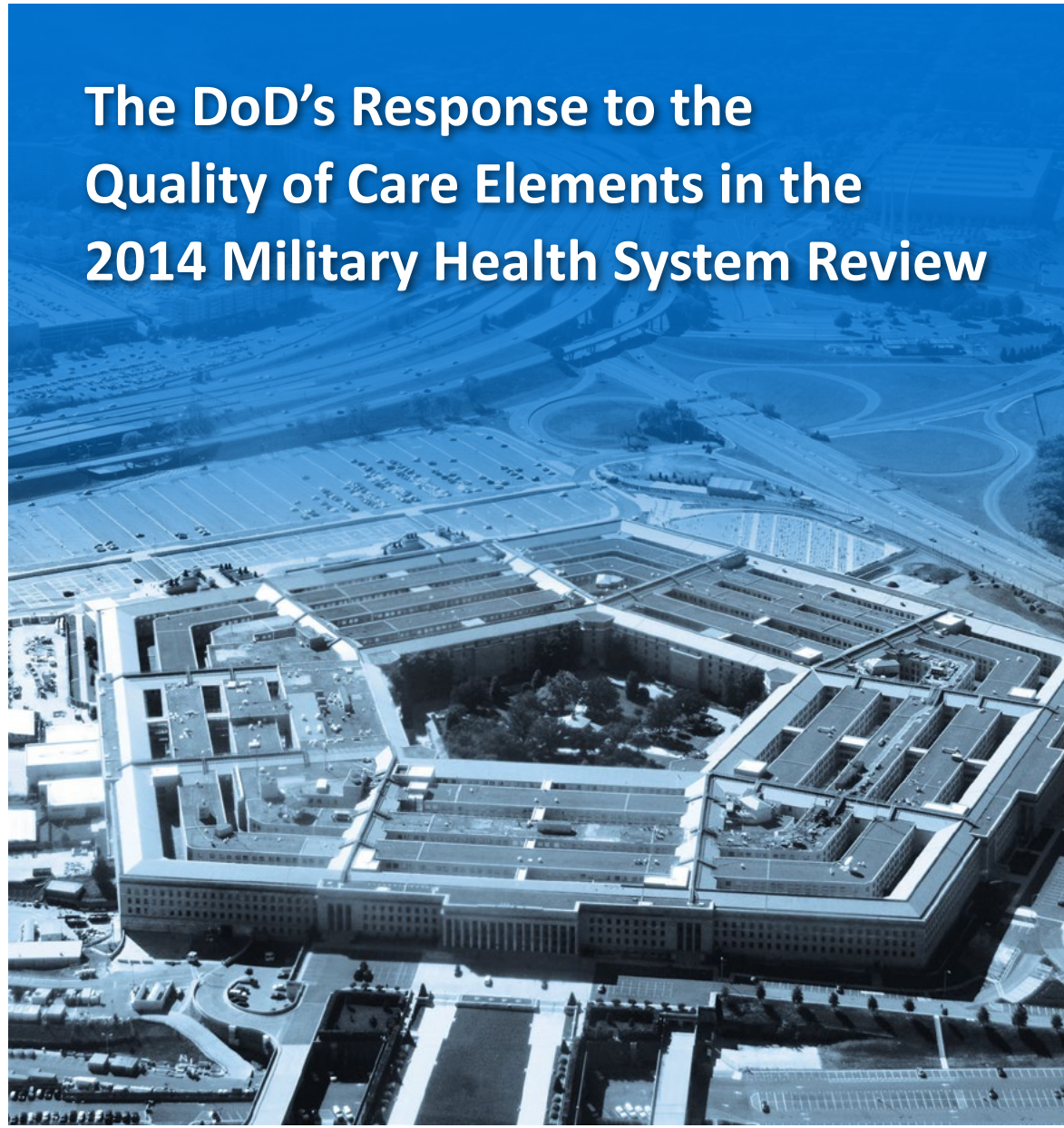




INSPECTOR GENERAL

U.S. Department of Defense

FEBRUARY 8, 2018



The DoD's Response to the Quality of Care Elements in the 2014 Military Health System Review

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Results in Brief

The DoD's Response to the Quality of Care Elements in the 2014 Military Health System Review

February 8, 2018

Objectives

We evaluated the DoD's response to the August 2014 "Final Report to the Secretary of Defense, Military Health System [MHS] Review." Our evaluation examined issues specific to quality of care to determine whether:

- the DoD responded to all of the MHS Review's quality of care recommendations;
- the DoD improved performance at the military treatment facilities (MTFs) that the MHS Review identified as outliers for National Perinatal Information Center (NPIC) measures;¹
- the DoD improved performance at the MTFs identified in the MHS Review as outliers needing improvement for the National Surgical Quality Improvement Program's (NSQIP) morbidity measure;²
- the DoD improved performance at the MTFs identified in the MHS Review as negative outliers for the Primary Care Manager (PCM) Continuity measure;³
- the MHS developed policy that gave the Military Services common quality of care goals, in accordance with the MHS Review's recommendation; and

¹ The MHS Review defines the NPIC as the entity that provides the MHS with quarterly direct care data, presented as comparisons to averages of civilian hospitals participating as members in the NPIC/Quality Analytics System Proprietary Perinatal Center Database. See Finding B for a definition of outliers for NPIC measures.

² See Finding C for the definition of morbidity.

³ See Finding D for the definition of PCM Continuity.

Objective (cont'd)

- the MHS used a performance management system to improve quality of care as the Secretary of Defense directed.

Background

In May 2014, the Secretary of Defense directed a 90-day comprehensive review of the MHS to evaluate DoD beneficiaries' access to care, patient safety, and quality of care. The MHS is a global, comprehensive, and integrated system of health care for the DoD, which includes combat medical services, peacetime care delivery, public health activities, medical education and training, and medical research and development.

Findings

We found that:

The MHS action plans contained courses of action to resolve all 44 recommendations in the quality of care section of the MHS Review. As of November 2017, the MHS has completed 22 of 26 action plans to address the 44 quality of care recommendations.

We found that all MTFs identified in the MHS Review as outliers for the NPIC quality of care measures regarding postpartum hemorrhage, Patient Safety Indicator #17 Birth Trauma, and shoulder dystocia developed action plans to improve performance as the Secretary of Defense directed.⁴ Our analysis of the Defense Health Agency data showed that these MTFs were no longer considered outliers, relative to the MHS Review, for the NPIC benchmarks by the end of the first quarter of CY 2017.

We found that all eight MTFs identified in the MHS Review as outliers "needing improvement" in the NSQIP's measure of morbidity had met standards.

⁴ See Finding B for an explanation of these NPIC measures.



Results in Brief

The DoD's Response to the Quality of Care Elements in the 2014 Military Health System Review

Findings (cont'd)

Our data analysis also found that three of the four MTFs that were “negative outliers” for the PCM Continuity measure at the time of the MHS Review were no longer negative outliers. The DoD deactivated the remaining MTF in FY 2015 and it is no longer in operation, so it is no longer being tracked.

In addition, we observed that the DHA-developed action plans, in response to the MHS Review, included implementing quality of care and process improvement governance. We also found that the DoD was developing a quality of care governance structure with common policy, procedure, and direction in accordance with the National Defense Authorization Act for FY 17.

Finally, we found that the MHS developed the Partnership for Improvement (P4I) performance management system. The MHS uses the P4I to monitor quality of care for areas requiring improvement.

Recommendations

We recommend that the Director of the Defense Health Agency notify the DoD Office of Inspector General when the MHS has implemented all actions in the MHS Review Action Plans regarding quality of care.

Management Comments and Our Response

The Director of the Defense Health Agency agreed with our recommendation to notify the DoD Office of Inspector General when the MHS has implemented all actions in the MHS Review Action Plans regarding quality of care. This recommendation is resolved but remains open.

Recommendations Table

Management	Recommendation Unresolved	Recommendation Resolved	Recommendation Closed
Director, Defense Health Agency	None	Yes	None

Note: The following categories are used to describe agency management’s comments to individual recommendations.

- **Unresolved** – Management has not agreed to implement the recommendation or has not proposed actions that will address the recommendation.
- **Resolved** – Management agreed to implement the recommendation or has proposed actions that will address the underlying finding that generated the recommendation.
- **Closed** – OIG verified that the agreed upon corrective actions were implemented.





**INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
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ALEXANDRIA, VIRGINIA 22350-1500**

February 8, 2018

MEMORANDUM FOR DIRECTOR, DEFENSE HEALTH AGENCY

SUBJECT: The DoD's Response to the Quality of Care Elements in the 2014 Military Health System Review (DODIG-2018-067)

We are providing this final report for action as appropriate. We conducted this evaluation from September 2016 through December 2017 in accordance with the "Quality Standards for Inspection and Evaluation" published by the Council of Inspectors General on Integrity and Efficiency in January 2012.

We considered management comments to a draft of the report while preparing the final report. Comments from the Director, Defense Health Agency were responsive and conformed to the requirements of DoD Instruction 7650.03. Therefore, we do not require additional comments.

We appreciate the courtesies extended to the staff. Please direct questions to [REDACTED]

or [REDACTED]

A handwritten signature in black ink, appearing to read "K.P. Moorefield", is positioned above the typed name.

Kenneth P. Moorefield
Deputy Inspector General
Special Plans and Operations

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Introduction

The Military Health System (MHS) is a global, comprehensive, and integrated system that includes combat medical services, peacetime care delivery, public health activities, medical education and training, and medical research and development. In May 2014, the Secretary of Defense directed a 90-day comprehensive review of the MHS to evaluate Department of Defense beneficiaries' access to care, patient safety, and quality of care.⁵

The MHS Review Group published the "Final Report to the Secretary of Defense, Military Health System Review," in August 2014.⁶ Afterwards, the Secretary issued a memorandum entitled "Military Health System Action Plan for Access, Quality of Care, and Patient Safety," on October 1, 2014, that directed the DoD to follow up on the MHS Review, improve transparency, and transform the MHS into a High Reliability Organization.⁷

In this evaluation, the Department of Defense Office of Inspector General (DoD OIG) reviewed the DoD's response to the "Final Report to the Secretary of Defense, Military Health System Review," specifically for quality of care. The DoD OIG addresses patient safety in a separate evaluation report and will evaluate access to care in the future.

Objectives

We evaluated the DoD's response to the quality of care sections of the MHS Review to determine whether:

- the DoD responded to all of the MHS Review's quality of care recommendations;

⁵ The Secretary of Defense addressed his May 28, 2014, memorandum to the Deputy Secretary Of Defense, Secretaries of the Military Departments, and Acting Under Secretary of Defense for Personnel and Readiness.

⁶ See Appendix B for an explanation of the MHS Review Group.

⁷ The Secretary of Defense addressed the October 1, 2014, memorandum specifically to Secretaries of the Military Departments; Chairman of the Joint Chiefs of Staff; Under Secretaries of Defense; Deputy Chief Management Officer; Chiefs of the Military Services; Chief of the National Guard Bureau; Director of Cost Assessment and Program Evaluation; Director of Operational Test and Evaluation; General Counsel of the Department of Defense; Inspector General of the Department of Defense; Assistant Secretaries of Defense; Department of Defense Chief Information Officer; Assistants to the Secretary of Defense; Directors of the Defense Agencies; and Directors of the DoD Field Activities. According to the MHS Review, a High Reliability Organization is an organization where harm prevention and quality improvement are second nature in the organization.

