsors the Combat Casualty Care Course (C^4) which has both a Tri-Service student body and faculty. This two-week long course gives didactic and hands-on training to physicians, nurses and dentists which will enable them to treat a wide variety of combat injuries. This course accounts for most of the non-Army officers attending the AHS. Reports indicate this program is well-run and well-received.[9] A more detailed analysis of joint medical training will be done in Chapter IV.

The Directorate of Combat Developments (DCD) at the AHS is also jointly staffed. The DCD is standardizing the DoD Medical Data Base. It is assessing the effects of increased mobility, tactics, distribution of wounds, acquisition of patients, distance to pick up points and casualty rates for all the Services. The DCD is determining in fine detail the personnel, equipment and time requirements to treat 309 patient conditions. This analysis will lead to a common understanding of wartime medical resource requirements. Upon this foundation mutually acceptable standardized medical equipment will be configured to meet the requirements.[10]

It is apparent that much is being done to improve joint operations. Some additional areas to be explored in recruitment might be coordinating or combining advertising campaigns. Officer training such as the C^4 is laudable. Should a similar program be instituted for joint medical operations?

MEDICAL INTELLIGENCE

This area probably demonstrates the most successful joint medical readiness effort presently in existence. The Armed Forces Medical Intelligence Center (AFMIC), Ft. Detrick, Maryland, is a DoD asset, jointly staffed, with access through the Defense Intelligence Agency to all systems of collection. This information is put out to all Services, the Center for Disease Control and the State Department via a weekly wire. The Tri-Service intelligence analysts track disease occurrence and military and civilian medical deployments outside the United States. In addition, they can rapidly provide answers to medical questions through the "Quick Response" program. Of 283 requests for information in 1984, half came from the Army. The AFMIC staff of 64 consists of 13 Army, 2 Navy and 2 Air Force servicemembers. The Director, though pleased with the joint effort, would like to see greater participation and awareness of the benefits by the Navy and Air Force.[11]

OPERATIONS AND PLANNING

One of the difficulties of coordinating and implementing joint medical readiness planning seems to be the fundamental difference in organization of the three Medical Services. For example, there is no single commander of all Air Force medical facilities. Command and control passes through the Air Force Command which the medical facility is tasked to support. The Navy had, until recently, a similar arrangement, but now (see Chapter 1) has a system somewhat akin to the Army's Health Services Command (HSC). In CONUS, Hawaii, Alaska and Panama, HSC acts as the command and control element for the regional medical centers which in turn have certain responsibilities for Army Medical Department activities within their region.

In order to ease the transition to war and improve the effectiveness of medical units, the Army is considering reducing its reliance on the Professional

Filler System (PROFIS) and adopting a mobilization plan similar to that in the Air Force in which entire wartime medical units are formed from the staff of a single peacetime facility. The PROFIS plan had fixed facility personnel individually scattering to deploying medical units and therefore the only time the members of the unit worked together was during exercises. The Air Force plan emphasizes cohesion, mutual trust and reliable capabilities assessment within the unit even before it deploys. This concept was successfully tested in REFORGER 1984 by deploying half the staff of a 500 bed contingency hospital from Wilford Hall Air Force Medical Center in Texas to the Royal Air Force Base in Little Rissington, United Kingdom. As the staff vacates the CONUS facility and forward deploys a reserve unit backfills into the openings. Little Rissington was a Communications Zone Hospital and a turn-key operation in a pre-positioned fixed facility (a World War II Air Force hanger). Army and Navy/Marine hospitals face different requirements since they can be deployed as far forward as Division rear boundaries, require extensive work to set up in the field and must be tactically mobile.[12]

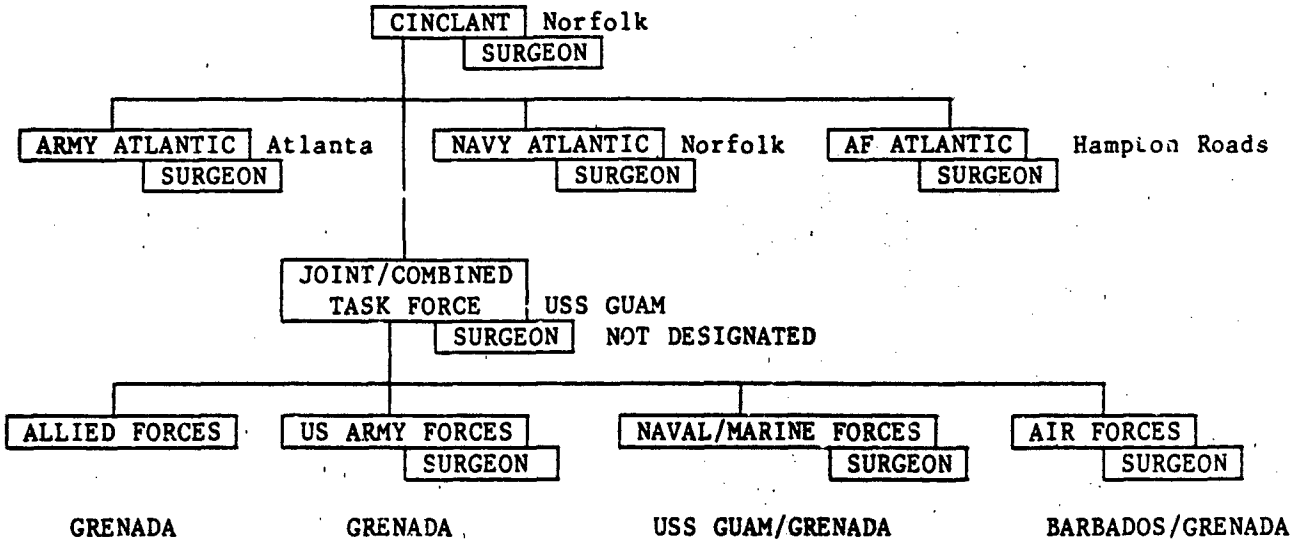
In 1980, DoD established the Civilian Military Contingency Hospital System to provide backup to DoD and VA medical facilities for national security emergencies. By 1984, 61,000 staffed hospital beds in 770 participating civilian general hospitals were identified. The Military Medical Services will jointly provide logistical support for patient regulation, patient movement and patient administration. This system has been incorporated into a larger National Disaster Medical System which will be comprised of 100,000 beds in 71 metropolitan areas to respond to both civilian and military emergencies.[13]

Perhaps one of the best examples of a successful joint medical planning effort producing improved readiness exists in Europe. The three Medical Services have formed a US European Command (EUCOM) Medical Coordinating Committee (UMCC) with sub-committees dealing with joint medical planning.

Particularly noteworthy are efforts at coordinating rapid medical responses to terrorist and other disaster situations; evacuation by ground, air and sea; and medical materiel support. Additionally, the Medical Services of the US Army, Air Force and Navy, that is the UMCC, meet with the single military medical agency of the armed forces of the Federal Republic of Germany at the Combat Logistics Support System conference. Headquarters, EUCOM, is the executive agent for wartime host nation support agreements. To facilitate the implementation of the EUCOM medical information and reporting system, an effort is being made to create a common medical communication system. The EUCOM Surgeon's Office is a regional joint operation. Theoretically, for peacetime planning and operations the three Service components of EUCOM should receive guidance and coordinating instructions from this office. But, unfortunately, the position of EUCOM Surgeon is an "extra hat" that the senior medical service commander wears. It appears unlikely that an organizational relationship conducive to effective, mandated cooperation will be established in the near future. At present, naval input into the UMCC is not significant. Although naval commitments range from Norway to Suez, the total naval medical strength in EUCOM is not great.[14]

The most recent real world joint operation was, of course, Operation URGENT FURY in Grenada. Army, Navy and Air Force afteraction reports were reviewed and correlated by the authors. While many positive results were demonstrated, there were also some fundamental problems. It seems that effective joint medical operations is a concept that unless one is constantly striving to implement it somehow, in the rush of preparations, gets overlooked. A military force will do well in war what it does well in peace. The major medical failures in Operation URGENT FURY were lack of a clear cut medical command and control compounded by inability to communicate due to lack of organic, secure equipment and unfamiliarity with service-unique reports and procedures.[15]

Figure 2.4 URGENT FURY Medical Organization



This schematic indicates the way the medical force was organized for the operation. With no Joint/Combined Task Force Surgeon designated there was no focal point, either from above or from below, for planning or resource allocation. Ingenuity, innovation and improvisation paid off again. Beginning four days after the operation started, the XVIII Airborne Corps Surgeon assumed the role of Joint/Combined Task Force Surgeon. As was recommended in one of the afteraction reports it is evident that the intensity and frequency of joint training must be increased with more involvement of the Navy and Marine medical operators.[16]

It is clear that some progress has been made in joint planning of medical operations, especially in EUCOM. However, to avoid tying success of these programs to the personal motivation and inclination of the participants, some organizational changes need to be made to make the regional, joint operation work predictably and consistently both in CONUS and overseas. One possible recommendation is to create a full time, joint regional medical director who outranks the component medical commanders.

RESEARCH AND DEVELOPMENT

In the Army, the combat concepts and organization developer is AHS, while the medical materiel developer is the Army Medical Research and Development Command. To provide oversight to the R&D efforts of the three Medical Services, the Armed Services Biomedical Research Evaluation and Management Committee (ASBREM) was formed. This committee was a direct result of congressional pressure to consolidate all medical research and development activities under a single organization administered at the OSD level.

> The ASBREM concept provides that the participant members are the senior research managers of the Military Departments. They are supported by Joint Technology Coordinating Groups composed of key personnel in each major biomedical thrust area from each Service. These working groups address management issues and make recommendations to the ASBREM. If either the working group or the ASBREM cannot resolve issues, the Research and Advanced Technology Division of the Office of the Undersecretary of Defense for Development, Research and Engineering settles them. In addition to its own internal program development, ASBREM is required to have formal approval from the Department of Health and Human Services of its activities to avoid research duplication of that Department's activities.[17]

Review of the proceedings of the seven Joint Technology Coordinating Groups provides evidence that a high level of cooperation exists and duplication of effort has been kept to a minimum. Synchronization of financial and military effort requires resources to be allocated at the critical point thereby resulting in economy of effort in other areas. This necessitates mutual trust, mission orientation and willingness to sacrifice Service self-glorification for the betterment of the whole.

LOGISTICS

Several joint agencies and projects which impact on medical readiness are operative in medical logistics. While TRILOG (see Chapter III) primarily develops medical logistics functions and systems in support of a health care

delivery environment in fixed facilities, the Defense Medical Standardization Board (DMSB) focuses on the field medical environment. This board, chartered in June 1984, replaced the Defense Medical Materiel Board and the DoD Deployable Medical Systems Board. As stated previously, the Directorate for Combat Developments, a joint directorate, through their analysis of 309 patient diagnoses, is determining the requirement in personnel, materiel and time to care for these combat medical conditions; then a list of deployable, standardized items and assemblages is compiled by the DMSB and approved by the ASD(HA). In the development of deployable medical systems, maximum use of standardized DoD materiel available from various commodity managers will be stressed. The product of this ongoing process is a "shopping list" from which the Medical Services will be required to purchase materiel, equipment and assemblages to fit their needs. This results in maximizing standardization and efficiency and minimizing costs. The DMSB consists of medical and dental officers from each Service with observers from ASD(HA) and the Defense Logistics Agency. An initial field test of this assemblage was completed in late 1984 and minor modifications were made.[18]

The Military Blood Program Office has been in existence since 1962. This joint office concerns itself with the collection, possessing, distribution and use of whole blood and its fractions by military hospitals on a regional basis. It ensures that plans are maintained for providing blood support to the Armed Forces, worldwide, in peace or war.

In wartime, the Armed Services Whole Blood Processing Laboratory, located at McGuire AFB collects blood from all major treatment facilities, then checks, repacks and distributes it according to requests from the overseas command surgeon. The Blood Program Office answers to DASD(MR) but receives administrative support from the Army. While each Service maintains its own blood program manager, they meet monthly to share data and coordinate activities.[19]

Other logistics areas that involve joint efforts include the optical fabrication of all eye glasses for the Armed Forces. The Army also provides medical maintenance and logistic support for all military induction processing. In EUCOM the Air Force and Navy have asked for provision, in peace and war, of medical supply support to US Air Force Europe (USAFE), US Navy Europe (NAVEUR) by the USAREUR medical depot system. In addition, discussion was held concerning the development of a regional medical materiel support capability wherein one component would be responsible for supporting the others in a particular geographic sub-region.[20] Extensive work is also being done in EUCOM to share logistical training, personnel and ideas with the German Defense Medical Agency. This is accomplished through the previously mentioned US-German Medical Coordinating Committee for Combat Logistics Support Systems. However, in a February 1985 meeting of the Committee, the Germans sent seven area experts, while the US Army sent seven and the US Air Force sent five. Surely as the Medical Services develop a more confident, knowledgeable corps of joint medical planners and operators, such duplication of time and effort will decrease.

ENDNOTES

1. US Congress, Senate, Committee on Armed Services, Subcommittee on Manpower and Personnel. Medical Readiness of the Armed Forces, May 1982, pp. 16-89.

2. Weinberger, p. 286.

3. Telephonic discussion with LTC Salko, Deputy Director Personnel, Office of Manpower, Personnel and Training of the Deputy Assistant Secretary of Defense (Medical Readiness), 12 March 1985.

4. Weinberger, p. 287.

5. Maximus, Inc., Wartime Availability of Medical Personnel Upon Mobilization, p. ES-9.

6. Telephonic discussion with William Vance, COL, Special Assistant for Reserve Affairs of the Deputy Assistant Secretary of Defense (Medical Readiness), 14 February 1985.

7. Maximus, Inc., p. ES-12.

8. Vance, COL, 22 February 1985.

9. In person discussion with COL Leahy, Director of Training and Doctrine, Academy of Health Sciences, 8 January 1985.

10. In person discussion with COL McKeever, Director Combat Developments, Academy of Health Sciences, 9 January 1985.

11. In person discussion with COL Walker, Director, Armed Forces Medical Intelligence Center, 18 February 1985.

12. Wilford Hall Air Force Medical Center, USAF Medical After-Action Report for RCS: JAF-SGH(AR), p. 3.

13. L. E. Mahoney, et al., "Planning a National Disaster Medical System," Military Medicine, December 1984, pp. 657-660.

14. EUCOM Surgeon's Office, USEUCOM Medical Coordinating Committee Minutes, February 1984, p. 2.

15. XVIII Airborne Corps Surgeon's Office, URGENT FURY After Action/Lessons Learned Report, p. 4.

16. 1st Aeromedial Evacuation Squadron (MAC), URGENT FURY After Action Report, p. 10.

17. DHA Study, p. D-3.

18. US Department of Defense, DoD Directive 6430.2: DoD Medical Standardization Board.

19. US Department of Defense, DoD Directive 6480.5: Military Blood Program.

20. [illegible] Surgeon's Office, USEUCOM Joint Medical Planning Meeting Minutes, 14 November 1984, pp. 3-4.

CHAPTER III

PEACETIME HEALTH SERVICES

BACKGROUND

The examination of cooperative efforts included in this chapter is presented as an overview of peacetime health services within the Military Health Services System. The intent is not to provide an exhaustive listing of all existing cooperative efforts.

The discussion is divided into the categories of:

- Health Services Delivery
- Self-Generated Cooperative Actions
- Externally-Directed Cooperative Actions
- Selected Joint Medical Organizations

DELIVERY OF HEALTH SERVICES

Basic guidance for cooperation and sharing among the three Military Medical Departments is found in Department of Defense (DoD) Directive 6015.5, Joint Use of Military Health and Medical Facilities and Services dated February 5, 1981. Policy direction calls for the Department of Defense to plan for and practice joint use of military health and medical services to attain the most efficient and economical operation of the Military Departments. This Directive also provides the guidance that optimum joint use shall be made of dental facilities and services, medical laboratory services and preventive medicine and veterinary services.

Primary Health Care

As of September 1984, the military direct care system for hospitalization consisted of 19,044 operating beds--of which 8,160 were in Army facilities, 4,846 in Navy facilities and 6,038 Air Force facilities.[1] The military medical treatment facilities provide care for active duty military personnel regardless

of Service; and on a space available basis for dependents of active duty personnel, retirees and their dependents and survivors of deceased sponsors. Additionally, non-active duty personnel are eligible for medical care through a parallel system, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The CHAMPUS system is managed by a field office (OCHAMPUS) of the Assistant Secretary of Defense (Health Affairs). If a military treatment facility cannot provide the needed care (or if the patient prefers civilian medical care for ambulatory services), non-active duty patients may use civilian providers and CHAMPUS pays for the care on a cost-sharing basis.[2]

Current inpatient and outpatient workload statistics reveal that the Military Medical Departments are providing medical care to all categories of beneficiaries regardless of the Service affiliation of the patient. Table 3.1 shows the number of beds occupied on a daily basis in military facilities to be 15,267 during the calendar quarter ending September 1984. Approximately 7,000 of those beds were occupied in Army facilities. Over 27 percent of the Army facility beds were occupied by patients not affiliated with the Army. Percentages for Navy and Air Force facilities are also shown.

Table 3.2 shows the number of hospital admissions in military medical facilities worldwide to be 245,733 during the calendar quarter ending in September 1984. Over 23 percent of the admissions during this period in Air Force facilities were for eligible beneficiaries not affiliated with the Air Force. Rates of admission at Army and Navy medical facilities are also shown.

Table 3.3 shows the number of outpatient visits at military medical facilities to be 12,062,611 during the calendar quarter ending in September 1984. Over 34 percent of these outpatient visits in Army medical facilities were by eligible beneficiaries other than active duty Army or dependents of active duty Army personnel. Rates of outpatient visits at Navy and Air Force facilities are also shown.[3]

Table 3.1

BEDS OCCUPIED (DAILY AVERAGE) - QUARTER ENDING SEP 84

	Army Facilities	Navy Facilities	Air Force Facilities
Total Beds Occupied (Daily)	6,987	3,723	4,557
Affiliated Patients	5,033	3,028	3,320
Non-Affiliated Patients	1,954	695	1,237
% Non-Affiliated Patients	27.9	18.6	27.1

NOTE: Affiliated means that patients are either Active, Retired or Dependents of sponsors of the same Military Service as the Service operating the treatment facility. Navy figures include Marine Corps affiliated patients.

Source: Office of the Secretary of Defense, Washington Headquarters Services, Selected Medical Care Statistics, Quarter Ending September 30, 1984, Directorate for Information Operations and Reports (DIOR), The Pentagon, Washington, D. C., p. 1.

Table 3.2

HOSPITAL ADMISSIONS WORLDWIDE FOR QUARTER ENDING SEP 84

	Army Facilities	Navy Facilities	Air Force Facilities
Total Admissions	104,825	61,418	79,495
Affiliated Patients	78,560	50,658	61,046
Non-Affiliated Patients	26,265	10,760	18,449
% Non-Affiliated Patients	25	17.5	23.2

Source: Office of the Secretary of Defense, Washington Headquarters Services, Selected Medical Care Statistics, Quarter Ending September 30, 1984, Directorate for Information Operations and Reports (DIOR), The Pentagon, Washington, D. C., p. 4.

Table 3.3

OUTPATIENT VISITS WORLDWIDE FOR QUARTER ENDING SEP 84

	Army Facilities	Navy Facilities	Air Force Facilities
Total Outpatient Visits	5,041,966	3,228,521	3,792,124
Affiliated Active Duty and Active Duty Dependent Visits	3,300,926	2,256,983	2,439,815
All Other Category Visits	1,741,040	971,538	1,352,309
% Other Than Active Duty Affiliated	34.6	30	35.6

NOTE: In this table affiliated includes only Outpatient visits by active duty personnel and their dependents of the same Military Service as the Service operating the treatment facility. Navy figures include Marine Corps patients.

Source: Office of the Secretary of Defense, Washington Headquarters Services, Selected Medical Care Statistics, Quarter Ending September 30, 1984, Directorate for Information Operations and Reports (DIOR), The Pentagon, Washington, D. C., p. 7.

