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**THE TIDEWATER VIRGINIA COORDINATED CARE
PROGRAM: A CASE STUDY**

A Graduate Management Project
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Masters of Health Administration
by
LCDR Stephen M. Ulbricht
July 1992

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TRICARE: A CASE STUDY

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ABSTRACT

The Tidewater area of Virginia is the site of the first Department of Defense (DoD) tri-service Coordinated Care Program. The three Military Treatment Facility Commanders (MTF), with the Navy as Executive Agent, are vested with the authority to develop a coordinated care program to meet the needs of the beneficiary population who number in excess of 380,000. An analysis of the information gathered during TRICARE-Tidewater's conceptual phase and a portion of its planning phase can serve as a useful tool for MTF managers faced with implementing coordinated care. The review and analysis was limited to documentation produced from the initial conceptual phase between the three MTF Commanders and the Assistant Secretary of Defense for Health Affairs (OASD-HA) through 31 December 1991. This case study analyzes in qualitative terms issues such as organizational performance/effectiveness, communication between the three services, and leadership. Through the use of structured interviews, the responses of key personnel at the three MTF's and TRICARE-Tidewater were analyzed. Finally, document review and participation-observation were employed to qualitatively analyze important issues. The lack of adequate policy and guidance from OASD(HA) and the lack of a Memorandum of Understanding

(MOU) between the services led to communication problems and a high level of frustration among the personnel interviewed at the TRICARE-Tidewater office. The lack of adequate communication within a program of such high visibility should remain open to facilitate innovation and participation.

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CHAPTER I. INTRODUCTION

The purpose of the case presented in this paper will be of a descriptive and exploratory nature. The goals of the researcher were to discover important questions, processes, problems, and relationships associated with the implementation of TRICARE-Tidewater's initial planning phase in 1990 to the end of calendar year 1991.

The Tidewater region of Virginia is the site of the Department of Defense' (DoD) largest coordinated care program. The area is composed of three overlapping catchment areas. The three Military Treatment Facilities (MTF's) include Portsmouth Naval Hospital (PNH), 1st Medical Group (Langely Air Force Hospital), and McDonald Army Hospital (Fort Eustis). According to the General Accounting Office (GAO) (GAO, October 1991, p.3) "Until recently, DoD had made little progress in implementing Coordinated Care at its one site in Virginia". This GAO report attributed the lack of success at TRICARE-Tidewater to disagreements and uncertainties among Health Affairs and the services over funding responsibilities and policies. In addition there had been only one full-time person working on the project since it began in September 1990 through mid-August 1991.

In mid-August 1991, the Navy put together a group of people referred to as a "rapid implementation team" (RIT), who possessed expertise in various areas that were needed to start up the project (GAO, October 1991, p.6). Many RIT members were given Temporary Authorization Duty (TAD) for six month periods. In other words, these members were sent to the TRICARE-Tidewater office for a period of time not to exceed six months. The personnel who comprised the RIT differed from the personnel originally requested.

All MTF's will soon be tasked with planning and developing Coordinated Care programs to curb the Department of Defense' spiralling CHAMPUS bill. The lessons learned in this first experiment can facilitate implementation in other catchment areas.

This chapter continues with an examination of the problems facing the Military Health Services System (MHSS) whose population currently is greater than 9 million beneficiaries. This chapter also incorporates a brief history of the RIT concept. A literature review of the case study methodology, the form of research chosen by the researcher is provided in Chapter II. Current theories of organizational performance\effectiveness follow and Chapter II concludes with a look at the history of managed care

from its inception to current hybrid forms. An explanation of the research methodology chosen is given in Chapter II, Methods and Procedures. Formal data collection and analysis are presented in Chapter IV. Factual information and a list of the personnel interviewed at the TRICARE-Tidewater program are presented in separate tables. Surveys employed at the three MTF's and at the TRICARE-Tidewater office are shown in the Appendix section.

Background

In this era of tightened budgets and manpower cuts, the current Military Health Services System (MHSS) is greatly overloaded in trying to meet the healthcare demands of an increasing dependent and retired population. That population now numbers over 9 million beneficiaries (OASD, 1991). The likelihood for real increases in defense spending dwindled in the mid-1980's in light of a changing international environment and large federal deficits. Utilization of healthcare increased during the 1980's especially through the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) (Hilsenrath, 1990). CHAMPUS is a medical benefit program that cost-shares charges for medically necessary treatment provided to eligible

beneficiaries. It is provided by civilian sources when needed services are not available from the military direct care system.

Table 1 provides a comparison of the DoD CHAMPUS expenditure and the civilian healthcare expenditure in 1981 and 1990. DoD's CHAMPUS bill rose at a rate more than twice that of the civilian sector for the period. The Navy's share of CHAMPUS costs swelled from \$648 million in FY 1986 to over one billion dollars in FY 1989 (Hilsenrath, 1990).

Table 1

A Comparison of DoD CHAMPUS Expenditures & Civilian
Healthcare Expenditures (In billions of dollars)

	1981	1988	Percentage Change	Annual Increase
CHAMPUS	.852	2.5	193	27.6
Civilian	288.6	539.9	87.07	12.4

Note. The data in Table 2 are from

Badgett, A. L. > (1990). Catchment area management: a
new management process for military healthcare.

Journal of Ambulatory Care Management, 13(3), 2.

United States Public Health Service (1990). Health
United States 1990 (DHHS PHS 91-1232), Washington,
D.C.: U.S. Government Printing Office, 184.

Table 2 illustrates how the CHAMPUS portion of DoD's healthcare bill compares with the direct-care system and the total DoD healthcare bill. The direct-care system bill has slightly outpaced the civilian healthcare bill, while the CHAMPUS component significantly outpaced both the direct-care cost and the total DoD healthcare bill.

According to the GAO (March 1990, p. 1), DoD's CHAMPUS cost are expected to exceed the direct-care cost of healthcare. Current Congressional estimates are that the FY 1991 CHAMPUS shortfall will be between \$750 million and \$1 billion dollars (PMA, 1991). The GAO (March 1990, p.2). defines a shortfall as the difference between the appropriated amount before supplemental appropriations and actual cost. The Military Health Services System is obviously overloaded and the estimated shortfall represents the potential overload on the system.

Table 2

DoD Healthcare Spending (In billions of dollars)

	1984/ % of Total	1990/% of Total	1991 projected	% Change from 1984-90	Annual Change from 1984-90
CHAMPUS	1.254/ 17.4	3.199/ 22.7	2.7/ 19.4	149	24.8
Direct- Care System	5.934/ 82.6	10.971/ 77.3	11.2/ 80.6	85	14.16
Total DoD Health- care bill	7.188	14.090	13.9		

Note. From the Congressional Budget Office (September 1991). CBO Papers: Managed care in the military: the catchment area management demonstrations. Washington, DC: U. S. Government Printing Office.

The GAO (March 1990), also concluded that the amount and cost of DoD beneficiaries' healthcare provided under CHAMPUS increased partly due to the decline in the amount of care provided at military facilities. Other reasons included the overall increase in the cost of providing medical care, an increase in the amount of DoD beneficiaries, and an increased rate at which beneficiaries utilize the medical care system.

From FY 1985 to 1987, the DoD significantly decreased the amount of medical care provided to beneficiaries in its facilities. Beneficiary inpatient admissions decreased about 64,000 (11 percent); outpatient visits decreased about 2.7 million (10 percent) (GAO, 1989). The greatest decrease took place in Navy facilities. These decreases were the cumulative result of a variety of factors to include a reduction in the number of patients certain specialists could see, staff shortages in critical specialties, increased readiness training and deployments, and an emphasis on quality assurance, which decreased the amount of physicians' time available for direct patient care (GAO, 1989).