- the DoD improved performance at the military treatment facilities that the MHS Review identified as outliers for the National Perinatal Information Center measures;⁸
- the DoD improved performance at the Military Treatment Facilities (MTFs) identified in the MHS Review as outliers needing improvement for the National Surgical Quality Improvement Program's (NSQIP) morbidity measure;⁹
- the DoD improved performance at the MTFs identified in the MHS Review as negative outliers for the Primary Care Manager Continuity measure;
- the MHS developed policy that provided the Military Services with common quality of care goals, in accordance with the MHS Review's recommendation; and
- the MHS used a performance management system to improve quality of care as the Secretary of Defense directed.

See Appendix A for scope, methodology, and prior coverage related to the objectives.

Background

According to the MHS Review, the MHS is a global, comprehensive, and integrated system that includes combat medical services, health readiness, a healthcare delivery system, public health activities, medical education and training, and medical research and development. The MHS's fundamental mission, providing medical support to military operations, differs from the mission of any other health system in the United States. The three Military Departments (the Army; the Navy, including the Marine Corps; and the Air Force) and the Defense Health Agency (DHA) share operational aspects of the Military Health System, with each controlling and operating its own medical centers, hospitals, and clinics worldwide.¹⁰

⁸ The MHS Review identified outliers in three NPIC measures: postpartum hemorrhage; Patient Safety Indicator (PSI) #17, Birth Trauma; and shoulder dystocia. The American Congress of Obstetricians and Gynecologists defines postpartum hemorrhage as a cumulative loss of blood greater than or equal to 1000 milliliters of blood accompanied by signs or symptoms of low blood volume within 24 hours following the birth process. The 2014 MHS Review defines PSI #17, Birth Trauma as the measure of birth trauma injury to infant, per 1000 newborns, excluding certain categories of infants with specific conditions. The American College of Obstetricians and Gynecologists defines shoulder dystocia as "a birth complication that requires additional maneuvers to relieve impaction of the fetal shoulder."

⁹ The MHS Review defined the NSQIP as the program that provides semi-annual reports that provide risk-adjusted, 30-day morbidity outcomes computed for each participating hospital. The NSQIP reported metric is a ratio that represents the estimated odds of a complication or event occurring in a specific hospital compared to the estimated odds of that event occurring in all participating NSQIP hospitals.

¹⁰ The DHA describes themselves as a joint, integrated Combat Support Agency that enables the Army, Navy, and Air Force medical services to provide a medically ready force and ready medical force to Combatant Commands in both peacetime and wartime. The DHA supports the delivery of integrated, affordable, and high quality health services to MHS beneficiaries, and is responsible for driving integration of clinical and business processes across the MHS.

Prior to the National Defense Authorization Act (NDAA) for FY 17, each Service headquarters was responsible for its own healthcare policy. The components that executed healthcare policy for the Services were as follows:

- DHA: National Capital Region Medical Directorate (NCR MD);
- U.S. Army: U.S. Army Medical Command (MEDCOM);
- U.S. Navy and Marine Corps: U.S. Navy Bureau of Medicine and Surgery (BUMED); and
- U.S. Air Force: Air Force Medical Operations Agency (AFMOA).

As one of the largest healthcare providers in the United States, the MHS combines resources from both direct and purchased care components.¹¹ The MHS provides healthcare to 9.6 million beneficiaries. These beneficiaries include service members, retirees, and eligible family members. As of December 2016, the worldwide direct care component consisted of 55 DoD MTFs, 373 ambulatory-care clinics, and 245 dental clinics.¹²

The MHS Review

On May 28, 2014, the Secretary of Defense directed a comprehensive review of the MHS. Subject matter experts from the Military Departments and the DHA reviewed the MHS with input from outside experts. The MHS Review evaluated whether:

- patient access to medical care in the MHS met defined access standards,
- the quality of healthcare in the MHS met or exceeded defined benchmarks, and
- the MHS created a culture of safety with effective processes for ensuring safe and reliable patient care.

The MHS Review was the first time the MHS had taken an enterprise view of such scope in these three areas.¹³

¹¹ According to the MHS Review, the DoD uses the purchased care component when it cannot provide care within the military system. The purchased care component includes civilian network hospitals and providers operating through TRICARE regional contracts. Direct care is care within the military system.

¹² In accordance with DoD Manual 6010.13-M, "Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities Manual," April 7, 2008, ambulatory care provides comprehensive primary medical care; diagnostic services, care, and treatment; ambulatory surgical procedures; medical examinations; mental health consultation; and proper medical disposition of inpatients and outpatients.

¹³ The scope of the MHS Review did not include healthcare provided to Combatant Commands and deployed operational forces.

The MHS Review Results

The MHS Review Group published the MHS Review on August 29, 2014. The MHS Review reported that the MHS provided “good quality care that was safe and timely, and is comparable to that found in the civilian sector.” However, the MHS Review also reported that the MHS demonstrated wide performance variability, showing better performance than its civilian counterparts in some areas and performance below the national benchmarks in other areas. The MHS Review stated the MHS must continue to improve in order to become a national leader in healthcare. The MHS Review also included a list of recommended actions.

The MHS Review reported several findings.

- National Perinatal Information Center (NPIC) data showed that the MHS direct care component had statistically better rates of infant mortality and maternal trauma than the NPIC averages.¹⁴ However, the MHS performed statistically worse than the NPIC average in postpartum hemorrhage and undefined neonatal trauma.
- Of the 17 MTFs participating in NSQIP, 8 needed improvement in the NSQIP morbidity measure.¹⁵
- Four negative outliers needed improvement for PCM Continuity, according to the National Committee for Quality Assurance.¹⁶

The MHS Review recommended that the MHS take several corrective actions:

- “The MHS should identify the cause of variance for military treatment facilities that are outliers for one or more measures and, when due to poor performance, develop corrective action plans to bring those military treatment facilities within compliance.”
- “The MHS should develop a performance management system adapting a core set of metrics regarding access, quality, and patient safety; further develop MHS dashboards with system wide performance measures; and conduct regular, formal performance reviews of the entire MHS, with the Defense Health Agency monitoring performance and supporting MHS governance bodies in those reviews.”

¹⁴ NPIC’s benchmark is composed of 86 high-volume obstetric hospitals.

¹⁵ The 2014 MHS review listed a limitation stating only 17 of 56 MTFs participate in NSQIP at the time of the review; additionally, these findings may not represent all MTFs because NSQIP has excluded low-volume facilities from participating.

¹⁶ The National Committee for Quality Assurance is an organization dedicated to improving health care quality. Their seal is widely recognized symbol for quality. Organizations incorporating this seal must first pass a rigorous, comprehensive review and annually report on their performance. The seal represents a reliable indicator that the organization is well managed and delivers high quality care and service.

- “The MHS should develop an enterprise-wide quality and patient safety data analytics infrastructure, to include health information technology systems, data management tools, and appropriately trained personnel. There should be clear collaboration between the Defense Health Agency’s analytic capabilities which monitor the MHS overall, and the Service-level analytic assets.”
- “The MHS should emphasize transparency of information, including both the direct and purchased care components, with visibility internally, externally, and to DoD beneficiaries. Greater alignment of measures for purchased care with those of the direct care component should be incorporated in TRICARE regional contracts.”¹⁷
- “[The MHS governance] policy guidance can be developed to provide the Services with common executable goals. While respecting the Services’ individual cultures, this effort would advance an understanding of the culture of safety and patient-centered care across the MHS.”
- “The MHS should continue to develop common standards and processes designed to improve outcomes across the enterprise in the areas of access, quality, and patient safety where this will improve quality, or deliver the same level of quality at decreased cost (i.e., better value).”

The Secretary of Defense Memorandum

On October 1, 2014, the Secretary of Defense responded to the MHS Review in a memorandum titled “Military Health System Action Plan for Access, Quality of Care, and Patient Safety.” The memorandum directed the Under Secretary of Defense for Personnel and Readiness to follow up on all MTFs that the MHS Review identified as outliers in the quality of care measures.¹⁸ The memorandum also directed the Under Secretary to address the MHS Review’s findings and recommendations.

The MHS Review Action Plans

The Under Secretary of Defense for Personnel and Readiness reported the Integrated Deliverable Document to the Secretary of Defense on February 3, 2015, in response to the Secretary of Defense memorandum. The Integrated Deliverable Document included the MHS Review Action Plans, which the Services and the DHA created to address the action items in the MHS Review.

¹⁷ The TRICARE website defines TRICARE as the health care program for uniformed service members and their families around the world. Each TRICARE region has its own managed care support contractor who administers the TRICARE program in that region.

¹⁸ In coordination with the Secretaries of the Military Departments and with the assistance of the Assistant Secretary of Defense for Health Affairs, Director of the Defense Health Agency, and the Surgeons General.

Finding A

Response to the Quality of Care Recommendations in the MHS Review

The MHS Review included 44 quality of care recommendations.

The MHS Review Action Plans contained 26 action plans with action items and milestones that addressed all 44 recommendations in the quality section of the MHS Review.¹⁹

As of November 2017, the MHS has completed 22 of 26 action plans to address the 44 quality of care recommendations.

Discussion

The MHS Review reported 44 recommendations related to quality of care.²⁰

In accordance with the October 1, 2014, Secretary of Defense memorandum, all MTFs identified in the MHS Review as outliers for quality measures must have action plans in place to improve performance within 45 days following the effective date of the memorandum. However, the memorandum did not indicate a date by which the MHS must complete the action plans.

Comparison

We compared MHS Action Plans with the 44 recommendations to determine if the MHS Action Plans addressed each recommendation.

For example, we found that the MHS Review recommended that MHS governance establish a mechanism to aggregate and communicate accreditation findings across the MHS. We compared this recommendation to the MHS Action Plans. We determined that the MHS Action Plan #19 contained action items and milestones to resolve the recommendation.

Although MHS Action Plan #19 was completed, we observed that the status of other plans such as MHS Action Plan #7 were still “in progress” as of November 2017. According to the November 2017 MHS Review Action Plan Tracker, the MHS completed 22 of 26 action plans. Action Plans 2, 7, 9, and 18 were still in progress.

¹⁹ The MHS developed 41 MHS Review Action Plans to address the recommendations in the 2014 MHS Review. Each action plan contained action items and milestones to address the recommendations. MHS Review Action Plans 1–2, 4–7, 9, 14–27, 30–31, and 34–37 contained action items and milestones to address the recommendations related to Quality of Care.

²⁰ See Appendix C for the 44 recommendations related to quality of care.

Conclusion

We determined that the MHS Action Plans contained courses of actions to resolve all 44 recommendations in the quality of care section of the MHS Review. However, as of November 2017, the MHS had not yet implemented all actions in the MHS Review Action Plans regarding quality of care.

Recommendation

We recommend that the Director of the Defense Health Agency notify the Department of Defense Office of Inspector General when the Military Health System has implemented all the Military Health System Review Action Plans regarding quality of care.

Management Comments

The Director of the DHA agreed with our recommendation to notify the DoD OIG when the MHS has implemented all actions in the MHS Review Action Plans regarding quality of care.

