REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. REPORT DATE *(DD-MM-YYYY)*	2. REPORT TYPE	3. DATES COVERED *(From - To)*
14-02-2005	Final Report	July 2004 to July 2005

4. TITLE AND SUBTITLE Department of Defense Instruction of Medical Management Programs Analysis

5a. CONTRACT NUMBER

5b. GRANT NUMBER

5c. PROGRAM ELEMENT NUMBER

6. AUTHOR(S)

Joseph P. Edger, Captain, Medical Service

5d. PROJECT NUMBER

5e. TASK NUMBER

5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)

TRICARE Management Activity
Skyline 5, Ste 515
5109 Leesburg Pike
Falls Church, VA 22041-3206

8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)

US Army Medical Department Center and School
BLDG 2841 MCCS-HRA (Army-Baylor Program in Healthcare Administration)
3151 Scott Road, Suite 1411
Fort Sam Houston, TX 78234-6135

10. SPONSOR/MONITOR'S ACRONYM(S)

11. SPONSOR/MONITOR'S REPORT NUMBER(S)

30-05

12. DISTRIBUTION / AVAILABILITY STATEMENT

A - Approved for public release; distribution is unlimited

13. SUPPLEMENTARY NOTES

14. ABSTRACT The purpose of this policy analysis is to evaluate the federal policy development process. This analysis employs the Bardach eight-step path to evaluate Military Health System (MHS) policy. The MHS is currently developing medical management (MM) program policy for use within the Direct Care System (DCS). Under the next generation of TRICARE contracts, a MM program will become essential in order to optimize the effectiveness and efficiency of the entire MHS. The new contracts will require diligent management of contractual shifts in responsibility and resource linking efforts under revised financing protocols. An exhaustive literature review supplements the policy evaluation with industry best practices, federal trends, and other evidence which suggests a preferred policy direction. Three policy alternatives were examined: a) status quo; b) revert to the previous contractual arrangement; and c) incorporate a DCS MM program. Each alternative is evaluated and judged on the following criteria: a) level of population health; b) securing financial viability; and c) political feasibility. The outcomes of this evaluation demonstrate that the preferred policy alternative is incorporating a DCS MM program slightly over reverting back to the previous contractual arrangement.

Although a DCS MM program is the preferred policy alternative, evidence exists which suggest a comprehensive education program must accompany such a change to realize the full benefit. This analysis proposes existing education programs within the MHS that may provide the comprehensive education necessary to support a MM program. Future policy analysis should explore the feasibility of these programs and others to provide the education necessary to support the DCS MM program.

15. SUBJECT TERMS

Policy Analysis, Medical Management, Utilization, Business Planning, Direct Care System

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			Education Technician
U	U	U	UU	36	19b. TELEPHONE NUMBER *(include area code)* (210) 221-6443

U.S. Army – Baylor University

Graduate Program in Healthcare Administration

Department of Defense Instruction of Medical Management Programs Analysis

A Graduate Management Project Proposal Submitted in Partial Fulfillment of Requirements for the Degree of Master in Healthcare Administration

February 8, 2005

By

Joseph P. Edger, Captain, USA, MS

Administrative Resident, TRICARE Management Activity

5109 Leesburg Pike, Skyline 6, Suite 515

Falls Church, VA 22041

Acknowledgements

I wish to thank RADM Richard A. Mayo, Deputy Director of TRICARE Management Activity (TMA), for the opportunities afforded me. RADM Mayo's willingness to provide me with many invaluable experiences and free and open access to a number of different forums has made this residency one of the best experiences of my professional life. As always, I am eternally indebted to LTC Richard Jones (Ret.), for his support and guidance. He has become the icon of my educational experience, Sir – Thank you!

I would like to also express my appreciation to the Front Office Staff for taking time out of their busy schedules to assist me in completing the project and enriching the residency experience during this year. In addition, I would like to thank the Office of General Counsel Staff for their administrative support and friendship.

I also wish to thank TMA's Dr. Bob Opsut, MAJ Lourdes Moore, and U.S. Army-Baylor staff LTC Chris Pate and CPT Ken Jones for their guidance and support. This project would have been much more difficult without their contributions.

There are many others who made this a wonderful year and I offer you my eternal thanks!

Abstract

The purpose of this policy analysis is to evaluate the federal policy development process. This analysis employs the Bardach eight-step path to evaluate Military Health System (MHS) policy. The MHS is currently developing medical management (MM) program policy for use within the Direct Care System (DCS). Under the next generation of TRICARE contracts, a MM program will become essential in order to optimize the effectiveness and efficiency of the entire MHS. The new contracts will require diligent management of contractual shifts in responsibility and resource linking efforts under revised financing protocols. An exhaustive literature review supplements the policy evaluation with industry best practices, federal trends, and other evidence which suggests a preferred policy direction. Three policy alternatives were examined: a) status quo; b) revert to the previous contractual arrangement; and c) incorporate a DCS MM program. Each alternative is evaluated and judged on the following criteria: a) level of population health; b) securing financial viability; and c) political feasibility. The outcomes of this evaluation demonstrate that the preferred policy alternative is incorporating a DCS MM program slightly over reverting back to the previous contractual arrangement.

Although a DCS MM program is the preferred policy alternative, evidence exists which suggest a comprehensive education program must accompany such a change to realize the full benefit. This analysis proposes existing education programs within the MHS that may provide the comprehensive education necessary to support a MM program. Future policy analysis should explore the feasibility of these programs and others to provide the education necessary to support the DCS MM program.

Table of Contents

Introduction

The purpose of this graduate management project is to analyze emerging policy from the MHS governing operational entity – TMA. The TMA organization has two offices, the majority of the staff is located in Falls Church, Virginia office and a small contracting office located in Aurora, Colorado. The organization is led by a Deputy Director, a two-star general officer, who is supported by approximately 200 military and civilian staff. The staff oversees an annual budget of $26 billion to serve almost 9 million beneficiaries consisting of the uniformed service members, service member families, retired service members, and other eligible beneficiaries (Office of the Secretary of Defense (Health Affairs)[OSD/HA], 2004). The Deputy Director of TMA serves as the principal advisor to the Assistant Secretary of Defense (Health Affairs) on Department of Defense (DoD) health plan policy and overall performance of its managed health care program.

The MHS is comprised of three contractors, often referred to as the Purchased Care System, and internal DoD resources, also known as the DCS. The three contractors include HealthNet Federal Services (North Region), Humana Military Healthcare Services (South Region), and TriWest (West Region). The DCS includes resources such as military treatment facilities (MTF), service members, civil service members, and contract staff.