Veterinary Services

Another major area of cooperative effort includes the delivery of veterinary services. As specified in DoD Directive 6015.5, the Army's veterinary services are used by all the Military Services. As the executive agent for DoD veterinary services, the Army provides:

- control of diseases common to man and animals
- veterinary care for government-owned animals
- provision of military veterinarians for research and development when required
- subsistence inspection

The Air Force's cessation of veterinary services was a relatively recent occurrence. Over the period October 1979 through September 1983 the Army absorbed the Air Force veterinary mission. Navy requirements for veterinary services are also exclusively met by the Army. As Air Force food inspection and animal care missions were transferred, personnel authorizations were also shifted from the Air Force to the Army. However, in the animal care mission area, only 85 authorizations were transferred to the Army even though records indicated over 200 man years were being expended annually by the Air Force on that mission.[4]

Medical Logistical Support

In the area of medical logistical support, one important cooperative effort occurs in optical fabrication. In 1978, the Army, Navy and Air Force Surgeons General signed an agreement which defined the optical fabrication service to be rendered. Army and Navy optical laboratories were required to provide eyewear fabrication service to all military medical treatment facilities within their assigned geographical support area.[5] In the Continental United States (CONUS), for example, the Army basically has responsibility for optical fabrication west of the Mississippi River and the Navy for fabrication required east of the

Mississippi River. The two optical fabrication systems, Army and Navy, appear to be completely separate operations which have divided up geographic responsibilities.

Another logistical area of cooperation occurs in the acquisition of medical supplies. The Defense Personnel Support Center (DPSC), an element of the Defense Logistics Agency, buys and manages food, clothing and medical supplies for the armed forces. The Military Medical Departments determine their own requirements, establish their own priorities and attempt to purchase as many items as possible through DPSC. This integrated supply system takes advantage of efficiencies such as bulk purchasing and standardization. Each Military Department has organized a medical element under its Surgeon General to provide user-interest input at the wholesale level to the Defense Logistics Agency. The user-interest organizations are the US Army Medical Materiel Agency and the Air Force Medical Logistics Office located at Fort Detrick, Maryland; and the Naval Medical Materiel Support Command located in Philadelphia, Pennsylvania. The joint location of Army and Air Force elements at Fort Detrick facilitates cooperation and information sharing. Indications are that the Navy plans to relocate its medical logistical element to Fort Detrick.[6]

Another notable logistical cooperative effort is occurring in the attempt to develop and field an automated information system to support health service logistics operations in military medical treatment facilities. The automated system is known as the Composite Health Care System-Logistics (CHCS-LOG). Functional direction and development priorities are provided by the Tri-Service Medical Logistics (TRILOG) Development Group comprised of senior medical logisticians of the Military Departments. Policy guidance and operational direction for the system development is provided by the Tri-Service Medical Information Systems (TRIMIS) Program Office which will be discussed later in this chapter.

The last logistical cooperative effort described here is the consideration of a new program for centralized/consolidated medical equipment acquisition. The present procurement system requires wholesale-level authorization for procurement of medical equipment costing $3000 or more. While some of this equipment is obtained through centralized procurement, most is purchased in a decentralized fashion by the local installation purchasing and contracting activities. A recent General Accounting Office (GAO) report cites the potential for significant savings (conservatively 10-15 percent) from increased consolidation and centralization of medical equipment procurement. Savings potential seems quite significant considering the Department of Defense's 1985 request for approximately $200 million for medical support equipment.[7]

Patient Evacuation

The Patient Evacuation System is a cooperative effort among the three Military Medical Departments which consists of medical regulating and patient movement. Medical regulating, the directing of patients to be evacuated to selected medical facilities, is the responsibility of the Armed Services Medical Regulating Office (ASMRO) while patient movement over long distances is accomplished by the Air Force's Military Airlift Command Aeromedical Evacuation System. ASMRO, located at Scott Air Force Base, Illinois, is a joint agency of the Department of Defense under the operational control of the Joint Chiefs of Staff (JCS).

It is DoD policy that, in both peace and war, the movement of military patients will be accomplished by airlift whenever available and conditions suitable. The mission of the air evacuation system is to train in peacetime to provide safe, efficient and effective patient evacuation in wartime. As a by-product of this training, the capability to airlift patients in peacetime is generated.

The ASMRO mission includes regulating patients from overseas to CONUS as well as within CONUS. Regulating patients within an overseas area (for example, intra-Europe) is not the responsibility of ASMRO but is the assigned mission of the military Unified Commander who has a Joint Medical Regulating Office (JMRO) to discharge the responsibility. Another potential peacetime mission for ASMRO is support of the National Disaster Medical System (NDMS) which could be activated in the event of a natural disaster. Under the NDMS concept, civilian or military patients could be transported by civilian and military resources from the disaster site to participating civilian or military medical facilities.[8]

Medical regulating statistics for 1984 illustrate the joint nature of the operation. Table 3.4 shows that of some 50,000 patients regulated, 49 percent or 24,284 were active duty members. The table also shows the Service affiliation of military patients. Table 3.5 indicates that 51 percent of the patients regulated were other than active duty military personnel. The table also shows the Service affiliation of these patients.[9]

DoD policy states that, in general, patients shall be evacuated to the closest DoD medical treatment facility having the capability of providing care. Medical regulating output for 1984 resulted in 24 percent of the patients being regulated to the closest Uniformed Services facility having the required capability; 7 percent were regulated based on physician preference; 51 percent sent to the hospital nearest the patient's place of residence or duty station; and 18 percent were regulated to other hospitals for teaching case purposes, follow-up care, or humanitarian and administrative reasons.[10]

Dental Laboratories

Dental clinics operated by the Army, Navy and Air Force normally have dental laboratories located within each clinic. However, for the more specialized and technically sensitive items, area dental laboratories are organized. To realize economies of scale, some of the more expensive equipment is located in

Table 3.4

PATIENTS REGULATED - 1984
(ACTIVE DUTY ONLY)

	To Army Facility	To Navy Facility	To Air Force Facility	To Other Facility	TOTAL
Army Patients	5,475	390	700	300	6,865
Navy Patients	403	7,018	554	359	8,334
Air Force Patients	1,244	256	7,313	123	8,936
Other Patients	15	62	55	17	149
				GRAND TOTAL	24,284

Source: Information Paper on Patient Evacuation, 13 Mar 85, Armed Services Medical Regulating Office, Scott Air Force Base, IL., Enclosure 4.

Table 3.5

PATIENTS REGULATED - 1984
(ALL OTHER PATIENTS)

	To Army Facility	To Navy Facility	To Air Force Facility	To Other Facility	TOTAL
Army Affiliated Patients	8,228	339	2,091	149	10,807
Navy Affiliated Patients	979	1,085	1,219	156	3,439
Air Force Affiliated Patients	2,863	402	7,790	157	11,032
Other Patients	201	71	107	149	528
				GRAND TOTAL	25,806

Source: Information Paper on Patient Evacuation, 13 Mar 85, Armed Services Medical Regulating Office, Scott Air Force Base, IL., Enclosure 5.

the area dental laboratories to provide dental fabrication services for the smaller laboratories of the dental clinics. Quality control and consultant services are also provided by the area dental laboratories. A variety of sharing arrangements exist among the Military Departments. For example, Army area dental laboratories provide services for military forces in the Alaska region while the Air Force provides area dental laboratory coverage for the Far East. Also, since the Army does not have an area dental laboratory in Europe, it sends some laboratory work to the Air Force's European dental laboratory. The remainder of the Army's European dental laboratory requirements are sent back to one of the four Army area dental laboratories in the United States.[11]

Medical Laboratories

Medical laboratories of the Military Departments will accept referral work from medical treatment facilities of the various Services. However, the most organized cooperative effort occurs in the Drug Testing Program. The Air Force provides urinalysis testing for Air Force and Army requirements generated in the south and central U.S. The Army then accomplishes urinalysis testing for Air Force and Army requirements generated in the remainder of the Continental United States. Additionally, Army medical laboratories in Hawaii and Europe conduct urinalysis testing under the Drug Testing program for both the Air Force and Army.[12]

SELF-GENERATED COOPERATIVE ACTIONS

Local Level

At the local level, cooperative or sharing efforts between military medical facilities occur on a daily basis based on the needs of the facilities and the capabilities and willingness of their neighbors. Many efforts are covered under "gentlemen's agreements" and not formally documented by interservice support agreements. These local efforts are self-generated by the medical facilities and not due to imposition of any directive by higher authority.

Policy Making Level

At the policy making level, cooperation is also occurring. In a June 1984 interview published in Medical Bulletin of the US Army Europe, then Army Surgeon General, LTG Bernhard T. Mittemeyer, stated that Quad-Service communication and cooperation had increased in the area of medical services support in the past two to three years. He also stated that the three military Surgeons General meet on a regular basis to ensure that Tri-Service cooperation receives its deserved high priority.

There is no doubt that staff members at the Offices of the Surgeons General are sharing information and cooperating. Interviews indicated that staffers are thinking and acting with "jointness" in mind. Many problems, solutions, proposed policies and regulations are being discussed in an informal manner among the Medical Services prior to final action or submission to outside agencies.

EXTERNALLY-DIRECTED COOPERATIVE ACTIONS

Many cooperative efforts occurring within the Military Health Services System are in response to external direction. In this section, Military Medical Department cooperation in several externally-directed activities in the peacetime health services will be examined.

Defense Health Council

As stated earlier, each military Surgeon General is a member of the DoD Health Council in accordance with DoD Directive 5136.8. In the area of peacetime health services, the council provides advice to the Assistant Secretary of Defense (Health Affairs) on ways to improve delivery of health care; seeks to develop and maintain health objectives and tasks to increase the productivity, efficiency and economy of the Armed Forces health care system without unnecessary duplication of resources; and, seeks to enhance recruiting, retention and training and use of health care professionals. Also, a sub-council, the Dental

Chiefs Council (DCC), provides a forum for consultation, discussion, and advice on DoD health plans, policies and issues and for facilitation of coordination among the Dental Corps of the Military Departments.

Defense Medical Resources Advisory Board

The Assistant Secretary of Defense (Health Affairs), by memorandum dated 17 October 1984, established this board to serve as the forum for discussion of the major issues facing the Military Health Services System that do not require the attention of the Defense Resources Board, the Deputy Secretary of Defense, or the Secretary of Defense. At the writing of this paper, the board has not yet met. Within this Board, the input and efforts of the Military Medical Departments have the potential to be significant.

Uniformed Services Health Benefits Committee

DoD Directive 6010.3 dated February 13, 1985, established this committee to act as a forum for discussion of policy issues affecting the delivery of health care benefits in the Uniformed Services health care system and as an advisory body to the Assistant Secretary of Defense (Health Affairs). The Uniformed Services are required to provide appropriate members to this committee. This committee is also required to consider issues concerning the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). In addition to the Uniformed Services, others represented on the committee are: the Offices of the Assistant Secretaries of Defense (Manpower and Reserve Affairs); National Oceanic and Atmospheric Administration; Veterans Administration; and the Director, Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS). The committee is chaired out of the Office of the Assistant Secretary of Defense (Health Affairs).

DoD Medical Standardization Board (DMSB)

This board established by DoD Directive dated June 21, 1984, was previously discussed in Chapter Two. Although the direction of this board is primarily

toward medical readiness, standardization of medical materiel used in the operation of the total health care system is DoD policy.[13] The chair of this committee is rotated every two years among the Military Services. Since the Assistant Secretary of Defense (Health Affairs) may assign additional duties and responsibilities to the Board, the future impact of the DMSB could be substantial for the peacetime health system. The location of the Board at Fort Detrick in close proximity to the wholesale level logistics managers for the three Military Medical Departments could facilitate close cooperation and a high degree of activity and achievement.

DoD Medical Facilities Acquisition and Maintenance Board

This Department of Defense Board is comprised of a variety of engineering and construction representatives from the DoD level, Departments of the Army, Navy and Air Force and the Veterans Administration. The three Military Medical Departments are also included on this Board. One key responsibility of the Board is to review the Office of Secretary of Defense programming, design, construction and operation and maintenance policies and criteria for military medical facility acquisition and operation. Another key responsibility of this Board is to investigate and develop specific actions leading to improved uniformity in military medical facility programming, design, construction and operations and maintenance activities. The chair of this Board is rotated equally among the Services for one year terms.[14]

Health Facility Planning Review Committee (HFPRC)

Authorized by DoD Instruction Number 6015.17 dated March 17, 1983, this Committee has the mission to review and validate the health facility construction projects proposed for inclusion in each Service's Five Year Military Construction Program. This committee meets at least once per year and is chaired by the Principal Deputy Assistant Secretary of Defense (Health Affairs). Included on this Committee are representatives of ASD (HA); Assistant Secretary

of Defense (Manpower, Reserve Affairs and Logistics); Assistant Secretary of Defense (Comptroller); Office of Management and Budget and the Surgeons General of the Military Departments.

Veterans Administration/DoD Health Resources Sharing

Through the enactment of Public Law 97-174, the Veterans Administration and DoD Health Resources Sharing and Emergency Operations Act, procedures for sharing health resources have been simplified. Military hospitals have been encouraged to develop sharing agreements with local Veterans Administration hospitals and to negotiate the lowest possible rates for services rendered or received. Many hospitals have enthusiastically supported this relatively new initiative as evidenced by the current scorecard as of April 1985 which shows 138 VA-DoD sharing agreements in operation at 82 sites and 8 new agreements in progress. An example of the potential value of these agreements is the recent mega-agreement between the Augusta Veterans Administration Medical Center and the Army's Eisenhower Army Medical Center. This agreement calls for significant sharing in cardiology, radiology and laboratory services. Total amount of sharing between these two Georgia facilities is estimated at $500,000 annually. Additionally, without the comprehensive agreement, the cost to the US Government could well be another $250,000 for the same services if the facilities were required to procure them on the civilian economy.[15]

A spinoff from PL 97-174 is that most military hospitals are completely relooking the various alternatives in provision of patient care. Using in-house services, using interservice support agreements and developing innovative sharing agreements with the Veterans Administration have all become potential weapons in the military hospital commander's arsenal to provide a wide spectrum of health services at the lowest possible cost.

DoD Regionalization

The Armed Forces Regional Health Services System was implemented by the Department of Defense in the Continental United States in 1973[16] and overseas in 1975.[17] Presently, sixteen DoD regions are organized worldwide, consisting of all the military health facilities in each region. A senior medical center commander chairs a Regional Review Committee (RRC) within each region. The RRC's meet on a periodic basis to consider matters of mutual interest and opportunities for cooperative improvement of health care delivery.[18] Also, the RRC is required to conduct a Tri-Service review of each request for medical equipment in its region which has a unit or system cost of $400,000 or more.[19] The RRC recommends concurrence or nonconcurrence on the medical equipment request based on assessment of the total need for the item within the region. The final approval authority for items of equipment of $400,000 or more lies with the Defense Health Council.[20]

Reports of regional meetings are forwarded from the region to the Office of the Assistant Secretary of Defense (Health Affairs) and the military Surgeons General. Attached in Appendix 8 and Appendix 9 are representative quarterly reports from the Japan Military Medical Region and Military Medical Region Eight. Perusal of these sample regional reports indicates that a great deal of voluntary cooperation and sharing is occurring.

However, there does not appear to be any formal feedback mechanism from the Office of the Assistant Secretary of Defense (Health Affairs) to indicate any appreciable monitorship, oversight or central direction. Rather, the degree of regional cooperation seems to be a function of the innovativeness and personalities of the medical commanders within the regions. Interestingly, a DoD Directive on Regionalization has never been published, even though several staffing attempts have been made.

Tri-Service Medical Information Systems (TRIMIS)

TRIMIS is the Department of Defense program for medical automation in the three Medical Departments. The Assistant Secretary of Defense (Health Affairs) is responsible for all aspects of the TRIMIS Program. TRIMIS works with the Military Departments through the Offices of TRIMIS-Army, Navy TRIMIS and the Air Force Medical Service Information Systems Division. Established in 1976, the TRIMIS Program mission is to acquire and implement effective medical information systems which meet DoD and Military Department requirements. To satisfy its mission, TRIMIS is developing a fully integrated automation system called the Composite Health Care System. Until the Composite Health Care System is fully implemented, TRIMIS has acquired interim systems for use in high volume work centers of many medical facilities. TRIMIS systems are presently providing some automated support to more than 200 military medical treatment facilities.[21] During May 1984 testimony before the Defense Subcommittee of the House Appropriations Committee, the Assistant Secretary of Defense (Health Affairs) indicated that several alternatives to the Composite Health Care System and also the Small Composite Health Care System are being studied. It appears that while cooperation occurs among the Medical Departments in the attempt to provide input for development of an automated medical data system, the output from TRIMIS still has far to go.

Joint Interservice Resource Study Group (JIRSIG)

Department of Defense Regulation 4000.19R, dated March 28, 1984, provides guidance and prescribes procedures for the Defense Regional Interservice Support (DRIS) Program which is just beginning to impact on the Medical Services of the Army, Navy and Air Force. The DRIS Program is designed to promote interservice, inderdepartmental, and interagency support within the Department of Defense and participating non-DoD agencies and to eliminate duplicate support services without jeopardizing mission accomplishment. The Program establishes Joint

Interservice Resource Study Groups (JIRSIGs) in specific geographical areas worldwide where potential for interservicing exists. Each JIRSIG is charged to review, within a five-year cycle, a myriad of support services provided within its specific geographical area. Health services, one category to be reviewed by the JIRSIGs, includes, but is not limited to, the furnishing of inpatient and outpatient treatment, medical, dental, nursing, veterinary, and other professional services and medical support. The JIRSIG is charged to accomplish two functions as follows:

- ascertain if duplicate functional support services exist between DoD Components
- recommend elimination or consolidation or new or increased interservicing of support services when duplication exists and when such actions may result in a more cost-effective method of providing support under normal or contingency circumstances

On the surface, the goals of the Defense Regional Interservice Support Program appear to have merit. If the studies of health services are conducted in rigorous fashion with an objective view toward the best use of resources, the JIRSIG process could be an opportunity for the Military Medical Departments to effect change when and where needed. Recommendations for revisions of missions and operating procedures which emanate from those currently providing the services may be a practical way to address the competing demands for resources. An example of an innovative study, attached at Appendix 10, is the executive summary of the Kaiserslautern Joint Interservice Resource Study Group Study on Health Services completed in June 1984. The Kaiserslautern study is a detailed review of all health services provided within the military community of Kaiserslautern, Germany. If approved, the study recommendations would result in annual budget savings in excess of $400,000, one time savings of $96,000 and a yearly cost avoidance of $152,000.[22]

SELECTED JOINT MEDICAL ORGANIZATIONS

To further economies of scale, cooperation, and sharing, joint medical organizations and activities have been developed to perform specialized tasks and services for the Department of Defense and the Military Medical Departments. Next is a discussion of selected joint medical organizations and their purposes.

Armed Forces Epidemiological Board

Initially, by authorization of the Secretary of War, on 27 December 1940, and presently through Department of Defense Directive Number 5154.8, the Armed Forces Epidemiological Board was established. This Board is responsible for providing timely scientific and uniquely professional medical advice and recommendations to the Assistant Secretary of Defense (Health Affairs) and the military Surgeons General. Areas of interest include operational programs, policy and research concerning new technological principles in the control of acute and chronic diseases, environmental protection, occupational health, and health maintenance systems for all the Uniformed Military Services. This Board has achieved an extremely effective method of recommending appropriate solutions for a myriad of disease threats and other common problems of the three Military Medical Departments and the Assistant Secretary of Defense (Health Affairs).[23] Executive management responsibility for the Board lies with the Office of The Surgeon General, Department of the Army.

Armed Forces Institute of Pathology (AFIP)

This Institute is a Department of Defense activity chartered to accomplish a three-fold mission of consultation, education and research. The Institute serves both governmental and civilian organizations throughout the world. The operating staff includes representation from of the three Military Medical Departments, the Veterans Administration, civil service employees and a number of civilians hired with funds provided by civilian research grants. The

professional staff studies the etiology and nature of disease and injury, ranging from the age-old problems of leprosy and malaria to the more recent concerns of cancer, trauma, drug toxicity and aerospace pathology.

The Institute is organized into six major elements including the Center for Advanced Pathology, the Center for Advanced Medical Education, the Center for Records and Information Management, the Center for Medical Illustration, the Administrative Support Services, and the Armed Forces Medical Museum. Particularly important to peacetime health services is the definitive consultation provided in the diagnosis of disease. The Center for Advanced Pathology includes such specialized areas as forensic, radiologic, dental and veterinary pathology. It also includes the histopathology laboratories which process all tissue sent to AFIP for consultation. Additionally, the Center for Advanced Medical Education conducts an educational program attended by nearly 3,000 professionals annually.[24] The Director of the Institute is a medical officer of the Army, Navy or Air Force who serves on a rotating basis normally every four years. As Management Agent, the Army is responsible for the determination and provision of adequate administrative support for the operation of AFIP.