Our Response

Management Comments were responsive to the recommendation. This recommendation is resolved but remains open. We request that the DHA send us written notification when it has implemented all actions in the MHS Review Action Plans regarding quality of care so that we can close this recommendation.

Finding B

Status of Military Treatment Facility Performance in the National Perinatal Information Center Measures

All 25 MTFs the MHS Review identified as outliers for the NPIC measure of postpartum hemorrhage were no longer outliers at the end of the third quarter of calendar year 2015 according to criteria established by the DHA's Perinatal Advisory Group (PAG).^{21, 22, 23, 24}

Additionally, all seven MTFs the MHS Review identified as outliers for the NPIC measure of Patient Safety Indicator (PSI) #17, Birth Trauma, were no longer outliers at the end of the third quarter of calendar year 2015 according to criteria established by the PAG.²⁵

Finally, all 11 MTFs the MHS Review identified as outliers for the NPIC measure of shoulder dystocia were no longer outliers at the end of the first quarter of calendar year 2017 according to criteria established by the PAG.²⁶

Discussion

In accordance with the October 1, 2014, Secretary of Defense Memorandum, all MTFs identified in the MHS Review as outliers with respect to the quality measures will have action plans to improve performance. We determined that all MTFs identified in the MHS Review as outliers in the NPIC measures had action plans to address their quality performance.

For example, in October 2014, the U.S. Army published "Annex C (MTF Corrective Action Plans) to OPOD [Operations Order] 15-10 (MHS Review Implementation Plan)-USAMEDCOM," which is a corrective action plan to address MTF outlier status

²¹ The American Congress of Obstetricians and Gynecologists defines postpartum hemorrhage as a cumulative blood loss of greater than or equal to 1000 milliliters of blood loss accompanied by sign or symptoms of hypovolemia within 24 hours following the birth process.

²² The MHS Review reported an MTF as an outlier when the MTF was two standard deviations above the NPIC average for two or more years out of four consecutive years.

²³ The DHA, MHS Perinatal Advisory Working Group (PAG) consists of clinical experts and service representatives, including the National Capital Region and TRICARE. The PAG charter directs it as their purpose to ensure that the MHS provides consistent standards-based-care for beneficiaries who are pregnant, through the delivery and postpartum phases. It includes care of infants and families.

²⁴ The Perinatal Advisory Group established the standard that any MTF whose performance is two standard deviations outside of the NPIC average (benchmark) for at least two consecutive quarters is considered an outlier.

²⁵ The 2014 MHS Review defines PSI #17, Birth Trauma as the measure of birth trauma injury to infant, per 1000 newborns, excluding certain categories of infants with specific condition.

²⁶ The American College of Obstetricians and Gynecologists defines shoulder dystocia as "a birth complication that requires additional maneuvers to relieve impaction of the fetal shoulder."

since the MHS Review occurred for postpartum hemorrhage; PSI #17, Birth Trauma; and shoulder dystocia NPIC measures.

Likewise, in October 2014, the U.S. Navy established action plans for each MTF identified as an outlier for the NPIC measures of postpartum hemorrhage; Patient Safety Indicator (PSI) #17, Birth Trauma; and shoulder dystocia.

Similarly, the U.S. Air Force established action plans to address outlier status for the three NPIC measures.

Finally, the NCR MD also established action plans to address outlier status for the three NPIC measures. (Please see Appendix D for detailed NPIC action plans.)

In addition, on October 8, 2015, the Acting Under Secretary of Defense for Personnel and Readiness reported to the Deputy Secretary of Defense that the NCR MD, MEDCOM, BUMED, and AFMOA monitored the performance of their respective outliers “through the routine maintenance of accreditation status and Service-driven quality improvement.”²⁷ Furthermore, MHS Review Action Plan #23, “Plan for Establishing an Enterprise P4I,” established a functional process to identify new MTF outliers and track each until they comply with established standards.²⁸

MTF Performance in the NPIC Measures

The MHS Review reported an MTF as an outlier when the MTF was two standard deviations above the NPIC average for two or more out of four consecutive years.

The MHS Review identified 25 MTFs as outliers in the NPIC measure of postpartum hemorrhage. The MHS Review also identified seven MTFs as outliers in the NPIC measure of PSI #17, Birth Trauma. Additionally, the MHS Review identified 11 MTFs as outliers in the NPIC measure of shoulder dystocia.

The October 1, 2014, Secretary of Defense memorandum stated any MTF identified in the MHS Review as an outlier would have an action plan to improve performance. To measure quality performance improvement, the Perinatal Advisory Working Group established the standard that any MTF whose performance is two standard deviations outside the NPIC average (benchmark) for at least two consecutive quarters is considered an outlier. According to the DHA’s Chief of Advanced Clinical Analytics, Clinical Support Division, defining an outlier this way is consistent with standards used by the Clinical Quality

²⁷ According to the Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health defines accreditation as the process that a healthcare institution, provider, or program undergoes to demonstrate compliance with standards developed by an official agency.

²⁸ According to the MHS Review Action Plan #23, the description for milestone 23.7 is, “Processes in place and functional for identifying outliers, tracking outliers to compliance, and developing new measures.”

Integration Board (CQIB).²⁹ Subsequently, the MHS expects every MTF to meet or exceed the NPIC average (benchmark) for perinatal metrics. The MHS no longer considers an MTF to be an outlier when it meets or exceeds the NPIC average (benchmark) for three consecutive quarters.

The DHA Chief for Advanced Clinical Analytics provided the quarterly NPIC data for postpartum hemorrhage; PSI #17, Birth Trauma; and shoulder dystocia since the MHS Review.



Postpartum Hemorrhage

We analyzed the DHA's postpartum hemorrhage data and determined that all 25 MTFs identified as outliers in the MHS Review have met or exceeded the NPIC benchmark for postpartum hemorrhage for three consecutive quarters since the MHS Review. Therefore, in accordance with the PAG-established standard, our analysis indicated that all 25 MTFs were no longer considered outliers for the NPIC measure of postpartum hemorrhage at the end of the third quarter of CY 2015. (Please see Table 1, MTF Performance in the NPIC Postpartum Hemorrhage Measure.)

²⁹ The Clinical Quality Integration Board (CQIB)'s four voting members are the DHA's Chief of Clinical Support Division and the three Services' Senior Clinical Quality Leaders. The CQIB members include clinical experts from the National Capital Region Medical Directorate, TRICARE, and DHA Legal Medicine Branch. The CQIB is chartered to oversee the assessment of clinical quality across the MHS and provide ongoing reports and recommendations to senior leadership.

Table 1: MTF Performance in the NPIC Postpartum Hemorrhage Measure

Military Treatment Facility	CY15 Q1	CY15 Q2	CY15 Q3	CY15 Q4	CY16 Q1	CY16 Q2	CY16 Q3	CY16 Q4	CY17 Q1
Tripler Army Medical Center	Green	Green	Green	Green	Green	Green	Green	Green	Green
Carl R. Darnall Army Medical Center	Green	Green	Green	Green	Green	Green	Green	Green	Green
Womack Army Medical Center	Green	Green	Green	Green	Green	Green	Green	Green	Green
Madigan Army Medical Center	Green	Green	Green	Green	Green	Green	Green	Green	Green
Irwin Army Community Hospital	Green	Green	Green	Green	Green	Green	Green	Green	Green
Martin Army Community Hospital	Green	Green	Green	Green	Green	Green	Green	Green	Green
Bassett Army Community Hospital	Green	Green	Green	Green	Green	Green	Green	Green	Green
Bayne-Jones Army Community Hospital	Green	Green	Green	Green	Green	Green	Green	Green	Green
Joint Base Langley-Eustis/633 MDG	Green	Green	Green	Green	Green	Green	Green	Green	Green
Eglin AFB/96 MDG	Green	Green	Green	Green	Green	Green	Green	Green	Green
Elmendorf AFB/673 MDG	Green	Green	Green	Green	Green	Green	Green	Green	Green
Nellis AFB/99 MDG	Green	Green	Green	Green	Green	Green	Green	Green	Green
Wright Patterson AFB/88 MDG	Green	Green	Green	Green	Green	Green	Green	Green	Green
Misawa AB/35 MDG	Green	Green	Green	Green	Green	Green	Green	Green	Green
Aviano AB/31 MDG	Green	Green	Green	Green	Green	Green	Green	Green	Green
Travis AFB/60 MDG	Green	Green	Green	Green	Green	Green	Green	Green	Green
Naval Medical Center San Diego	Green	Green	Green	Green	Green	Green	Green	Green	Green
Naval Hospital Camp LeJeune	Green	Green	Green	Green	Green	Green	Green	Green	Red
Naval Hospital Camp Pendleton	Green	Green	Green	Green	Green	Green	Green	Green	Green
Naval Hospital Okinawa	Green	Green	Green	Green	Green	Green	Green	Green	Green
Naval Hospital Bremerton	Green	Green	Green	Green	Green	Green	Green	Green	Green
Naval Hospital Yokosuka	Green	Green	Green	Green	Green	Green	Green	Green	Green
Naval Hospital Pensacola	Green	Green	Green	Green	Green	Green	Green	Green	Green
Naval Hospital Guam	Green	Green	Green	Green	Green	Green	Green	Green	Green
Walter Reed NMMC	Green	Green	Green	Green	Green	Green	Green	Green	Green

 Indicates MTF Average was within two standard deviations or below the NPIC average (GOOD)
 Indicates MTF Average was at least two standard deviations above the NPIC average (BAD)




Source: DoD OIG-generated table based on data from the DHA’s Chief of Advanced Clinical Analytics, Clinical Support Division.

Patient Safety Indicator #17, Birth Trauma

We also analyzed the DHA's PSI #17, Birth Trauma data and determined that all seven MTFs identified as outliers in the MHS Review have met or exceeded the NPIC benchmark for PSI #17, Birth Trauma, for three consecutive quarters since the MHS Review occurred. Therefore, in accordance with the PAG-established standard, our analysis indicated that all seven MTFs were no longer considered outliers for the NPIC measure of PSI #17, Birth Trauma at the end of the third quarter of CY 2015. (Please see Table 1, MTF Performance in the NPIC Postpartum Hemorrhage Measure.)

Table 2: MTF Performance in the NPIC PSI #17, Birth Trauma Measure

Military Treatment Facility	CY15 Q1	CY15 Q2	CY15 Q3	CY15 Q4	CY16 Q1	CY16 Q2	CY16 Q3	CY16 Q4	CY17 Q1
Carl R. Darnall Army Medical Center	GOOD	GOOD	GOOD	GOOD	GOOD	BAD	BAD		
Madigan Army Medical Center	GOOD	GOOD	GOOD	BAD	GOOD	BAD	BAD		
Martin Army Medical Center	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD		
Joint Base Langley-Eustis / 633 MDG	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD		
Naval Medical Center Portsmouth	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD		
Naval Hospital Camp Pendleton	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD		
Ft. Belvoir Community Hospital	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD		

	Indicates MTF Average was within two standard deviations or below the NPIC average (GOOD)
	Indicates MTF Average was at least two standard deviations above the NPIC average (BAD)
	Indicates PSI 17 data is not available. Measure on hold waiting for AHRQ algorithm update.

Source: DoD OIG-generated table based on data from the DHA's Chief of Advanced Clinical Analytics, Clinical Support Division.