Conditions Which Prompted the Study

The MHS is facing tumultuous times. Unlike the combatant forces, the MHS has two enemies. The first being the traditional enemy faced in time of war, and the second being the rising cost of health care. When the window of opportunity comes, political leaders will scrutinize the enormous defense budgets that have transpired in recent years. Likewise, DoD leaders will look within to secure the fiscal health of the defense budget. For these reasons,

although not alone, the MHS must increase the effectiveness and efficiency of its health care delivery system. The DCS of the MHS may very well be the most vulnerable to fiscal scrutiny. For decades and still today, the MTF of the DCS have served as the point of care for many beneficiaries, to include serving as training bases for physicians, nurses, and medics. However, alternative methods may substitute or even surpass the value of maintaining the DCS, e.g., purchased care, or training opportunities in non-military hospitals.

The recent award of the TRICARE Next Generation contracts greatly improves our ability to manage the delivery of health care and reach a higher level of effectiveness and efficiency. Under the new contracts, the number of contractors was reduced from seven to three, and the number of regions was reduced from 11 to 3. Given these changes in the structure of TRICARE will allow the MHS to benefit from economies of scale, centralization, and infuse greater flexibility at the local level. Many differences exist between the TRICARE 2.0 contracts and the TRICARE Next Generation contracts. Two major differences include a contractual shift of responsibility from the Contractors to the DCS and a new financial model throughout the MHS; both changes will impact the environment in which the MHS operates.

The shift of responsibility includes healthcare services such as utilization management (UM), health care information line (nurse advice), referral management, appointing, and health enrollment and review assessment surveys. Under TRICARE Next Generation, the contractors are no longer responsible to provide the aforementioned services to enrolled beneficiaries of the DCS. In other words, patients not enrolled to a MTF will continue to receive like services from the contractors. However, patients enrolled to a MTF will receive these services from the MTF itself, local contract, or not at all. Also, revised financing principles will be put into practice throughout the MHS. This entails a fiscal environment in which the MTF receives a capitated

funding amount for all TRICARE enrollees to cover their purchased care costs for the fiscal year (FY). In essence, the MTF assumes financial responsibility to perform all care requirements of enrollees in return for the capitated payment from the respective military service. This marks a drastic change in the fiduciary responsibility of the MHS which most notably impacts on the future financial viability of MTFs. As a result of these major changes, new policies are required to establish general business rules, and create the general framework for which the MHS must follow when delivering future health care.

This policy analysis will include a thorough evaluation of the policy making process in the development of the MM program policy. In the civilian sector, MM is a critical tool used to mitigate rising costs, manage risk, and bolster quality. The benefits of such a program include cost containment, reduction of clinical and business risk, and improved delivery of appropriate and quality health care. No quintessential definition exists for MM. TMA (2004a) defines MM as:

> . . . an evolving model in the healthcare industry that integrates UM, CM [case management], and DM [disease management] into a hybrid approach to managing patient care. It includes a shift to evidence-based, outcome-oriented UM, and greater emphasis on integrating clinical practice guidelines (CPGs) into the MM process, then holding the system accountable for patient outcomes. (TMA, p. iv)

Moreover, MM programs are beneficial for both clinical and business outcomes. The benefits offered by a MM program can mitigate the challenges faced by the MHS as a result of the two major differences between contracts.

Statement of the Problem

Can a MM program in the DCS better enable the MHS to overcome the mandated responsibility shift of health care services and the resource linking challenges of revised financing? As the nation's health care system serving our armed forces and eligible beneficiaries, the MHS has a duty to prevail over these challenges and continue to provide the finest health care services. Therefore, implementing a policy which mandates the use of MM principles in the DCS will aid the MHS. More specifically, a MM policy can provide direction and guidance through the mandated responsibility shift of UM, health care information line (nurse advice), and the resource linking challenges of revised financing. Furthermore, adherence to the principles of MM have routinely benefited the MHS civilian counterparts and will more than likely contribute to improving the overall effectiveness and efficiency of the DCS, as well as the MHS.

Literature Review

The Population Health/MM division, under the purview of the Office of the Chief Medical Officer (OCMO), TMA has been given the responsibility to establish the MM program policy for the DCS of the MHS. Once established, a policy can provide direction and guidance to MTFs in regards to filling the void of services, enabling better financial success, patient satisfaction and improved population health. This is supported by the Assistant Secretary of Defense (Health Affairs) (Winkenwerder, 2004a) when suggesting that implementation of MM activities is critical to the success of business plans and improves the delivery and quality of healthcare.

The MHS has continually redefined UM policy for the DCS. Over the course of ten years, the Assistant Secretary of Defense (Health Affairs) has put forth UM policy on four different occasions. A brief overview of each policy is provided to demonstrate the evolution

from UM to MM. For the most part, each policy builds upon the next. The one common outcome of all policies seems to be the level of acceptance and embracement among the users. The less than optimal use of these policy guidelines may be the reason for a more authoritative policy such as a Department of Defense Directive (DoDD).

In 1994, the Assistant Secretary of Defense (Health Affairs), Secretary Stephen C. Joseph, signed Health Affairs Policy (HAP) #94-005, *Utilization Management Activities in the Direct Care System under TRICARE.* HAP #94-005 creates general guidance under traditional UM principles such as prospective, concurrent, and retrospective review, discharge planning, and CM. Even in 1994, the importance and impact that UM can have on good financial stewardship and quality of care was recognized. Secretary Joseph (1994) states, " TRICARE utilization management processes are patient focused, ensuring delivery of necessary and appropriate care at the most effective level without jeopardizing quality or access" (p. 1).

Less than two years later, Secretary Joseph redefines HAP #94-005 with HAP #96-025, *Updated TRICARE Policy Guidance* (Joseph, 1996). HAP #96-025 contains a breadth of prescriptive traditional UM principles as well as other non-utilization aspects that remarkably resemble the current policy. Similarities between these policies include business plans, resource sharing (e.g., coordination of regional resources for efficient consumption among regional MTFs), resource linking (e.g., budget allocation based on population health requirements), and capitation methodology.

In 1998, TMA would once again redefine UM with HAP #98-031, *Revised Utilization Management Policy for the Direct Care System* (Christopherson, 1998). Building upon the previous policies, HAP #98-031 incorporated the principles of DM, demand management, wellness and health promotion, and clinical guidelines. The most significant tenet of this policy

was the removal of prescriptive procedures and allowance of more flexibility at the local and regional levels. Clearly this policy was written with the foresight of TRICARE Next Generation of contracts in that the policy provides greater autonomy at the local and regional levels.