Congress has initiated several plans to decentralize the management of the CHAMPUS budget. In

October 1988, the CHAMPUS budget was allocated directly to the military departments, which provided a basis for the integration of the two health care systems (direct care and CHAMPUS). The CHAMPUS budget was allocated by catchment area at the military department level in October of 1989 (Badgett, 1990). A catchment area is defined as an approximate 40-mile radius around a military hospital. The Tidewater Service Area is comprised of four overlapping 40-mile circles that surround military hospitals in the southeast portion of Virginia. The military hospitals include: 1st Medical Group Langley AFB, located north of Hampton; McDonald Army Hospital, Fort Eustis, to the northwest of Newport News; and the Portsmouth Naval Hospital, in Portsmouth. The TRICARE-Tidewater project does not include the Fort Lee Kenner Army Hospital in Petersburg, Virginia. Numerous medical clinics and ambulatory care facilities are also located within the Tidewater Service Area. These include Army clinics at Fort Eustis, Fort Lee, Fort Monroe, and Fort Story; and Navy clinics at the Norfolk Naval Base, Norfolk Naval Shipyard, Oceana Naval Air Station, Little Creek Naval Amphibious Base, Dam Neck Naval Base, Northwest Security Group in Chesapeake, and the Yorktown Weapons Station.

Within the 1988 CHAMPUS reallocation, Congress authorized a number of demonstration projects aimed at controlling the growing CHAMPUS costs; Catchment Area Management (CAM) demonstration is one of these. Under this demonstration, the CHAMPUS budget for a catchment area is delegated to the military hospital commander. The commander can use this budget in combination with the normal operating budget for the provision of health care to all eligible beneficiaries within the area. This applies regardless of whether care is given in the military or civilian sector.

Five military sites were selected to participate in the 3-year CAM demonstration: two Army, two Air Force, and one Navy. The four primary objectives common to all sites were to:

- 1) contain the rate of growth in CHAMPUS costs;
- 2) improve accessibility to health care;
- 3) improve satisfaction with health care; and
- 4) maintain quality of health care (Badgett, 1990).

For the DoD to manage the provision of healthcare to its beneficiaries effectively and efficiently, a comparison of MTF and CHAMPUS costs must take place. The Center for Naval Analyses (CNA) has developed a method that compares CHAMPUS and MTF inpatient cost

(CNA, 1991, p. v). The method uses Medical Expense and Performance Reporting System (MEPRS) data to calculate the MTF cost per admission for a category of care. Lack of reliable MEPRS data presented a major obstacle to the application of the study, however. The CNA Report (CNA, 1991, p. v) mentioned that visits to several MTF's and discussions with MEPRS-personnel identified several problems with the data collection procedures used to produce the occupied bed day (OBD) and ancillary reports. The CNA Report (1991) concluded that MEPRS data has not provided an accurate estimate of work center cost per OBD. In summary, DoD is still struggling with the MTF cost per visit.

The combination of shrinking defense budgets and ever-increasing health care costs will only intensify the pressure of healthcare on the defense budget (CBO, Sept 1991). DoD's answer to this problem has been to increase reliance on "managed care". To accomplish this, managed care interjects financial incentives, penalties, or administrative procedures into the doctor-patient relationship to alter the decision making of physicians and hospitals. Specifically, managed care tries to influence when care is given, where it is provided, how much is given, and how long treatment continues (Boland, 1991). Many employer-

sponsored health care plans use at least some aspect of managed care to control health care costs.

The GAO (May 1990, p.4) reported that many large firms have attempted to reduce healthcare costs by adopting systems to control and coordinate employee use of healthcare services-and thereby lessen their use. Some of the managed care options include health maintenance organizations (HMO's) or preferred provider plans, which restrict the range of healthcare providers from which the employee may receive services. This GAO report also reported that more than 70 percent of workers with employer-sponsored health coverage were enrolled in managed care plans in 1988.

According to the Congressional Budget Office (CBO) (Sept 1991, p.4) "experiences gained through these managed care demonstrations have led to the Coordinated Care Program, DoD's current plan for revamping the military healthcare system nationwide". Coordinated care appears to be modeled after catchment area management. The critical feature of coordinated care is the local health care delivery system. This system is based on arrangements between the military and civilian health care providers and is managed locally, as in the CAM demonstrations. However, the CBO (Sept 1991) also stated that since the five CAM

demonstrations have been operational only for a period of between one and two years, it was premature to draw definitive conclusions about them.

The GAO (October 1991, p.11) reported that DoD's contractor, the RAND Corporation, has a substantial research project underway to determine the feasibility and cost-effectiveness of the CHAMPUS Reform Initiative (CRI) and CAM demonstrations. Apparently, there is no comparable study underway or planned for Coordinated Care. The DoD is devising a system of performance indicators and measurement tools that can be used to assess the performance of hospital commanders in delivering high-quality healthcare that is cost-effective and accessible. The GAO agreed with the CBO regarding the need for a CAM evaluation at this time.

In June 1990, the first meeting of the Joint Services/Office of the Assistant Secretary of Defense (OASD) Health Affairs Task Force for Coordinated Care Operations took place (TRICARE-Tidewater Chronology of Events, 1 August 1991). This group addressed the need for the establishment of a managed care system in the Tidewater area. In September 1990, the initial meeting of tri-service MTF commanders took place to discuss the concept of establishing a coordinated catchment area management project in Tidewater (TRICARE-Tidewater

Chronology of Events, 1 August 1991). The three MTF's include Portsmouth Naval Hospital (PNH), 1st Medical Group (Langley Air Force Base), and McDonald Army Hospital (Fort Eustis). In January 1991, the Army, Navy, and Air Force Surgeons General agreed on the basic concept of operations for the Tidewater Coordinated Care Project (TRICARE-Tidewater Chronology of Events, 1 August 1991). At this time, the Navy Surgeon General forwarded a request to OASD(HA) to go ahead with the development and implementation of the Project. The TRICARE-Tidewater staff then proceeded to work with OASD(HA) in an effort to ensure that their response addressed the requirement for resources to implement the project.

Progress in the implementation of TRICARE-Tidewater had been less than desirable due to a lack of adequate resources, both financial and personnel, as of late July 1991 (Nelson, 1991, p.3). According to Nelson (1991, p.3), the project was "billed as the first test of coordinated care where military hospital commanders working across service lines provide the best, most cost-effective health care to one of the largest concentrations of military and retired families nationwide". Since the Tidewater region is home to nearly 400,000 beneficiaries who generate an annual

CHAMPUS bill of over 100 million dollars (exclusive of mental healthcare), the Project received a great deal of public and Congressional interest prior to the Summer of 1991.

Although TRICARE-Tidewater is the first tri-service coordinated care effort, there were other joint arrangements in DoD health care. The Joint Military Medical Command (JMMC) in San Antonio, Texas grew out of a political battle over the size of a new hospital at Fort Sam Houston-Brooke Army Medical Center, since the Air Force had a new facility at Wilford Hall Medical Center (Harben, 1991). Harben (1991, p.6) stated that the JMMC was controversial among the services and the community and many problems resulted from the assignment of civilian personnel. However, during its four and one-half year existence, JMMC was credited with many cooperative efforts among the Army and Air Force Medical Departments.

Other joint arrangements in the DoD health care system include the Delaware Valley Health Services System (DV-HSS), in which the Army was designated as the Executive Agent for the tri-service initiative, and the San Francisco Medical Command (SFMC) (U.S. Army Health Services Command Information Paper, 1991). The SFMC is a joint service medical command that reports

directly to the Commander, Bureau of Medicine and Surgery (BUMED), who is acting on behalf of the Executive Agent, the Secretary of the Navy. Both the SFMC and DV-HSS have long lists of their sharing and cooperative efforts.

According to the GAO (October, 1991), "the DoD made little progress in implementing coordinated care in Tidewater due to disagreements and uncertainties among Health Affairs and the services over funding responsibilities and policies". In addition, this GAO report (October, 1991) mentioned that there was only one person assigned on a full-time basis to the project since it began in September 1990 through mid-August 1991.