However, according to the DHA's NPIC quality measures, Carl R. Darnall Army Medical Center and Madigan Army Medical Center both became PSI #17 outliers at the end of the third quarter of CY 2016.³⁰ Both medical centers became outliers after the original reason the MHS Review identified them as outliers had been resolved; therefore, the MHS Review does not include the fact that they became outliers in the third quarter of CY 2016. We did determine, though, that the MHS put action plans in place to track the status of all MTF outliers and take action when they identify those outliers. (For details about newly identified MTF outliers since the MHS Review, please see Appendix F).




³⁰ According to the DHA's Perinatal Advisory Working Group, an MTF whose performance is two standard deviations outside the NPIC average (benchmark) for at least two consecutive quarters is considered an outlier.

Shoulder Dystocia

Finally, we analyzed the shoulder dystocia data and determined that all 11 MTFs identified as outliers in the MHS Review have met or exceeded the NPIC benchmark for shoulder dystocia for three consecutive quarters since the MHS Review. Therefore, in accordance with the PAG-established standard, our analysis indicated that all 11 MTFs were no longer considered outliers for the NPIC measure of shoulder dystocia at the end of the first quarter of CY 2017. (Please see Table 3, MTF Performance in the NPIC Shoulder Dystocia Measure.)

Table 3: MTF Performance in the NPIC Shoulder Dystocia Measure

Military Treatment Facility	CY15 Q1	CY15 Q2	CY15 Q3	CY15 Q4	CY16 Q1	CY16 Q2	CY16 Q3	CY16 Q4	CY17 Q1
Blanchfield Army Community Hospital	Red	Green	Green	Red	Green	Green	Green	Green	Green
Winn Army Community Hospital	Green	Green	Green	Green	Green	Green	Green	Green	Green
Bayne-Jones Army Community Hospital	Green	Red	Green	Green	Green	Green	Green	Green	Green
Reynolds Army Health Clinic	Green	Green	Green	Green	Green	Green	Green	Grey	Grey
Joint Base Langley-Eustis/633 MDG	Green	Green	Green	Green	Green	Green	Red	Green	Green
Eglin AFB/96 MDG	Green	Red	Green	Red	Green	Red	Green	Green	Green
Elmendorf AFB/673 MDG	Red	Green	Green	Green	Green	Green	Green	Green	Green
Travis AFB/60 MDG	Green	Green	Green	Green	Green	Green	Green	Green	Green
Naval Medical Center San Diego	Green	Green	Red	Green	Red	Green	Green	Green	Green
Naval Medical Center Camp Lejeune	Green	Green	Green	Green	Green	Green	Green	Green	Green
Naval Hospital Pensacola	Green	Green	Green	Green	Green	Green	Green	Green	Green

	Indicates MTF Average was within two standard deviations or below the NPIC average (GOOD)
	Indicates MTF Average was at least two standard deviations above the NPIC average (BAD)
	Indicates MTF had no cases for the quarter.

Source: DoD OIG-generated table based on data from the DHA's Chief of Advanced Clinical Analytics, Clinical Support Division

Conclusion

The 2014 MHS Review identified MTFs as outliers for the NPIC quality of care measures of postpartum hemorrhage; PSI #17, Birth Trauma; and shoulder dystocia. According to our analysis of the DHA's data, we determined that all MTFs identified in the MHS Review as outliers for the NPIC benchmarks met or exceeded the NPIC benchmarks for at least three consecutive quarters since the MHS Review. Therefore, in accordance with the PAG-established standard, they are no longer considered outliers, relative to the MHS Review, for the NPIC benchmarks by the end of the first quarter of CY 2017.

We also determined that, since the MHS Review, the MHS established Action Plan #23, "Plan for Establishing an Enterprise P4I," to identify MTF outliers and track each until they comply with established standards.

Finding C

Status of Military Treatment Facility Performance in the National Surgical Quality Improvement Program's Morbidity Measure

All eight MTFs identified in the MHS Review as outliers “needing improvement” for the National Surgical Quality Improvement Program’s measure of morbidity were no longer considered outliers needing improvement according to the methodology used in the MHS Review.³¹

Discussion

The MHS Review evaluated NSQIP data collected on 17 MTFs from July 2010 through June 2013. The MHS Review identified eight of the evaluated MTFs that had higher-than-expected levels of morbidity and subsequently identified those MTFs as outliers “needing improvement.”

In accordance with the October 1, 2014, Secretary of Defense memorandum, any MTF identified in the MHS Review as an outlier with respect to the quality and safety measures used in the MHS Review will have an action plan to improve performance. We determined that all eight MTFs identified as outliers that needed improvement in the MHS Review had action plans to address their performance in NSQIP’s measurement of morbidity.

In addition, on October 8, 2015, the Acting Under Secretary of Defense for Personnel and Readiness reported to the Deputy Secretary of Defense that the NCR MD, MEDCOM, BUMED, and AFMOA monitored the performance of their respective outliers “through the routine maintenance of accreditation status and Service-driven quality improvement.”³² Furthermore, MHS Review Action Plan #23 established a functional process to identify new MTF outliers and track each until they comply with established standards. Additionally, milestone number 23.7 of Action Plan #23 calls for functional processes in place for identifying outliers, tracking outliers to compliance, and developing new measures.

³¹ The Foundations of Public Health defines morbidity as a diseased state, disability, or poor health due to any cause. The term may be used to refer to the existence of any form of disease, or to the degree that the health condition affects the patient. The MHS Review identified statistically significant outliers. The MHS Review described facilities performing statistically much better than expected in any category as “exemplary,” facilities whose outcome was similar to other facilities included in the model as “as expected,” and those performing statistically much worse than expected as “needs improvement.”

³² According to the Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health defines accreditation as the process that a healthcare institution, provider, or program undergoes to demonstrate compliance with standards developed by an official agency.

MTF Performance in the NSQIP Morbidity Measure

The DHA's Chief of Integrated Quality Support Branch provided morbidity measure information taken from the American College of Surgeons NSQIP's Carepoint MHS Dashboard. According to this information, all eight MTFs identified in the MHS Review as outliers that needed improvement in NSQIP for the morbidity measure no longer needed improvement. At the end of CY 2016, seven of the eight MTFs performed as expected and one MTF's performance was exemplary.

Table 4: MTF Performance in the NSQIP Morbidity Measure

MTF	2014 MHS Review	CY 2016
Michael O'Callaghan Federal Hospital	Need Improvement	Exemplary
Evans Army Community Hospital	Need Improvement	As Expected
San Antonio Military Medical Center	Need Improvement	As Expected
Madigan Army Medical Center	Need Improvement	As Expected
Womack Army Medical Center	Need Improvement	As Expected
Fort Belvoir Community Hospital	Need Improvement	As Expected
Navy Medical Center Portsmouth	Need Improvement	As Expected
Navy Medical Center San Diego	Need Improvement	As Expected

Source: DoD OIG-generated table based on DHA provided data from the American College of Surgeons NSQIP's Carepoint MHS Dashboard.

Conclusion

Based on information we received from the DHA, we concluded that all eight MTFs identified in the MHS Review as outliers needing improvement in the NSQIP's morbidity measure no longer needed improvement.

Finding D

Status of Military Treatment Facility Performance in the Primary Care Manager Continuity Measure

The MHS Review reported four DoD military treatment facilities as “negative outliers” for the Primary Care Manager (PCM) Continuity measure.

We used data provided by the DHA’s Chief of Patient Centered Medical Home to identify the names and locations of the MTFs identified as “negative outliers” and to determine each MTF’s PCM Continuity rates.³³

Our analysis of the DHA’s data indicated that three of the four MTFs were no longer considered negative outliers at the end of May 2016, according to the methodology used in the MHS Review.³⁴ Meanwhile the Air Force deactivated the remaining MTF, Royal Air Force Menwith Hill Clinic, 421st Medical Flight, in FY 2015. Because the clinic is no longer in operation, it is no longer being tracked.

Discussion

According to the MHS Review, one of the core principles of the Patient Centered Medical Home (PCMH) model is that patients have a consistent relationship with a PCM.³⁵ The MHS Review also stated that a continuous relationship with a PCM was one of the top four items that patients requested, and increasing the level of PCM continuity was a major quality initiative for the three Services and the NCR MD in support of PCMH implementation.

The 2014 MHS Review reported four MTFs as negative outliers for PCM Continuity at the end of May 2014. However, the MHS Review did not identify the MTFs by name or location. The DHA Chief of PCMH Primary Care provided us the PCM Continuity data for October 2013 through May 2014. We analyzed the DHA’s data using the same methodology used during the MHS Review.³⁶

³³ According to the MHS Review, the PCM Continuity measure is the rate of all appointments in primary care that are with the MTF enrollee’s assigned PCM. Negative outliers are MTFs with PCM Continuity rates that were more than two standard deviations below the mean.

³⁴ According to the MHS Review, negative outliers are MTFs with PCM Continuity rates that were more than two standard deviations below the mean.

³⁵ The MHS implemented the PCMH model of care in order to improve health care quality, medical readiness, access to care, and patient satisfaction, and to lower per capita cost growth.

³⁶ Negative outliers are MTFs with PCM Continuity rates that were more than two standard deviations below the mean.

According to our analysis, the four facilities referred to in the MHS Review and their average PCM Continuity rates from October 2013 through May 2014 were:

- Columbus Air Force Base, 14th Medical Group – 38 percent
- Royal Air Force Menwith Hill, 421st Medical Flight – 31.7 percent
- Joint Base Lewis-McChord, 62nd Medical Squadron – 29.4 percent
- Kunsan Air Force Base, 8th Medical Group – 21.6 percent

The MHS Review identified MTFs with PCM Continuity rates lower than 40.6 percent as “negative outliers.” The Air Force deactivated the remaining MTF, Royal Air Force Menwith Hill Clinic, 421st Medical Flight in FY 2015. Therefore, because it is no longer in operation, it is no longer being tracked.

The DHA Chief of PCMH Primary Care also provided us the PCM Continuity data for October 2015 through May 2016, downloaded from the TRICARE Operations Center website.³⁷ According to our analysis, we determined that the MTFs at Columbus Air Force Base, Joint Base Lewis-McChord, and Kunsan Air Force Base were no longer negative outliers at the end of May 2016. These three facilities’ average PCM Continuity rates from October 2015 through May 2016 were:

- Columbus Air Force Base, 14th Medical Group – 48.5 percent
- Joint Base Lewis-McChord, 62nd Medical Squadron – 45.5 percent
- Kunsan Air Force Base, 8th Medical Group – 69.2 percent

According to the methodology used in the MHS Review and the data provided by the DHA, the MHS considered MTFs with PCM Continuity rates lower than 44.7 percent as “negative outliers” at the end of May 2016.

Conclusion

The MHS Review reported four MTFs as negative outliers for the PCM Continuity measure, but did not identify the MTFs by name or location. We used the data that the DHA’s Chief of PCMH Primary Care provided to identify the four facilities referred to in the MHS Review. We also used the data to determine each facility’s PCM Continuity rates. The data indicated that three out of the four MTFs had improved and were no longer negative outliers at the end of May 2016, according to the methodology used in the MHS Review.

The Air Force deactivated the remaining MTF, Royal Air Force Menwith Hill Clinic, 421st Medical Flight, in FY 2015. Because it is no longer in operation, it is no longer being tracked.