Yet again (2004a), TMA would redefine UM with HAP #04-008, *Interim Policy Guidance for Implementation of Medical Management Programs* (Winkenwerder). HAP #04-008 signifies a UM renaissance in the MHS. Almost all of the principles in HAP #04-008 can be found in HAP #98-031 but repackaged in a way that will promote UM and align MHS practices and terminology with the civilian sector trends. A revitalization of UM, coupled with the practice of case and DM brings together the MM program of the DCS. Furthermore, a DCS MM program is essential for the MHS to achieve the objectives which lie ahead.

In a memorandum dated, 9 March 2004, TMAs Deputy Director, Richard A. Mayo, Rear Admiral, Medical Corps, United States Navy, stated:

> With the new generation of TRICARE contracts [TRICARE Next Generation], every military treatment facility inherits new challenges and responsibilities, namely services for utilization [UM], case [CM], and disease management. In keeping pace with current medical trends, the MHS has combined all three of these services under the title, medical management. (TMA, 2004a, p. ii)

The term MM is widely accepted in the civilian health care industry, and is gradually permeating throughout the MHS. The acceptance and indoctrination of MM programs at each and every MTF within the MHS is critical to meeting new challenges and responsibilities. Past UM policies have attempted to inculcate the importance and advantage of such programs to the military services. According to an audit report (Inspector General – Department of Defense [IG-DoD], 1998) the DCS has seen dissimilar levels of acceptance and effort towards utilization programs,

such as wide variation in full-time equivalents (FTE) dedicated to performing UM functions. In addition, McKendry (2002) and Hodgkin, Horgan, Garnick, Merrick, and Goldin (2000) found that decentralized contracts, such as the TRICARE contracts, creates duplications, redundancies, and extra work that weakens access and quality of care metrics among major health plans. Also, Miller and Levy (2004) report a significant difference of TRICARE prime enrollees having a far less probability of receiving well-woman preventative services (Pap test and breast exam) than an enrollee of a civilian plan. Furthermore, only the mammogram exceeds the DoD/Healthy People 2010 goal. Well-woman preventative services are just one of many examples that can be improved. As a result of varied implementation, the MHS has not realized the full benefits of a utilization program. The time has come that MM programs must be fully embraced and given maximum support to overcome the new challenges and responsibilities presented by the TRICARE Next Generation of contracts.

The civilian healthcare sector has demonstrated the clinical and business benefits of a MM program. However, the civilian sector operates under a complex and modern financial model – prospective payment system. The MHS has never fully embraced such a financial system. The next generation of TRICARE contracts will introduce revised financing procedures to the entire MHS. A general overview of the MHS's new financial model will emphasize the importance of increasing effectiveness and efficiency.

Under revised financing procedures, commanders can no longer rely on TRICARE contractors to provide health care services to DCS patients at the expense of the MHS central budget. Revised financing entails a prospective payment system based primarily on a capitated payment methodology. This method offers MTF incentives to increase enrollment sufficiently to optimize patient capacity. However, a MTF can become fiscally endangered if careful analysis

and consideration is not given to the potential commitment of referral bills for purchased care. Under these procedures, MTFs are now responsible and financially accountable to provide appropriate and quality care for enrolled patients. Otherwise, the financial objectives of a MTF's business plan are in jeopardy of failure. In order to meet these new requirements, commanders must improve the effectiveness and efficiency of their operations. This entails determining base budgets on outputs rather than inputs, forecasting the health care demand, and managing the respective population's health.

Under the new contracts, accountability for improved effectiveness and efficiency will be measured according to the MTF's self-prescribed business plans that link resources to metrics. In addition to MTF commanders, the Services' Surgeons General are accountable to TMA's Deputy Director. The business plan will serve as the primary tool to achieve such a strategic objective. The plans document accountability and responsibility for provided health care, staffing and staff training requirements, capability and demand capacity, and productivity and financial objectives.

The landscape within the DCS has drastically changed. MTFs must provide direct care services previously performed through the managed care support contracts (MCSC), and provide these services in an effective and efficient manner in order to meet established objectives of the business plan. The stakes have never been higher for MTF commanders and Services' Surgeons General. The TRICARE Next Generation contracts will require new business rules that guide such actions as financial management, demand capacity, trending and forecasting techniques for both clinical and business lines. Such change raises the criticality and importance of MM to offset financial pressures and at the same time deliver appropriate quality health care.

MM can reduce costs and increase access when incorporated in clinical strategies and business plans. Costs minimization and improved access can have a positive impact on quality. Previous studies on cost savings from using MM techniques typically show $2.50 to $3.50 saved for every dollar invested (Kongstvedt, 2001). MTF Commanders must now decide whether to provide MM services directly, through local contract, or not at all under TRICARE Next Generation. Commanders will have full autonomy over the delivery of patient care and development of business plans within their catchment area. Catchment areas are generally defined as the eligible beneficiaries residing within a forty-mile radius of the MTF. Although the MHS is not in search of making a profit, its facilities are striving to contain costs to within its appropriated resources. Needless to say, MM techniques will play an important role as one of many techniques necessary for the MHS to reach a higher standard of financial success while simultaneously improving health care quality and patient outcomes.

In order to revitalize the MHS UM practices and provide MTFs with a tool which assists them with the new processes, the OCMO has established an interim policy governing the MM program for the DCS of the MHS. This policy is HAP #04-008, *Interim Policy Guidance for Implementation of Medical Management Programs*. What makes this policy interesting from other HAPs is that it is an interim policy. The development of a permanent directive is currently underway with the intent of the directive becoming a Department of Defense Instruction (DoDI).

The 2004 DoDD Number 5025.1, *DoD Directive System* states policy and responsibilities governing all directives within DoD entities. The (2004) DoDD System defines a DoDI as:

> DoD Instructions that implement policy, or prescribe a uniform method or delineate a specific plan of action for carrying out the policy, or provide directions or details for operating a program or activity; and assign responsibilities. A DoD Instruction

> implements a DoD Directive and shall be approved and signed by only a PSA [Principal Staff Assistants] and/or the Secretary or Deputy Secretary of Defense. A PSA may assign program responsibilities to another PSA or the Head of a DoD Component in a DoD Instruction when authorized by a DoD Directive. (Washington Headquarters Service, Department of Defense Issuances, p. 3)

Therefore, policy which never becomes a DoDD is technically only guidance for policy. In other words, the interim policy, to some degree lacks the authority of the Secretary of Defense. Policies that never reach the point of becoming a DoDD are not uncommon. In fact, much of the policy developed at TMA is only policy guidance. However, the fact that the initial MM program policy was written as an interim policy awaiting DoDI approval, signifies TMA's determination to infuse the principles of MM in the DCS of the MHS.