Armed Forces Pest Management Board

In 1956, the medical entomology programs within the three Military Medical Services were reorganized into a single Department of Defense Organizational Board. That initial Tri-Service organization, which served only as a coordinating and advisory body, has evolved into the Armed Services Pest Management Board. Today, the Board's missions include the development of pest management policy for DoD, service as a scientific/research body, coordination for DoD professional pest management activities and the operation of the Defense Pest Management Information Analysis Center (DPMIAC). The Board is composed of members appointed from the Army, Navy, Air Force, and selected DoD agencies, with liaison representatives outside DoD having a mutual interest in pest management.

The DPMIAC uses computers to store, retrieve and disseminate detailed information on every aspect of preventing and controlling vector-borne diseases throughout the world. An ongoing project of the DMPIAC is the development of Disease Vector Ecology Profiles which are publications describing vector-borne disease threat for countries where US forces are most likely to become involved. The overarching purpose of the Board is to minimize the adverse effects of orthopods and rodents on DoD personnel and property to protect the health of the soldier and the welfare of the environment.[25]

Armed Forces Radiobiology Research Institute (AFRRI)

This Institute was established in 1961 as a subordinate command of the Defense Nuclear Agency. Currently operating within the guidance of DoD Directive 5105.33 dated November 17, 1981, the Armed Forces Radiobiology Research Institute conducts a major portion of the Western world's military radiobiology research. AFRRI is particularly concerned with examining the effects of ionizing radiation on military personnel. For example, in the event of a nuclear detonation, scientists would use the information provided by AFRRI to treat nuclear casualties. The military Surgeons General act as members of AFRRI's Board of Governors to provide oversight and identify research requirements. The Institute also conducts the Medical Effects of Nuclear Weapons education program to disseminate the latest available information on the medical aspects of nuclear warfare.

SUMMARY

This chapter has described and discussed cooperation concerning the delivery of health services, self-generated and externally-directed cooperative efforts, and selected joint medical organizations. The intent was to provide a snapshot of peacetime health services from the viewpoint of cooperation within the Military Health Services System.

The following chapter deals with the issue of quality assurance which has impact and influence on both medical readiness and peacetime health services.

ENDNOTES

1. US Department of Defense, DoD Selected Medical Care Statistics, Quarter Ending September 30, 1984, p. 1.

2. The Rand Corporation, Health Care in the Military, p. 2.

3. US Department of Defense, DoD Selected Medical Care Statistics, Quarter Ending September 30, 1984, pp. 1-7.

4. Telephonic discussion with Colonel Via, Office of the Chief, Veterinary Corps, Office of the Surgeon General, Department of the Army, 29 March 1985.

5. US Army, Navy, Air Force Ophthalmic Fabrication Service Agreement, 1968, p. 3.

6. Telephonic discussion with Colonel Holland, US Army Medical Material Agency, 29 March 1985.

7. US Department of Defense, Memorandum from Acting Principal Deputy Assistant Secretary, Office of Assistant Secretary of Defense (Health Affairs), Congressional Reporting Requirement--Centralized Medical Equipment Procurement, 20 February 1985.

8. US Armed Services Medical Regulating Office, Information Paper: Patient Evacuation, 13 March 1985, p. 2.

9. Ibid., Encl. 4.

10. Ibid., Encl. 5.

11. Telephonic discussion with Lieutenant Colonel Woods, Office of the Chief, Dental Corps, Office of the Surgeon General, Department of the Army, 3 April 1985.

12. Telephonic discussion with Colonel J. E. Spiker, Jr., Laboratory Sciences Consultant, Office of the Surgeon General, Department of the Army, 2 April 1985.

13. US Department of Defense, Directive 6430.2: DoD Medical Standardization Board, p. 1.

14. In person discussion with Colonel J. L. Peacock, Commander, US Army Health Facilities Planning Agency, 3 January 1985.

15. US Department of Defense (Health Affairs), VA/DoD Sharing Report, Number 4, April 1985, p. 2.

16. US Department of Defense, Memorandum from Deputy Secretary of Defense: Regionalization of Peacetime Health Services Support, 5 September 1973.

17. US Department of Defense, Memorandum from Deputy Secretary of Defense: Regionalization of Peacetime Health Care Support Overseas, 18 October 1974.

18. Delphic Concepts, Inc., Report for the Secretary of Defense On the Feasibility and Benefits to Be Gained From Creating the Defense Health Agency, 26 August 1983, p. H-1.

19. In person discussion with Colonel M. Vigneault, Chief, Logistics Division, Office of the Surgeon General, Department of the Army, 3 January 1985.

20. US Department of the Army, Army Regulation 40-65, para. 4-f.

21. US Department of Defense, TRIMIS Program, FACT SHEET: What is TRIMIS? undated.

22. James R. Lumpkin, Headquarters, United States European Command, Letter: Kaiserslautern Joint Interservice Resource Study Group (JIRSIG) Study on Health Services, 14 December 1984.

23. US Department of the Army, Information Paper: Armed Forces Epidemiological Board, Office of the Surgeon General, 11 December 1984.

24. US Department of the Army, Information Paper: Armed Forces Institute of Pathology, undated.

25. US Department of Defense, Information Paper: Armed Forces Pest Management Board, undated.

CHAPTER IV

QUALITY ASSURANCE

BACKGROUND

Quality assurance is the term used to describe all the efforts that contribute in a direct manner to quality patient care. At some levels, it is called the quality assurance program (QAP). The QAP consists of establishing standards; formulating policies and procedures; monitoring care, facilities, equipment, and providers; and insuring adequacy of education and training. The QAP has different focuses at the various levels of the system. For example, the QAP at the Assistant Secretary of Defense (Health Affairs) [ASD(HA)] and at the Services' Surgeons General levels is focused on establishing policy, whereas at the hospital or clinic level, the emphasis is more on the monitoring of care and providers. However, the predominant concern at all levels is to detect and resolve problems associated with patient care.

The concept of quality assurance has for a long time been emphasized. It would be unfair to think that it was invented in this generation. At the most basic level, the physician asking a patient to return to monitor the progress of treatment is quality assurance. The physician and patient are agreeing to meet and check on the efficacy of therapy. The modern era of quality assurance began in the first quarter of the 20th century when the American College of Surgeons started surveying hospital and surgical care. The program evolved into the present day organization known as the Joint Commission on Accreditation of Hospitals (JCAH). The JCAH has developed into a powerful accrediting body since it has recognition of the US Congress. No hospital can collect federal funds, i.e., medicare, medicaid, for health care unless the hospital has been accredited by JCAH.

Since the DoD health system is a congressionally funded endeavor, the DoD treatment facilities particularly in CONUS are expected to undergo and successfully comply with JCAH standards. The military health service industry has also been impacted by the malpractice crisis. In order to defend against suits, a practitioner or hospital must have documented well the type and caliber of care that was rendered.

In the Military Health Services System, the QAP was given increased emphasis beginning in 1981 when the first and many subsequent cases of therapeutic mis dventures were brought to public attention. Dozens of tragic cases of malpractice and poor treatment outcomes have been aired on television, in the major magazines, and in the newspapers. This attention and the desire to improve care has led to the formation of Quality Assurance Offices at every level of the system.

It is the opinion of the authors that the QAP of the Military Health Service System is being benefited by sharing among the Services. The current sharing efforts will be discussed and opportunities for future sharing will be explored. The current efforts will be addressed from an organizational standpoint, that is, at what level the coordination is taking place. The efforts are divided into four levels: Department of Defense level, Service level, Major Command level and hospital/clinic level. The Department of Defense level refers to that sharing and cooperation occurring as a result of participation by personnel from ASD (HA) and the Military Departments. The Service level refers to these actions that occur among or between the Services without participation from DoD. The Major Command level will discuss any lateral coordination or sharing at this level and similarly for the hospital/clinic level. Regionalization is noted, but is discussed in more detail in Chapter III.

DEPARTMENT OF DEFENSE LEVEL

At the top level of management and leadership, as previously shown in Fig. 1.5, there is a significant amount of sharing and cooperation taking place in the area of quality assurance. A recent statement by the Secretary of Defense indicates quality assurance as the top priority of the Military Health Services System.[1] The ASD (HA), Dr. William E. Mayer, has stated that quality assurance is among his top priorities.[2] Lt. General Max B. Bralliar, the Surgeon General of the Air Force gives strong support and states, "We have several indicators which show a positive trend in our quality assurance efforts.[3] Vice Admiral Lewis H. Seaton, Director of Naval Medicine and the Navy Surgeon General, espouses a strong commitment to quality assurance.[4] LTG Bernhard T. Mittemeyer, then The Surgeon General of the Army, states "Medical quality assurance programs continue to receive the highest priority within the Army Medical Department (AMEDD).[5] During late 1983 and 1984, ASD (HA) and the three Services Medical Departments established quality assurance offices and formed a Tri-Service Committee on quality assurance, so there is a shared feeling at the top leadership level that quality assurance is of the utmost importance. There is a strong commitment to provide all soldiers, sailors, marines, airmen, retirees and their families with the best possible health care.

The Tri-service committee on quality assurance which was formed in 1984 is a coordinating body which seeks to develop sound policy for the TSG's and ASD (HA). The committee's early work concerned the policies and procedures for the credentialing of health care providers and the supervision of non-physician providers. The Tri-service committee on quality assurance has been a big step forward in joint efforts on quality assurance. LTC Nancy R. Adams, an Army nurse presently assigned to OASD (HA), states "the Tri-service committee on quality assurance has been a great asset in the deliberation of quality assurance related matters at the top level."[6] For a more indepth view of the Tri-service

committee agenda, see Appendix 11 for a copy of the minutes of meetings held on 26 July 1984 and 18 October 1984. CAPT. John Babka, Navy SG/QA, and Col. Frank Zimmerman, AFSG/QA, are convinced the Tri-service committee on quality assurance provides an excellent mechanism for the coordination of quality assurance matters.[7, 8]

SERVICE LEVEL

At the Service level, there is coordination between the personnel officers that assign physicians. This has assisted the Services in filling critical shortages and providing compassionate assignments for specific physicians. At present, the Air Force is providing a neurosurgeon to the Army in exchange for a cardiologist. Even though both Services are short of neurosurgeons, the Army is more so than the Air Force. COL Ronald Blanck, Chief of Army Medical Corps Career Activities, states "the Services will take advantage of cross-service assignments wherever it is mutually beneficial."[9] This is not practical in many cases because all Services are short in the same specialties, which are most of the surgical specialties. However, as indicated above, should one Service be extremely understrength in a specialty, and another Service not so much so, there is a mechanism for sharing.

Physician graduate medical education (GME) is another area receiving considerable joint coordinating efforts. COL Jim Hasting, Chief of GME for the Army Surgeon General's Office, indicates that he is in contact on a weekly basis with his counterparts at the Navy SGO and the AFSGO.[10] COL Hasting believes that physician GME is fertile ground for sharing since the proper mix of specialists is essential for the optimum delivery of health services. Each Service has a different requirement for specialists and also possesses different training base capacity. On the whole, the Army trains 85 percent of its specialists, the Air Force trains about 50 percent and the Navy trains 60 to 70 percent. The percent of requirement trained also varies by specialty. In one

specialty, Otorhinolaryngology, the Army has more training base than necessary and the other two Services do not have enough, so the Army has agreed to train an Air Force physician in this specialty. It is possible that there will be other opportunities in the future for sharing, so one Service or another will not have to close down training slots or a program, but can instead take in residents from the other Services.

The three Services have also coordinated very closely on the neurosurgeon requirement. None of the Services have adequate training capacity. The Air Force has developed an excellent "out of house" capability and has agreed to share information and resources with the other two Services. To facilitate this sharing in the GME arena, the program manager from each Service attends the other Services' resident selection conferences in order to stay current.

Another excellent example of sharing is the Uniformed Services University of the Health Sciences. This institution is responsible for the education of a portion of the future Medical Corps officers for the Military Health Services System. It is staffed by physician specialists from the Army, Air Force, Navy, and the civilian medical community. This school provides an excellent source of physicians who incur long obligations and who are given intense military training thereby instilling a strong identification with the military. These graduates, having been trained in the joint setting, should have a stronger inclination for sharing and cooperating with the other Services than present-day Medical Corps officers. Although these graduates will provide only a small percentage of the DoD requirements for physicians, they will provide a nucleus of officers with early joint experience and should serve well the need for better synchronization of the total Military Health Services System.

In the area of enlisted and other officer training, the driving force behind sharing, is the Interservice Training Review Organization (ITRO) and the

Health Care Committee portion of ITRO.[11] The Health Care Committee is permanently chaired by the Navy. The incumbent traditionally has been the commanding officer of the Naval Health Services Education and Training Command at Bethesda, Maryland. Committee representation is tri-service, consisting of members representing the Medical Departments education and training committees. Meeting as required, usually triannually, the committee conducts its comprehensive review utilizing a three year cycle. Officer and enlisted programs are scheduled for review by occupational subgroup classifications using the DoD Occupational Conversion Manual.

In general, the Health Care Committee determines if a particular area of training can be consolidated or collocated cost-effectively based on program and facility analysis, feasibility studies, and preliminary plan developments leading to detailed study and final plan formulation. Committee reports are reviewed and acted upon by the three Surgeons General, thus offering a unified Military Medical Department position. Next, there follows review and action by the ITRO Steering Committee and Board concurrently with each Service's implementation of study findings by tasking instructions to its respective training command.

The functions of the Health Care Committee are carried out by four subcommittees composed of personnel from the Army, Navy and Air Force in the medical, dental, nursing and veterinary areas. The Health Care Committee utilizes an internal cost and manpower team to complete its studies. Results are further certified by the ITRO Cost Analysis and Manpower Analysis Subcommittees.

Discussion with COL Harry Clark, Lt. Col. Susan Okanski and Capt. Jerry McClellan of the Army, Air Force and Navy Surgeons General Offices respectively reveals a marked enthusiasm for the level of shared training that is occurring as a result of the ITRO process.[12, 13, 14] See Appendix 12 for more detailed information concerning the types of enlisted and officer training that is being jointly conducted by the Army and Navy. At present, the Air Force is not

training any personnel for the other Services. Also shown in the Appendix is number of personnel being trained by the Army in FY 85.

As indicated in Appendix 12, the Army has assumed a significant joint training responsibility as a result of the ITRO process. Initial training of enlisted medical support personnel for the Army occurs almost exclusively at the Academy of Health Sciences (AHS) at Ft. Sam Houston, Texas. In FY 84, approximately 10 percent of the AHS student load was comprised of students from the Air Force, Navy, Coast Guard and Marines. These enlisted servicemembers receive training primarily in the low density military occupational specialties (MOS). The Combat Casualty Care Course accounted for the vast majority of non-Army officer trainees. Together, these 2700 non-Army students fit in well with their Army counterparts and reported an excellent training experience. For FY 85, the number of student spaces reserved for other Services will increase to 2800.

The presence of multi-service students has been matched by multi-service instructors. Presently, the AHS includes 46 Navy and 36 Air Force instructors. The quality of these instructors is high and assignment to these positions is actively sought. Several of the branch chiefs come from other Services. All instructors input and review curriculum materials and format so that a broad perspective is obtained. The curriculum committee is tri-service. Oftentimes Navy and Air Force instructors are subject matter experts because of their specialized medical knowledge. The other Services send delegations to evaluate training and the student product of the courses. They have been so pleased that additional student positions especially in the Laboratory Specialist Course have been requested. The AHS has difficulty funding and spacing the needs. With the standardization of the worksite, be it operating room or laboratory, it would be feasible to cross-balance shortages with servicemembers from other Services. The administrative obstacles are more significant than the technical ones. Such cross-balancing would require JCS/DoD support.

.he higher density MOS training is exclusively single Service. There are two commonly accepted reasons for this. The Army 91A and 91B30 training programs are relatively new and the other Services are waiting to see the quality of the product produced. Secondly, the Navy corpsman, because of his potential for isolated duty, receives a great deal more cross-training than do the Army or Air Force medic. If the 91A or 91B30 courses live up to expectations, it is conceivable that Air Force and Marine medics would be trained at the AHS.

Only a portion of the critical medical skills are formally taught at the AHS. About 40 percent remain to be taught once the medics reach their units. In addition, the common soldier tasks are taught at the unit, while the AHS teaches a core curriculum which is Service immaterial. The curriculum requires that the receiving unit or Service make a significant contribution in order for the medic-technician to be totally prepared.

The Army is sending cardiopulmonary, dermatologic, electroencephalography and clinical nuclear medicine technicians into Navy facilities for training. Thirty percent of the annual training at the AHS is given to reserve components, which are primarily Army. The AHS staff felt that tri-service act'vities appear to be emphasized more in the active than in the reserve force.

It appears that the Air Force will join in with the Army to provide instructors and students for the physicians assistant program at the AHS.

MAJOR COMMAND LEVEL

At the major command level, interviews were conducted with individuals from the Army and Navy. At the Army's 7th Medical Command in Europe, BG Bill Lefler described the sharing of dental laboratory facilities between the Army and Air Force (see Chapter III).[15] The Executive Officer for Dental Affairs of 7th MEDCOM identified sharing in dental officer continuing education between the

Army and Air Force Dental Care Systems in the European Theater.[16] This program sets forth the sharing of certain programs by allocating spaces, setting times and places of conferences. The Surgical Consultant at 7th MEDCOM relates the sharing of neurosurgical and cardiothoracic surgical support between Army and Air Force.[17] COL Cannady, the Medical Consultant for 7th MEDCOM identified an Army meeting on QA where the Air Force physicians were invited as an example of QA sharing.[18] LTC Edward Haines, the Quality Assurance Consultant for 7th MEDCOM, relates that there is presently no formal QA meetings among the Services and that information is shared by informal exchange. These informal channels serve to bring about sharing of some laboratory and radiological resources as well as continuing health education conferences. LTC Haines further relates that he feels there needs to be more sharing among the QA officers in the European Theater.[19]

Discussion with CDR Paul Daniel of the Naval Medical Command, QA Office, revealed no direct coordination between his office and the other Services.[20] This discussion produced quite a comprehensive understanding of how the Navy is approaching QA and also gave some ideas for the future on sharing, but nothing that appears presently at the MACOM level. Similarly, Major Dohannos at the USA Health Services Command Quality Assurance Office states that there exists little cooperation with the other Services at his level. He indicated that most of the coordination and sharing occurs at a higher level or on a regional basis.[21]

HOSPITAL/CLINIC LEVEL

At the lowest level of the Military Health Services System, that is the hospital and clinic level, there is significant, but inconsistent, sharing as it relates to quality assurance. There was not opportunity to interview representatives from the roughly 160 hospitals and 310 clinics and research facilities located around the world. It is therefore necessary to address this level from

the perspective of the personal experience of the study participants and from the effectiveness of regionalization. Regionalization has been discussed in Chapter III and will not be expanded further here. The author's experience has revealed some excellent examples of sharing between the Services. One concerns the provision of inpatient psychiatric service and outpatient otorhinolaryngology support to Reynolds Army Community Hospital, Ft. Sill, Oklahoma, by the USAF Hospital at Sheppard Air Force Base, Wichita Falls, Texas.[22] There are numerous sharing agreements of this kind between Services; for some examples, see Appendices 8 and 9.

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18. In person discussion with COL Preston Cannady, Medical Consultant, 7th MEDCOM, 21 February 1985.

19. Telephonic conversation with LTC Edward Haines, Quality Assurance Consultant, 7th MEDCOM, 10 March 1985.

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21. In person discussion with MAJ D. W. Dohannos, Health Services Command, QA Office, 3 January 1985.

22. Personal experience of COL Lowman E. Gober, MC, while serving as Deputy Commander at Ft. Sill MEDDAC, June 1980 to June 1981.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

A number of conclusions and recommendations have been reached by the study group. Conclusions and recommendations are presented for each of the following areas:

- Medical Organization
- Medical Readiness
- Peacetime Health Services
- Quality Assurance

MEDICAL ORGANIZATION

Conclusions

1. The MHSS has been examined numerous times during the past four decades. Problems identified have resulted in the evolution toward increasing centralization of authority at the Department of Defense level.

2. Gradual modifications of the MHSS through proliferation of various boards, committees and councils have improved joint efforts but have occurred without benefit of a system-wide analysis of medical functions and programs.

3. The US Military Health Services System cannot easily be compared to allied military health systems due to differing national military strategies. Specifically, worldwide deployment, military size, population supported and separate Military Services are factors which make the US MHSS unique.

Recommendations

1. DoD should direct a system-wide analysis of medical functions, requirements, programs, and resources for both peacetime and wartime. Each Military Medical Department should conduct a separate review following the model of the

Army's Medical System Program Review currently being accomplished by the Academy of Health Sciences. Then a joint review should occur with the goal to optimize cooperative efforts, efficiency and effectiveness in medical readiness, health services, and quality assurance.

2. The US MHSS should reflect US military strategy. Caution must be used when comparing the military medical organization of the United States to those of allied nations.