³⁷ The TRICARE Operations Center is the central information center providing standard operational access to care reports for use by military treatment facilities worldwide.

Finding E

Military Health System Quality of Care and Process Improvement Governance

The MHS Review recommended the MHS develop policy guidance through MHS governance to provide the Services with common executable goals to advance quality of care and process improvement.

We determined that the DoD is developing a quality of care governance structure with common policy, procedure, and direction in accordance with the NDAA FY 17.

We also observed that the DHA is developing specific clinical action plans resulting from the MHS review, which include plans for developing quality of care and process improvement governance.

Discussion

Governance Responsibility

Prior to the NDAA FY 17, Service headquarters were responsible for their own healthcare policy. The components that executed healthcare policy for the Services were as follows:

- DHA: NCR MD;
- U.S. Army: MEDCOM;
- U.S. Navy and Marine Corps: BUMED; and
- U.S. Air Force: AFMOA.

The NDAA FY 17 directs that, beginning October 1, 2018, the DHA will be responsible for the administrative policy and procedure of each military treatment facility. In accordance with section 702 of NDAA 2017, beginning October 1, 2018, the DHA Deputy Assistant Director for Medical Affairs will be responsible for policy, procedures, and direction of clinical quality and process improvement. Section 702 also makes the DHA Assistant Director for Medical Affairs responsible for policy, procedures, and direction of patient safety, infection control, graduate medical education, clinical integration, utilization review, risk management, patient experience, and civilian physician recruiting.

DHA's Clinical Care and Process Improvement Governance Action Plans

The DHA Integrated Quality Support Branch reported to us in September 2017, that the MHS continued to work on implementing Action Plan #1, "Plan for Achieving a High Reliability Organization," as well as other MHS Review Action Plans. Action items regarding Action Plan #1 include the following:

- Action Item 11. QUALITY: The Assistant Secretary of Defense for Health Affairs (ASD(HA)) and the DHA should develop policy, guidance in support of the Department of Defense Instruction and Manual 6024.13 with specific direction on quality measurement, performance improvement, and requirements for education and training.
- Action Item 12. QUALITY: The ASD(HA) should develop policy and guidance to manage and track compliance of the Services and the DHA with applicable DoD policies and directives.

See Appendix D for a further listing of the MHS Review Action Plans for quality of care and process improvement governance.

NDAAs 2017 Implementation Plan

The DoD senior military medical leadership published operating principles to guide the implementation of all NDAAs 2017 medical requirements.³⁸ One of the operating principles was for the DHA to create the healthcare policies for the direct care system.³⁹

In March 2017, the Principal Deputy of the ASD(HA) explained to our team that prior to the NDAA 2017 each of the Services' clinical and business functions dictated how each Service operated regarding policy, policy analysis, compliance, and management activities, including clinical quality and process improvement. The NDAA 2017 directs a new organizational structure within DHA to support clinical quality and process improvement.

The Principal Deputy of the ASD(HA) explained that the DoD intends to eliminate duplicate governance in each of the clinical and business functions by consolidating their separate systems (Army, Navy, and Air Force) into a single DHA-governed system for key MTF operational functions. The Principal Deputy further explained that while much of the DHA's preliminary planning was not specific to clinical

³⁸ According to the High Reliability Organization Task Force Report, "A Resource Guide for Achieving High Reliability in the Military Health System," September 15, 2015, the DoD's senior military medical leadership included the ASD(HA); the Surgeons General of the Army, Navy, and Air Force; the Director of the DHA; and the Joint Staff Surgeon.

³⁹ According to the MHS Review, direct care is care within the military system.

quality and process improvement, this planning provided the necessary foundation to comply with section 702 of NDAA 2017. This section includes the responsibility for policy, procedures, and direction of clinical quality and process improvement.

The DoD submitted the first interim report to the Armed Services Committees of the Senate and House of Representatives on March 31, 2017. The report contained the plan to implement section 702 of NDAA 2017. The report explained that the DoD established a Program Management Office, under the direction of the ASD(HA), to ensure that the DoD implemented the requirements in section 702.

The first interim report included a description of the decision and process to pursue a component model of administration in which the Director of the DHA administers the MTFs through Service-led intermediary commands.⁴⁰

The DoD submitted the second interim report to the Armed Services Committees of the Senate and the House of Representatives on June 30, 2017. The report included the following information as prescribed by statute:

- How the Secretary will carry out NDAA 2017, subsection 702.⁴¹
- What efforts exist to eliminate duplicative DHA and military department activities.
- What efforts exist to maximize efficiencies in DHA activities.
- How the Secretary will implement NDAA 2017, section 1073c, in a manner that reduces the number of Armed Forces members, civilians who are full-time equivalent employees, and contractors who do work relating to MHS headquarters activities.

Furthermore, the Principal Deputy of the ASD(HA) informed us that the DoD plans to submit a final report on March 1, 2018, with full details on how the DoD intends to implement the component model of administration, which begins October 1, 2018.

⁴⁰ An example of an intermediary command is the Army corps, which is the intermediate headquarters between divisions and the theater army.

⁴¹ NDAA 2017, subsection 702, inserted into Chapter 55 of the 10 United States Code section 1073c (a), which states that, beginning October 1, 2018, the Director of the Defense Health Agency shall be responsible for the administration of each military medical treatment facility, including with respect to, budgetary matters; information technology; health care administration and management; administrative policy and procedure; military medical construction; and any other matters the Secretary of Defense determines appropriate.

Conclusion

The DHA-developed action plans resulting from the MHS Review included implementing quality of care and process improvement governance. Beginning October 1, 2018, the DHA Deputy Assistant Director for Medical Affairs will be responsible for policy, procedures, and direction of clinical quality and process improvement in accordance with NDAA 2017, section 702.

The DoD prepared a plan to develop governance for policy, procedure, and direction to reform the administration of the DHA and the MTFs in accordance with NDAA FY 17, section 702. While much of the DoD's planning did not specifically address clinical quality and process improvement, the planning provided the necessary foundation to address section 702, which directed a new organizational structure within the DHA to support quality of care and process improvement.

Also, to meet the NDAA requirements, the acting Under Secretary of Defense for Personnel and Readiness submitted an interim report in March 2017 to the Committees on Armed Services of the Senate and the House of Representatives describing the plan to implement title 10 of the United States Code, section 1073c (2017). The DoD also submitted a second interim report to Congress on June 30, 2017, and will submit a final report by March 1, 2018.

Finding F

Military Health System Performance Management System

We determined that the MHS developed a Secretary of Defense-directed performance management system, referred to as the Partnership for Improvement (P4I).

We also determined that MHS used the P4I to monitor quality of care for areas requiring improvement.

Discussion

Performance Management System or Partnership for Improvement (P4I)

In the 2014 Secretary of Defense memorandum, the Secretary directed the DHA to establish and use an MHS performance management system. As directed, the MHS developed a performance management system named the P4I.

The P4I surveys MHS-wide core performance measures and related dashboards to detect areas requiring improvement. The P4I's capabilities include:

- an enterprise plan to guide measurement and improvement efforts;
- an enterprise performance dashboard with measures and thresholds aligned to the MHS Quadruple Aim;⁴²
- organizational clarity and established focus areas for improvement;
- performance improvement capability for the Services and the NCR MD; and
- a mechanism to review performance, allocate resources, and make adjustments.

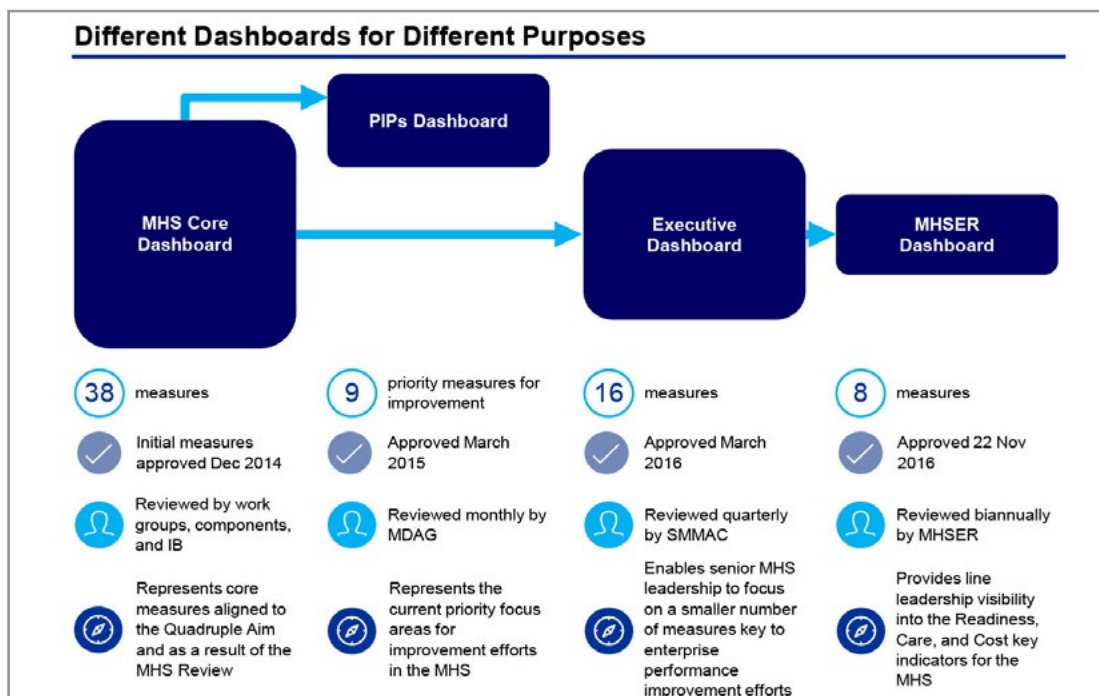
The MHS performance management system consists of different dashboards for different measurements. (See Figure 1).

- The MHS Core Dashboard represents the core measures aligned to the MHS.

⁴² The MHS Quadruple Aim of Increased Readiness, Better Care, Better Health, and Lower Cost rests on the pillars of three key domains of change for high reliability identified by High Reliability Organization experts: leadership commitment to achieving zero preventable harm, a culture of safety, and continuous process improvement.

- The PIP (Process Improvement Priorities) Dashboard represents current focus areas for improvement efforts in the MHS.
- The Executive Dashboard enables MHS senior leadership to focus on a smaller number of measures considered key to enterprise performance efforts.
- The MHSER (Military Health Service Executive Review) Dashboard gives leadership visibility into the readiness, care, and cost key indicators for the MHS.

Figure 1. MHS Performance Management System Dashboards



Source: MHS P4I Performance Management System.

Improved Quality of Care

We determined that the MHS used the P4I to prioritize enterprise quality of care improvements by analyzing MHS's focus area of "Outcome for Condition-Based Quality Care."

On March 18, 2015, the attendees at the MHS quarterly Review and Analysis meeting identified “Outcome for Condition-Based Quality Care” as a focus area for quality of care improvement.⁴³ Figure 2 illustrates one example of the MHS’s capability to monitor quality of care after P4I was implemented:

- choose areas for improvement of strategic importance,
- understand the process that needs to be improved,
- assess current performance against standard measures,
- set enterprise targets, and
- monitor progress at regular performance review meetings.