Methods and Procedures

The Eight-Step Path to Public Policy Analysis (Bardach, 1996) guided this policy analysis. Bardach, a professor of Public Policy at the Richard and Rhoda Goldman School of Public Policy – University of California, Berkeley is a broadly based political scientist with wide ranging teaching and research interests. He focuses primarily on policy implementation and public management, and most recently on problems of facilitating better inter-organizational collaboration in service delivery (e.g., in human services, environmental enforcement, fire prevention, and habitat preservation). This analysis uses qualitative rationale in conjunction with an exhaustive literature review. The eight-step policy analysis includes:

1. Defining the problem is the first crucial step of policy analysis. This step provides purpose and a sense of direction for gathering information. Usually, the raw material for your problem definition will come from your client, and derives from the ordinary language of

discussion in the client's political environment. The difficult task is keeping the definition neutral yet evaluative since not everyone will think the facts you have defined as a problem are really a problem (Bardach).

2. Assembling evidence is the second step. Gathering evidence is critical in that collected data (e.g., statistics, interviews, studies, facts, etc.) must be reliable and valid. This information can then be converted into evidence that could affect stakeholders' existing beliefs about the features of the problem. Evidence is recommended for three purposes. First, collected evidence must support the defined problem. Second, the evidence allows the researcher to assess the policy situation through the study of internal and external factors, and lastly to assess policies created by similar entities faced with similar situations (Bardach).

3. Constructing alternatives is the third step. Alternatives serve as policy options that may be better suited to mitigate the problem. In addition, alternatives may be discarded, combined, or reorganized into a basic alternative. Ultimately, the chosen policy alternative should be concise and simple (Bardach).

4. Selecting the criteria is the fourth step. Selected criteria are evaluative standards used to judge the goodness of the projected policy outcomes associated with each of the alternatives. Evaluative criteria commonly used in policy analysis include effectiveness, efficiency, and equity. Criteria such as effectiveness, efficiency, and equity are used to evaluate developed policy options (Bardach).

5. Projecting the outcomes is the fifth step. Projected outcomes are created for each constructed alternative. Projection depends on a thorough understanding of cause-and-effect relationships. These projections can be both negative and positive, and look at the general

direction and magnitude of the outcome. Outcome projection is the hardest step. The researcher must be able to look into the future, but at the same time remain realistic (Bardach).

6. Confronting the tradeoffs is the sixth step. This entails clarification of the tradeoffs between outcomes associated with different policy options. The most common tradeoff is between the allocations of funds in exchange for goods/services, but other considerations play into this step. The old adage, decisions are made on the margin, holds true in policy analysis (Bardach).

7. Making a decision is the seventh step. Decide what to do on the basis of your analysis. In the event a decision cannot be made, the policy analyst will more than likely not convince stakeholders. In such an event, the process reverts back to step 6 (tradeoffs) to reevaluate the analysis (Bardach).

8. The final step is the telling of your story. Following an in-depth analysis of the policy, the analyst should be capable of telling their story in basic terms. By articulating this in a germane discussion, the authoritative body can implement into policy, regulation, or a law (Bardach).

I will analyze the policy making process in the development of the MM policy. Furthermore, my analysis will delineate the clinical and business aspects of MM focusing on criteria such as population health, financial viability, and political feasibility. Population health and financial viability have been generically defined up to this point, and generally understood. However, political feasibility may require further defining in the context of policy analysis. Bardach (1996) suggests of thinking in terms of support and opposition. In order to achieve an optimal political position, there must be enough support or at least minimal opposition from stakeholders for a policy action to be considered politically feasible. Achieving optimal support

and/or minimal opposition is a daunting task in itself considering that all Americans could be viewed as stakeholders, for example, tax-payers, elected political leaders, TRICARE beneficiaries which include active duty service members, retirees, veterans, family members, and the Military Coalition. The Military Coalition, a consortium of military lobbyist, is comprised of 35 organizations representing the interests of more than 5.5 million members of the uniformed services.

The intent of this analysis is to develop a proposition for consideration in solving the challenges of shifted health care services responsibility and resource linking under revised financing. The proposition may also serve as a reinforcement tool to bridging the gap between physicians and executives in the development of a DCS MM program.

Define the Problem

The MHS began transitioning to the next generation of TRICARE contracts in June, 2004. Under the new contracts, MTF Commanders have greater autonomy to incorporate the best use of resources for their populations. Along with greater autonomy comes greater risk, most notably financial risk.

Decisions must be made on how to deliver multiple health care services previously provided by the MCSC. The purpose of this policy analysis is to systematically evaluate the policy making process as it relates to the development of the MHS's MM program. Therefore, utilization services and health care information lines (nurse advice) are the focal point of the health care services that have shifted from contractor to MTF within the DCS. The necessity of utilization services remains in both direct and purchased care systems, but the burden of resource allocation is now borne unto the DCS. This new resource requirement is at the core of the problem. MTFs will not receive additional funding to execute these services. To make matters

more challenging, most MTFs are not staffed or trained appropriately to provide the volume and level of services required by a MM program.

In addition to the change of responsibility, today's healthcare environment stresses the importance of MM. Recent trends indicate the civilian sector moving towards a robust combination of demand management, DM, CM, and UM to form MM. Multiple factors such as an aging population, higher prevalence of chronic illness, cost containment pressures, scrutiny over prescription drug costs, physician and consumer resistance to tighter management, technological advances, consumerism, and the quality gap have contributed to such a drastic measure (Carneal & Caprio, 2002). Although unique, the MHS is just as susceptible to these environmental pressures as is the civilian sector. The *Medical Management Guide* reinforces these variables as factors that are driving the same MM evolution within the MHS (TMA, 2004a).

The second problem, resource linking under revised financing protocols, is more of an existing business rule that is being enforced through new processes and procedures. The history and origin is important to fully understand the circumstances that contribute to the problem.