In Mid-August 1991, the Navy assembled and sent a team of people to TRICARE-Tidewater to speed the implementation of the tri-service project (GAO, October 1991). Members of the team, referred to as the "rapid implementation team" have expertise in areas that were needed to start up the project, such as communications, procurement, managed care, and information systems. The use of a RIT in the TRICARE-Tidewater project represents the second application of this concept. The first use of a RIT resulted from a 19 October 1988 meeting of the Medical Blue Ribbon Panel (BRP), whose

function was an in-depth analysis of Navy medicine. The BRP recommended that a RIT be sent to Naval Hospital Bethesda to "address issues pertaining to the reestablishment of the National Naval Medical Center, the disestablishment of the Naval Medical Command, National Capital Region and the Naval Medical Clinic, Washington, D.C., and all other recommendations affecting Navy healthcare delivery in the Washington D.C. area" (Department of the Navy, Office of the Chief of Naval Operations, Memorandum, 8 November 1988). The mission of the RIT at that time was to improve management effectiveness at Naval Hospital Bethesda and to reestablish Bethesda's position as the Flagship of Navy Medicine. The Surgeon General of the United States Navy, Vice Admiral Donald Hagen, MC, USN, stated "that the use of a RIT at Naval Hospital Bethesda provided a link between the entire Navy and Navy Medicine" (telephone interview, 15 April 1992). In addition, Vice Admiral Hagen stated that "the RIT at Naval Hospital Bethesda was very effective and met every goal they sought to undertake" (telephone interview, 15 April 1992).

The TRICARE-Tidewater RIT is comprised of nine Military Officers; specifically seven Navy members, and one Army Reserve Medical Service Officer, and one Air

Force Physician. In addition, in July 1991, the Army and Air Force provided a Medical Service Officer (Deputy Commanders) to work full-time on the project. The TRICARE-Tidewater Coordinated Care Program will closely approximate the combined total beneficiary population of the five existing DoD CAM demonstration projects, as Table 3 illustrates.

The TRICARE-Tidewater catchment area is comprised of nearly 400,000 beneficiaries; 70% of whom are Navy; 15% Army; and 15% Air Force. The Navy is serving as the Executive Agent and the jointly staffed operation provides day to day management and coordination of all health care delivery in the catchment area.

Table 3

DoD Catchment Area Management Projects As Compared To
TRICARE-Tidewater

Site	Total DoD Beneficiaries
TRICARE-Tidewater	386,000
Luke & Williams AFBs, Phoenix	75,400
Naval Hospital, Charleston	103,800
Bergstrom AFB, Austin	41,700
Ft. Carson Colorado Springs	122,300
Ft. Sill, Lawton, Oklahoma	55,700
	Total CAM Population: 398,900

Note. The data in Table 4 are from DMIS (1989).

Problem Statement

The Military Health Services System has no experience with planning for the implementation of tri-service coordinated care. The TRICARE-Tidewater Coordinated Care Program is tasked with an implementation date of 1 October 1992. While there are currently five CAM demonstration projects operational, their combined beneficiary population is just slightly larger than that of TRICARE's (398,900 versus 386,000).

Purpose

The purpose of this case study is to analyze the activities undertaken by the TRICARE-Tidewater Coordinated Care Program and PNH in planning for the implementation of DoD's first tri-service coordinated care program to date.

CHAPTER II. LITERATURE REVIEW

This chapter will examine the research methodology chosen, namely qualitative, followed by current theories on organizational performance and effectiveness. The final portion of this chapter will review the history of managed care. Sections on methods of healthcare financing, indemnity plans, Health Maintenance Organizations (HMO's), Preferred Provider Organizations (PPO's), medical group practice, and the current status of managed care are provided.

Case Studies

The case study is one of several ways of conducting social science research. It is also used in organizational and management studies. Yin (1989, p.13) states that the case study method of research is appropriate when a "how" or "why" question is being asked about a contemporary set of events, over which the investigator has little or no control. Field & Morse (1985) state that qualitative methods should be used when there is little known about a domain.

"In qualitative research, the general research question or topic, related literature, significance, and research design are interrelated; each one building on the others" (Marshall & Rossman, 1989). Marshall & Rossman (1989) also note that the design must remain

flexible, since it will probably change during the research cycle. They also refer to the fact that a qualitative study must demonstrate its significance. Significance, or utility, arises from: contributing to knowledge; relevant policy arenas should find meaning in the study; and the study should be useful for practitioners (Marshall & Rossman, 1989, p. 31).

Case studies can take many forms, depending on the intent of the investigation. Generally speaking, there is no single best format for a case study. Sypher (1990) and Yin (1989), recommend that the structure of the problem statement, investigation and analysis, and recommended solution be custom designed to meet the needs of the researcher.

Examples of formats used in case analysis include the linear analytic structure, comparative structure, chronological structure, theory-building structure, suspense structure, and the unsequenced structure. Table 4 illustrates the different case study structures and the advantages and disadvantages of each.

Table 4

Comparisons of case study structures

TYPE OF CASE STUDY	ADVANTAGES	DISADVANTAGES
1) Linear-Analytic	Standard approach for research, Uses: Explanatory, descriptive, exploratory	
2) Comparative	Fits well when comparing alternative descriptions or explanations of the same case. Uses: all three types	Challenge is to avoid being too repetitive
3) Chronological	Works well in explanatory type where events occur over time. Uses: all three types	Devoting a large amount of attention to the early events
4) Theory-building	Best suited for a scenario that requires a compelling statement. Uses: all but descriptive	The challenge is to uncover a new segment of the theoretical argument being made
5) Suspense	Best suited for explanatory type	The argument/explanation must be compelling
6) Unsequenced	Utility in descriptive type	Test of completeness is needed

The linear-analytic structure is best described as the standard approach for composing research reports (Yin, 1989). The sequence of subtopics in this method involve the issue being studied, methods used, findings from the data collected and analyzed and the conclusions and implications from the findings.

A comparative structure typically repeats the same case study two or more times which serves well in comparing alternative descriptions or explanations of the same case. The chronological structure simply presents the case in chronological order (Yin, 1989, p. 139). Yin (1989) warns against focusing too much attention on the early stages of the case in this format. The theory-building structure best serves a researcher who is trying to produce a theoretical argument. Yin (1989, p. 139) refers to each chapter or section as "unravelling a new part of the theoretical argument being made". By utilizing the suspense structure, the researcher presents the answer or outcome of a case study in the initial chapter or section and devotes the remainder of the case to developing an explanation of this outcome. The unsequenced structure is a method in which the sequence of sections or chapters is assembled in no particular manner. In this structure, the particular order of the

chapters or sections is not critical. Yin (1989, p. 140) mentions that descriptive case studies used for organizational situations in business settings that attempt to highlight the dynamics commonly use this method.

The case presented in this paper is constructed in the unsequenced structure, as discussed by Yin (1989). This method allows the researcher to tailor the case to best fit the scenario under study. A goal kept in mind by the researcher is that the final product of the study will have "real-life" applications to the situation under investigation.

Organizational Performance\Effectiveness

Organizations can be viewed as work-performing and problem-solving entities. Charns and Schaefer (1983) refer to healthcare organizations as an aggregate of people with a large variety of skills and talents work together to provide services aimed at solving healthcare problems. The degree to which this aggregation of people solve these problems is a measure of organizational performance (Charns & Schaefer, 1983). Charns & Schaefer (1983, p.6) mention that performance is composed of two parts: effectiveness and efficiency. Effectiveness can be determined by asking:

"to what degree and how well does an organization deliver the services it proposes" and "which of the services provided by an organization produces or has the potential for producing the quality of healthcare it aims to deliver" (Charns & Schaefer, 1983, p.6). The efficiency of an organization relates to the cost of producing those services. For an organization to do well in terms of performance, it must do so in terms of effectiveness and efficiency. Military healthcare systems, many times, were effective, but their efficiency was not stressed.

The concept of organizational effectiveness is quite complex due to a number of reasons. Charns & Schaefer (1983) cite three factors that contribute to the complexity. The first is related to the fact that organizations can be viewed in a systems framework. Organizations usually produce multiple outputs (goods and services), some of which are intended and some unintended. The second factor relates to the fact that different people place different values on outcomes. In other words, an organization may be viewed as effective from one perspective and not another. The third factor contributing to the complexity of effectiveness is the fact that outcomes can be

interpreted differently by different people (Charns & Schaefer, 1983).

There are two major ways of assessing an organization's performance or outcome: goal attainment and the systems resource perspective. The goal attainment approach maintains that each organization should be evaluated in terms of the degree to which it achieves its goals. The systems resource approach evaluates an organization in terms of its ability to obtain scarce resources, such as capital and people, that allow it to continue as a system and survive. (Charns & Schaefer, 1983)

Pennings and Goodman (1977) combined the goal and system resource approach by examining organizations in the context of their environments. Within the environment are people and other parts of the organization that determine an organization's inputs or outputs ("determinants"), or influence evaluation of effectiveness ("constituencies").