Figure 2. Improve Quality Outcomes for Condition-Based Care

Improve Quality Outcomes for Condition-Based Care							
Strategic Importance	Improving quality in the common conditions helps ensure the MHS is following the best evidence to improve outcomes for patients. A condition-by-condition approach allows the MHS to learn as a system and perfect its processes for identifying and spreading best practices.						
Process to Improve							
Current Performance	Measure	MHS	Army	Navy	Air Force	NCR MD	As of
	HEDIS Appropriate Care Index	45%	40%	64%	63%	60%	Feb 2015
	HEDIS Diabetes Index	54%	71%	83%	75%	82%	Feb 2015
Target Performance	<ul style="list-style-type: none"> • HEDIS Appropriate Care Index: 70% • HEDIS Diabetes Index: 70% 						

Source: The High Reliability Organization Task Force Report, September 15, 2015.

The Medical Deputies Action Group uses the P4I every month to monitor quality of care issues contained in the P4I’s “Outcome for Condition-Based Quality Care” focus area.⁴⁴ We attended the January 24, 2017, Medical Deputies Action Group MHS monthly performance review. The meeting participants used Outcome for Condition-Based Quality Care information from the P4I to review the quality of

⁴³ The Review and Analysis meeting is an extended Senior Military Medical Action Council with the primary attendees being the ASD(HA), Principle Deputy of the ASD(HA), the Service Surgeons General, the DHA Director, the Joint Staff Surgeon, and the President of the Uniformed Services University of Health Sciences. Other attendees may include the Deputy Assistant Secretaries of Defense, Flag and Senior Executive Service leaders of the Services and the DHA, and subject matter experts. Part of the meeting includes a review of the MHS Performance Measures focused on the Process Improvement Priorities and Executive Dashboard. The attendees discuss changes in performance, variations, success, and impediments to improvement; they also share best practices. The four focus areas for improvement are Improve Access, Increase Direct-Care Primary Care Capacity, Improve Quality Outcomes for Condition-Based Care, and Reduce Patient Harm.

⁴⁴ The Medical Deputies Action Group includes the Principal Deputy of the ASD(HA), Service Deputy Surgeons General, and the DHA Deputy Director.

care gap-to-threshold, trends, and variability for the Healthcare Effectiveness Data and Information Set (HEDIS) Diabetes Composite, and the HEDIS Acute Care Composite.⁴⁵ The P4I data showed that the NCR MD, Army, Navy, and Air Force obtained the desired performance rate for the HEDIS Diabetes Composite and the HEDIS Acute Care Composite.

Additionally, the Medical Deputies Action Group meeting participants used the information from the P4I to identify areas of quality of care requiring improvement regarding the HEDIS Diabetes Composite and the HEDIS Acute Care Composite, which included an analysis of gaps in performance and strategies to narrow gaps in performance.

Conclusion

The MHS developed a Secretary of Defense-directed performance management system referred to as the Partnership for Improvement, or the P4I. The MHS identified “Outcome for Condition-Based Quality Care” in the P4I as one focus area for improvement. The P4I’s “Outcome for Condition-Based Quality Care” focus area included quality of care issues such as the HEDIS Diabetes Index and the HEDIS Appropriate Care Index. Therefore, we concluded that the MHS used a performance management system to monitor quality of care for areas requiring improvement.

⁴⁵ The Healthcare Effectiveness Data and Information Set (HEDIS) is the gold standard in health care performance measurement, used by more than 90 percent of the nation’s health plans and many leading employers and regulators. HEDIS is a set of standardized measures that specifies how organizations collect, audit and report performance information across the most pressing clinical areas, as well as important dimensions of customer satisfaction and patient experience.

Appendix A

Scope and Methodology

We conducted this evaluation from September 2016 through December 2017 in accordance with the Council of the Inspectors General on Integrity and Efficiency “Quality Standards for Inspection and Evaluation,” January 2012. These standards require that we plan and perform this evaluation to obtain sufficient, competent, and relevant evidence to provide a reasonable basis for our findings, conclusions, and recommendations based on our evaluation objectives. We believe that the evidence obtained provides a reasonable basis for our findings, conclusions, and recommendations.

Scope

We limited the scope of this evaluation to the DoD’s response to the MHS Review’s sections on the quality of care within the DoD MHS. Our intent was to determine if the DoD took actions to address the MHS Review’s recommendations in accordance with the Secretary of Defense’s direction.

For Finding A, we limited our scope to evaluating if either the MHS Action Plans or the DHA addressed every quality of care recommendation in the MHS Review. Our scope included determining whether the MHS had implemented all of its Review Action Plans for quality of care.

For Findings B through D, we limited our scope to the MTFs in the MHS Review specifically identified with the word “outlier” with respect to the quality of care measures used in the MHS Review. We did not evaluate the status of all DoD MTFs during the time of this evaluation.

For Findings E and F, we limited our scope to compliance with the MHS Review’s recommendations and the Secretary of Defense’s directions.

In addition, we did not address purchased care or healthcare provided in support of the Combatant Commands and deployed operational forces because the MHS Review did not address these elements.

Methodology

To evaluate our objectives, we first reviewed:

- August 2014 Final Report to the Secretary of Defense, Military Health System Review;
- the National Defense Authorization Act for FY 2017, section 702;

- the “High Reliability Organization Task Force Report”;
- DoD Manual 6025.13, “Medical Quality Assurance (MQA) and Clinical Management in the Military Health System,” October 29, 2013; and
- official memorandums from the Office of the Secretary of Defense.

We visited sites within the National Capital Region from November 2016 to December 2017. We visited MEDCOM at Joint Base San Antonio-Fort Sam Houston, Texas, and AFMOA at Joint Base San Antonio-Lackland, Texas, in December 2016. We visited Army-conducted training at Southbridge, Massachusetts, in January 2017.

We interviewed the following program officials from November 2016 to December 2017:

- Commander of AFMOA;
- Director of the Office of Strategy Management, DHA;
- Chief of the Integrated System Support Board, DHA;
- Chief of the Clinical Support Division, DHA;
- Program Manager of the Office of the Chief Medical Officer, DHA;
- Strategic Planning Analyst, Partnership for Improvement, DHA;
- Chief of the Patient Centered Medical Home Primary Care, DHA;
- Chief of the Health Service Delivery Support, DHA;
- Government Lead for the MHS High Reliability Organization Program Integration Office, DHA;
- Chief of the Patient Safety Program, DHA;
- Program Manager for the Perinatal, Pediatrics, and Special Medical Programs, DHA;
- Deputy Director for TRICARE, Purchased Care, DHA;
- MEDCOM Deputy Chief of Staff for Quality and Safety;
- MEDCOM Director of the Clinical Performance Assurance Directorate;
- MEDCOM Deputy Chief, High Reliability Organization;
- MEDCOM Clinical Performance Assurance Directorate;
- MEDCOM Director of Strategy Management;
- Special Assistant to the Air Force Surgeon General for Trusted Care, AFMOA;
- Vice Commander of AFMOA;
- Inpatient Service Quality manager, NSQIP Advisor, AFMOA;
- Chief of Medical Staff for Inpatient Quality Services, AFMOA;

- Chief Medical Officer, BUMED;
- Deputy Chief Medical Officer, BUMED;
- Risk Management Officer, BUMED;
- Chief, Quality Officer, NCR MD; and
- Executive Director, Bureau of Medicine and Surgery

We observed the following meetings:

- Medical Deputies Action Group held November 15, 2016;
- Transparency Initiative Group held November 16, 2016;
- Clinical Quality Integration Board held November 16, 2016;
- Medical Operations Group held November 21, 2016;
- High Reliability Coordination Board held November 21, 2016;
- Performance Management Cell held December 7, 2016;
- Review and Analysis held December 14, 2016;
- Clinical Measures Working Group held January 4, 2017;
- MHS Governance Synchronization Group held January 19, 2017;
- Decision Science Training: Clinician Leader Camp held January 22-24, 2017, in Southbridge, Massachusetts; and
- Medical Deputies Action Group held January 24, 2017.

We also obtained and analyzed testimonial and documentary evidence from the DHA, NCR MD, MEDCOM, BUMED, and AFMOA to determine our objectives during and after our site visits.

Limitations

The MHS Review evaluated access to care, patient safety, and quality of care. However, we limited the scope of this report to the quality of care sections of the MHS Review. In addition, we did not evaluate healthcare provisions for the Combatant Commands and deployed operational forces.

Use of Computer-Processed Data

The DHA's Chief of Advanced Clinical Analytics provided us raw data from the Senior Programmer Analyst from the National Perinatal Information Center for the associated performance of the MTFs highlighted in this report. The NSQIP uploaded the same raw data to the DHA clinical management website, which was subsequently downloaded by DHA staff and available to the MTFs. The NPIC's Senior Programmer Analyst provided direct e-mail correspondence to us

validating the specific NPIC data from 2014 through 2016 used in this report (Postpartum Hemorrhage; PSI #17, Birth Trauma; and Shoulder Dystocia). Therefore, we are confident in the accuracy of the NPIC data used for Findings B.

In addition, we asked the DHA's CQIB officials how they verified the data for accuracy. The CQIB officials stated that they collect the data from their respective entities (the NPIC, AHRQ, and NSQIP). They then verify the data monthly with Service and the NCR MD representatives to ensure completeness and accuracy of data in their system. Therefore, we have confidence in the accuracy of the NSQIP data used for Finding C.

The DHA's Chief of PCMH Primary Care provided us data for PCM Continuity downloaded from the TRICARE Operations Center website. The DHA also provided us the data results applying the methodology used during the MHS Review. We applied the same methodology to the data from October 2015 through May 2016. Therefore, we have confidence in the accuracy of the PCM Continuity data used for Finding D.

Thus, we determined that the computer-processed data reasonably met our objective.

Prior Coverage

During the last 5 years, the Government Accountability Office (GAO) issued a report discussing the availability of quality measurement of women's health care services in U.S. military hospitals. Unrestricted GAO reports can be accessed at www.gao.gov.

GAO

Report No. GA0-16-596, "Defense Health Care, Availability of Quality Measurement of Women's Health Care Services in U.S. Military Hospitals," June 2016

The report summarized the extent to which women's health care services are available to service members and other beneficiaries at domestic military hospitals. It further describes how the MHS selects quality measures for women's health care services provided at military hospitals and the quality measures that the MHS has selected for women's health care services. These selected measures are used to improve the quality of care.

The GAO found that almost all domestic military hospitals offered general women's health care services, with fewer offering specialty care services. Furthermore,

the MHS draws on the expertise of internal advisory groups and national clinical organizations to select quality measures. Lastly, the MHS selected 90 quality measures for women's health care services in 2015 and used them in a variety of quality improvement activities. The GAO made no recommendations in this report.

MHS

August 2014 "Final Report to the Secretary of Defense, Military Health System Review"

On May 28, 2014, the Secretary of Defense directed a comprehensive review of the MHS. Subject matter experts from the Military Departments and the DHA conducted the MHS Review with input from outside experts in the areas of quality of care and patient safety. The 2014 MHS Review was the first enterprise-view of the MHS that specifically sought to determine whether the MHS had effective processes for ensuring safe and reliable care. The MHS Review included 44 recommendations related to quality of care.