MEDICAL READINESS

Conclusions

1. Recruiting of medical professional personnel is accomplished by each Military Service in a unique manner. Service recruiting personnel conduct semi-annual recruiting conferences where medical information is shared.

2. The Combat Casualty Care Course, the Combat Developments Branch of the Academy of Health Sciences, Armed Forces Medical Intelligence Center, Armed Services Biomedical Research Evaluation and Management Committee, the Defense Materiel Standardization Board, and the Military Blood Program Office are particularly worthwhile joint efforts in support of medical readiness.

3. Since the European Command Surgeon position is an additional duty for the Senior Medical Officer in the European Theater and due to understaffing of the EUCOM Surgeon's Office, medical planning in Europe has been less than adequate.

4. The European Command Medical Coordinating Committee, chaired by the EUCOM Surgeon, has provided a significant benefit to joint medical planning. However, the Navy has not participated in committee functions to a level commensurate with its commitments in the region.

5. Recent combat operations in Grenada revealed a less-than-optimal level of joint medical planning which resulted in lack of central direction and

authority at the site of the operations. For example, there was no Joint/ Combined Task Force Surgeon appointed. The Services demonstrated a lack of familiarity with the others' medical operations, reports, communications equipment and procedures.

6. The medical logistical support in Europe is primarily an individual Service responsibility.

Recommendations

1. There should be an increase in sharing of recruiting information among the Medical Departments on both a formal and informal basis.

2. There should be increased awareness of the capabilities of the Armed Forces Medical Intelligence Center throughout the Medical Departments. Additionally, the Air Force and Navy should increase their participation in the staffing of AFMIC. One method for increasing awareness would be through presentations by AFMIC at the Services' medical commanders' conferences.

3. The EUCOM Surgeon's position should be a full-time billet occupied by the senior US medical officer in the European Theater. Additionally, the EUCOM Surgeon's Office should be resourced commensurate with its level of responsibility.

4. The joint medical planning occurring in EUCOM should be continued with efforts to extend this model to other unified commands. Greater consideration should be given to exchanging medical planners among the Medical Departments as is being planned in EUCOM.

5. During crisis situations, such as Grenada, existing medical plans should be considered and utilized if appropriate. These plans could be modified by joint planners to insure standardization of medical operations, reports, communications equipment and procedures. Additionally, joint medical training should be increased and include participants from each Military Service.

6. Interservice medical logistical support should be pursued. Specifically, two issues should be evaluated:

- provision of medical supply support to NAVEUR and USAFE by USAREUR in peacetime and wartime
- development of the regional medical materiel support capability where one component would be responsible for supporting the other components in particular geographic areas

PEACETIME HEALTH SERVICES

Conclusions

1. The consolidation of DoD Veterinary Services under the responsibilities of the Army was completed in 1983. Concern over transfer of sufficient personnel authorizations to the Army remains.

2. While the worldwide optical fabrication mission is currently divided between the Army and Navy there appears to be no service-unique requirement for two separate systems.

3. DoD regionalization lacks sufficient emphasis, guidance and oversight from the OASD(HA). Significant achievements have occurred through personal innovation and initiative within the regions.

4. The Tri-Service Medical Information System (TRIMIS), in existence since 1976, has not yet delivered the level of automation support needed throughout the MHSS.

5. The Joint Interservice Resource Study Group (JIRSIG) process offers the potential to assess the most effective and efficient use of medical resources within a geographic area.

Recommendations

1. The ASD(HA) should examine the DoD Veterinary Services to determine whether the manpower authorizations transferred from the Air Force to the Army were sufficient to accomplish the consolidated mission.

2. Consideration should be given to consolidating the Army and Navy optical fabrication systems, using the model provided by the DoD Veterinary Services.

3. ASD(HA) should publish a DoD Directive on regionalization to provide a structure for implementation, oversight, feedback and direction. Consideration should be given to providing some resource authority to the DoD Regional Coordinating Committee (RCC) in addition to high dollar medical equipment review. For example, a RCC certification of need could be required prior to Service approval for initiation of a new service at any medical treatment facility within a region.

4. The ASD(HA) should critically analyze the current status and future utility of the present TRIMIS organization and programs to insure its efficacy.

5. The JIRSIG process should be actively supported and promulgated by the three Surgeons General. Innovative suggestions for sharing resources and consolidation of medical functions should be pursued where appropriate.

QUALITY ASSURANCE

Conclusions

1. The Tri-Service Committee on Quality Assurance is a highly effective medium for the coordination and formulation of common QA matters at the highest levels of the MHSS.

2. There has been notable progress in the standardization of credentialing of health care providers as a result of the Tri-Service Committee on Quality Assurance; however, there exists need for further accomplishments.

3. The Services are sharing information and are coordinating closely in the area of physician graduate medical education for a few specific specialties; however, there needs to be joint functional reviews in all other critical specialties.

4. The Interservice Training Review Organization (ITRO) has provided significant sharing of training resources; however, there still remains a duplication of training effort in some low-density military occupational specialties and no sharing of training in the high-density military medical occupational specialties.

Recommendations

1. The Tri-Service Committee on Quality Assurance should continue identifying the critical elements of quality assurance that require a commonality of policies and procedures.

2. The ASD(HA) and the Military Medical Departments should continue to assess the issues of provider credentialing and granting of privileges in order to establish, wherever practicable, standardized policies and procedures.

3. The study of neurosurgical training capabilities and needs represents an example of cooperation in physician graduate medical education that should be duplicated for each specialty. These functional specialty reviews should determine the MHSS requirement for each specialty, assess the training base capability, and formulate plans for achieving total end strength requirements for each specific specialty.

4. The ITRO process should continue assessment of the total training requirements of the MHSS in order to consolidate all areas of training where there exists no service-unique requirement for separateness.

SUMMARY

Within the last ten years the United States Military, supported by Congress, has made genuine progress toward the synchronization of military health services by establishing and implementing several joint medical programs. This progress has resulted in economies of effort and resources. Even more significant has been the shift in attention and interest toward developing additional joint ventures. This Study Project has identified and reviewed selected aspects of cooperative and joint efforts presently in effect and has noted certain areas that should be considered in the future. Progress in these areas must be driven from the top down, but will require the wholehearted commitment of all. It remains for the senior leaders of the Military Health Services System to act in the common interest and, where practicable, produce additional benefits for those who deserve the very best--the American servicemembers and their families.

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Appendix 1 DOD Directive 5136.1: Assistant Secretary of Defense (Health Affairs)

Department of Defense

DIRECTIVE

October 5, 1984
NUMBER 5136.1

ASD(C)

SUBJECT: Assistant Secretary of Defense (Health Affairs)

References:
(a) DoD Directive 5136.1, "Assistant Secretary of Defense (Health Affairs)," May 31, 1979 (hereby canceled)
(b) Title 10, United States Code, Section 136
(c) Title 10, United States Code, Chapter 133
(d) Title 10, United States Code, Chapter 55
(e) DoD Directive 5105.46, "Civilian Health and Medical Program of the Uniformed Services," December 4, 1974
(f) DoD Directive 5025.1-M, "Department of Defense Directives System," October 16, 1980
(g) DoD Directive 5000.19, "Policies for the Management and Control of Information Requirements," March 12, 1976
(h) DoD Directive 1332.18, "Uniform Interpretation of Laws Relating to Separation from the Military Service by Reason of Physical Disability," September 9, 1968

A. REISSUANCE AND PURPOSE

This Directive:

1. Reissues reference (a).

2. Designates, pursuant to reference (b), one of the positions of Assistant Secretary of Defense as the Assistant Secretary of Defense (Health Affairs) (ASD(HA)).

3. Assigns responsibilities, functions, relationships, and authorities, as prescribed herein, to the ASD(HA) pursuant to the authority vested in the Secretary of Defense under references (b) and (c).

B. DEFINITION

DoD Components. The Office of the Secretary of Defense (OSD); the Military Departments; the Organization of the Joint Chiefs of Staff (OJCS); the Unified and Specified Command; the Office of the Inspector General, Department of Defense; and the Defense Agencies.

C. RESPONSIBILITES

Under reference (b), the ASD(HA) has statutory responsibility for overall supervision of the health affairs of the Department of Defense. The ASD(HA) shall also serve as the principal staff assistant and advisor to the Secretary

of Defense for all DoD health policies, programs, and activities. Subject to the direction of the Secretary of Defense, the ASD(Health Affairs) shall exercise oversight of all DoD health resources. The ASD(Health Affairs) shall:

1. Develop policies, conduct analyses, issue guidance on DoD plans and programs, and advise the Secretary of Defense, as appropriate

2. Develop systems, standards, and procedures for the administration and management of approved DoD plans and programs.

3. Develop plans, programs, actions, and taskings to ensure adherence to DoD health policies and national security objectives and to ensure that programs and systems are designed to accommodate operational requirements.

4. Establish requirements and standards for medical facility and material acquisition programs.

5. Establish requirements for DoD research and development programs in medical fields. Keep abreast of technical developments to provide for their orderly transition to operational status. Make recommendations to the Secretary of Defense on funding levels for DoD research and development programs in medical fields.

6. Serve as program manager for all DoD health and medical resources. Develop the medical portion of the Defense Guidance. In coordination with the Assistant Secretary of Defense (Comptroller), and Director, Program Analysis and Evaluation, review all Program Objective Memoranda and budget submissions, and make determinations regarding priorities and resources for health and medical programs. Provide input to Program Decision Memoranda and Program Budget Decisions to the Director, PA&E and ASD(C) for incorporation into the PPBS process. Monitor the execution of approved health and medical programs by the DoD Components and, subject to the direction of the Secretary of Defense, make such determinations regarding priorities and resources as may be required to achieve DoD-wide program objectives. Serve as a member of the Defense Resources Board.

7. Review, evaluate and make recommendations to the Secretary of Defense on health requirements and priorities.

8. Review and evaluate plans and programs to ensure adherence to approved policies, standards, and resource guidance and decisions.

9. Promote coordination, cooperation, and mutual understanding within the Department of Defense and between the Department of Defense and other federal agencies and the civilian community.

10. Serve on boards, committees, and other groups pertaining to ASD(HA) functional areas.

11. Exercise direction, authority, and control over:

a. The Office of Civilian Health and Medical Program of the Uniformed Services consistent with reference (d) and reference (e).

b. The Tri-Service Medical Information Systems Program Office.

D. FUNCTIONS

The ASD(HA) shall:

1. Carry out the responsibilities described in section C. for the following functional areas.

a. Medical readiness

b. Preventive medicine

c. Health promotion

d. Health benefits programs

e. Drug and alcohol abuse

f. Cost containment

g. Quality assurance

h. Medical information systems

i. Procurement, professional development and retention of medical and dental personnel, and related health care specialists and technicians

j. That portion of medical research and development associated with clinical technology, such as research involving the prevention of infectious diseases and care of combat casualties. That portion associated with increasing the effectiveness and performance of people as integral parts of weapons systems, and with protecting people from hazards of the combat and natural environment, shall be the responsibility of the USD(Research and Engineering).

2. Perform such other functions as may be assigned.

E. RELATIONSHIPS

1. In the performance of assigned duties, the ASD(HA) shall:

a. Coordinate and exchange information with other OSD Officials and heads of DoD Components having collateral or related functions.

b. Consult, as appropriate, with the Assistant Secretary of Defense (Comptroller) and the Director, Program Analysis and Evaluation to insure that medical planning, programming, and budget activities are integrated with the DoD Planning, Programing, and Budgeting System.

c. Use existing facilities and services of the Department of Defense or other federal agencies, whenever practicable, to achieve maximum efficiency and economy.

d. Represent the Secretary of Defense, as an ex officio member, on the Board of Regents of the Uniformed Services University of the Health Sciences.

2. Other OSD officials and heads of DoD Components shall coordinate with the ASD(HA) on all matters concerning the functions cited in section D., above.

F. AUTHORITIES

The ASD(HA) is hereby delegated authority to:

1. Carry out the responsibilities and functions described in sections C. and D.

2. Issue orders and DoD Instructions, consistent with the provisions of reference (f), regarding the accomplishment of functions and responsibilities delegated by the Secretary of Defense in this issuance. Orders and Instructions to the Military Departments shall be issued through the Secretaries of those Departments, or their designees. Orders and Instructions to Unified or Specified Commands shall be issued through the Joint Chiefs of Staff.

3. Obtain reports, information, advice and assistance, consistent with reference (g), as the ASD(HA) deems necessary.

4. Communicate directly with heads of DoD Components. Communications to the Commanders of the Unified and Specified Commands shall be coordinated through the JCS.

5. Make determinations with respect to the uniform implementation of laws relating to separation from the Military Departments by reason of physical disability as prescribed in reference (h).

6. Develop, issue, and maintain regulations, with the coordination of the Military Departments, as necessary and appropriate to fulfill the Secretary of Defense's responsibility to administer reference (d).

7. Establish arrangements for DoD participation in nondefense governmental programs for which the ASD(HA) has been assigned primary cognizance.

8. Communicate with other government agencies, representatives of the legislative branch, and members of the public, as appropriate, in carrying out assigned functions.

G. EFFECTIVE DATE

This Directive is effective immediately.

William H. Taft

William H. Taft, IV
Deputy Secretary of Defense

ASSISTANT SECRETARY OF DEFENSE

WASHINGTON D.C. 20301

HEALTH AFFAIRS

17 OCT 1984

MEMORANDUM FOR THE SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN, JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
ASSISTANT SECRETARIES OF DEFENSE
GENERAL COUNSEL
DIRECTOR, PROGRAM ANALYSIS AND EVALUATION

SUBJECT: Establishment of a Defense Medical Resources Advisory Board (DMRAB)

To discharge the responsibilities assigned to Health Affairs under its revised charter, I am by this memorandum establishing the Defense Medical Resources Advisory Board (DMRAB). The DMRAB will serve as the forum for discussion of the major issues confronting the Military Health Services System and to aid in the resolution of those issues that do not require the attention of the Defense Resources Board (DRB), the Deputy Secretary of Defense, or the Secretary of Defense. To insure that the views of all concerned parties receive full weight, the organization and procedures of the DMRAB will be patterned after those of the DRB.

The Principal Deputy Assistant Secretary of Defense (Health Affairs) will chair the DMRAB. The permanent membership will comprise the Deputy Assistant Secretaries of Defense (Health Affairs) and representatives of the Service Secretariats, of the CJCS, of the ASD(C), the ASD(MI&L), the ASD(RA), and the Director, PA&E. The associate membership will be comprised of representatives of other OSD principals; the associate members will participate when appropriate by invitation of the Chairman. The Director, Office of Program and Policy Coordination (Health Affairs) will serve as Executive Secretary to the Board.

The DMRAB will the review the Service POMs and Budget Submissions for the Assistant Secretary of Defense (Health Affairs). Among its responsibilities will be:

Aiding in the resolution of as many issues as possible on a mutually satisfactory basis without higher intervention.

Ensuring that decisions, once made in the course of the annual program and budget review, are not revisited in the absence of new information.

Appendix 2 Establishment of a Defense Medical Resources Advisory Board (DMRAB)

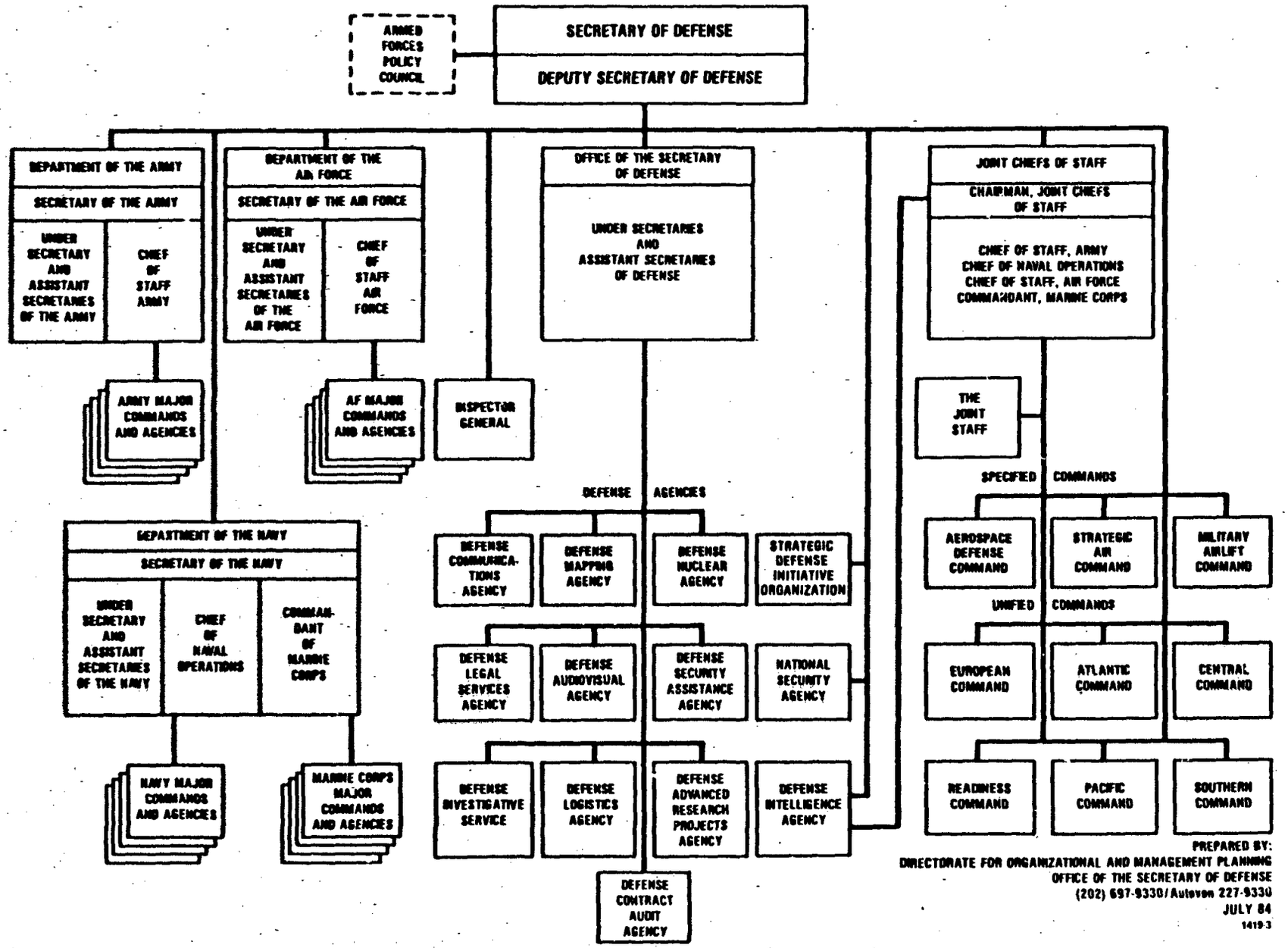
The DMRAB will serve as an advisory body to me. The actions and recommendations of the DMRAB will not have authority until approved specifically by me.

Please inform the Director, OP&PC (Health Affairs) of the identity of your DMRAB representative by October 24, 1984. Members will be informed of the date and agenda for the first meeting.

William Mayer, M.D.