In 1993, Congress passed a statutory law known as Government Performance and Results Act (GPRA). According to the Managing Director of Federal Budget Issues (Posner, 2004) "A key purpose of the act is to create closer and clearer links between the process of allocating scarce resources and the expected results to be achieved with those resources" (p. 1). As part of President George W. Bush's President's Management Agenda, the administration made GPRA a priority. As a result of this priority, the Office of Management and Budget has developed a diagnostic tool called Program Assessment Rating Tool (PART). The diagnostic tool provides a methodology to evaluate federally funded programs efficiency and effectiveness. In partial

fulfillment of striving for greater efficiency and effectiveness, TMA developed a TRICARE Governance Plan and was approved by the Deputy Secretary of Defense on 20 January 2004 (TMA, 2004b). The organization structure in Figure 1 depicts the Deputy Secretary of Defense and other politically appointed leader's level of authority and relationship to TMA from the Office of the Secretary of Defense to the Deputy Director of TMA. Within the governance plan, the Under Secretary of Defense for Personnel and Readiness (Honorable David S. C. Chu) provides the general framework that will lead to the creation of new business rules. Specifically, the governance plan calls for the creation of business plans at every MTF under revised financing rules. Furthermore, Dr. Chu states, "the objective for the business planning process is to achieve optimal utilization of the DHP [Defense Health Program] resources and provide management accountability at every level of the MHS" (TMA, 2004b, p. 11). He also places an emphasis on utilization when stating, "Revised financing provides the MTF Commander with the incentives to closely manage total health care utilization and cost for their enrollees" (TMA, 2004b, p. 11). In union with the new TRICARE Governance Plan, the Assistant Secretary of Defense for Health Affairs (Honorable William Winkenwerder, Jr.) disseminated his measures for success in a message to the Services' Surgeons General and

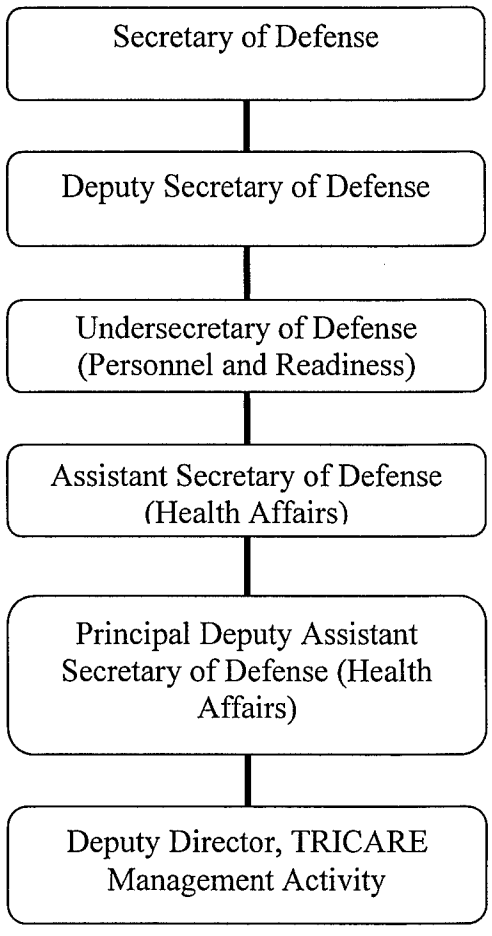

Figure 1. Office of the Assistant Secretary of Defense (Health Affairs) organization structure depicting the relationship between the Secretary of Defense to the Deputy Director, TRICARE Management Activity. As of February 1, 2005.

senior leaders of the MHS on 20 September 2004. In Dr. Winkenwerder's letter (2004b) are four measures (a) medical readiness, (b) health care quality, (c) efficient use of resources, and (d) customer satisfaction. Throughout the chain of command, from the President's President Management Agenda to the local MTF business plan, an obvious theme can be identified – effective and efficient use of resources. Furthermore, an effective and efficient MM program can bolster outcomes of all four measures for success.

Assemble Some Evidence

Health plans continually strive to deliver appropriate care that provides both quality care at optimal costs, while simultaneously juggling the challenges that exist within the health care environment. Insurers and health plans are forced to decide between policies of status quo or some other alternative means to mitigate the rising costs of health care given limited resources in order to optimize not only the population's health, but also their organizations viability. The tenets of MM programs across the world have shown to be an effective tool of an organization's arsenal to meet current health care industry challenges.

Most health care entities can identify specific cost savings from MM programs at the corporate level. This ability allows management and senior executives to make informed decisions. URAC researchers (Greenberg, Carneal, & Hattwick, 2002) concluded in a national survey of health care organizations that 78% of the respondents were optimistic of MM programs improving quality of care, and that 74% of the respondents were also optimistic that such changes would reduce overall costs. Health care companies are saving money and often doing so with fewer staff by placing an emphasis on MM. The positive outcomes are more visible and dramatic at the lower levels of organizations. Wheeler (2003) reports a five to one ratio of expenditure savings to program costs at six hospital sites using the principles of MM for

chronically-ill patients in an in-patient setting. Additionally, Ofman Badamgarav, Henning, Knight Gano, Levan, et al. (2004) concluded from 102 different studies that MM precepts do in fact improve quality of care and outcomes for patients.

In the MHS, the complexity and uniqueness of the financial methodology has made data from such corporate-level programs unattainable by researchers (IG– DoD, 1998; Ramsaroop, Ball, Beaulieu, and Douglas, 2001). However, some research exists from data compiled at the MTF-level. Carey (1999) reported a 62% decrease in monthly emergency room visits per month following educational classes which are a key component of any MM program. Also, the IG–DoD (1998) joint audit report concluded that the audited Army MTF's demonstrated a 20% reduction in staffing while experiencing 12% reductions in cost per disposition and 6% reduction in overall operating costs attributable to UM programs. Despite the proven benefits from a MM program in both civilian and military medicine, the MHS continues to have dissimilar levels of interest and effort for such programs.

The same IG– DoD (1998) report demonstrates this inequity by the differing levels of FTEs performing UM functions at MTFs within the MHS. The comparison showed six medical centers FTE variation from 1.5 to 24.7. With such a wide variation of UM FTEs among MTFs, it is to be expected that MM levels of effort are neither optimized nor producing optimal outcomes for the MHS. In addition, it is known that TRICARE's lower employee cost share compared to civilian health plans employee cost share increases utilization rates of the MHS (OSD/HA, 2004). The MHS increase in utilization rates can be seen across the organization. Between FY 2001 and FY 2003, purchased care inpatient dispositions increased by 21%, purchased care outpatient workload increased by 31%, and the Prime enrollee utilization rate (discharges per 1,000 enrollees) increased by 16.2% while the rate of their civilian counterparts decreased by

1.5% (OSD/HA, 2004). As recent as the 2005 TRICARE Conference, the Acting Deputy Assistant of Defense Health Budgets and Finance Policy stated, "The rich [TRICARE] benefit design drives increased users and utilization" (personal communication, January 25, 2005). The disparity between health care utilization rates of MHS and civilian sector places an enormous tension on the MHS to close the gap. The MHS is faced with the added challenges of deploying service members and units, federal downsizing, increasing ghost population, and military readiness requirements (e.g., healthy force). All challenges which the civilian sector does not face. The term ghost population is common terminology among the TMA staff. The term refers to eligible beneficiaries not enrolled, such as retirees that elect to enroll in their civilian health plans. However, as civilian health plan's deductibles and premiums increase due to the nation's rising cost for health care, eligible TRICARE beneficiaries will enroll in TRICARE for reduced deductible and premium payments. Nonetheless, the MHS is a federally funded program that inherently causes scrutiny over its efficacy and comparison to civilian counterparts.