Hrebiniak (1991, p.58) states that goals or desired outcomes are the primary factors that influence decision making. Hrebiniak (1991) maintains that cost and resource concerns are important, but support secondary decisions. Organizations that are efficient and non-effective cannot survive. Hrebiniak (1991,

p.59) lists four critical ingredients that are essential in designing an organization that is effective and will survive:

1. Sound strategy formulation and planning processes
2. Structure appropriate to the strategic thrust of the organization
3. A means of achieving effective coordination and integration, especially laterally, across function or skills
4. Incentives and controls that support the objectives and operating structure of the organization.

Hrebiniak (1991, p. 59) states that sound strategic and short-term planning processes should provide a focus on objectives and emphasize the match between internal capabilities of an organization and external factors. Strategic and short-term planning are essential to ensure that an organization performs "the right things".

The second critical factor that Hrebiniak (1991, p. 59) mentions is an appropriate structure; or the way an organization groups and uses specialized human resources. Structure is composed of process specialization and purpose specialization. Hrebiniak (1991) states that process specialization is made up of

"common functions, skills, or areas of expertise".

Purpose specialization refers to a unit performing all the necessary tasks.

The third step in designing an effective organization necessitates that coordination or integration is performed well. Hrebiniak (1991, p. 63) mentions that "how the formal organizational structure relates to the informal role of the individuals within it depends on coordination". There are many ways to achieve integration such as frequent, direct contact among the players or more complex means such as matrix organizational structures.

The final part in designing an effective organization requires that appropriate incentives and controls be used. Incentives must be associated with goals or outcomes to achieve effective performance (Hrebiniak, 1991).

Managed Care

Health Care Financing

The number of people without health insurance is certainly gaining increased attention along with the issue of national health insurance in this 1992 election year. In 1984, approximately 16% of the civilian population under age 65 (33 million people)

was without some form of private health insurance (Shouldice, 1991). This figure grew to 14.7% by the end of 1988. Some of the self-pay people may have had some public financing of their health services, but many were directly responsible for payment of their own medical care. Many of these private-pay patients actually translated to "no-payment" and their accounts become bad debt write-offs. Healthcare organizations attempt to recoup these losses by cost-shifting and charging higher fees to patients with other finance methods. Today, however, cost-shifting is becoming increasingly more difficult due to prospective payment mechanisms.

The HMO concept evolved over the past 80 years and grew from the need of this country's workers to obtain adequate healthcare, usually when the traditional fee-for-service type approach could not cope with the demand (Shouldice, 1991). The Great Depression of 1929 saw the social structure of American life changing including the financing and delivery of healthcare. The Depression also persuaded the country's hospitals to depend less on philanthropic revenues and more on patient payment revenues for their services.

Blue Cross & Blue Shield (BC/BS) are considered "service plans" and their movement first began when a

group of 1,250 school teachers formed an arrangement with Baylor Hospital to provide them with hospital care on a prepayment basis (Shouldice, 1991). Current Blue Cross programs have evolved from the social insurance function of income redistribution and risk assumption. By 1933, the Blue Cross type plan and prepayment principle for group hospitalization had been adopted by the American Hospital Association (AHA).

Blue Cross member benefits began with the first dollar of care rendered on the first day of a hospital stay-referred to as the "first dollar, first day" coverage. This plan proved to be relatively expensive, but a socially valuable insurance arrangement, and one whose characteristics have changed little over the 60-plus years that BC plans have been in existence (Shouldice, 1991).

Blue Shield Plans, which are similar hospital service plans, are nonprofit medical service plans that have developed in a similar vein as the BC model. In the northwest United States prior to the Great Depression, the lack of medical resources encouraged the growth of various industrial contract practices. In particular, the lumber industry in Washington State had been contracting with physicians for the care of workers since the early 1900's. The motivations that

faced employers in the early 1900's to develop comprehensive and affordable health coverage are not unlike the concerns of today's health benefits officers.

In 1934, the American Medical Association (AMA) House of Delegates adopted a set of principles to provide guidance in the development of medical service plans (Blue Shield) (Shouldice, 1991, p.5). In 1935, the AMA recommended that its local medical societies develop medical service plans; California Physicians' Services and the County Medical Society in Oregon and Washington being the first such plans.

In recent years, independent and separate Blue Cross and Blue Shield plans have banded together to form single corporations in order to pool resources and become more effective in competing with alternative delivery systems. In the early 1970's, BC/BS plans developed their own HMO's, thereby entering the alternative delivery system market.

Indemnity Plans

Insurance companies prior to the Great Depression were interested in insuring individuals only against loss of income due to inability to work as a result of sickness, accident or loss of life. The development of the BC/BS plans in the 1930's saw commercial carriers

entering this new market utilizing their expertise in risk-pooling and actuarial techniques. In 1940, both life and casualty carriers began to underwrite health insurance (Shouldice, 1991, p.6)

Health Maintenance Organizations (HMO's)

The HMO concept combines a financing mechanism and a delivery system under the control and direction of a single management entity-the health plan. Shouldice (1991, p. 13) defines an HMO as "any organization, either for-profit or nonprofit, that accepts responsibility for providing and delivering a predetermined set of comprehensive health maintenance and treatment services to a voluntarily enrolled population for a prenegotiated and fixed periodic premium payment".

The term "HMO" was developed in the early 1970's as part of the Nixon administration's strategy to promote the growth of prepaid group practices and other prepaid plans as a means of improving the capacity and efficiency of the healthcare system (Gold, 1991, p.289). The term HMO encompasses several models, including prepaid group practice (PGP) plans, prepaid individual practice plans (PIP), individual practice associations (IPA's), and Foundations for Medical Care (FMC's) (Shouldice, 1991).

HMO's are based upon concepts that have been a part of the medical services delivery system for many years. Early efforts to provide prepaid group practice medical care were developed by the Federal government for military personnel and merchant seaman at the beginning of the 20th century (Shouldice, 1991). HMO-like organizations began to evolve with the industrialization of the western United States to support workers involved in the railroads and the lumber industry. Medical care arrangements were developed in "company towns" by these firms. Kaiser-Permanente had its origins in the 1930's to 1940's as Dr. Sidney Garfield strived to provide healthcare to individuals involved with the Kaiser corporation's construction and shipbuilding projects in California, Oregon, and Washington (Gold, 1991).

During the 1950's to early 1970's, many innovative approaches to Prepaid medical care resulted from the role of labor. Many national studies, especially the 1967 Report to the President, recommended group practice & prepaid group practice as possible solutions to the high cost of healthcare. In 1970, there were less than 40 such plans with about 3 million enrollees (Shouldice, 1991). The federal Health Maintenance Act of 1973 provided financial support for the development

of HMO's and defined the basic principles of these organizations by statute. This Act also encouraged plan growth by mandating employer participation on a dual choice basis and preempted restrictive state laws (Gold, 1991, p.289). The growth of HMO's as a result of this Act was slower than anticipated due to restrictive requirements, but by 1980 there were 236 HMO's with 9.1 million enrollees.

Federal financial support for HMO development was phased out in the 1980's but the HMO industry grew substantially during this period; the number of plans more than doubled and enrollment increased almost fourfold (Gold, 1991, p. 289). Many of the newer plans are IPA's that do not require the extensive capital and organizational support due to provider networks based in existing facilities and practices. Since 1987, the HMO industry has been consolidating after a period of rapid growth. Although enrollment continues to increase, the number of plans has declined from a high of 662 to below 600 (Gold, 1991, p. 289). According to the Group Health Association of America, Inc. (GHAA) (1991, p.1), there were 569 HMO's at the end of 1990 serving 36.5 million people nationwide. These 569 HMO's represent 61 staff model plans, 75 group model plans, 80 networks, and 353 IPA's.

Preferred Provider Organizations

Preferred Provider Organizations (PPO's) first appeared in the U.S. health care system in the 1980's. The origination of PPO's can be attributed to the continued rise in health care costs and the limited enrollment success of HMO's (Leyland, 1991). The period from 1984-1987 saw the largest growth in the number of PPO's with an annual increase of over 100 new PPO's (Leyland, 1991). According to the American Managed Care and Review Association, there were 800 PPO's operating in early 1991 with between 55 and 60 million people eligible for benefits under this type of managed care delivery.