Appendix 3 Department of Defense Organization Chart

DEPARTMENT OF DEFENSE

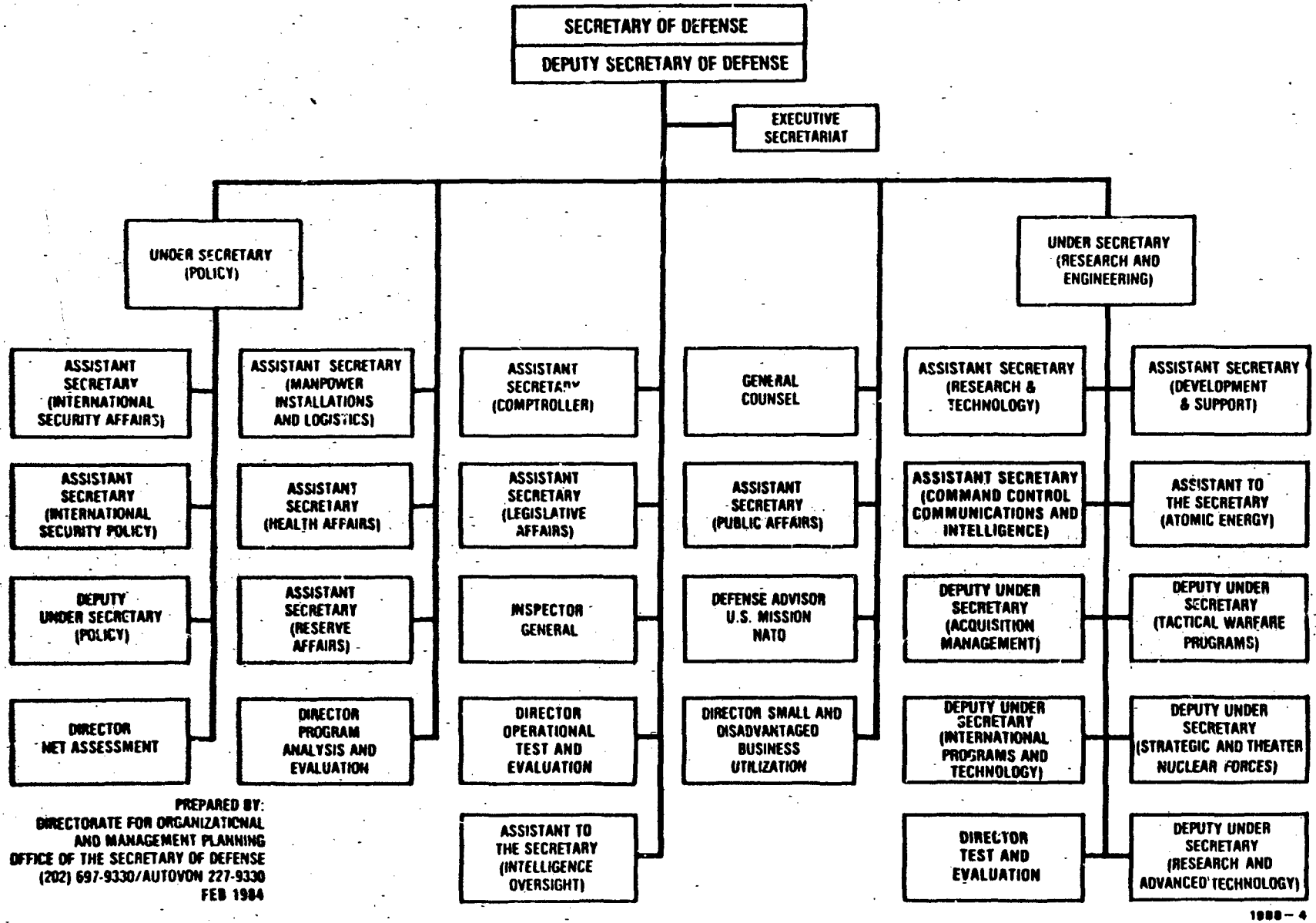


PREPARED BY:
DIRECTORATE FOR ORGANIZATIONAL AND MANAGEMENT PLANNING
OFFICE OF THE SECRETARY OF DEFENSE
(202) 697-9330/Autovon 227-9330

JULY 84
1419-3

Appendix 4 Office of Secretary of Defense

OFFICE OF THE SECRETARY OF DEFENSE

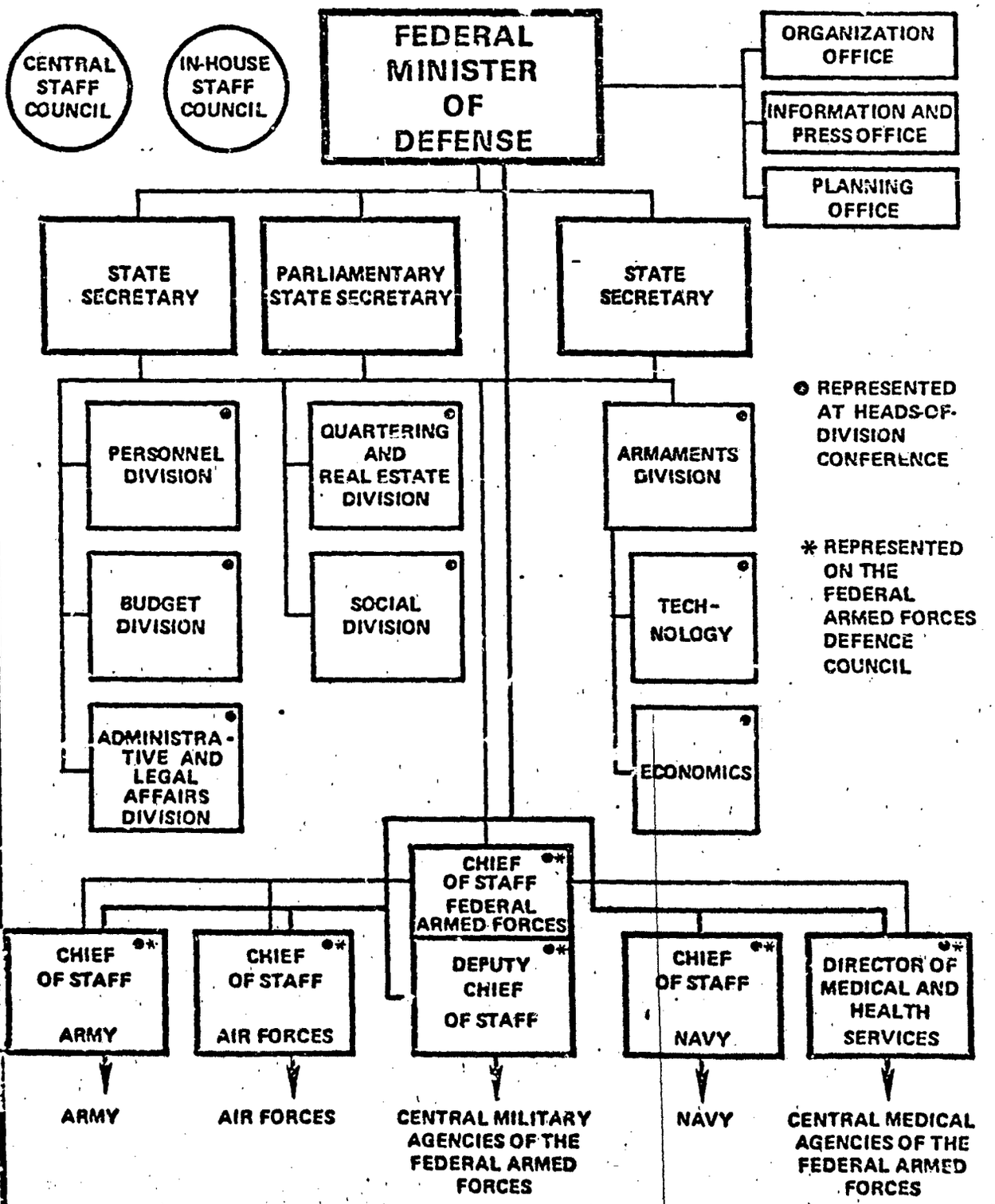


PREPARED BY:
DIRECTORATE FOR ORGANIZATIONAL AND MANAGEMENT PLANNING
OFFICE OF THE SECRETARY OF DEFENSE
(202) 697-9330/AUTOVON 227-9330
FEB 1984

1988 – 4

Appendix 5 Organization of the Federal Ministry of Defense

ORGANIZATION OF THE FEDERAL MINISTRY OF DEFENCE



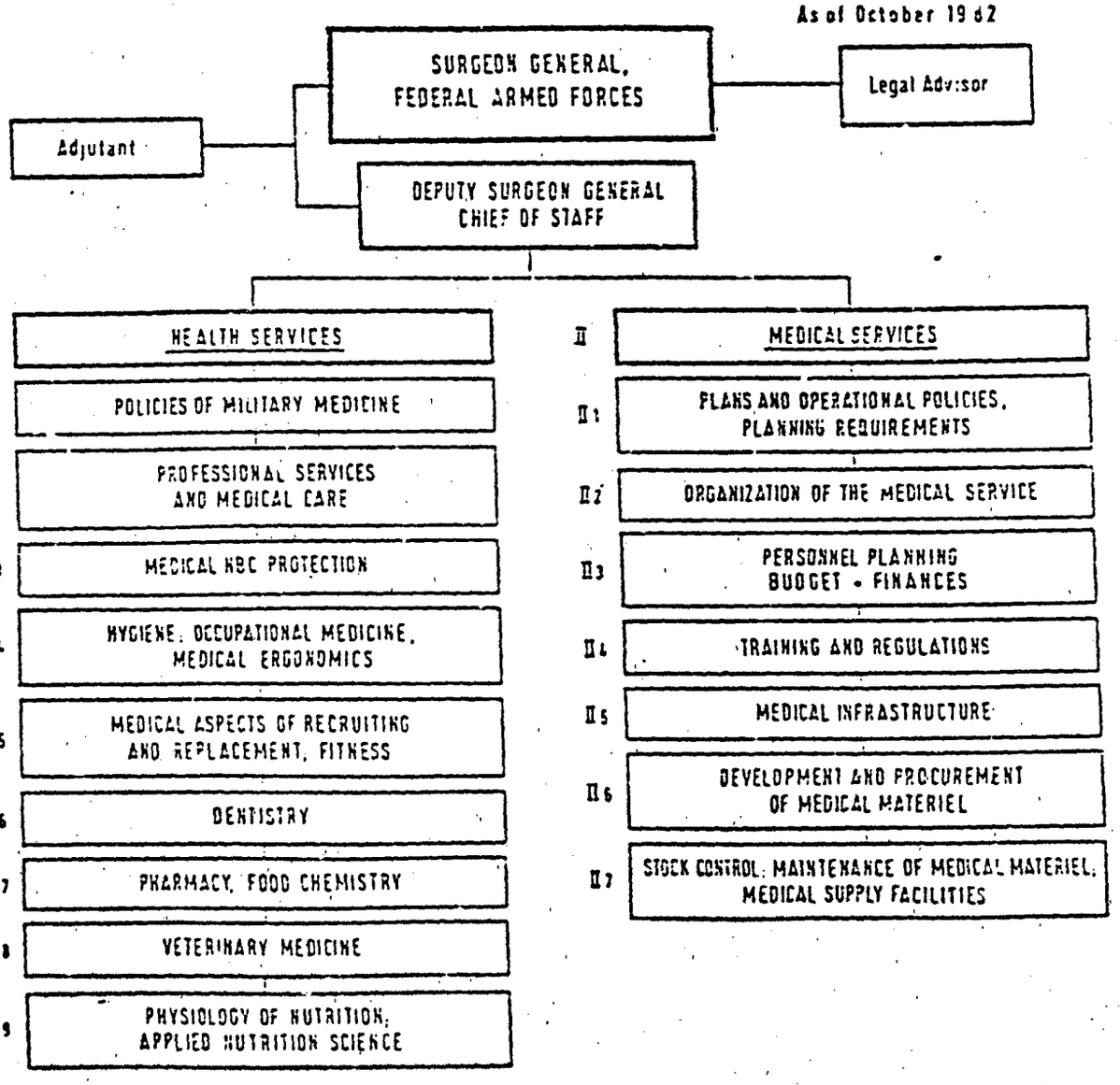
Appendix 6 Federal Armed Forces Directorate of Health and Medical Services

BMVg
InSan
II 2

Federal Armed Forces Directorate of Health and Medical Services

Datum: Okt. 1982
Tgb Nr:
Aust Anz.: Aust Nr.
Nr.:

As of October 1982



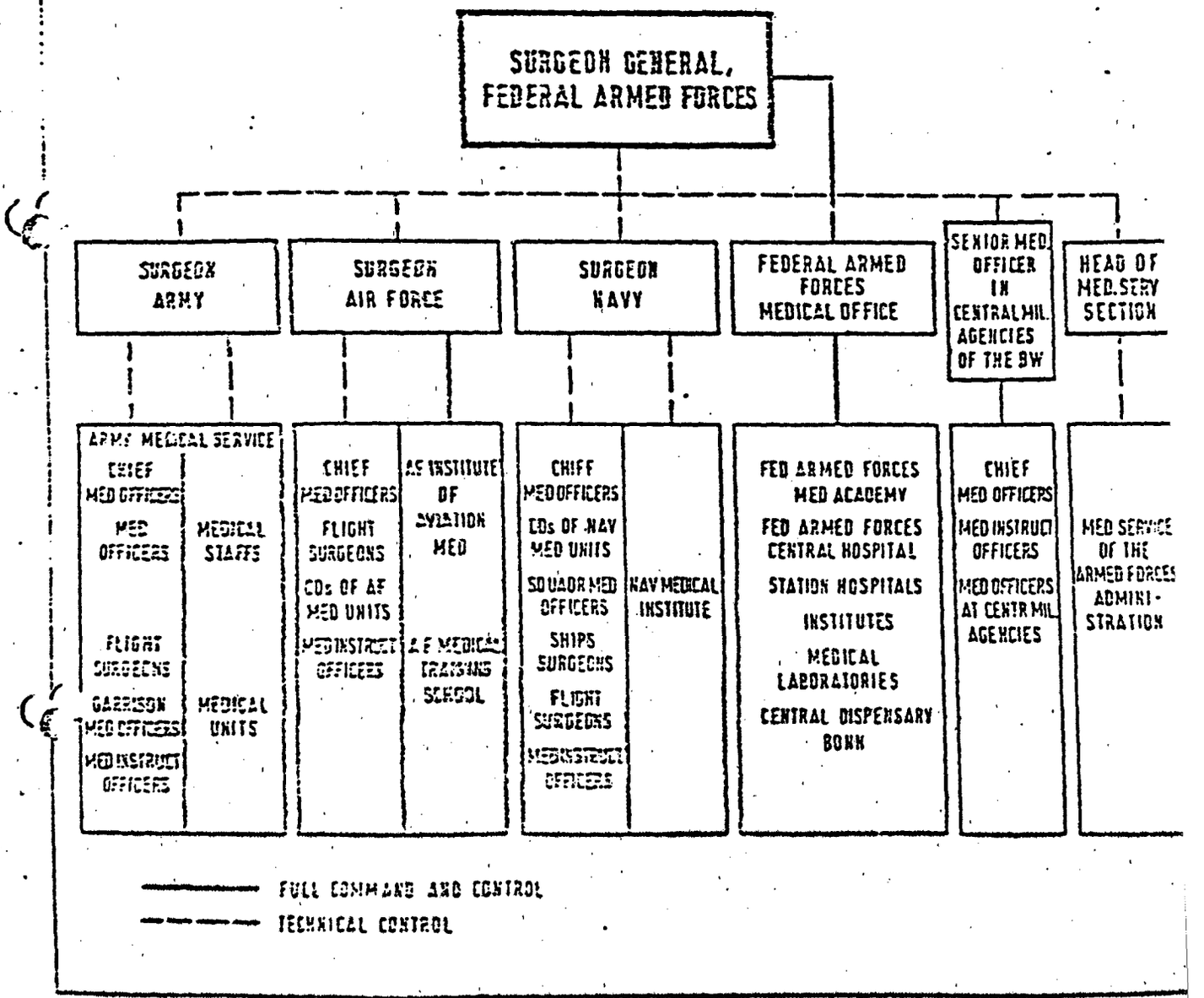
Appendix 7 Federal Armed Forces Medical and Health Services

BMVg
InSan
II 2

FEDERAL ARMED FORCES MEDICAL AND HEALTH SERVICES

Datum: Okt. 1982
Tgb Nr:
Ausl Anz.: Ausl Nr.
Nr.:

As of October 1982



Appendix 8
Minutes of Quarterly Japan Military Medical Region Meeting
5 January 1984

DEPARTMENT OF THE NAVY
COMMANDING OFFICER
U.S. NAVAL HOSPITAL, YOKOSUKA, JAPAN
FPO SEATTLE 98765

ADDRESS REPLY TO
COMMANDING OFFICER
REFER TO
01:JAW:eew
5050
25 January 1984

From: Chairman, Japan Military Medical Region, U.S. Naval Hospital, Yokosuka, Japan
To: Military Medical Regions Task Group, USAF/SGHA, Bolling AFB, Washington, DC 20332
Via: Commander in Chief Pacific, Code J76, Camp H.M. Smith, HI 96861

Subj: Minutes of Quarterly Japan Military Medical Region meeting of 5 January 1984; submission of

Ref: (a) CINCPACINST 6320.2E of 16 Aug 1982

Encl: (1) Subject minutes

1. In accordance with reference (a), the minutes of the Quarterly Japan Military Medical Region meeting held 5 January 1984 are forwarded as enclosure (1).

W. F. MINER

Copy to:
Chairman, Marianas Mil Med Rgn, USNH Guam
Chairman, Korea Mil Med Rgn, HQ USAMEDCOMK
Chairman, Mid-Pac Mil Med Rgn, TAMC
Chairman, SW Pacific Mil Med Rgn, USAFRGNMEDCEN Clark
Commander, Naval Medical Command Pacific Region

01:JAW:eew
5050
25 January 1984

Subj: Minutes of Quarterly Japan Military Medical Region meeting of 5 January 1984; submission of

3. Old Business:

a. Regarding alcohol rehabilitation services for U.S. Air Force personnel: Current regulations prohibit sending U.S. Air Force personnel to other than U.S. Air Force treatment facilities unless all such facilities are filled and backlogged. The question was raised whether or not to request a formal waiver of this policy. Follow-up was addressed under new business.

b. As a follow-up to the night-flight briefings and orientation flights conducted by the U.S. Army Aviation Detachment at Camp Zama, CPT Hebert announced that a briefing/flight would be held sometime the following week at Yokota; Camp Zama and Yokosuka have already participated in the briefing and flight. He stated that he felt that the briefings and night flights were beneficial for those who participated. CAPT Miner inquired about conducting more briefings in the fall as there will be many new medical personnel in the Japan area at that time. CPT Hebert advised that this would be possible, and the topic will be resurfaced later this year.

c. Regarding ambulance zones: Due to the loss of the maps provided by Yokota last meeting, this issue will have to be tabled until the next quarterly meeting. COL Reppart related a recent case where "the system worked" regarding ambulance responsibilities.

d. The question of handling off-base ambulance calls for active duty personnel was discussed. USNH responds to off-base calls. The USAF Hospital at Yokota refers off-base calls to Japanese ambulances, using the base transportation office as a contact point. The Army uses both methods. Patients are asked to use Japanese ambulances if at all possible, but hospital ambulances respond if necessary.

e. The daily notification of admissions/disposition of Army personnel and dependents has been implemented by USNH and is working well according to LCDR Wassell and COL Yamaoka. Action is now considered complete.

4. New Business:

a. CDR Welch informed the group about the Japan Joint Interservice Resource Study Group (JIRSG) which is looking into the dollars and cents of shared/consolidated services among the three military services in Japan. During CY84 one of the areas to be studied is health services. Due to the geographic separation of the various facilities in Japan, the consolidation of facilities does not appear feasible; however, the possibility of doing a study on the consolidation of ARS services within Japan was suggested to the committee. COL Reppart suggested LTC Vosburg, a psychiatrist at Yokota, and CPT Stepherson, NC, as members of the study group. CDR Scaramozzino from USNH was also nominated, along with Mr. Stan Debeck from Camp Zama. This study could possibly negate the need for requesting a waiver in regards to treating Air Force personnel. (See item 3.a.) It was decided that a preliminary report by the study group would be due for the next meeting of the Tri-Service committee.

DEPARTMENT OF THE NAVY
COMMANDING OFFICER
U.S. NAVAL HOSPITAL, YOKOSUKA, JAPAN
FPO SEATTLE 98765

ADDRESS REPLY TO COMMANDING OFFICER
REFER TO
01:JAW:eew
5050
25 January 1984

From: Chairman, Japan Military Medical Region, U.S. Naval Hospital, Yokosuka, Japan
To: Distribution

Subj: Minutes of Quarterly Japan Military Medical Region meeting of 5 January 1984; submission of

Ref: (a) CINCPACINST 6320.2E of 16 Aug 1982

Encl: (1) Tri-Service Cooperation

1. In accordance with reference (a), the second FY84 quarterly meeting of the Japan Military Medical Region was opened by the Chairman, CAPT Walter F. MINER, MC, USN, at 1006 at the U.S. Naval Hospital, Yokosuka, Japan. The following personnel were present:

AIR FORCE:	COL	Reppart	USAF Hospital, Yokota
	COL	Krusee	" " "
	LTC	Jablunovsky	" " "
	LTC	Sorrells	" " "
ARMY:	COL	Yamaoka	USAMEDDACJ, Camp Zama
	LTC	Lumpkin	" "
	LTC	McFarland	" "
	MAJ	Wilde	" "
	MAJ	Firth	" "
	CPT	Hebert	USA Avn Det, Camp Zama
	CPT	Courtney	USA Yokosuka Veterinary Activity
NAVY:	CAPT	Miner	USNH Yokosuka, Japan (Chairman)
	CAPT	Oliver	" "
	CAPT	Novak	" "
	CDR	Welch	" "
	CDR	Honeywell	" "
	LCDR	Wassell	" "
	CAPT	Kellner	USNDC Yokosuka, Japan
	LCDR	Barina	Branch Medical Clinic, NAF Atsugi
	LT	Duprey	Branch Medical Clinic, MCAS Iwakuni

Additional USNH Yokosuka, Japan staff in attendance were: CDR J. A. Scaramozzino, Head, ARS/Substance Abuse Department; LCDR J. W. Bishop, Director for Ancillary Ser[illegible] LCDR K. F. McNamara, Head, Facilities Management Department.