One such measure to close the gap might be the creation of business plans within the MHS. Authors Cardamone, Shaver, and Werthman (2004) write about the Johns Hopkins Hospital and Health System (JHHHS) business plans and the important role these plans have had on their organization since 1995. Throughout JHHHS business plan, many key terms and elements can be matched to those found in the MHS business plan. The most recurring theme found in both plans is financial analysis. Furthermore, both financial analyses require utilization projections. Requiring utilization projections underlines the importance of MM programs.

Construct the Alternatives

The third step of the policy analysis is to construct the alternatives. The alternatives will serve as policy options that may be better suited to resolve the issues which the policy is

intended to remedy. Alternatives may be later discarded, combined, or reorganized into a basic alternative, but ultimately leading to a concise and simple option.

The eight step process recommends that the first alternative is to take no action. In other words, policy makers should forego any policy development and allow trends to naturally evolve. As previously stated, the MHS is faced with the same external forces that have driven the implementation of MM programs throughout the civilian health care industry, such forces include an aging population, higher prevalence of chronic illness, cost containment pressures, scrutiny over prescription drug costs, physician and consumer resistance to tighter management, technological advances, consumerism, and the quality gap. To take no policy action would seem to have a negative outcome for the MHS. Evidence reveals the beneficial impact a MM program can have on an organization. Examples of these beneficial impacts include the Wheeler (2003) report of a five to one ratio of expenditure savings, the Ofman et al. (2004) report of 102 different studies that MM precepts do in fact improve quality of care and outcomes for patients, and the IG– DoD (1998) joint audit report showing reductions in staffing (20%), cost per disposition (12%), and overall operating costs (6%) at audited Army MTFs.

An additional alternative is to reassess the cost-effectiveness and necessity of the MCSC being responsible for the MM of all MHS beneficiaries, to include the business planning (e.g., population health analysis and financial forecasting). This option would eliminate the need for local programs executed through contract or internal resources, and eliminate geographic variation among programs. Furthermore, a national contract would create cost-avoidance through economies of scale, and create one standard eliminating the dissimilar levels of support for MM in the MHS.

Another alternative is to incorporate a comprehensive education program that provides the necessary skill sets to the right DCS employees such as commanders, senior executives, health care providers, and administrators. Multiple education programs exist such as the U.S. Army-Baylor University Graduate Program in Health Care Administration that are offered to DoD and Department of Veterans Affairs employees; the Joint Medical Executive Skills Institute offers educational opportunities to MTF Commanders and senior executives, and the Uniformed Services University of the Health Sciences offers multiple professional degrees to our health care providers. Based on the few examples of educational programs listed, it is apparent that this education can take place at the entry and senior level, across service lines, and perhaps more importantly among clinicians and administrators. Ramsaroop et al. (2001) states that the MHS must keep pace with change in the 21st century in that faculty and curricula must address the expanding list of organizational and industry-wide change. Enabling the DCS staff with the proper skill sets to execute the clinical and business aspects of a MM program builds the crucial foundation required to implement the most effective and efficient MM program using internal resources. Kongstvedt (2001) supports this when he stated, "It will be important to improve the ability of the [military health] system to respond to external and internal changes to maintain a viable, cost-effective health care delivery program for military beneficiaries" (p. 1132).

Select the Criteria

The fourth step includes criteria selection to judge the goodness or beneficence of the projected policy outcomes associated with each of the alternatives. Bardach (1996) suggests thinking of policies having two interconnected but separate plot lines. The analytical plot line deals with the facts, and the evaluative plot line focuses on subjective value. A third type of criteria may exist, referred to as practical criteria (e.g., political feasibility). The critical task in

step four is to use the selected criteria to judge the outcomes, not the alternatives, in order to select the best alternative based on the analyst's judgment.

The selected criteria used in my policy analysis are: a) improving population health, b) securing financial viability, and c) determining level of political feasibility. The criteria were selected to represent a broad standard from both the clinical and business setting. The level of political feasibility was selected due to the effects politics have on federally funded programs.

Results

In order to provide a structured presentation of the results, the following outcome labels were assigned to each alternative's criteria: a) favorable, b) no difference, and c) not favorable. A table is provided in the Appendix that displays all three alternatives including the respective criteria and outcome. In the subsections to follow, historical evidence is used to warrant the chosen label for each alternative's criteria.

Project the Outcomes

The next task in the eight steps of policy analysis is to project the outcomes. Bardach enforces that policy analysts should use convincing evidence with a mindset towards realism and the future during this step. Projections, negative or positive, should include magnitude when possible.

Alternative One

Alternative one is to take no action, or allow present trends to continue undisturbed. Allowing present trends to continue undisturbed will more than likely result in a negative predictable outcome. The MHS has experienced increases in utilization rates over the past few years. From FY 2001 to FY 2003, purchased care inpatient dispositions increased by 21%, purchased care outpatient workload increased by 31%, and the Prime enrollee utilization rate

(discharges per 1,000 enrollees) increased by 16.2% while the rate of their civilian counterparts decreased by 1.5% (OSD/HA, 2004). The disparity between health care utilization rates of MHS and civilian sector will inevitably bring scrutiny of the effectiveness and efficiency of the MHS from its stakeholders. To take no action would be irresponsible when both the civilian studies (Carey, 1999; Kongstvedt, 2001 & Wheeler, 2003) and DoD audits (IG – DoD, 1998) have shown that MM principles improve the overall effectiveness and efficiency of health care delivery. Moreover, impacting both clinical (e.g., quality and access) and business (e.g., overall cost) aspects, resulting in less than optimal levels of population health and financial viability. Furthermore, such performance would inevitability gain negative attention making it politically unfeasible.