Medical Group Practice

Medical group practices sponsored by physicians appeared with the development of medical service delivery organizations. The first was the Mayo Clinic, founded in Rochester, Minnesota in 1887 by Dr. W.W. Mayo and his 2 sons W.J. & C.H. Mayo (Shouldice, 1991). The first prepaid group practice plan was organized by the Western Clinic in Tacoma, Washington around 1910; its members were employees of the lumber mills. A chain of 20 prepaid industrial clinics was established in 1911 in the Tacoma area. Two of these clinics ultimately became present-day HMO's-the Group Health

Cooperative of Puget Sound & the King County Blue Shield alternative delivery system.

Current Status of Managed Care

The group of approaches to delivering and financing health services in the United States includes HMO's, PPO's, and other innovative methods. These organizations are described as "managed care organizations" due to their emphasis on creating structures that enhance control and management of the financing and delivery of health services (Shouldice, 1991, p. 11). According to the GHAA (1991), employers paid 16% per employee per year less for HMO coverage than for traditional health insurance. The 1980's saw the number of HMO's decrease and many plans developed serious financial difficulty. The current situation appears brighter with 87% of the plans the GHAA (1991) surveyed stating that they expected to generate a profit/surplus for 1991. Quality of care is one of the utmost concerns for all stakeholders in healthcare. The RAND Corporation, in its 12-year, \$80 million health insurance experiment, showed that HMO members experience up to 40% fewer admissions and save up to 28% on healthcare costs, compared to those in a fee-for-service system (GHAA, 1991, p. 3).

The growing concern over healthcare costs in the 1990's are bringing employers and providers together in an attempt to cut out the middleman, or specifically the large administrative component of most managed care plans. Federal and state government are seeking out managed care as a means to control the spiralling cost of providing care to the Medicare and Medicaid population. Currently, 10% of the nation's Medicaid population is enrolled in managed care networks in 30 states (Johnson, 1992, p. 31).

HMO's attribute their recent turnaround in the last few years to tighter cost controls, better utilization management, and larger premium increases (Stevens, 1991). Innovativeness on the part of today's managed care systems is shown by their offering point-of-service or open-ended plans that allow patients to decide whether to use a network provider, and pay little or nothing out of pocket, or to pay a higher deductible and copayment to see an outside physician. Other approaches include "one-stop shopping" whereby companies like the Travelers offer their own HMOs, PPOs, and managed-indemnity plans.

Leyland (1991) states that although substantial progress has been made in the managed care sector, managed care has not stemmed the rising cost of

healthcare; demonstrated by the 59% increase in health plan costs per employee from 1985 to 1989. Americans will spend more than \$800 billion on healthcare this year which will approach 14% of our Gross National Product (Enthoven, 1992, p. 34). Leyland (1991, p.163-4) also mentioned the effects upon managed care as a result of concerns with cost and adverse selection problems. Some of the implications upon the direction of managed care in the 1990's are:

- a) the continued growth of managed care programs,
- b) a flattening growth rate for HMO's and PPO's and a sharper growth in POS programs, and
- c) further consolidation within the managed care industry.

CHAPTER III. METHODS AND PROCEDURES

This chapter will define the unit of analysis for this case study, review the study design, and address the validity and reliability of the study. In addition, Chapter III will review the data collection methods utilized and discuss the utility of results.

Unit of Analysis

The TRICARE-Tidewater Coordinated Care Project will serve as the unit of analysis for this study. Personnel assigned to the Project and members of the three MTF's who are involved with the TRICARE-Tidewater Project will be part of the study.

Study Design

The case study was selected as the format for this research project. One criticism of the case study design is that it affords little control (Poister, 1978). Control refers to a researcher's ability to manipulate the conditions or variables of a study. Research conducted in a laboratory setting provides an experimental design with a high degree of control. Case studies, a type of non-experimental design, are often used in conducting applied research in fields

where the conditions offer the researcher little or no control.

Yin (1989) states that common criticisms of case studies have been the lack of rigor on the part of the researcher, the use of equivocal evidence, and biased views by the researcher. It is incumbent upon the researcher to overcome these criticisms.

Validity and Reliability of the Study

An integral component of qualitative research according to Yin (1989, p.42) is the use of "multiple sources of evidence, use of chains of evidence, and reviews of drafts or portions of the study by key informants". This methodology will be utilized by the researcher.

Internal validity in this study represents how well the findings represent the state of affairs or condition within the TRICARE-Tidewater Project. Yin (1989) states that internal validity only applies to explanatory and causal studies where a researcher is attempting to determine whether event X led to event Y. Since this case study is of a descriptive and exploratory nature, internal validity does not apply.

External validity deals with whether or not a study's findings are generalizable beyond the immediate

case study. DoD's first tri-service Coordinated Care Project should provide numerous opportunities to generalize the findings of this case study to future Coordinated Care Projects where catchment areas overlap. The external validity of this study is at risk because it only represents a sample of one. However, the goal of qualitative research is to analyze or to solicit questions, not one of statistical generalization (Yin, 1989).

Reliability refers to the extent to which a measurement procedure yields the same answer or its reproducibility (Kirk & Miller, 1986). Reliability can be maintained by utilizing a case study data base and a case study protocol. Yin (1989) mentions that the goal is to minimize errors and biases in the study.

The research will be conducted according to a research plan (proposal) approved by members of the faculty which increases the reliability of the study. The case study data base will consist of notes taken during interaction with the TRICARE-Tidewater Project, a file of TRICARE-Tidewater correspondence, and a file of interview notes, summaries and tapes.

Data Collection Methods

This is a case study. This case study will rely upon accepted modalities of data collection including participant-observation, document review and analysis, and structured interviews.

The case study will be conducted through the review and analysis of documents maintained by the TRICARE Coordinated Care Project produced from its inception to 31 December 1991. The closing date on the document review is required to allow time for analysis of the reviews. Documents will involve correspondence between PNH and the Bureau of Medicine and Surgery (BUMED) or Office of the Surgeon General, minutes of meetings and other internal documents from the TRICARE-Tidewater Project. Objectives of the document review will be to monitor the events as they occurred and to identify the state of organizational issues and processes in this tri-service effort (i.e., changes in leadership, changes in communication, and changes in roles and responsibilities).

Along with the document review, data will be collected via participant-observation and structured interviews. The role of participant observer will assist this researcher in gaining access to key personnel and in obtaining a close-up view of TRICARE.

As a member of the PNH staff, the researcher has and will continue to attend numerous meetings and briefings within the Naval Hospital and the TRICARE-Tidewater Project. A danger exists with the role of a participant-observer in that the researcher may go "native" and therefore has the potential to bias the results of the study. This is a valid concern.

Structured interviews serve as a primary data collection method. The researcher will interview all RIT members, Deputy Commanders for Navy, Army and Air Force at TRICARE-Tidewater as well as the following members of the three MTF's: Commanding Officer/Commander, Director for Administration or Administrator, and the Director/Department Head for Coordinated Care. The main objective of the interviews will be to gather information and opinions concerning the organizational effectiveness of the TRICARE-Tidewater initiative.

Expected Findings & Utility of Results

Due to academic constraints, it is beyond the scope of this GMP to include the entire planning phase of the TRICARE Coordinated Care Project since this phase ends 30 September 1992. Since TRICARE involves overlapping catchment areas, decisions regarding such

areas as establishing a healthcare network, beneficiary enrollment, and the procurement of resources and personnel will be complex. As coordinated care is implemented in other overlapping catchment areas, the lessons learned from TRICARE-Tidewater will be invaluable to other MTF commanders. The use of a Rapid Implementation Team is an innovative approach to assist TRICARE-Tidewater's start-up. The goal of this case study is to delve "in-depth" into the processes and complexities and to address the organizational effectiveness of the RIT.

CHAPTER IV. FINDINGS AND IMPLICATIONS

In the remaining chapters of this study the results of the data collection and analysis are presented, implications of the study are discussed, and conclusions offered.

Formal Data Collection and Analysis

A variety of data collection methods have been employed in this study and are discussed in chapter III. The primary methods of formal data collection include structured interviewing and document analysis. Structured interviews were conducted with selected members of the TRICARE-Tidewater staff and RIT members, and Commanders, Administrators, and staff of the Managed Care Departments at each of the three MTF's.