2. CAPT Miner welcomed the members to the second Quarterly Japan Military Medical Region meeting held at U.S. Naval Hospital, Yokosuka, Japan. CAPT Miner preceded the official meeting by announcing that the USNH Yokosuka has been accredited for three years, without contingencies, by the Joint Commission on Accreditation of Hospitals.

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25 January 1984

Subj: Minutes of Quarterly Japan Military Medical Region meeting of 5 January 1984; submission of

b. LCDR Wassell submitted a list of 51 current formal and informal agreements by which the three services are cooperating (enclosure (1)). LCDR Wassell solicited additions, deletions, corrections to this list so that a final list may be prepared for next quarter's meeting. Please advise LCDR Wassell of any changes required; his mailing address is Director for Administration, U.S. Naval Hospital, FPO Seattle 98765; or he may be contacted at 234-7134/5335. A decision to formalize some of the agreements may be made at a later time.

c. The gains and losses of the three services were discussed. USAF Hospital Yokota has requested that their urology billet be changed to an ENT billet to better fill their needs. USNH's urologist has agreed to visit Yokota once a month to see patients requiring his services. This summer Yokota will be losing two primary care physicians to be replaced by two board-certified family physicians. Yokota anticipates that at that time they will go to a full family practice mode. This change will ease the load on OB-GYN in regards to Iwakuni and Sasebo. All other services are stable. The clinic at Camp Zama has hired a civilian pediatrician. Because she is a foreign graduate, she will be working as a PA and in both pediatrics and general medicine. Zama has lost their nurse-midwife and has hired an OB nurse. They are changing a military physician billet to a civilian billet, hoping to get a board-certified family practitioner. USNH Yokosuka will lose one pediatrician with no replacement currently planned and will be plus one ENT physician until mid to late spring. During the next 11 months, USNH will have a turnover of approximately 50% of its credentialled staff. Many of the billets will be gapped. It is again requested that USNH Yokosuka be contacted prior to transferring a patient to avoid a possible second transfer if the specialist is not available. The Medical Officer of the Day (MOOD) is always onboard and may be contacted to find out what specialists are/are not available. The MOOD may be reached at 234-7141/5137 (Emergency Room). Presently, it is anticipated that both orthopedists will be away taking their boards during the upcoming summer.

5. The following additional items were discussed:

a. The upcoming visit by the Assistant Secretary of Defense for Health Affairs, Dr. William E. Mayer, was discussed. He will be accompanied by Dr. Jay Bisgard, Acting Deputy Assistant Secretary of Defense for Medical Readiness, and Ms. Diana Tabler, Executive Assistant. Also accompanying will be COL John E. Murphy, Office of the Surgeon, PACAF. Dr. Mayer will visit the three main facilities in this area; visit with Mr. Shimada, the Medical Director of the Japan Defense Agency; and tour the Japan Defense Agency Medical College, if possible. He would like a formal briefing by each facility to include specifically QA/Risk Management, medical readiness, and major facility construction projects that are anticipated or are being planned. He would also like a formal briefing by the senior line commander at each of the installations. LtGen Donnelly of U.S. Forces Japan is the formal point of contact and Yokota is the action office for the visit. Dr. Mayer's itinerary includes Clark, Kadena, Guam, Japan, and Korea.

b. It was announced that the second annual Shogun Society meeting is scheduled for 23-24 April 1984 at the New Sanno. MAJ Bongiorno of USAF Hospital Yokota and LT Flowe of USNH Yokosuka are coordinators for the Shogun. MAJ

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25 January 1984

Subj: Minutes of Quarterly Japan Military Medical Region meeting of 5 January 1984; submission of

Bongiorno is in charge of the program, and LT Flowe is in charge of facilities and support.

c. LTC Lumpkin announced that they are offering their services for teaching a War Surgery Course. A 30-day notice would be appreciated, if anyone is interested in scheduling this course. LTC Lumpkin also announced that there are now veterinary technicians at Misawa and Yokota, and a veterinary officer visits Yokota three days per week.

d. COL Krusee advised that dental at Yokota will request the War Surgery Course in May. Camp Zama will participate in this course.

e. LTC McFarland then commented that the dental activity at Zama would not be in existence if it weren't for the tri-service support received from both the Air Force and Navy.

f. The annual tri-service dental meeting will take place at the New Sanno 11-13 April 1984.

g. LT Duprey, Senior Medical Officer at Branch Medical Clinic, MCAS Iwakuni, advised that the problem with medical records between Iwakuni and Yokota had not been completely resolved. COL Reppart offered the following solution: Iwakuni should keep the original outpatient record and only send photocopies of the prenatal records to Yokota with the patient. Yokota will then be responsible for sending a Narrative Summary back to Iwakuni with the patient upon her return. The difficulty of the situation lies in the differences between the Navy and Air Force record-keeping regulations.

h. A question was raised regarding what medical records, if any, are required to accompany a patient on a medevac flight. COL Reppart advised that the patient is required to have an active form 602 (doctor's orders on what the patient receives in transit) and that all patients should have their pertinent medical records with them. OB patients should have photocopies of the prenatal record.

i. CAPT Miner asked for status reports from the branch medical clinics in Japan:

(1) Atsugi: Tri-service they are doing very well. There is a slight problem with optometry, but it is being resolved.

(2) Sasebo: Continuing to grow. The branch medical clinic billets have been approved. It looks good for construction of a new facility at Sasebo.

(3) Iwakuni: Increasing accompanied-tour billets.

j. LTC Lumpkin would like data on Iwakuni and Sasebo to support a request for extra personnel at those facilities. COL Reppart would like a copy of the same information. USNH will provide directly to the requestors.

6. The next quarterly meeting of the Japan Military Medical Region is scheduled for 5 April 1984.

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25 January 1984

Subj: Minutes of Quarterly Japan Military Medical Region meeting of 5 January 1984; submission of

7. The meeting was adjourned at 1115.

W. F. MINER
Captain, Medical Corps
United States Navy
Commanding
Chairman, Japan Military Medical Region

Distribution:
COL Reppart, Chief, Hospital Services, USAF Hospital Yokota
COL Krusee, Base Dental Surgeon, USAF Hospital Yokota
LTC Jablunovsky, Chief Nurse, USAF Hospital Yokota
LTC Sorrells, Administrator, USAF Hospital Yokota
COL Yamaoka, Commander, USAMEDDACJ, Camp Zama
LTC Lumpkin, Commander, USA Veterinary Activity Japan, Camp Zama
LTC McFarland, Commander, USA Dental Activity Japan, Camp Zama
MAJ Wilde, Executive Officer, USAMEDDACJ, Camp Zama
MAJ Firth, Chief Nurse, USAMEDDACJ, Camp Zama
CPT Hebert, Assistant Operations Officer, USA A[illegible] Detachment, Camp Zama
CPT Courtney, Chief, USA Yokosuka Veterinary Activity
CAPT Miner, Commanding Officer, U.S. Naval Hospital, Yokosuka, Japan (Chairman)
CAPT Oliver, President of the Medical Staff, USNH Yokosuka, Japan
CAPT Novak, Area Health Care Coordinator, USNH Yokosuka, Japan
CDR Welch, Executive Officer, USNH Yokosuka, Japan
CDR Honeywell, Assistant Director for Nursing Services, USNH Yokosuka, Japan
LCDR Wassell, Director for Administration, USNH Yokosuka, Japan
CAPT Kellner, Commanding Officer, U.S. Naval Dental Clinic, Yokosuka, Japan
LCDR Barina, Officer in Charge, Branch Medical Clinic, NAF Atsugi
LT Duprey, Senior Medical Officer, Branch Medical Clinic, MCAS Iwakuni

1 January 1984

TRI-SERVICE COOPERATION

	RECEIVER	TYPE OF AGREEMENT	SPECIFIC HEALTH SERVICE SHARED	SUPPLIER	FREQUENCY/ DATE OF TERMINATION
1.	NAVHOSP Yokosuka	Formal-ISSA #WT5SMU-80001-118	Emergency and routine medical evacuation helicopter support	U.S. Army Aviation Detachment	Ongoing/April 1987
2.	Pediatricians from Army (Camp Zama), Air Force (Yokota), and Navy (Okinawa and Yokosuka)	Informal	Far East Pediatric Seminar	NAVHOSP Yokosuka	19-20 August 1983
3.	U.S. Army Yokosuka Veterinary Activity	Formal-ISSA #N68292-80065-004	Clinical resources for the care and treatment of government-owned animals	NAVHOSP Yokosuka	Ongoing/March 1986
4.	U.S. Army Clinic, Camp Zama	Informal	GI endoscopy procedures	NAVHOSP Yokosuka	Bi-monthly
5.	U.S. Army, Camp Zama and USAF Yokota	Informal	Treadmill procedures	NAVHOSP Yokosuka	As needed
6.	U.S. Army, Camp Zama and USAF Yokota	Informal	Medicine ICU support for critical patients	NAVHOSP Yokosuka	As needed
7.	U.S. Army Clinic, Camp Zama	Informal	Medical lectures by staff internists	NAVHOSP Yokosuka	Bi-yearly (1982)
8.	U.S. Army Clinic, Camp Zama and USAF Hospital, Yokota	Informal	Outpatient consultations in pediatrics, OB/GYN, neurology, and orthopedics	NAVHOSP Yokosuka	Ongoing/as needed

Enclosure (1)

	RECEIVER	TYPE OF AGREEMENT	SPECIFIC HEALTH SERVICE SHARED	SUPPLIER	FREQUENCY / DATE OF TERMINATION
9.	U.S. Army Clinic, Camp Zama	Informal	Over 40 C-V Risk Program	NAVHOSP Yokosuka	Ongoing/as needed
10.	U.S. Army Clinic, Camp Zama	Informal	IPPD Screening Program	NAVHOSP Yokosuka	Ongoing/as needed
11.	U.S. Army Clinic, Camp Zama and USAF Hospital, Yokota	Informal	PFT testing	NAVHOSP Yokosuka	Ongoing/as needed
12.	U.S. Army Clinic, Camp Zama, USAF Hospital, Yokota, and NAVHOSP Yokosuka	Informal	ACLS training and instruction	U.S. Army Clinic, Camp Zama, USAF Hospital, Yokota, and NAVHOSP Yokosuka	Ongoing/every 2-4 months
13.	U.S. Army Clinic, Camp Zama, USAF Hospital, Yokota, and NAVHOSP Yokosuka	Informal	Assist in supply in critical items when needed immediately	U.S. Army Clinic, Camp Zama, USAF Hospital, Yokota, and NAVHOSP Yokosuka	Ongoing/as needed
14.	U.S. Army Clinic, Camp Zama	Informal	Training of medical repair personnel	NAVHOSP Yokosuka	Ongoing/14-30 days/ as needed
15.	U.S. Army Yokosuka Veterinary Activity	Informal	Biomedical repair and preventive maintenance of clinic equipment	NAVHOSP Yokosuka	Ongoing/as needed
16.	USAF Hospital, Yokota	Informal	Provide sterilization support for CSSR when processing equipment is inoperable	NAVHOSP Yokosuka	Ongoing/as needed
17.	U.S. Army Yokosuka Veterinary Activity	Informal	Provide CSSR support	NAVHOSP Yokosuka	Ongoing/as needed

	RECEIVER	TYPE OF AGREEMENT	SPECIFIC HEALTH SERVICE SHARED	SUPPLIER	FREQUENCY/ DATE OF TERMINATION
18.	U.S. Army Yokosuka Veterinary Activity	Informal	Provide excess/expired medical supplies and equipment	NAVHOSP Yokosuka	Ongoing/as needed
19.	U.S. Army Clinic, Camp Zama	Informal	Pediatric and OB/GYN clinics at Camp Zama, including training/ teaching	NAVHOSP Yokosuka	Ongoing/monthly and bimonthly
20.	NAVHOSP Yokosuka	Informal	Exchange of operating room equipment	USAF Hospital, Yokota	Ongoing/as needed
21.	NAVHOSP Branch Clinic, NAF Atsugi	Informal	Optometric service	U.S. Army Clinic, Camp Zama	Biweekly/ongoing since June 1981
22.	NAVHOSP Branch Clinic, NAF Atsugi (reciprocal)	Informal	Back-up ambulance coverage	U.S. Army Clinic, Camp Zama (reciprocal)	Ongoing/as needed
23.	NAVHOSP Branch Clinic, NAF Atsugi	Informal	Immediate initial child abuse intervention for school children by Mental Health Department	U.S. Army Clinic, Camp Zama	Ongoing since January 1983
24.	U.S. Army Clinic, Camp Zama, USAF Hospitals, Yokota and Misawa (reciprocal)	Informal	Borrowing and loaning of pharmaceutical medications and supplies	NAVHOSP Yokosuka (reciprocal)	Ongoing/as needed
25.	USAF Hospital, Yokota (reciprocal)	Informal	Urology services, including surgeons and supplies	NAVHOSP Yokosuka (reciprocal)	Ongoing

	RECEIVER	TYPE OF AGREEMENT	SPECIFIC HEALTH SERVICE SHARED	SUPPLIER	FREQUENCY/ DATE OF TERMINATION
26.	U.S. Army Clinic, Camp Zama	Informal	X-ray services, including ultrasounds and special studies	NAVHOSP Yokosuka	Ongoing/daily
27.	USAF Hospital, Yokota (reciprocal)	Informal	X-ray services, including ultrasounds and special studies. Also, radiologist covering on emergency basis has been provided for periods of leave and TAD	NAVHOSP Yokosuka (reciprocal)	Ongoing
28.	USAF Hospital, Yokota	Informal	Ophthalmology clinic and services	NAVHOSP Yokosuka	Monthly/ongoing for past four years
29.	All health care treatment facilities	Informal	Tri-Service meeting of optometrists	All	Yearly
30.	USAF Hospitals, Yokota and Misawa, and U.S. Army Clinic, Camp Zama	Informal	Audiology services, including: 1) monthly clinics at USAF Hospital, Yokota; 2) annual Hearing Conservation Techniques Certification course (Yokota and Misawa); 3) provide audiometers as needed; 4) technical advice	NAVHOSP Yokosuka	Ongoing
31.	USAF Hospital, Yokota	Informal	Dermatology clinic	NAVHOSP Yokosuka	Ongoing/monthly
32.	U.S. Army Clinic, Camp Zama	Informal	Physical Therapy support--clinic and training	NAVHOSP Yokosuka	Ongoing

	RECEIVER	TYPE OF AGREEMENT	SPECIFIC HEALTH SERVICE SHARED	SUPPLIER	FREQUENCY/ DATE OF TERMINATION
33.	U.S. Army Clinic, Camp Zama	Informal	ARS Level III inpatient treatment and two-week Alcoholism Orientation course	Alcohol Rehabilitation Service, NAVHOSP Yokosuka	Ongoing
34.	NAVHOSP Yokosuka	Informal	Mental health services for Family Advocacy and ARS referrals	USAF Hospital, Yokota	Ongoing
35.	U.S. Coast Guard	Informal	Level III ARS treatment for 14th District personnel	Alcohol Rehabilitation Service, NAVHOSP Yokosuka	Ongoing
36.	All	Informal	ARS Education and Awareness training	Alcohol Rehabilitation Service, NAVHOSP Yokosuka	Ongoing
37.	U.S. Army Garrison Honshu	Formal-ISSA #N68292-80095-005	Provide entomology services, environmental quality control services, and occupational services to U.S. Army Ammunition Depot Okizuki	Branch Clinic MCAS Iwakuni	Ongoing/April 1986
38.	All services	Informal	Kanto Plains Drug and Alcohol Council shares resources, ideas, and training	All services	Quarterly
39.	NAVHOSP Yokosuka	Formal-ISSA #FB5209-81120-193	Provide mortuary services for eligible U.S. Navy Marine Corps, and Military Sealift Command members	475th ABW	Ongoing/March 1987

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	RECEIVER	TYPE OF AGREEMENT	SPECIFIC HEALTH SERVICE SHARED	SUPPLIER	FREQUENCY/ DATE OF TERMINATION
40.	U.S. Army, Camp Zama	Informal	Provide entomology assistance, pest control research, Public Health Information, cooperative epidemiological investigations, water chemistry testing, and shared training	Preventive Medicine Division, NAVHOSP Yokosuka	Ongoing/as needed
41.	USAF Hospital, Yokota	Informal	Shared Public Health Information, cooperative epidemiological investigations, and shared training	Preventive Medicine Division, NAVHOSP Yokosuka	Ongoing/as needed
42.	NAVHOSP Yokosuka	Informal	Extensive laboratory support, education and training, professional consultations and information exchange, professional symposiums and equipment exchange	U.S. Army Environmental Center, Sagami Depot	Ongoing/as needed
43.	U.S. Army Defense Property Disposal Office Activities	Informal	Periodic occupational health and industrial hygiene surveys and education and training	Occupational Health Department, NAVHOSP Yokosuka	Ongoing/as needed
44.	USAF Hospital, Yokota	Informal	Periodic industrial hygiene surveys	Occupational Health Department, NAVHOSP Yokosuka	Ongoing/upon request

	RECEIVER	TYPE OF AGREEMENT	SPECIFIC HEALTH SERVICE SHARED	SUPPLIER	FREQUENCY/ DATE OF TERMINATION
45.	NAF Misawa	Informal	Industrial hygiene support. Also, occupational health services including audiograms, chest x-rays, laboratory studies, and specialist referrals	Occupational Health Department, NAVHOSP Yokosuka	Ongoing/as needed
46.	Forty-five Armed Forces medical facilities throughout the Pacific Region	Informal	Provide reference laboratory testing	Laboratory Department, NAVHOSP Yokosuka	Ongoing/as needed
47.	Japan Army, Air Force facilities	Informal	All cytology testing	Laboratory Department, NAVHOSP Yokosuka	Ongoing/as needed
48.	USAF Hospital, Yokota	Informal	Laboratory support, including: 1) pathology coverage for leave or TAD; 2) performance of autopsies and surgical pathology; 3) pathology consultation in surgical pathology, blood banking and clinical pathology; 4) reciprocal blood donor procurement programs; 5) close cooperation on all aspects of blood banking including emergency and contingency planning	Laboratory Department, NAVHOSP Yokosuka	Ongoing/as needed
49.	U.S. Army, Japan	Informal	Autopsies on active duty deaths	Laboratory Department, NAVHOSP Yokosuka	Ongoing/as needed

	RECEIVER	TYPE OF AGREEMENT	SPECIFIC HEALTH SERVICE SHARED	SUPPLIER	FREQUENCY/ DATE OF TERMINATION
50.	U.S. Army Yokosuka Veterinary Activity	Informal	Process tissue sections for autopsies and biopsies	Laboratory Department, NAVHOSP Yokosuka	Ongoing/as needed
51.	U.S. Army Clinic, Camp Zama and USAF Hospital, Yokota	Informal	Loan of laboratory reagents	Laboratory Department, NAVHOSP Yokosuka	Ongoing/as needed

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Appendix 9

Armed Services Regional Health Services System Report
Military Medical Region Eight
October 1983 - December 1983

ARMED SERVICES REGIONAL HEALTH SERVICES SYSTEM REPORT

MILITARY MEDICAL REGION EIGHT

Report Period: October 1983 - December 1983

INTRODUCTION

On 6 December 1983, Military Medical Region Eight convened its quarterly meeting. The meeting was hosted by the Naval Medical Command, Mid-Atlantic Region, Norfolk, Virginia.

- The Veteran's Administration and the United States Public Health Service were invited to the meeting, with the Veteran's Administration attending.

- Womack Army Community Hospital received a full 3-year accreditation by the Joint Commission on Accreditation of Hospitals (JCAH). In July 1983 the development and implementation of the first on-line automated Quality Assurance Program in the U. S. Army was completed.

- Womack Army Community Hospital began the installation of computerized axial tomography equipment and a renovation/ expansion of the Emergency Room in the later part of calendar year 1983.

- In September 1983, Womack Army Community Hospital had a minimum commitment of 523 beds for the Civilian Military Contingency Hospital System (CMCHS). This commitment can be expanded to 818 beds dependent upon a contingency bed census reduction at the participating hospitals.