Alternative one is scored as follows: a) level of population health (not favorable); b) securing financial viability (not favorable); and c) political feasibility (not favorable).

Alternative Two

Alternative two is to reassess the feasibility of the MCSC being responsible for the MM of all MHS beneficiaries. This alternative can provide a positive analytical plot line. Intuitively, the elimination of numerous contracts to one national contract will have a similar positive effect that is expected from the transition of TRICARE 2.0 contracts to TRICARE Next Generation contracts. TMA's (2004b) TRICARE Governance Plan emphasizes improved accountability for patient satisfaction, joint decision-making, and resource allocation through minimization of contracts. Although difficult to quantify without proceeding to contract negotiation, economies of scale and cost-avoidance would be anticipated in a single contract resulting in improved efficiency. Using the same thought process used in the development of the TRICARE Next

Generation of contracts, it is plausible to suggest that the level of population health and securing financial viability can be better achieved with a single national contract.

Along an evaluative plot line, many variables may be considered in weighting criteria. The MHS has had four different policies pertaining to some level of MM over the past 10 years. Past policies have attempted to stress the importance and advantage of such programs but have had dismal success of achieving only dissimilar levels of acceptance and effort (IG– DoD, 1998). As a result, the MHS has never fully capitalized from a MM program. Another variable of consideration might be the level of experience between MHS resources and civilian contractors. The civilian sector has already begun to see improvements from the implementation of MM techniques such as Kaiser, where 30% of their three million beneficiaries have experienced a reduction in death due to heart DM (Thompson, 2004). Selecting an experienced and successful company such as Kaiser to perform MM on all MHS beneficiaries may be more appealing than the MHS attempting to do so for the first time with internal resources. One last variable of consideration is political feasibility. How much political clout will have to be exhausted in order to return to the old system of the MCSC providing MM for the DCS beneficiaries? Moreover, how many additional monies will Congress have to appropriate to the already highly scrutinized rising DHP budget? Political feasibility is difficult to place a quantifiable number or magnitude. Bardach (1996) suggests categorizing political feasibility as acceptable or unacceptable based on opposition and support. The political feasibility of this option may vary drastically depending on the nation's political environment and concerns over the rising costs of health care and defense budgets.

Alternative two is scored as follows: a) level of population health (favorable); b) securing financial viability (favorable); and c) political feasibility (not favorable).

Alternative Three

Alternative three is to provide the necessary skills sets to the MHS staff through a comprehensive education program. Kongstvedt and Ramsaroop et al. (2001) agree that the success of the MHS depends on its ability to be flexible and react to change. The MHS can strategically plan for and implement a MM program, but without the depth of staff members having sufficient skill sets to manage such a program, implementation may lead to less than optimal results.

The Institute of Medicine (IOM) (2001) suggests that MM techniques must be provided to clinical, administrative, and governance entities through current training and education curricula. Current training and education programs are an underlining task to achieve the "Six Aims for Improvement" in the nation's health care delivery system. The MHS is equally as vulnerable as the civilian health sector is to factors such as an aging population, higher prevalence of chronic illness, cost containment pressures, scrutiny over prescription drug costs, physician and consumer resistance to tighter management, technological advances, consumerism, and the quality gap. Current methods of training the next generation of clinicians and non-clinicians are not enough. The MHS must be creative in their efforts to retool practicing clinicians and management rather than relying solely on traditional methods such as conferences. According to the IOM, traditional conferences alone have little effect on clinician behavior. Lastly, it is not enough to educate new providers and administrators at entry level programs. The skill sets provided to new graduates must be reinforced beyond the basic coursework at the organization. Reinforcement at the organizational level often requires senior leader and command acceptance. Education and training offered in early careerist programs such as the U.S. Army-Baylor University Graduate Program in Healthcare Administration and senior level

programs such as the Joint Medical Executive Skills Institute may be one method of providing such skills at both ends of the career continuum.

A comprehensive education program throughout the MHS can reduce the variation in the level of support for MM efforts. The IG– DoD (1998) report FTEs performing UM functions at six MHS medical centers ranged from 1.5 to 24.7. In addition, it is plausible to suggest that MM functions incorporated at MTFs can achieve similar improvements identified in the IG– DoD (1998) joint audit report showing reductions in staffing (20%), cost per disposition (12%), and overall operating costs (6%). Such improvements would have a positive effect on the rising utilization rates that have occurred between FY 2001 and FY 2003 making alternative three a good option to consider for improving the level of population health and securing financial viability. Multiple education programs already exist within the MHS. In other words, the infrastructure and funding resources for these programs are already in place. Thus, curricula changes can be made internally and the need for external resources is minimized making alternative three a more politically feasible option.

Alternative three is scored as follows: a) level of population health (favorable); b) securing financial viability (favorable); and c) political feasibility (favorable).

Discussion

Bardach (1996) states that some policy alternatives will produce better outcomes than any other alternative. When this occurs, the alternative with better outcomes has achieved dominance and no trade-offs exist. Oftentimes, the most common trade-off is between money and some public good or service.

Confront the Trade-offs

Policy judgments are often persuaded by the evaluative plot line over the analytical plot line. While our country is currently at war on terrorism, scrutiny over money in support of those who volunteer to serve as well as those who have served their country is less scrutinized. But keeping a pragmatic view, generous funding of defense programs exists only temporarily. Using this mindset, political feasibility should be viewed from both a short and long range perspective. In essence, the answer to today's question while the nation embraces its armed forces may be much different from the answer in a decade when the nation may be grappling with an unmanageable deficit and/or uncontrollable health care costs.

Decide!

The development and implementation of a MM program DoDI, in conjunction with a comprehensive education program, is the most plausible means for the DCS to overcome the mandated responsibility shift of health care services and the resource linking challenges of revised financing. Providing clinicians and administrators with compatible skill sets at all stages of the career continuum and across service lines can only bolster the elements of improved accountability for patient satisfaction, joint decision-making, and resource allocation, to include bridging the gap between clinicians and administrators. Although bridging the gap between clinicians and administrators is a project unto itself, having common curricula in both clinical and business military education programs can clearly foster attainable common goals across the professions, of the greater profession of serving one's country.

Tell Your Story

After completing the eight steps of policy analysis, in conjunction with conducting an exhaustive literature review, a convincing and strong argument may be made that the DCS MM program must coexist with a comprehensive education program to maximize optimal effectiveness and efficiency. The Population Health/MM division has already constructed an excellent platform to advance MM educational opportunities. The Division's staff provides both basic and advance level training upon request, capitalizes on conference speaking engagements, and offers a robust webpage on TMA's website. The next best course of action may be to develop curricula for instructional purposes at higher education programs such as the U.S. Army-Baylor University Graduate Program in Healthcare Administration, the Uniformed Services University of the Health Sciences, or the Joint Medical Executive Skills Institute.