The objectives of each interview are to: obtain a general feeling for the organization (climate, communication), address organizational effectiveness, and to solicit staff opinions regarding TRICARE-Tidewater in general.

Administration of Survey A

Survey format A, located in Appendix A, was administered to members of the Command group at each of

the MTF's (Commander, Senior Administrator), and the Military Officers in each of the Coordinated Care Departments. The interviews were conducted with each subject in the privacy of his/her own office or in a separate conference room. All subjects allowed the researcher to use a tape recorder to facilitate data analysis. The researcher assured them that the tapes would be destroyed after the completion of the GMP. The researcher conducted these interviews during the period 26 February to 31 March, 1992. It was not the intention of the researcher to spread these interviews out over this length of time, however, many interviews had to be rescheduled several times due to the subjects' fluctuating schedules.

Question 1 of Interview Format A was designed to address the communication/coordination between the 3 MTF's. The 3 MTF Commanders stated that they were satisfied with the communication/coordination that has occurred regarding TRICARE-Tidewater. There was concern mentioned by the Army and Air Force Commanders regarding the rank of the Navy Commander at Naval Hospital Portsmouth. Namely, the Commander of Portsmouth Naval Hospital is an O-8 (Rear Admiral) versus an O-6 (Colonel) at the Army and Air Force facilities. Several key personnel perceived

communication/coordination to be less than satisfactory. One respondent stressed that the By-Laws of TRICARE-Tidewater were not being adhered to regarding the role of the Deputy Commanders and the requirement that they meet in executive session with the Chairman of the TRICARE board. No other respondents made this criticism, however. Members in all 3 MTF' Coordinated Care Departments expressed concern over the quality of communication between members at TRICARE-Tidewater and each of the Coordinated Care Departments.

Question 2 was designed to compare the 3 MTF's Coordinated Care Departments. All of the respondents stated that the Army and Air Force Medical Departments committed resources (financial and staff) up front to their respective Coordinated Care Departments. In particular, the Army received adequate direction from Health Services Command (HSC) and has been allowed to hire the necessary people in their new division. The Air Force respondents also spoke favorably regarding their support from Headquarters. The Navy respondents, however, mentioned that problems have been experienced in obtaining the necessary funds and billets to staff the new Coordinated Care Directorate. The Executive Officer at the Naval Hospital voiced concern that many

people may be taken "out of hide" to staff the new Directorate.

Question 3 is an extension of the previous one and was designed to solicit the subjects' opinions regarding whether or not support was adequate in the development of the Coordinated Care Directorate. As mentioned previously, the Army and Air Force respondents were satisfied that their respective services provided the necessary financial and personnel support. However, the Army and Air Force subjects mentioned that they have sent requests to fund equipment-type items to TRICARE-Tidewater and are optimistic that the support will be provided.

Question 4 was designed to address future training issues of Coordinated Care staff members. All respondents stated that Coordinated Care for the Department of Defense Healthcare System is relatively new and additional training should be provided. The respondent who heads the Air Force Coordinated Care Division had the opportunity to specialize in Managed Care in her Graduate Program and the senior Medical Service Corps Officer (Administrator) at this facility spoke highly of this fact.

Question 5 was designed to address the staff composition at TRICARE-Tidewater and in each of the

Coordinated Care Departments. Namely, was the staff composition appropriate? Most of the Army and Air Force respondents questioned the use of a mostly all-Navy RIT. Most of the Navy subjects mentioned that although the RIT members were not those originally requested by TRICARE-Tidewater back in August of 1991; the members who made up the RIT were the best talent available. All RIT members were from the Tidewater area with the exception of one Navy MSC officer from the CAM site in Charleston, South Carolina-CAMCHAS (Catchment Area Management Charleston).

Question 6 was designed to ascertain whether or not the subjects felt TRICARE-Tidewater had been effective in accomplishing its mission. The majority of respondents stated that TRICARE-Tidewater had been effective in this regard. The few negative responses came from Army and Air Force subjects and they voiced concern over the excessive "meddling" from OASD and others.

Question 7 was designed to obtain the respondents' opinions regarding ways of improving DoD's first tri-service Coordinated Care Program. The majority of subjects stated that TRICARE-Tidewater was not provided with sufficient financial backing, guidance, or policy from OASD (HA). Many of the Army and Air Force

respondents expressed concern that the person in charge of the RIT had no healthcare experience and that a senior healthcare administrator should have been put in this position.

Summary of Survey A Findings

Based upon the results of Interview Format A, communication/coordination between the 3 MTF's has been satisfactory. According to some respondents, the distance between the Navy facility and the Army and Air Force MTF's, although not great, has presented problems since one must travel over bridges and through a tunnel to reach the South Hampton Roads area from the Peninsula. Based upon the personnel interviews, the Naval Hospital was still struggling with staffing and budgetary issues in its new Strategic Planning and Coordinated Care Directorate while the other services moved ahead from the beginning in these areas. This lack of adequate staffing and capital, as Charns & Schaefer (1983) mention, will cause difficulties in designing an effective organization. All respondents mentioned that OASD (HA) needed to provide the necessary funding, guidance, and policy up front.

Administration of Survey B

Survey format B, located in Appendix B, was administered to members of the Rapid Implementation Team (RIT) and the Deputy Commanders for Army, Navy, and Air Force. The interviews were conducted with each respondent in the privacy of his/her own office or in a private conference room. All subjects allowed the researcher to use a tape recorder to facilitate data analysis. I assured them that the tapes would be destroyed after the completion of the GMP. The researcher conducted the interviews during the period 26 February to 31 March 1992. As was the case with the administration of survey format A, some interviews had to be rescheduled many times.

Question 1 was designed to obtain the background and work experience of the 12 members interviewed. The Service branch, Corps (i.e. Medical, Nurse, Medical Service), rank, and specialty of the members at TRICARE-Tidewater interviewed are represented in table 5.

Table 5

Personnel Interviewed at TRICARE-TIDEWATER

SERVICE	CORPS	RANK	SPECIALTY
Navy	Medical Service Corps	Commander (O-5)	Computer Systems
Navy	Supply Corps	Captain (O-6)	Business/Financial Management
Navy	Unrestricted Line	Lieutenant Commander (O-4)	Public Affairs
Navy	Medical Service Corps	Lieutenant (O-3)	Healthcare Admin
Navy	Nurse Corps	Captain (O-6)	Healthcare Admin
Navy	Civilian	(GS-5)	Secretarial, Health Benefits Advisor
Navy	Medical Service Corps	Captain (O-6)	Pharmacist, Healthcare Admin
Air Force	Medical Corps	Colonel (O-6)	Family Practice
Air Force	Medical Service Corps	Lt Colonel (O-5)	Healthcare Admin
Army	Medical Service Corps	Lt Colonel (O-5)	Healthcare Admin
Army	Medical Service Corps	Lt Colonel (O-5)	Healthcare Admin
Navy	Line	Captain (O-6)	Surface Warfare/Computer Systems

Question 2 was designed to obtain the subjects' sense of the organizational climate at TRICARE-Tidewater. Many of the respondents referred to the climate as "chaotic" and one of "who's in charge?". Other terms used by the respondents were "confusing", "uncertainty", "nebulous", "dynamic", and "the pits".

Question 3 was designed to address the issue of tri-service communication/coordination at TRICARE/Tidewater and whether or not interservice rivalry had been noticed. 9 of the 12 respondents mentioned that there had been problems in this area. Of the subjects who had referred to problems, 4 mentioned that the Air Force frequently kept to "their own agenda". One respondent stressed the fact that the 3 Deputies (Army, Air Force, and Navy) report to 3 different people which has led to difficulties in the communication/coordination area. It is interesting to note that Section 3 of Article II of the TRICARE-Tidewater Bylaws (TRICARE-Tidewater Bylaws, 1991, p.2) indicates that one of the duties of the Governing Board shall be: "to ensure coordination and cooperation among the military healthcare treatment facilities".