Appendix B

MHS Review Group

The Deputy Secretary of Defense led the MHS Review, assisted by the Acting Under Secretary of Defense for Personnel and Readiness and the Assistant Secretary of Defense for Health Affairs, with the direct participation of the Secretaries of the Military Departments, the Service Chiefs, and the Joint Staff. The MHS Review included the individual perspectives of outside experts in the areas of patient safety and quality of care.

The Deputy Secretary of Defense established the Senior Executive Review Committee. Chaired by the Deputy Secretary of Defense, members of this committee included the Acting Under Secretary of Defense for Personnel and Readiness, the Under Secretaries of the Military Departments, the ASD(HA), the Director of the Joint Staff, the Military Departments' Surgeons General, and the Director of the DHA.

In addition to the Senior Executive Review Committee, the Deputy Secretary of Defense could call upon the Deputy's Executive Committee, the "TANK," or the Deputy's Management Action Group during the MHS Review. The Deputy's Executive Committee included the Secretaries of the Military Departments, the Under Secretaries of Defense, and General Counsel. The "TANK" consisted of the Chairman and Vice Chairman of the Joint Chiefs of Staff, along with the Service Chiefs and Chief of the National Guard Bureau. The Deputy's Management Action Group included the Secretaries of the Military Departments, Under Secretaries of Defense, the Deputy Chief Management Officer, Chiefs of the Military Services, the Chief of the National Guard Bureau, the Commander of United States Special Operations Command, and the Director of Cost Assessment and Program Evaluation.

An action group supported the MHS Review. An Office of the Secretary of Defense, Health Affairs action officer chaired this action group, which was composed of action officers from each of the Military Departments' medical programs, the DHA, the Joint Staff, Service Senior Enlisted personnel, and a representative from the National Guard Bureau.

Similarly, a Senior Action Council supported the action group. The Principal Deputy of the ASD(HA) chaired this Council, which was composed of the Deputy Assistant Secretaries of Defense in the Office of the Assistant Secretary of Defense for Health Affairs, the Deputy Director of the DHA, the Deputy Surgeons General, and the Joint Staff Surgeon.

Appendix C

MHS Review Recommendations

Table 5 shows the 44 recommendations related to quality of care reported in the MHS Review.

Table 5. MHS Review Recommendations

Recommendations in the MHS Review		MHS Review Page No.
Recommendation for Responding to Prior Reviews of MHS Quality		
a.	DHA should integrate requirements for purchased care clinical quality data on TRICARE beneficiaries into the TRICARE Operations Manual and future TRICARE regional contracts.	83
Recommendations to Address Gaps in Training and Compliance with Policies		
a.	ASD (HA) and DHA should develop policy guidance in support of DoDI and DoDM 6025.13 with specific direction on quality measurement, performance improvement, and requirements for education and training.	84
b.	ASD (HA) should develop policy guidance to manage and track compliance of the Services and DHA with applicable DoD policies and directives.	84
Recommendations Regarding Quality of Care Training		
a.	The DHA Education and Training Directorate should conduct an in-depth review and needs assessment of quality training to adequately assess the efficacy of training.	85
b.	MHS governance should determine the requirements to guide the development and implementation of a quality expert career path.	85
Recommendations Regarding Accreditation and Certification		
a.	MHS governance should establish a mechanism to aggregate and communicate accreditation findings across the MHS.	88
b.	MHS governance should evaluate the utility of adding additional fellowship opportunities with TJC or other nationally recognized programs, and the Services should explore optimizing and standardizing Service fellow utilization by aligning training with follow-on assignment after fellowship completion.	88
Recommendations Related to MHS Performance on HEDIS Measures		
a.	DHA Health Plans should give purchased care contractors the authority to use supplemental databases to improve the capture of clinical information for purchased care enrollees.	92
b.	DHA Health plans should evaluate alternative methods of incentivizing contractors and/or providers to improve the provision of clinical preventive services and HEDIS performance. This may require statutory or regulatory changes, since new, innovative payment mechanisms may have to be developed to encourage compliance.	92

Recommendations in the MHS Review		MHS Review Page No.
c.	MHS governance should assess the value of expanding the number of HEDIS measures monitored to evaluate care provided to enrolled beneficiaries.	92
d.	MHS governance should establish policy to guide processes for verification of clinical data and capture in AHLTA (DoD's outpatient electronic health record) regarding preventive services that are obtained outside of the direct care component.	92
e.	DHA should develop plans to improve Other Health Insurance documentation in DEERS for all beneficiaries to ensure those with Other Health Insurance are not included in HEDIS calculations.	92
f.	MHS governance should develop a strategy for MTFs to maximize the use of "action lists" generated by the MHS Population Health Portal to ensure beneficiaries receive clinical preventive services in a timely manner.	92
Recommendation Regarding Quality Data in the Civilian Network		
a.	DHA should integrate requirements for purchased care clinical quality data on TRICARE beneficiaries into the TRICARE Operations Manual and future TRICARE regional contracts.	94
Recommendations Regarding MHS Performance on National Hospital Quality Measures		
a.	DHA Health Information Technology should prioritize electronic health record upgrades by aligning needed data elements into Essentris (the inpatient electronic 97 health record). All inpatient MTFs should have the capability to remotely access health records to facilitate expeditious and timely data extraction for clinical measure calculation.	97
b.	MHS governance should establish goals and processes for increasing the number of MTFs achieving The Joint Commission Top Performer status annually.	98
Recommendation Regarding MHS Performance Against PQI Measures		
a.	MHS governance should implement provider level PQI education followed by an evaluation of MTF utilization of AHRQ PQI measures and implementation of a monitoring program requiring improvement plans as indicated.	99
Recommendations Regarding Readmission Rates		
a.	MHS governance should establish an implementation plan for the MHS Population Health Portal readmissions site to ensure maximum utilization so as to reduce avoidable readmissions.	101
b.	The DHA Healthcare Operations Directorate should complete transition to the HEDIS All-Cause Readmission standardized measure, which is risk-adjusted and has national benchmarks.	102
Recommendations Regarding MHS Perinatal Services		
a.	MHS governance should require a review of perinatal provider documentation and coding practices at MTFs to validate data integrity.	110
b.	MHS governance should ensure that standardization of accurate perinatal coding practices is implemented across direct care.	110

Recommendations in the MHS Review		MHS Review Page No.
c.	MHS governance should investigate readmissions of mothers and infants. This clinical review of diagnostic codes at readmission will identify the medical conditions that drive these rates and determine if lagging performance is a quality issue or related to military-unique issues and flexibility.	110
d.	Health Affairs policy is needed to standardize annual and interval training requirements related to perinatal care.	110
e.	The Perinatal Advisory Group should conduct a comprehensive review of clinical practices related to metrics where MHS is underperforming. Through a dashboard and standardized metric reporting requirements, intervention plans should be developed and actions prioritized.	110
Recommendations Regarding Surgical Quality Improvement		
a.	MHS governance should explore expanding NSQIP® participation to all remaining direct care inpatient facilities performing surgery. In addition, it should ensure all ambulatory surgery platforms participate in a similar surgical quality improvement program.	118
b.	The DHA Healthcare Operations Directorate should partner with the American College of Surgeons NSQIP staff to improve MTF collaboration and sharing of best practices of top performing facilities, thereby decreasing overall direct care morbidity and improving clinical outcomes.	118
c.	MHS governance should task the NSQIP® working group to assess morbidity shortfalls to the Medical Operations Group for Tri-Service/DHA engagement, collaborative support, and facility action.	119
Recommendations Regarding Mortality Measurements		
a.	MHS governance should integrate measures of mortality into its quality monitoring and performance improvement programs.	122
b.	MHS governance should require Service facilities with higher-than-expected mortality on an IQI measure for more than one quarter to perform an investigation and implement improvement activities as indicated.	122
c.	MHS governance should evaluate the use of the risk-adjusted standardized mortality ratio (SMR) model in direct care. Facilities with higher-than-expected mortality should validate the risk-adjusted SMR model data and perform a root cause analysis as indicated.	122
Recommendations Regarding Patient Satisfaction		
a.	MHS governance should continue to study determinants of patient satisfaction and develop strategies to meet or exceed civilian benchmarks in satisfaction with primary care and obstetrics for every MTF.	128
b.	MHS governance should continue to guide MTFs in implementation of strategies to optimize PCMH operations and use of secure messaging, Nurse Advice Line (NAL), and other customer service tools.	128
c.	Services and DHA should continue to evaluate determinants of satisfaction with primary care and ensure ongoing maturation of PCMH in all MTFs.	129

Recommendations in the MHS Review		MHS Review Page No.
Recommendation Regarding Primary Care Manager Continuity		
a.	The PCMH Advisory Board should assess processes that affect PCM continuity at high-performing PCMH sites and promulgate best practices across the MHS to support improvement initiatives.	132
Recommendations to Improve Quality from Site Visits		
a.	DHA should establish clear and consistent guidelines for the CONUS TRICARE Regions and the OCONUS Area Offices on reporting and processing quality and patient safety issues identified in the purchased care component.	136
b.	MHS governance should work with the Services to increase the use of Clinical Practice Guidelines in the direct care component.	136
c.	MHS governance should evaluate the feasibility of DoD and TRICARE regional contractor collaborations/MOUs with local purchased care organizations to support electronic health record accessibility.	136
d.	MHS governance should develop processes to ensure standardized notification requirements for laboratory and radiology services.	136
Quality of Care: Overall Findings and Recommendations		
1.	It is clear that the MHS is dedicated to quality health care and performance improvement. In several areas, the MHS outperforms or is equal to national benchmarks. Other areas were identified for focused improvement in performance and to reduce variation in performance. It will be necessary to refocus the organization's quality culture for more rapid and continued improvement in quality of care. The MHS Review Group recommends that MHS governance research and implement health care industry best practices of a high reliability organization to revitalize and sustain necessary cultural changes throughout the MHS.	138
2.	While comparison to national benchmarks is helpful, because of the variances inherent among health care systems, direct comparison between the MHS and civilian health systems proved challenging, with limitations in the comparative portion of the analysis. The MHS Review Group recommends that the MHS continue building relationships with civilian health systems to participate in collaboration and data sharing in order to facilitate more complete comparisons.	138
3.	Under-developed MHS-level enterprise processes currently limit data standardization, collection, and analysis to drive system wide improvement (e.g., governance, standard business and clinical processes, shared services). Variation exists in the use of existing data to identify and prioritize objectives. The MHS Review Group recommends that the MHS develop and implement a performance management system that links to MHS and Service strategies with MHS dashboards and common systemwide performance measures to support visibility of those measures across the enterprise. The MHS should also create and use a MHS data analytics capability to provide analysis and actionable information to the Services and DHA.	138

Recommendations in the MHS Review		MHS Review Page No.
4.	DOD quality policy (DODI/DoDM 6025.13) lacks specificity with regard to quality measurement and performance improvement. The MHS should update or supplement DoDI and DoDM 6025.13 with specific guidance on quality measurement, performance improvement, and requirements necessary for assessing and improving quality education and training.	139
5.	While there is a significant amount of quality training occurring in the Services, there is no clearly prescribed quality-specific training and education by MHS policy. The DHA Education and Training Directorate should conduct an in-depth review and needs assessment of quality training to assess the efficacy of training being accomplished.	139
6.	There are gaps in the enterprise processes to validate Service compliance with policies and directives disseminated from ASD(HA). The MHS Review team recommends ASD(HA) develop and implement a process to manage and track compliance of Services and DHA with applicable DoD policies and directives.	139

Source: DoD OIG-generated based on information from the MHS Review.