- Workload at Womack Army Community Hospital increased from a program of 1,308 Medical Care Composite Units to an actual workload of 1,362 Medical Care Composite Units. This 4-percent increase was performed without an increase in personnel assets.

- Fort Eustis provides a Podiatrist and a Urologist one day per week to the Kenner Army Hospital, Fort Lee, Virginia.

- A CMCHS exercise was held in November 1983 by the Naval Hospital, Portsmouth, Virginia.

- Branch Dental Clinic, Marine Corps Logistics Base, Albany, Georgia was realigned with the Naval Medical Command, Southeast Region. Functional transfer is pending.

- Naval Medical Command East Coast Equal Opportunity Program Team approved Command Equal Opportunity Programs at the Naval Dental Clinic, Parris Island, South Carolina.

ENCLOSURE (1)

- Liaison visit by Commodore H. W. Yamanouchi, DC, USNR-R regarding Reserve Affairs was held with the Naval Dental Clinic, Parris Island, South Carolina.

- Local accounting procedures were streamlined at the Naval Dental Clinic, Parris Island, South Carolina due to installation of on-line real time financial data provided by an Integrated Disbursing and Accounting (IDA) IIB remote terminal.

- Naval Dental Clinic, Parris Island, South Carolina implemented the Department of the Navy Family Ombudsman Program.

- Dental productivity at the Naval Dental Clinic, Parris Island, South Carolina was 10% above the same period in FY 83 and 21% above the Navy average.

- Seymour Johnson AFB Dental Service has established a patient oriented appointment system. The centralized system allows for auditing available time on an ongoing basis, easier rescheduling, increased provider productivity time, and decreased patient backlog.

EXTENT OF INTERSERVICE REGIONALIZATION ACHIEVEMENTS:

- Womack Army Community Hospital participated in "Operation Urgent Fury" to Grenada through the provision of medical personnel in support of deploying combat troops. This included the provision of health services to personnel who were evacuated for combat-sustained injuries.

- U.S. Navy Hospital, Roosevelt Roads functioned as the primary site for the triage and evacuation for all combat casualties sustained during "Operation Urgent Fury" in Grenada. The command External Disaster/Mass Casualty Plan was instituted and successfully implemented. The hospital staff was subsequently augmented by MMART personnel from Naval Hospital, Bethesda, Maryland. Casualties were received, appropriately treated and evacuated. Post-action critiques pointed out the critical requirement for Mass Casualty Plans that are concise, current and flexible.

- Army veterinary support for all services increased in 1983 through the initial performance of Army Food Inspectors at Camp Lejeune Marine Corps Base and Cherry Point Marine Corps Air Station, additional enlisted support to the Combat Ration Assembly Plant at Mullins, South Carolina, and Animal Care Specialist assignments to Myrtle Beach and Seymour Johnson Air Force Bases.

- Inter-hospital and inter-service agreements have been established between McDonald U. S. Army Community Hospital and

the U. S. Air Force Hospital, Langley AFB, Virginia. Langley will be responsible for all obstetrical care on the peninsula, primarily for active duty, and when available, for dependents of active duty. No obstetrical facilities are available at Fort Eustis or Fort Monroe.

- Fort Eustis and the Hampton Veteran's Administration are exploring the possibility of educational meeting exchange, in addition to the use of the VA Hospital, Hampton, Va. for Cardiology and Gastroenterology consultations for patients from Fort Monroe.

- Fort Eustis and the hospital at Langley AFB have established an integrated orthopedic service with mutual support for on-call and weekend duties.

- Dental resource sharing agreements have been established between Fort Eustis, the Naval Dental Clinic, Norfolk, Virginia, and the Air Force Dental Facility, Langley AFB.

- A Memorandum of Support was established between the Branch Dental Clinic, Yorktown, Virginia and the U.S. Army Dental Activity, Fort Eustis, Virginia. The Army will provide specialty care to Navy personnel if required. Navy dental officers assigned to the Branch Dental Clinic, Yorktown, will be included in the after hours, weekend, and holiday duty rosters of the Fort Eustis Dental Activity.

- A Memorandum of Support was established between Fort Story and the Branch Dental Clinic, Naval Amphibious Base, Little Creek, Virginia. The Navy will provide specialty care to Army personnel stationed at Fort Story. Army dental officers assigned to Fort Story will be included in the after hours, weekend, and holiday duty roster at the Branch Dental Clinic, Little Creek, Virginia.

- Air Force Dental Facility, Langley AFB, provided Oral Surgical support to Army personnel from Fort Eustis and Fort Monroe. Army dental officers assigned to Fort Monroe are included in the after hours, weekend, and holiday duty roster at Langley AFB.

- U.S. Army Dental Activity, Fort Lee, Virginia provided dental support to Air Force and Navy personnel stationed at the Defense General Supply Center (DGSC), Richmond, Virginia, U.S.M.C. Battalion personnel attached to the Quartermaster Brigade, Fort Lee, Virginia, and personnel from the Army Logistics Management Center and Logistics Center, Fort Lee, Virginia.

- The Naval Hospital, Portsmouth, Virginia sponsored and co-sponsored a number of medical education conferences or symposia which was available to all Services. They included:

the Yon Symposium on Urology, the Anesthesia Symposium, the Ophthalmology Symposium, and the Medical/Religion Symposium.

- The Naval Hospital, Roosevelt Roads, Puerto Rico is currently negotiating with the Veteran's Administration Hospital, San Juan, Puerto Rico, in regard to sharing services in Nuclear Medicine and Neurosurgery.

- Naval Hospital, Cherry Point, North Carolina is providing medical support to both active duty and dependent beneficiary populations of the Army, Air Force and Coast Guard.

- Memorandum of Agreement for a Tri-Service Pharmacy System has been established between the Commander, Naval Medical Command, Mid-Atlantic Region, Commanding Officer, McDonald Army Community Hospital, Fort Eustis, Virginia, Commanding Officer, U.S. Army Community Health Clinic, Fort Monroe, Virginia, and the Commanding Officer, USAF Regional Hospital, Langley AFB, Virginia. The System is now installed in the Pharmacies of Langley AFB, Fort Eustis, and Fort Monroe.

- Cross-servicing of patient beneficiary populations has been established between the Naval Dental Clinic, Charleston, South Carolina, and the Air Force Dental Facility, Charleston AFB, South Carolina on an as-needed basis.

- Naval Dental Clinic, Norfolk, Virginia has provided the services of dental repairmen to the Coast Guard Dental Facility, Elizabeth City, North Carolina, for the installation of dental units and chairs.

- Naval Dental Clinic, Norfolk, Virginia has provided the services of dental repairmen to the Coast Guard Reserve Headquarters, Yorktown, Virginia for the installation of an emergency field compressor to keep the facility "on-line" until a new unit could be procured and installed.

- Naval Dental Clinic, Roosevelt Roads, Puerto Rico provides specialty dental services, consultations, and dental equipment dental repair services to U.S. Army Dental Facility, Fort Buchanan, Puerto Rico, and the Coast Guard Station, Borinquen, Puerto Rico, as well as reimburseable supply services.

- USAF Hospital, Myrtle Beach, South Carolina has established an agreement with Moncrief Army Hospital to conduct a monthly Orthopedic clinic at the Myrtle Beach AFB Hospital. This has greatly improved the consultation services available to the professional staff at Moncrief Army Hospital. This service is also available to Army personnel from Fort Jackson, South Carolina.

PROBLEMS OR CONSTRAINTS ENCOUNTERED:

- Some members felt that the authority to issue Certificates of Non-availability (CNA's) was somewhat restrictive. Example given was the DoD policy of June 1983 which states in essence that CNA's would be issued for only three reasons: 1) Non-availability of staff 2) Non-availability of facilities or 3) Medically inappropriate.

- CNA issuance should be available for patients required to travel unreasonable distances. The new "zip code" policy contributes to establishing these excessive distances (as far as 250 miles).

- Continuing shortages in certain specialty areas as Orthopedics and Neurosurgery. Also, automated data processing (ADP) capability.

- The Grenada Operation pointed out specific problems and shortfalls, e.g., lack of adequate communications and liaison, and difficulty in identification of casualties due to removal of personal effects.

COMMITTEE REMARKS AND RECOMMENDATIONS:

- The three Services discussed and stressed the importance and the need to identify and label dependents of active duty personnel who require specialized care in terms of assignment of their sponsor.

- The importance of sharing workload reporting information was discussed and encouraged.

- Major emphasis was placed on developing management initiatives to improve productivity. Commanders and Commanding Officers discussed methodology used at their respective commands.

- Memorandums of Understanding (MOU's), Intra-Service Support Agreements (ISSA's), and other cross-servicing agreements were requested from all attendees for forwarding to DoD.

- The provisions of social services (Family Advocacy Programs), was discussed and it was emphasized that medical department staffs, e.g. social workers, were responsible for immediate intervention and referral to the Family Service Center.

- Methodology for the procurement of high-cost medical equipment (excess of $400K) was explained and copies of the Joint Services Regulation was provided.

- Commands were encouraged to establish working agreements where catchment area overlaps, especially in the sharing of limited assets and resources.

- Committee recommended the establishment of "Crisis Telephone Directory" that would list numbers for emergency situations. Numbers to be included would be the State Department (Army, Navy, and Air Force Casualty Sections), supply points and duty officers among others.

- Tri-Service and Federal cooperation and sharing have been the theme of this Committee and have been enthusiastically encouraged and supported by all attendees.

Region #8 High Cost Equipment - FY 84

Request from: Womack Army Community Hospital, Fort Braggs, North Carolina
Equipment: Digital Subtraction Angiography equipment
Cost: $490,000
Action: Disapproved

Request from: Naval Hospital, Camp Lejeune, North Carolina
Equipment: Computerized Axial Tomography equipment
Cost: $1,190,000
Action: Pending

Appendix 10
Joint Interservice Resource Study Group (JIRSIG)
Kaiserslautern, Germany
Study of Health Services

JOINT INTERSERVICE RESOURCE STUDY GROUP (JIRSG)

AREA E-6, GE

KAISERSLAUTERN, GERMANY

STUDY OF

HEALTH SERVICES	AL
TITLE	SUPPORT CATEGORY CODE

LANDSTUHL ARMY REGIONAL MEDICAL CENTER APO NY 09180 (LEAD UNIT)	JUNE 1984 COMPLETED

HEALTH SERVICES INTERSERVICE RESOURCE STUDY

KAISERSLAUTERN MILITARY COMMUNITY

Prepared June 1984

HEALTH SERVICES JOINT INTERSERVICE RESOURCE STUDY GROUP
KAISERSLAUTERN MILITARY COMMUNITY

A. EXECUTIVE SUMMARY

1. Introduction: During the period November 1983 to April 1984, a study to determine the optimum use of health care resources in the Kaiserslautern Military Community was conducted. The study reviewed four outpatient clinics, five dental clinics, one hospital and one veterinary unit. Twenty-two sub-functions were reviewed in the health services area.

2. Conclusions: A review of the consolidation possibilities in the inpatient, outpatient, dental and veterinary areas revealed no alternatives that were more cost effective, more responsive to wartime missions or gave more strategically placed facilities to provide timely, life-saving medical care than the current facility configurations. Staffing patterns for each clinic based on population supported was in line with generally - accepted manpower guidelines for each separate major population area within the Kaiserslautern Military Community. Consolidation efforts when reviewed moved health care support away from the population supported causing a medically endangering situation and imposed greater transportation demands on the beneficiary population. Facility renovation costs could not be justified because of the current state of the existing clinics and the scarcity of available buildings in the community. The committee was unable to resolve the disparity between the wording of the agreement "USAREUR will operate the Landstuhl Army Medical Center and existing Health and Dental Clinics in the Kaiserslautern area" and the fact that there are Air Force run medical and dental facilities on Ramstein and Sembach Air Bases. It is assumed that the medical annex to the Creek Swap agreement omitted this clarification.

3. Recommendations:

a. Ongoing operations should continue in the joint use of military health and medical facilities and services as mandated in DOD Directive 6015.5 dated 5 February 1981 (TAB A) and the Creek Swap Agreement dated 1 July 1975 (TAB B). The agreement should be amended to portray current responsibilities for Ramstein/Sembach clinics.

b. There should be no closures or consolidation of existing facilities (TAB C).

c. Cost Savings: (Formalize in current support agreements so that savings may be recognized.).

(1) That support to the Ramstein Health clinic by general surgeons from the USAF Wiesbaden Regional Medical Center is no longer needed. Adequate general surgery staff is available at Landstuhl to support these referrals in a timely manner. Elimination represents travel savings to AF of $1,300 annually (TAB D).

(2) That if AF makes an exception to its recent policy that all AF health clinics have a specified list of required journals and book sets, $1,000 in one-time savings and $1,500 in recurring annual costs will be realized by Ramstein and Sembach clinics each (TAB E). This literature is available from the Landstuhl medical library and some of the journals pertain to medical specialties not on staff at the AF clinic.

(3) Eliminate two AF neurosurgical positions identified for staffing Landstuhl, thus freeing spaces for elsewhere. Cancellation of the current memorandum of understanding (MOU) between USAREUR and USAFE will formalize savings annually to AF of $145,086 (TAB F).

(4) If AF does not require Ramstein clinic to hire positions to support an Exceptional Family Member Program and duplicate services offered by Landstuhl, annual cost savings of $208,186 in personnel and one-time estimated savings of $56,000 in facility renovation will be realized (TAB G).

(5) Family practice physicians at Ramstein clinic should follow AF affiliated expectant mothers at the clinic until delivery. Only cases which present potential complications are referred to Landstuhl. When the patient is admitted an AF physician is called to Landstuhl and performs the delivery. This procedure allows the AF family practice physician to maintain professional skills in this area without costly formal or informal refresher training when they return to the CONUS (TAB H), costing $40,301.

d. Cost Avoidances: (Continue efforts that support avoidances to DOD)

The avoidances shown below are a result of Ramstein Clinic personnel jointly sharing in the hospital community workload and supporting Landstuhl in this effort.

(1 The radiologist at Ramstein clinic currently works sixteen hours per week approximately forty-seven weeks a year in the Landstuhl radiology department. The effort supplements the Landstuhl staff and gives the Ramstein radiologist an opportunity to stay current in all radiological procedures other than film interpretation. The annual cost avoidance to Landstuhl is $17,737 (TAB I), and the cost of additional training is avoided when the radiologist returns to CONUS.

(2) An internist is assigned to Ramstein clinic. This person spends approximately fifty-two man days a year at Landstuhl assisting in endoscopic procedures and conducting treadmill testing. This effort is a cost avoidance to Landstuhl of $12,224 annually (TAB J).

(3) Ramstein has discontinued operation of an emergency room after normal duty hours, on weekends, and on holidays. Ramstein patients are treated at the Landstuhl emergency room. Physicians from the Ramstein clinic work 27

days a month at the Landstuhl emergency room. The support provided to Landstuhl is costed at $94,158 annually (TAB K).

(4) The oral surgeon at Ramstein dental clinic does inpatient surgery at Landstuhl. This effort supplements the Landstuhl oral surgery staff, and enables the Ramstein oral surgeon to maintain current proficiency of his surgical skills. In addition, this oral surgeon rotates on-call status with the Landstuhl oral surgeons. The support represents a cost avoidance to the Landstuhl oral surgery staff of $19,950 annually (TAB L).

e. Areas Where No Changes Are Recommended:

(1) The availability of one inpatient facility in the Kaiserslautern Military Community is adequate. Landstuhl Army Regional Medical Center has an operating bed capacity of 253 beds and serves as the major inpatient specialty referral center for Europe, Africa and the Middle East (TAB M).

(2) Physical Therapy capability is available on a limited outpatient basis at Ramstein clinic and on a broad, specialized basis including burn rehabilitation at Landstuhl. The review indicated the services at both locations were working optimally and in a coordinated manner (TAB N).

(3) A review of DOD Directive 6015.5 designating the Army as the DOD executive agent for Veterinary services revealed no reasons for any recommended changes (TAB O).

(4) A review of the food and sanitation inspection ongoing by both the Army and Air Force revealed no gaps in service, no duplication of effort or no reason for consolidating services (TAB P).

(5) After hours emergency dental care is available at Ramstein, Sembach and Landstuhl by on-call personnel. Because of the infrequent need for these services (less than one a day at each location), the fact that the dentists work the following day without compensatory time and the convenience to population, no significant savings can be realized by consolidation (TAB Q).

(6) Professional development resources are being utilized in an optimally efficient manner. Schedules of meetings, seminars and symposiums are sent to each clinic and prevent duplication of needed efforts for commonly needed, required or desired professional topics of mutual interest (TAB R).

(7) The need for an Air Force liaison at Landstuhl Army Regional Medical Center was reviewed and found to be fully justified based on the service rendered to a widely dispersed Air Force active duty population that is treated at Landstuhl (TAB S).

(8) A review of the medical logistics system indicated no justification for consolidation because of wartime missions and incompatible automated systems. However, the review of these separate systems operating in a peacetime environment may be justified at the DOD level (TAB T).

(9) The ability for all health facilities to communicate with each other did exist; however, there is only one mode of communications (dial telephone) between Sembach and Landstuhl. Ramstein and Landstuhl have dial phone, radio and direct line access to each other. It was also felt by the committee that a central dispatch system handling not only medical but also fire and police should be explored; however, recent adverse stateside publicity over this type of arrangement must be carefully considered if any change to the decentralized current method is tried (TAB U).

(10) The Community Health Nursing responsibilities of the Kaiserslautern Military Community are being met but not with the resources required. The Air Force does not have this capability in this community. The Army has been disallowed use of the Air Force population figures by the USAREUR Manpower survey team and cannot obtain proper staffing without. A request to obtain relief from this situation was forwarded to 7th Medical Command on 13 November 1983. Resolution is currently being attempted by 7th Medical Command between USAFE and the USAREUR Manpower survey team but the problem is currently unresolved (TAB V).

(11) Each outpatient medical treatment facility requires time responsive clinical laboratory support to provide routine care. The current distribution of laboratory support within the Kaiserslautern Military Community meets this requirement. The existing system does triage patients to insure that laboratory specimens are processed at the facility that has the capability to perform the test. The planned electronic communication of test results from the 2d General Hospital to the outlying Army clinics will improve the quality of care rendered at these facilities. The clinical laboratories at Ramstein and Sembach provide timely and responsive services to their medical staffs within their capabilities. The referral workload for Ramstein is minimal. Although the referral workload for Sembach is considerably more, the majority of this workload is kept within the Kaiserslautern community at 10th Medical Lab. Replacement of existing lab equipment due to normal programmed replacement cycles with state of the art equipment could recapture some of this referral workload (TAB W).

f. Recommended Change with No Identifiable Dollar Savings.

(1) A review of the ambulance coverage by the health facilities in the Kaiserslautern Military Community was made and recommended changes were made to provide quicker response time within the community. Boundaries were drawn beyond which it is more medically appropriate for patients to call the German Red Cross ambulances. The geographical areas of support for all health clinics were agreed upon. The information on ambulance support should be publicized in community newspapers and made available to all eligible beneficiaries in the Kaiserslautern Military Community at a later date (TAB X).

(2) The current method of disposing of contaminated waste is no longer feasible. Three alternatives were examined: first, upgrade of the incinerator at LARMC; second, purchase of autoclaves so all clinics can neutralize their contaminated waste; third, contracting disposal service to a company

specializing in biohazardous waste elimination. The third alternative is the most attractive and will cost the government about $54,000 a year (Tab Y).

C. FACTS

a. The greater Kaiserslautern Military Community comprises an area of approximately 750 square miles having an eligible beneficiary population of approximately 63,000 active duty, dependent, retired and DOD civilian personnel. High densities of this population are located in Ramstein, Vogelweh, Landstuhl, Kaiserslautern and Sembach (Table 1). Each of these major population concentrations has both outpatient and dental capability available. The average monthly outpatient medical clinic workload alone exceeds 42,000 visits (Table 2) some of whom come from outside the catchment area of the above population for treatment. The only DOD inpatient capability is located at Landstuhl at the Landstuhl Army Regional Medical Center. This facility is the major medical referral center for all of Europe, Africa and the Middle East. At any given time, over half of the beds are occupied by active duty service members (Table 3).

b. All facilities studied had both peacetime and wartime missions. The two Air Bases also have operational flight lines which have required medical support. The Kaiserslautern Military Community is said to have the single largest concentrations of American citizens in one place outside the boundaries of the Continental United States. It does not lend itself well to facility consolidations while at the same time providing timely medical care to the resident eligible beneficiary population in this large geographical area without increasing risks in providing quality health care or performing wartime missions.

c. All DOD medical treatment facilities located in close proximity to each other are required to make a constant effort to insure maximum utilization of medical resources. This mandate is found in DOD Directive 6015.5, dated 5 February 1981, subject: Joint Use of Military Health and Medical Facilities and Services. Additionally, in the Kaiserslautern Military Community, the joint-service medical responsibilities are outlined in the medical annex to the Creek Swap Agreement, dated 1 Jul 75.