Question 4 was designed to ascertain if the mission/objectives were clear at TRICARE-Tidewater. Over half of the respondents stated that the mission

and objectives were not totally clear. Many subjects stated that the lack of DoD OASD (HA) guidance created difficulties and led to different interpretations by the staff of TRICARE-Tidewater and OASD (HA). The RIT Commander, a Navy Line Captain (O-6), stated that "their vision was clear, but specific objectives were not" and "that there is always a risk in moving ahead of policy".

Question 5 was designed to address the communication process at TRICARE-Tidewater. Many respondents stated that the communication process was less than desirable and that the daily meetings that occurred in the early days of the project should have continued. Many of the respondents felt that they had been left "out of the loop" and therefore relied on the informal communication process. The RIT Commander stated, however, that communication was good at all levels.

Question 6 was designed to address the leadership style of the RIT Commander. The majority of the respondents stated that he was autocratic and authoritarian. Other respondents referred to the RIT Commander as one of the best leaders they had ever worked for and he allowed frequent participation in decision making. One Army respondent brought up the

question of why a Line Officer with no healthcare administration experience was put in charge of this project.

The RIT Commander himself, stated that he "micro-managed" more than he usually did, but that he felt that "it was necessary in a project of this visibility".

Question 7 was designed to ascertain whether the respondents felt that the organizational structure was appropriate. There was no general consensus to this question. The responses to question 7 are as follows:

- "mismatches in service representation, too much time devoted to learning about managed care in the beginning"
- "adequate organizational structure"
- "people needed to be more responsible"
- "inadequate, TRICARE-Tidewater needed a Flag Officer in-charge"
- "a project team would have been a better approach"
- "more support personnel needed at the onset"
- "Clinical Services was under the Operations division initially"
- "the utilization management area should be in an advisory role"

- "concerns over the experience of some staff members"
- "the RIT caused the group to draw away from the format set up in the By-Laws"
- "management by committee is not a good idea" and
- "the 3 services had different missions in mind"

Question 8 was designed to ascertain whether or not the subjects felt that they had been given appropriate feedback as to their performance. All respondents, with the exception of the nurse assigned, felt that they had received appropriate feedback.

Question 9 was designed to ascertain the subjects opinion as to whether or not TRICARE-Tidewater had been successful in meeting its objectives. The respondents were asked to refer to the initial 3-4 month period (ending 31 December 1992) for the purposes of the researcher. Five of the twelve respondents indicated that they felt TRICARE-Tidewater did not meet its objectives. Six of the twelve respondents felt that TRICARE-Tidewater did meet its objectives. One subject did not answer the question and stated that the objectives were not clear. Other responses were that there was "too much brass at the project"; the "objectives changed too much", "BUMED and OASD (HA)

interfered too much"; and that the "arrival of the RIT was at the wrong time".

Question 10 was designed to ascertain if the staff composition was appropriate. Six of the respondents indicated that they felt that the staff composition was appropriate. Two subjects indicated that more Army and Air Force RIT members were needed. Three subjects mentioned that the original RIT members requested from the 3 Services were not assigned. Other responses were:

- "an official Service Memorandum of Understanding was needed"
- "more business-oriented staff were needed"
- "there was a lack of clerical support in the beginning"
- "the timing of the RIT was inappropriate since there was a lack of adequate work space; a month or two later would have been better"

It is interesting to note that the RIT Commander stated that "he felt that the team had the right mix of people at the right time".

Question 11 allowed the subjects to express their suggestions regarding TRICARE-Tidewater. The subjects were not limited as to the number of suggestions they could recommend. One-half of the respondents stated

that there should have been specific policies established by OASD (HA) and Memorandums of Understanding (MOU) between the three services in order to facilitate the undertaking of this massive endeavor. This group also mentioned that there has been a general "lack of guidance from OASD (HA)". Five of the twelve subjects mentioned that lack of adequate fiscal resources has been a source of difficulties. Five respondents mentioned that they had concerns over the lines of authority or chain of command of TRICARE-Tidewater and the respective services. Four subjects expressed concerns regarding the staffing of TRICARE-Tidewater. Staffing concerns were timing of the RIT and the mix of personnel. Two respondents mentioned that a lack of clearly defined goals for this tri-service coordinated care program has hampered progress. One subject stated that the excessive politics (i.e., frequent visits by politicians) has interfered with the project. And lastly, one respondent mentioned that the RIT Commander should have been a Medical Service Corps Officer.

Question 12 was designed to allow the respondents to give their recommendations for future DoD managed care initiatives. Again, most of the respondents, (nine), stated that there must be adequate guidance

from our policy makers and clear MOU's between the services must be firmly in place. The next most frequent responses voiced were concerns regarding staffing (four) and adequate financial backing (three). Two respondents mentioned that this project has not adequately utilized the "lessons learned" from the five CAM's. Two respondents mentioned that the goals of any tri-service coordinated care initiative must be firmly in place. Two responses stated that the committee structure is the wrong way to do things. Other responses (one each) were:

- that "DoD is moving too fast in coordinated care";
- that "an extensive analysis via forecasting must be done up-front";
- "the MTF mission must come first";
- "we must overcome the corporate culture problems of the three services" and
- "a Joint Command must be established".

Summary of Survey B Findings

Based upon the results of Survey Format B, many respondents felt that there should have been more representation by the Air Force in the RIT. However, there are two Air Force staff members (one administrator and one Physician). Similarly, the Army

staff consists of two Healthcare administrators (one of which was on extended Reserve assignment and left the program in April 1992). It may be too early to conclude whether or not the Air Force and Army were adequately represented since TRICARE-Tidewater is not scheduled to be implemented until late 1992. The fact that the Deputy Commanders for Navy, Air Force, and Army each report to their MTF Commanders may have contributed to the "who's in charge" atmosphere described by many of the respondents. In addition, the fact that TRICARE-Tidewater is the first tri-service coordinated care program certainly justifies the attention of our politicians and senior OASD (HA) officials. There are an ever-increasing number of "determinants" in TRICARE-Tidewater's environment.

Most of the staff of TRICARE-Tidewater indicated that a greater degree of communication needed to occur to keep them informed. Adequate coordination and integration is one of the essential ingredients needed for an organization to be effective according to Hrebiniak (1991). Although many respondents mentioned that the RIT Commander utilized an authoritarian-type management style and questioned his lack of healthcare experience, an almost equal number praised him for his accomplishments as a leader. Many subjects expressed

concern over the lack of managed care experience and healthcare experience of some RIT members. The selection of members for the RIT was indeed based on who was available, as the Surgeon General of the Navy, VADM Hagen mentioned.

The question of whether or not TRICARE-Tidewater had accomplished its objectives successfully or not was answered nearly equally by the subjects interviewed. The subjects' recommendations for TRICARE-Tidewater and future DoD coordinated care programs were nearly identical with the majority mentioning that adequate OASD (HA) policy and a MOU between the three services is necessary. That TRICARE-Tidewater and future DoD coordinated care programs be adequately resourced (financial and staff) and have a direct line of authority to OASD (HA) was stressed by many respondents.

No amount of information can adequately prepare MTF managers for the many complexities in the political arena that disrupt the planning process and atmosphere of an organization. It appears that the TRICARE-Tidewater program faced a major obstacle in "moving out ahead" of policy. to facilitate planning in times of uncertainty more information is needed. TRICARE-Tidewater lacked the necessary information in terms of

OASD (HA) policy and guidance. The agreement among groups of respondents concerning what was lacking at TRICARE-Tidewater points to a high level of communication regarding the organizational mission and goals.

Participation-Observation

The researcher attended many briefings and meetings at Portsmouth Naval Hospital and at the TRICARE-Tidewater office. The role of participant-observer allowed the researcher to gain access to these meetings and the key personnel at TRICARE-Tidewater and the three MTF's. While attending these meetings the researcher was always free to ask questions or to clarify information.

Document Review

The researcher reviewed several sources of documentation maintained by the TRICARE-Tidewater office during the period summer 1990 to 31 December 1991. The closing date on the document review was required to allow adequate time for analysis, completion of the surveys, and compiling of results.

The minutes of the TRICARE-Tidewater Commanders board were utilized for the document analysis. All

property, affairs, and business of TRICARE-Tidewater are managed by the TRICARE-Tidewater Commanders Board. The board is composed of the Commanders of the Naval Hospital Portsmouth, the Army Medical Department Activity at Fort Eustis, and the First Medical Group at Langely AFB. The Commanders Board is scheduled to meet monthly, however during the period of time used for this research, the Board met every 2-3 weeks. The researcher attended several of these meetings.