The best way to tell my story is to engage senior MHS leadership and publication. The staff of the Population Health/MM division may benefit from this policy analysis if a decision paper is written on whether or not MM should be taught at higher educational programs within the MHS.

Conclusions and Recommendations

The MHS must become increasingly vigilant in its quest for improved effectiveness and efficiency as it faces external government demands, internal contractual pressures, and an ever-changing health care environment. A DoDD requiring the practice of MM principles will place the MHS on the right path to meet such challenges. Furthermore, eliminating the dissimilar levels of support for MM across the DCS, similar improvements such as reductions in staffing (20%), cost per disposition (12%), and overall operating costs (6%) identified in a 1998 IG-DoD audit of MTFs utilizing techniques of MM can be achieved. Likewise, McKendry (2002) and

Hodgkin et al. (2000) found that well integrated MM programs provide organizations the opportunity to improve effectiveness and efficiency through elimination of duplications, redundancies, and extra work. Furthermore, a comprehensive education program can bridge the gap between providers and administrators to reach common strategies and goals (e.g., delivering appropriate care, in a timely manner, at the appropriate level, for the best cost, and assuring reasonable outcomes). The final and possibly most important outcome may be a sustainable and vibrant DCS.

Appendix

Projecting the Outcomes: Alternative Matrix

Alternatives	Outcomes
Alternative One: Take no action	
Level of Population Health	Not Favorable
Securing Financial Viability	Not Favorable
Political Feasibility	Not Favorable
Alternative Two: Reassess feasibility of the MCSC being responsible for DCS MM	
Level of Population Health	Favorable
Securing Financial Viability	Favorable
Political Feasibility	Not Favorable
Alternative Three: DCS responsible for MM & implements education program	
Level of Population Health	Favorable
Securing Financial Viability	Favorable
Political Feasibility	Favorable

References

Bardach, E. (1996). *The eight-step path of policy analysis.* Berkeley, CA: Berkeley Academic Press.

Cardemone, M. A., Shaver, M., & Werthman, R. (2004). Business planning: Reasons, definitions, and elements. *Healthcare Financial Management, April,* 40-46.

Carey, M. (1999, November). Pediatric asthma education class [Msg 99082]. Message posted to http://www.tricare.osd.mil/HCR/abclnacs.cfm

Carneal, G., & Caprio, L. (2002). *Case management trends: An overview of recent industry and regulatory developments.* Washington, DC: URAC.

Christopherson, G. A. (1998). *Health affairs policy, 98-031: Revised utilization management policy for the direct care system.* Retrieved September 1, 2004, from http://www.ha.osd.mil/policies/1998/umpd9831.html

Greenberg, L., Carneal, G., & Hattwick, M. (2002). *Trends and practices in medical management: 2001 industry profile.* Washington, DC: URAC.

Inspector General - Department of Defense. (1998). *Military health system utilization management program at medical centers.* Retrieved September 14, 2004, from http://www.dodig.osd.mil/audit/reports/fy98/98-136.pdf

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century.* Washington, DC: National Academy Press.

Hodgkin, D., Horgan, C. M., Garnick, D. W., Merrick, E. L., & Goldin, D. (2000). Why carve out? Determinants of behavioral health contracting choice among large U.S. employers. *Journal of Behavioral Health, 27,* 2

Joseph, S.C. (1994). *Health affairs policy, 94-005: Utilization management (UM)*

activities in the direct care system under TRICARE. Retrieved September 1, 2004, from http://www.ha.osd.mil/policies/1994/umpl9405.html

Joseph, S.C. (1996). *Health affairs policy, 96-025: Updated TRICARE policy guidance.* Retrieved September 1, 2004, from http://www.ha.osd.mil/policies/1996/trimhss1.html

Kongstvedt, P. K. (2001). *The managed health care handbook* (4th ed.). Gaithersburg: Aspen Publishers.

McKendry, M. J. (2002). *Medical management: An overview.* Washington, DC: The Health Insurance Association of America.

Miller, R. D., & Levy, R. A. (2004). *Comparing TRICARE with other federal and civilian healthcare plans.* Virginia: The CNA Corporation.

Office of the Secretary of Defense (Health Affairs). (2004). *Evaluation of the TRICARE program: Fy 2004 report to congress.* Retrieved October 12, 2004, from http://www.ha.osd.mil/asd/eval_report.pdf

Ofman, J. J., Badamgarav, E., Henning, J. M., Knight, K., Gano, A. D., Levan, R. K., et al. (2004). Does disease management improve clinical and economic outcomes in patients with chronic diseases? A systematic review. *American Journal of Medicine, 117,* 1-15.

Posner, P. L. (2004). Examining the government performance and results act. Retrieved September 1, 2004, from EBSCOhost database.

Ramsaroop, P., Ball, M. J., Beaulieu, D., & Douglas, J. V. (2001). *Advancing federal sector health care: A model for technology.* New York: Springer.

Thompson, A. (2004). *Kaiser bucks the HMO trend.* Retrieved December 21, 2004, from http://www.msnbc.msn.com

TRICARE Management Activity. (2004a). *The medical management guide.* Retrieved September 1, 2004, from http://www.mhsophsc.org/public/spd.cfm?spi=mmguide

TRICARE Management Activity. (2004b). *TRICARE governance plan.* Retrieved September 1, 2004, from http://www.ha.osd.mil/policies/2004/tricare_governance_guidance.pdf

Washington Headquarters Service, Department of Defense Issuances. (2004). *Department of defense directive number 5025.1.* Retrieved September 1, 2004, from http://www.dtic.mil/whs/directives/corres/pdf/d50251_071404/d50251p.pdf

Wheeler, J. R. C. (2003). Can a disease self-management program reduce health care costs?: The case of older woman with heart disease. *Med Care, 41,* 706-715

Winkenwerder, W. (2004a). *Health affairs policy, 04-008: Interim policy guidance for implementation of medical management programs.* Retrieved September 1, 2004, from http://www.ha.osd.mil/policies/2004/04-008.pdf

Winkenwerder, W. (2004b). *Message from the assistant secretary of defense for health affairs: Military health system – measures for success.* Retrieved September 1, 2004, from http://www.ha.osd.mil/asd/mhs_measures.cfm