D. ASSUMPTIONS

1. The beneficiary population is stable despite short term losses.

2. There are no major geographical or demographic shifts in beneficiary population that would cause existing clinics to close.

E. ALTERNATIVES

1. Retain the current configuration of activities and facilities.

2. Consolidate possible outpatient, dental, and veterinary areas.

F. DISCUSSION OF ALTERNATIVES

1. The status quo is the more cost effective arrangement, and is more responsive to wartime missions. Furthermore, it provides timely, life-saving medical care. The clinics are ideally located in close approximation to eligible beneficiary concentrations. In addition to day-to-day health care operations, the war-time roles of these organizations must also be reviewed and practiced during the year to insure combat readiness.

2. No areas considered for possible consolidation of activities/facilities were found to be more cost effective. Health care support would be moved away from the population supported causing a medically endangering situation and imposing greater transportation demands on the population. Consolidation would require major facility renovation which would not be cost effective. The only facility with potential to expand is Sembach AB. Consolidating there would move health care availability from the large population areas in Kaiserslautern, Ramstein, and Vogelweh (13 miles) requiring family medical care.

TABLE 1
ESTIMATED POPULATION SERVED
(Average Monthly Strength of Organizations
Provided Primary Health Care, Apr-Jun 83)

	Active Duty	Family Member	Other	Totals
USAF Facilities				
Ramstein	9,915	16,855	6,500	33,270
Sembach	2,700	4,050	43	6,793
US Army Facilities				
Kleber Kaserne (East K'lautern)	5,235	0	0	5,235
Vogelweh	843	10,200	2,800	13,843
Landstuhl	2,038	1,587	688	4,313
Totals	20,731	32,692	10,031	63,454

Source: AF clinics - Report of Patients (RCS: HAFSGS (M) 7118)
Army clinics - Medical Summary Report (RCS: MED-302)

TABLE 2
OUTPATIENT MEDICAL CLINIC WORKLOAD
(Average Monthly Clinic Visits, Apr-Jun 83)

	Active Duty	Family Member	Other	Totals
USAF Facilities				
Ramstein	5,320	5,648	394	11,362
Sembach	1,713	1,485	91	3,289
US Army Facilities				
Kleber Kaserne (East K'lautern)	1,656	0	0	1,656
Vogelweh	1,071	2,977	302	4,350
Landstuhl	10,419	9,143	1,901	21,463
Totals	20,179	19,253	2,688	42,120

Source: AF clinics - Report of Patients (RCS: HAFSGS (M) 7118)
Army clinics - Medical Summary Report (RCS: MED-302)

TABLE 3
INPATIENT WORKLOAD
(Daily Average Hospital Beds Occupied, Apr-Jun 83)

	Active Duty	Family Member	Other	Totals
US Army Facility				
Landstuhl	107	80	18	205

Source: LARMC Command Performance Summary 3rd quarter FY 83.

Appendix 11
Minutes of the Tri-Service Committee
on Quality Assurance
26 July 1984
18 October 1984

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

1 AUG 1984

HEALTH AFFAIRS

MEMORANDUM FOR THE TRI-SERVICE COMMITTEE ON QUALITY ASSURANCE

SUBJECT: Minutes of the Tri-Service Committee on Quality Assurance

1. The Committee met at 1330 hours on 26 July 1984 in Room 1B657, the Pentagon.

2. The following individuals were present:

a. Committee Members:
Dr. Jarrett Clinton
LTC Phil Velthuis
LTC Nancy Adams
COL Graham Beard
CAPT John Babka
COL Frank Zimmerman

b. Guests:
LCDR Brian Gooch

3. Old Business: Minutes from the previous meeting (28 June 1984) were approved.

4. New Business:

a. Changes to the Credentials Directive that were received from the coordinating offices were discussed. A copy of the directive with the proposed changes was given to each member. The changes were accepted as written except for the following:

1. Under policy the statement concerning not granting privileges beyond those that could be supported by the MTF or DTF was moved to page 5 at the end of paragraph d.

2. On page 4 it was agreed to delete Independent Duty Technicians and Submarine Corpsmen from the list of health care providers requiring credentials. The listing of duties for these groups and the required evaluation for renewal of their patient care diagnosis and treatment responsibilities will be further elaborated in a forthcoming change to DoDD 6025.2, Nonphysician Health Care Providers.

b. Dr. Clinton discussed the decision made by the Defense Health Council (DHC) regarding the use of Occurrence Screening. The DHC decided to replace the reporting of complications rates required under DoDD 6025.1 with occurrence screening data. Each occurrence has an effective acceptable frequency or rate of 0% (i.e. if it happens it will be reported and a review initiated). It was agreed, therefore, that the occurrence screening approach was in compliance with the directive which requires the establishment of norms or rates for complications. The format for reporting the data will be decided at the next meeting of the Tri-Service QA Committee.

c. The concept of credentialing interns, residents, and fellows was briefly discussed. It was agreed that since these individuals are in training programs it was not appropriate to credential them as independent providers. A separate process to be monitored by the graduate education and training committee was decided to be the proper mechanism to monitor the activities and performance of medical and dental interns, residents, and fellows. The Credentials Directive was annotated to reflect this. Under Section D, Policy, this sentence was added: "Medical and dental interns, residents, and fellows are not credentialed since they are in training programs. However, a process for granting clinical privileges and profiling professional and clinical activities comparable to that required of physicians and dentists under this directive shall be established by each Military Department, applied to these providers and administered by the MTF or DTF graduate education and training committee."

5. Recommendations Pending: Develop format for reporting of the occurrence screening data.

6. The meeting was adjourned at 1530 hours. The date for the next meeting is 9 August 1984, at 1000 hours in room 1B657.

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WASHINGTON, D.C. 20301

HEALTH AFFAIRS

4 December 1984

MEMORANDUM FOR THE TRI-SERVICE COMMITTEE ON QUALITY ASSURANCE

SUBJECT: Minutes of the Tri-Service Committee on Quality Assurance

1. The Committee met at 1300 hours on 18 October 1984 in Room 5D1016, the Pentagon.

2. The following individuals were present:

a. Committee Members:

Capt John Babka	Navy/SG
Col Graham Beard	DASG/PSQ
Capt Ed Blount	OASD/PA&QA
LTC Phil Velthuis	OASD/PA&QA

b. Alternates:

Capt Kevin O'Shea	AF/SG(sitting for absent member Col Frank Zimmerman)

3. Old Business:

LTC Velthuis advised the Committee members that effective with the minutes from this current meeting, there would no longer be the formal requirement for the members to endorse a copy of the Committee minutes back to the Chairman. Rather, the members would be expected to present any comments or corrections to the minutes of a given meeting, to the Chairman, no later than the day of the Committee's next meeting. Any comments not provided by that time would not be able to be considered.

4. New Business:

a. LTC Velthuis introduced Captain Ed Blount, USN, MC, a new staff member in OASD/PA&QA and a new member of the Committee.

b. LTC Velthuis passed out copies of comments received from the Services on the latest draft of the proposed DoD Directive on Credentialing. He proceeded to lead the Committee through a discussion of each of the points that had been raised by the Services, relating the proposed handling of each issue/comment based on a prior discussion of these items by the Health Affairs' quality assurance staff. The specific items discussed and their resolution are as follows:

(1) In response to each of the Service's comment that the Provider Profile contains items which are too difficult to gather without the help of an automated system, and that phasing-in the Profile requirement should be considered, the Committee agreed to a 3-phased implementation of the Provider Profile requirement, as follows:

Phase I, to be effective at date of the Directive's issue, to include the reporting elements of Number of inpatients discharged, Number of deaths, Number of surgical patients with normal tissue, Number of malpractice claims filed, Number of validated occurrence screening variations by type, and the Number of continuing education credits.

Phase II, to be effective the 1st quarter of FY 1986, adding the Number of transfusion variations, Number of medical record deficiencies, and the Number of medical record delinquencies.

Phase III, to be effective the 3rd quarter of FY 1986, adding the Number and type of procedures performed, Number of drug utilization variations, and the Number of validated patient complaints.

The phasing of the provider profiling requirement will be stipulated in the Credentialing Directive. (The Navy committee member indicated that the Navy continues to prefer that none of the Provider Profile data collection requirements be mandated before the implementation of the complete automated system.)

(2) Responding to an Army suggestion, the scope of the Directive was expanded to include Foreign National Hire civilian personnel.

(3) The Army comment, that reporting a provider's training in cardiopulmonary resusitation (CPR), advanced cardiac life support (ACLS) and advanced trauma life support (ATLS),should be deleted since these training courses do not represent continuing medical education; was dismissed as a misreading of the language of the proposed Directive. The wording in the proposed Directive does not attempt to include these training requirements within the context of continuing education. They are to be part of the provider's profile simply to show currency in trauma care.

(4) The Army comment, that additional definitions be included in the proposed Directive to clarify specific items being reported in the Provider Profile, would, it was felt, be unnecessarily detailed for a policy directive. Should amplification or clarification of some specifi requirements be needed subsequent to issuance of the Directive, these could be addressed by Health Affairs in a memo format.

(5) The Air Force comment, that the word "validated" should be eliminated from Provider Profile data elements, was dismissed as not in the best interests of the individual provider or the Department of Defense and that variations in patient care should only be entered into the provider's permanent credentials file after they have been reviewed and validated as being or not being provider attributable by a peer review functionary. The Committee felt that the Air Force concern over the subjectivity of such data is lessened by the fact that the raw or unreviewed provider data will be collected and available for examination under the forthcoming computerized quality assurance support system.

(6) Responding to an Air Force comment that the requirement for original or authenticated precredentialing documents be tempered by adding the words "if applicable", the Committee chose instead to address the specific nature of the Air Force comment by altering the precredentialing requirement for "Continuing education" to "Certified continuing education." This will eliminate the need for and confusion over normally undocumented Category II, III, and IV continuing medical education.

(7) The Air Force comment, that MTF and DTF commanders be allowed to designate an alternate person in the MTF or DTF as the person with the authority to grant clinical privileges, was dismissed on the basis that the current wording in Section E of the proposed Directive has enough implied flexibility to allow the MTF or DTF commander to delegate this duty in the case of temporary privileges. Also, retaining the present wording makes clear the DoD policy that the MTF or DTF commander is held accountable for the clinical privileges that are authorized to providers practicing within his or her facility.

(8) The Committee agreed with the Air Force request that the category of credentialing designated as "Conditional Privileges" in the proposed Directive be changed to "Provisional Privileges". However, based on a Navy comment suggesting elimination of the provisional privileges category, in subsequent discussions between the HA Quality Assurance staff and the Committee members, it was agreed to collapse the three categories of privileges in the proposed Directive into two categories, since there seemed to be a degree of redundancy between the temporary and provisional categories. That is, the categories of clinical privileges grantable will be defined as either Temporary Privileges or Full Privileges, Provisional Privileges having been subsumed within the Temporary Privileges category. (The Navy Committee member indicated that Navy continues in its position that standardization of privileging categories across the Services has no particular merit.)

(9) The Committee agreed with the Air Force request to drop the Precredentialing requirement for a letter of recommendation from a peer of the provider seeking entry into the DoD system.

(10) Responding to the Air Force request to drop the Precredentialing requirement that each incoming provider be interviewed by an officer of the same corps and same specialty, the Committee decided that the current wording in the proposed Directive, which only indicates a preference, not a requirement, for an interview by an officer of the same corps and specialty; provides sufficient flexibility in cases where this is not practical.

(11) Responding to a Navy comment that the Provider Profile was not appropriate for shipboard or field Marine Corps providers because they are not involved in the same type of activities as a hospital-based provider, the Committee decided to add the words ". . .to the extent that such activities are performed or required", to give necessary flexibility to the requirement that all providers must have such profile data maintained on them.

(12) Responding to the Navy comment that clinical "privileges" cannot be granted to providers in training, i.e., interns, residents and fellows, the Committee agreed to change the wording of paragraph D. Policy, as follows: "However, a process for defining, profiling and evaluating professional and clinical activities equivalent to that required of physicians and dentists under this Directive shall be applied to these providers and administered by the MTF or DTF graduate education and training committee."

5. Based on discussions between the HA Quality Assurance staff and the Service QA Directors on 2 November 1984, it was jointly agreed to add the following language to the Precredentialing section of the proposed Directive: "Written verification or telephonic verification from the issuing source or professional clearinghouse, with documentation of the result of such verification, shall be requested for the following documents: (a) qualifying degree (including diploma), (b) board certification, (c) ECFMG certification, and (d) registration/ licensure.". This addresses the growing concern nationally that fraudulent medical credentials are too easily obtainable and that DoD would be remiss not to require written or telephonic verification from the issuing office.

6. The HA Quality Assurance office will revise the proposed Directive on Credentialing based on the Service comments and the Committee's discussion, preparatory to Dr. Mayer's final coordination and his recommendation to the Secretary of Defense for signature.

7. The meeting adjourned at approximately 1500 hours. There was no meeting in November due to the Emergency Services Conference and the Thanksgiving holidays. The next meeting will be at 1000 hours, 13 December 1984, Room 1B657, the Pentagon.

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Appendix 12
Joint Medical Training

SGPE-ED
11 Mar 85

INFORMATION PAPER

SUBJECT: Bi-service/Tri-service Course Conducted by the Army Medical Department (AMEDD)

1. Purpose. To provide information on the Bi-service and Tri-service courses conducted by the AMEDD under the Interservice Training Review Organization (ITRO) and to provide information on the conduct of each course during mobilization.

2. Facts.

At Enclosure 1 is a listing of all enlisted Bi-service and/or Tri-service courses conducted by the AMEDD. Also included is a proposal which identifies those courses to be taught during the first 180 days of mobilization.

1 Encl

CPT(P) Stieneker/50928

AMEDD TRI/BI-SERVICE COURSES

COURSE NUMBER	COURSE TITLE	CONDUCTED DURING MOBILIZATION	PARTICIPATION AIR FORCE	NAVY	MARINE CORPS	COAST GUARD
300-91V10	Respiratory Specialist	No		X		
300-91Y10	Eye Specialist	Yes				X
301-91D10	Operating Room Specialist	Yes				X
302-91F10	Psychiatric Specialist	Yes		X		
302-91G10	Behavioral Science Specialist	Yes	X		X	
303-91J10	Physical Therapy Specialist	Yes		X		
303-91L10	Occupational Therapy Specialist	Yes	X			
304-91H10	Orthopedic Specialist	Yes				X
311-92B10	Medical Laboratory Specialist (Basic)	Yes		X		X
312-91Q10	Pharmacy Specialist	Yes				X
313-91P10	X-Ray Specialist	Yes				X
321-91R10	Veterinary Specialist (Basic)	Yes	X		X	
322-91S10	Environmental Health Specialist	Yes				X
4B-F2/198-35G10	Biomedical Equipment Specialist (USAMEDS)	Yes		X		X
311-92B10	Medical Laboratory Specialist	Yes		X		X
311-92B30	Medical Laboratory Specialist (Advanced)	No				X
311-92E20	Cytology Specialist	No	X			
321-91R20	Veterinary Specialist (Advanced)	No			X	
300-F4	Allergy/Clinical Immunology Specialist	No	X			

AMEDD TRI/BI-SERVICE COURSES

COURSE NUMBER	COURSE TITLE	CONDUCTED DURING MOBILIZATION	PARTICIPATION			
			AIR FORCE	NAVY	MARINE CORPS	COAST GUARD
4B-202A/198-35U20	Biomedical Equipment Specialist (Adv)	No		X		X
4B-F4/198-F4	Advanced Digital Theory	No		X		
4B-F5/198-F5	Polyphase X-Ray Systems	No		X		
4B-F6/198-F6	BHR Compliance Testing	No		X		
4B-F7/198-F7	Microprocessors	No		X		
4B-F8/198-F8	Closed Circuit T.V.	No		X		
6A-C4	Combat Casualty Care Course	No		X		
6H-F17	Laser Microprocessor Hazards	No	X	X		
6H-F18/323-F18	Medical X-Ray Survey	No		X		
6H-F20	Occupational Medicine	No	X	X		
6H-F22	Infection Control	No		X		
6H-F23	Tropical Medicine	No	X	X		
6H-F25/323-F25	Medical Management of Chemical Casualties	No	X	X		
6H-67A	Baylor Health Care Admin Course	No	X	X		

FACT SHEET

HSHA-ITO
4 Jan 85

SUBJECT: Training of Other Services in AMEDD Courses

ISSUE. The Academy of Health Sciences trains members of the Air Force, Navy, Coast Guard, and Marines in a variety of AMEDD formal courses. This fact sheet provides statistics on other service training.

FACTS.

1. In FY 84, approximately 10% of the Academy of Health Sciences (AHS) student load was comprised of other services. Over 2,700 individuals were trained in formal AMEDD numbered courses. In FY 85, close to 2,800 students from other services are scheduled to attend Army Medical Training. Enclosure 1 provides a course by service breakout of the training. Enclosure 2 provides a brief description of the courses extracted from DA PAM 351-4, US Army Formal Schools Catalog.

2. Army Medical Students also participate in training conducted by the Navy. Participation of Army students is coordinated by Army Medical Department Personnel Support Agency (AMEDDPERSA). Enclosure 3 provides information on the Navy training.

3. In order to assist in the training of other services, 46 Navy instructors and 36 Air Force instructors are assigned to the Academy of Health Sciences.

4. The Combat Casualty Care Course (6A-C4) trains the largest number of other services and has the majority of other service intructors. The 6A-C4 course is offering an additional version to the physician training in FY 85. The new course, 6A-C4A, will train potential commanders and service chiefs of corps level deployed hospitals.

FY 85 (Programmed)

COURSE NO.	COURSE TITLE	NUMBER IN COURSE AF	NV	CG	MC	TO
300-F4	Allergy/Clinical Immunology Specialist	30				3
300-91V10	Respiratory Specialist		27			2
300-91Y10	Eye Specialist			1		
301-91D10	Operating Room Specialist			4		
302-91F10	Psychiatric Specialist		156			15
302-91G10	Behavioral Science Specialist	70			12	8
303-91J10	Physical Therapy Specialist		56			5
303-91L10	Occupational Therapy	10				1
311-92B10	Medical Laboratory Specialist (Basic)		245	6		25
311-92B30	Medical Laboratory Specialist (Advanced)			1		
311-92E20	Cytology Specialist	6				
312-91Q10	Pharmacy Specialist			6		
313-91P10	X-Ray Specialist			6		
321-91R10	Veterinary Specialist (Basic)	300			12	31
321-91R20	Veterinary Specialist (Advanced)				6	
322-91S10	Environmental Health Specialist			4		
4B-F2/198-35G10	Biomedical Equipment Specialist (Basic)		80	3		8
4B-F4/198-F4	Advanced Digital Theory		18			1
4B-F5/198-F5	Polyphase X-Ray Systems		9			
4B-F6/198-F6	BRH Compliance Testing		9			
4B-F7/198-F7	Microprocessors		6			
4B-F8/198-F8	Closed Circuit Television		9			
4B-202A/198-35U20	Biomedical Equipment Specialist (Advanced)		45	2		4
6A-C4	Combat asualty Care	800	800			160

FY 85 (cont)

COURSE NO.	COURSE TITLE	NUMBER IN COURSE AF	NV	CG	MC	TOTA
6H-F17	Laser Microwave Hazards	15	2			17
6H-F18/323-F18	Medical X-Ray Survey Techniques		2			2
6H-F20	Occupational Medicine	1	1			2
6H-F22	Prevention & Control of Hospital Associated Infections (Basic)		6			6
6H-F23	Tropical Medicine	1	4			5
6H-F25/323-F25	Medical Management of Chemical Casualties	5	12			17
6H-67A	US Army/Baylor University Program in Health Care Administration	2	5			7
	TOTALS	1240	1492	33	30	2795

FACT SHEET

HSHA-ITO
4 Jan 85

ARMY INPUT INTO NAVY COURSES

Number	Title	Length	ASI	Location
B-300-0018	Cardiopulmonary Technician	52w	Y6	(Bethesda)
B-300-0029	Dermatologist Technician	12w	D2	(San Diego)
B-302-0043	Electro-encephalography Tech	26w	T6	(Bethesda)
B-311-0016	Clinical Nuclear Medicine Tech	16w (Phase I)	91W MOS	(Bethesda)

ENCL 3

END

FILMED

9-85

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