During the period 26 June 1991 to 31 December 1991 10 Commanders Board meetings were held. Minutes for these meetings were obtained and reviewed. During this period, attendance included the 3 MTF Commanders, RIT personnel and typically the coordinated care Department Head/Director for coordinated care at each of the 3 MTF's. Meetings were conducted according to a structured format and time was provided for open discussion. The researcher planned to attend the Commanders Board meetings through July of 1992 to follow the course of events. However, in early January 1992, the Army and Air Force Commanders requested that attendance be limited to the Board. RIT personnel were permitted to attend via invitation only.

Summary of Document Review

The review and analysis of the Commanders Board minutes showed that the meetings held after the RIT and its leader were on board were more structured. The quality of these minutes improved and included agendas and action items. A full-time secretary was responsible for maintaining meeting minutes from that point on. The length of the Commanders Board meetings was typically 2-3 hours. The number of attendees at these ten meetings ranged from 11 to 19 (including Board members).

Meeting length remained fairly constant throughout this period. As the year progressed, increased attendance occurred. One explanation for this was that additional TRICARE staff reported for duty in November and December 1991. A high level of communication appeared to be occurring at these meetings as evidenced by the length of the meetings and increased number of issues discussed and subsequent action items. Most issues were resolved at these meetings. However, it was interesting to note that the Bylaws for TRICARE-Tidewater were discussed at three meetings prior to resolution. A review of participation by the 3 MTF Commanders indicated that the Commanding Officer of the Naval Hospital participated more. This increased

participation may be due to the fact that he is Chairman of the Board.

An issue involving Nonavailability Statements (NAS) at Fort Eustis and Langely AFB and the referral of patients to Naval Hospital Portsmouth was discussed at several meetings. The after hours transfer of patients from these 2 facilities to PNH is a complicated one due to the fact that it is a teaching facility. The NAS issue was not totally resolved and was left open for ongoing monitoring.

An issue involving the need to channel information concerning the TRICARE-Tidewater program to Army and Air Force higher authorities was raised by the CO at PNH. This issue coincides with a survey finding that some Air Force and Army personnel perceived the program as mainly a Navy program. This issue points to a breakdown in communication that occurred between TRICARE-Tidewater and the Army/Air Force Offices of Surgeon Generals and/or Fort Eustis and Langely AFB. This coincides with recommendations made by numerous survey respondents that there be an MOU between the 3 services for DoD's first tri-service coordinated care program and not simply a gentlemen's agreement.

In addition, at the 14 November 1991 Commanders Board meeting minutes mentioned that the DoD needed to

decide upon accountability for TRICARE-Tidewater. This correlates with a finding from the survey in which many respondents indicated that OASD(HA) did not provide adequate guidance and direction for the program. The Commanding Officer at PNH mentioned that there were "people" who would prefer to see the TRICARE-Tidewater program as a separate command at this meeting. Some survey respondents voiced their concern over the organizational structure at TRICARE-Tidewater. The PNH CO voiced his disagreement with changing the approved concept of command and control as executed by the Board of Directors.

Budgetary concerns were mentioned by many survey respondents in the form of inadequate funding or the fact that funds used by the TRICARE-Tidewater office were solely from BUMED. As of the 14 November 1991 meeting, all financial backing for TRICARE originated from BUMED with the exception of the \$3.2 million in FY 92 for initial requirements.

One final issue raised at several of the Commanders Board meetings was the OCHAMPUS Case demonstration Project in which OCHAMPUS has contracted for case management at several Dod MTF's. A case management program for the Tidewater catchment area has the potential to save \$4.6 million in CHAMPUS

expenditures with a \$1.3 million investment. All 3 MTF commanders voiced their optimism over the case management demonstration project. It was mentioned at the 18 December 1991 meeting that congressional reports indicated a possible CHAMPUS Reform Initiative (CRI) program for the Tidewater area. The news of a possible CRI-type program lessened the likelihood of the OCHAMPUS Case Management demonstration.

CHAPTER V. CONCLUSIONS AND RECOMMENDATIONS

The TRICARE-Tidewater program is the first DoD site to implement the Coordinated Care Program in the Tidewater Service Area. The overall goal of the program is to encourage optimal MTF utilization of DoD healthcare resources within this area in conjunction with a civilian provider network which will augment the direct-care system. On 8 January 1992 the Coordinated Care Program guidelines were issued by the Assistant Secretary of Defense for Health Affairs, Enrique Mendez Jr., M.D. (Assistant Secretary of Defense Memorandum, 8 January 1992). In March of 1992, the Navy was directed, after coordination with the Army and Air Force, to provide Dr. Mendez with an implementation plan and concept of operations by 3 April 1992. On 7 February 1992 the Surgeon General of the Navy released the proposed interservice Memorandum of Understanding for the project between the 3 services (Navy Surgeon General Memorandum for the Assistant Secretary of the Navy, 7 February 1992).

This study was an attempt to examine the issue and complexities in the initial phase of DoD's first tri-service coordinated care program. Communication has been fostered between the 3 MTF's and appears to be flourishing. Working groups have been established

between the 3 MTF's and the Department of Veteran's Affairs Hospital in Hampton, Virginia in the following areas: Nursing, Supply, Radiology, Laboratory, and Pharmacy. Some of these groups have been existence for over a year, however the increased cooperation between the MTF's resulted in the most recent additions to the working groups.

The use of a RIT appeared to be an effective means of facilitating the planning phase for the TRICARE-Tidewater program. However, it was perceived by many respondents as a convenient means of bringing on staff. Future DoD tri-service Coordinated Care Programs should consider the use of a greater mix of personnel from the three services.

The lack of adequate policy and guidance from OASD(HA) and the lack of a MOU between the services led to communication problems and a high level of frustration among the personnel interviewed. The lack of communication at TRICARE-Tidewater added to the chaotic organizational climate. Communication within a program of such high visibility should remain open to facilitate innovation and participation.

The problems encountered by this tri-service Coordinated Care Program should be addressed by OASD

(HA) planners and procedures developed to avoid duplicating them in future programs.

Future studies are needed in the Tidewater Service Area to examine the complexities of the implementation of the TRICARE-Tidewater program in FY 93.

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Appendix A

INTERVIEW FORMAT A

The following questions are to be administered to the 3 MTF Commanders & the Directors for Coordinated Care.

1. Please comment on the communication/coordination between the 3 MTF's regarding TRICARE-Tidewater.
2. Please describe your respective Coordinated Care Directorate/Department.
3. Was additional support such as resources and/or personnel needed in the development of your Coordinated Care Directorate?
4. Would you recommend that the Coordinated Care staff be exposed to additional civilian managed care experience (ie. Kaiser)?
5. Was the staff composition in your Coordinated Care Directorate and at TRICARE-Tidewater appropriate?
Should the staff composition have changed at any point?
6. Has TRICARE-Tidewater been effective in accomplishing its mission?
7. Could you suggest any way of facilitating the process of establishing this tri-service Coordinated Care Program that was not provided?

Appendix B

INTERVIEW FORMAT B

The following questions are to be administered to members of the TRICARE-Tidewater staff and RIT members.

1. What expertise do you bring to TRICARE-Tidewater?
2. Describe the organizational climate at TRICARE-Tidewater.
3. Discuss the tri-service component of TRICARE-Tidewater with respect to communication/coordination.
4. Have the mission and your objectives been clear at TRICARE-Tidewater?
5. Describe the communication process at TRICARE-Tidewater.
6. Describe the leadership style of the RIT Commander.
7. Has the organizational structure of TRICARE-Tidewater been appropriate to accomplish its mission?
8. Have you been given feedback as to your performance?
9. Do you feel that TRICARE-Tidewater has been successful in meeting its objectives for the period ending 31December 1991?
10. Was the staff composition at TRICARE-Tidewater appropriate and should it have changed at any time for the period ending 31December 1991?

11. Could you suggest anything that would have facilitated the process of establishing this tri-service Coordinated Care Program?

12. Do you have any suggestions for future tri-service Coordinated Care Programs?