Appendix D

Action plans for Military Treatment Facility Performance Measures in the National Perinatal Information Center Measures by Service

The NCR-MD established the following action plans to address all MTFs with NPIC outlier status:

- NCRMD-06 for Postpartum Hemorrhage
- NCRMD-05 for PSI #17, Birth Trauma

In November 2014, the Army Medical Command published “Operations Order 15-10 (MHS Review – Implementation Plan) and Annex C (MTF Corrective Action Plans) To Operations Order 15-10 (MHS Review – Implementation Plan) – USAMEDCOM” to address all MTFs with NPIC outlier status.

In October 2014, the U.S. Navy established the following action plans to address MTF NPIC outlier status:

- Postpartum Hemorrhage
 - NME-Q-007 for Naval Hospital Pensacola
 - NME-Q-033 for Naval Hospital Camp Lejeune
 - NMW-Q-05 for Naval Medical Center San Diego
 - NMW-Q-06 for Naval Hospital Camp Pendleton
 - NMW-Q-07 for U.S. Naval Hospital Okinawa
 - NMW-Q-08 for Naval Hospital Bremerton
 - NMW-Q-09 for U.S. Naval Hospital Yokosuka
 - NMW-Q-10 for U.S. Naval Hospital Guam

Patient Safety Indicator #17, Birth Trauma

- NME-Q-026 for Naval Medical Center Portsmouth
- NME-Q-11 for Naval Hospital Camp Pendleton

Shoulder Dystocia

- NME-Q-008 for Naval Hospital Pensacola
- NME-Q-034 for Naval Hospital Camp Lejeune
- NMW-Q-12 for Naval Medical Center San Diego

In October 2014, the U.S. Air Force established the following action plans to address all MTFs with NPIC outlier status:

- N-2-PPH for Postpartum Hemorrhage
- PS-PSI-17 for Patient Safety Indicator #17, Birth Trauma
- N-1-SD for Shoulder Dystocia

Appendix E

DHA's Clinical Care and Process Improvement Governance Action Plans

Finding G discussed the DHA's MHS Review Action Plan #1, Action Items 11 and 12. This appendix provides a further listing of the MHS Review Action Plans for clinical care and process improvement governance.⁴⁶

Action Plan #2

- Action Item #29. QUALITY: MHS Governance should work with the Services to increase utilization of Clinical Practice Guidelines in the direct care component.

Action Plan #4

- Action Item #46. QUALITY: MHS Governance should continue to study determinants and develop a strategy to meet or exceed civilian benchmarks in satisfaction with primary care and obstetrics for every MTF.

Action Plan #5

- Action Item #4. QUALITY: MHS Governance should task NSQIP working group to assess surgical mortality shortfalls to the Medical Operations Group for Tri-Service/Defense Health Agency (DHA) engagement, collaborative support, and facility action.
- Action Item #24. QUALITY: MHS Governance should explore expanding NSQIP participation to all remaining direct care inpatient facilities performing surgery; in addition, ensure ambulatory surgery platforms all participate in a similar surgical quality improvement program.

Action Plan #6

- Action Item #6. QUALITY: MHS Governance should require a review of perinatal provider documentation and coding practices at MTFs to validate data integrity.
- Action Item #56. QUALITY: MHS Governance should ensure that standardization of accurate perinatal coding practices is implemented across direct care.

⁴⁶ The DHA provided this action plan to the DoD OIG on January 24, 2017.

Action Plan #7

- Action Item #7. QUALITY: MHS Governance should develop a strategy for MTFs to maximize the use of action lists generated by the MHS Population Health Portal to ensure beneficiaries receive clinical preventive services in a timely manner.
- Action Item #27. QUALITY: MHS Governance should continue to guide MTFs in implementation of strategies to optimize PCMH operations and use of secure messaging, Nurse Advice Line, and other customer service tools.
- Action Item #29. QUALITY: MHS Governance should work with the Services to increase utilization of Clinical Practice Guidelines in the direct care component.

Action Plan #16

- Action Item #23. QUALITY: MHS Governance should establish goals and processes for increasing the number of MTFs achieving The Joint Commission (TJC) Top Performer status annually.

Action Plan #17

- Action Item #25. QUALITY: MHS Governance should require Service facilities with higher-than-expected mortality on an Inpatient Quality Indicators (IQI) measure for more than one quarter to perform an investigation and implement improvement activities as indicated.
- Action Item #57. QUALITY: MHS Governance should integrate measures of mortality into quality monitoring and performance improvement programs.

Action Plan #18

- Action Item #30. QUALITY: MHS Governance should develop processes to ensure standardized patient notification requirements for laboratory and radiology.

Action Plan #19

- Action Item #31. QUALITY: MHS Governance should establish a mechanism to aggregate and communicate accreditation findings across the MHS.

Action Plan #23

- Action Item #48. QUALITY: MHS Governance should develop and implement an enterprise Partnership for Improvement (P4I) that links to MHS and Service strategy with dashboards and common performance measures to support visibility of those measures across the enterprise.
- Action Item #49. QUALITY: MHS Governance should create and task an MHS data analytics cell to provide actionable information to the Services and DHA at the enterprise level.
- Action Item #50. QUALITY: MHS Governance should establish policy to guide processes for verification of clinical data and capture in AHLTA (DoD Outpatient Electronic Health Records) regarding preventive services that are obtained outside of the direct care component.

Action Plan #25

- Action Item #52. QUALITY: MHS Governance should implement provider-level Prevention Quality Indicators (PQI) education, followed by an evaluation of MTF utilization of Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators measures and implementation of a monitoring program requiring improvement plans as indicated.

Action Plan #26

- Action Item #53. QUALITY: MHS Governance should establish an implementation plan for MHS Population Health Portal readmissions site to ensure maximum utilization to reduce avoidable readmission.
- Action Item #80. QUALITY: MHS Governance should investigate readmissions of mothers and infants; this clinical review of diagnostic codes at readmission will identify the medical conditions that drive these rates and help determine if lagging performance is a quality issue or related to military-unique issues and flexibility.

Action Plan #30

- Action Item #64. QUALITY: MHS Governance should determine the requirements to guide the development and implementation of a Quality Expert career path.

Action Plan #31

- Action Item #65. QUALITY: MHS Governance should evaluate the utility of additional fellowship opportunities with TJC or other nationally recognized programs, and the Services should explore optimizing and standardizing Service fellow utilization with follow-on assignment after fellowship completion.

Action Plan #34

- Action Item #72. QUALITY: MHS Governance should identify and implement leading healthcare industry methods for instilling and maintaining cultural changes throughout a large system.

Action Plan #35

- Action Item #71. QUALITY: MHS Governance should evaluate the feasibility of DoD and TRICARE regional contractor collaborations/MOUs with local purchased care organizations to support electronic health record accessibility.

Action Plan #37

- Action Item #78. QUALITY: MHS Governance should assess the value of expanding the number of HEDIS measures monitored to evaluate care provided to enrolled beneficiaries.

Appendix F

MTFs Identified as MTF Outliers since the MHS Review

MHS Review Action Plan #23, “Plan for Establishing an Enterprise P4I,” established a functional process to identify MTF outliers and track each until they comply with established standards.⁴⁷ Since the MHS Review, various groups at DHA such as the Clinical Measures Working Group, Clinical Quality Integration Board, TRICARE Service P4I Steering Committee, Medical Deputies Action Group, and MHS Quarterly Review and Analysis meeting periodically review NPIC and other quality measures at regular intervals.⁴⁸

For example, the DHA’s Pediatric Advisory Working Group meets at least quarterly to assess NPIC data to include PSI #17, Birth Trauma. The group takes appropriate actions when necessary if the data identifies MTFs as new outliers.⁴⁹

Regarding to the two MTFs identified as outliers for PSI #17 at the end of the third quarter of CY 2016, the DHA Chief of Analytics explained that assessing PSI #17 performance for the fourth quarter of CY 2016 and later, requires data from the Agency for Healthcare Research and Quality (AHRQ).⁵⁰ He also stated that the data to assess outlier status improvements for PSI #17 became unavailable from AHRQ during the fourth quarter of CY 2016 due to the changes in the algorithms used to derive PSI #17. He added that he expects the new AHRQ algorithms used to derive PSI #17 data to be available in January 2018.

The DHA Chief of Analytics further explained that once the new algorithms became available, the DHA planned to resume monitoring all DoD MTFs to observe how the new PSI #17 data scored according to the new algorithms. He also stated the DHA would then take appropriate actions to track each identified MTF outlier until they comply with established standards.

⁴⁷ According to the MHS Review Action Plan #23, the description for milestone 23.7 is, “Processes in place and functional for identifying outliers, tracking outliers to compliance, and developing new measures.”

⁴⁸ In October 2014, the MHS formed a DHA TRICARE Service P4I Steering Committee (P4I-SC) to develop an enterprise performance dashboard allowing senior medical leaders to track progress toward achieving the Quadruple Aim. The Medical Deputies Action Group includes the Principal Deputy of the ASD(HA), Service Deputy Surgeons General, and the DHA Deputy Director. The MHS Quarterly Review and Analysis meeting is an extended Senior Military Medical Action Council with the primary attendees being the ASD(HA), Principle Deputy of the ASD(HA), the Service Surgeons General, the DHA Director, the Joint Staff Surgeon, and the President of the Uniformed Services University of Health Sciences. Other attendees may include the Deputy Assistant Secretaries of Defense, Flag and Senior Executive Service leaders of the Services and the DHA, and subject matter experts. The meeting includes a review of the MHS Performance Measures focused on the Process Improvement Priorities and Executive Dashboard. The attendees discuss changes in performance, variations, success, and impediments to improvement.

⁴⁹ The DHA chairs the Pediatric Working Group. The Pediatric Working Group’s membership consists of representatives and subject matter experts from each Service.

⁵⁰ The Agency for Healthcare Research and Quality (AHRQ) is the lead Federal Agency charged with improving the safety and quality of America’s healthcare system. AHRQ develops the knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions.

Management Comments

Director of the Defense Health Agency



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JAN 17 2018


MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL.

SUBJECT: Department of Defense Inspector General Draft Report, "DoD's Response to the Quality of Care Elements in the 2014 Military Health System Review" (Project No. D2016-D00SPO-0222.000)

Thank you for the opportunity to review and comment on the Department of Defense draft report, Project No. D2016-D00SPO-0222.000) – "DoD's Response to the Quality of Care Elements in the 2014 Military Health System Review," announced December 21, 2017.

I concur with Recommendation A and will notify you upon completion of the open action plans.

Please feel free to direct any comments on this topic to [REDACTED].


R. C. BONO
VADM, MC, USN
Director

Acronyms and Abbreviations

AFMOA	Air Force Medical Operations Agency
AHRQ	Agency for Healthcare Research and Quality
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
BUMED	Navy Bureau of Medicine and Surgery
CQIB	Clinical Quality Integration Board
DHA	Defense Health Agency
HEDIS	Healthcare Effectiveness Data and Information Set
MEDCOM	U.S. Army Medical Command
MHS	Military Health System
MQA	Medical Quality Assurance
MTF	Military Treatment Facility
NCR MD	National Capital Region Medical Directorate
NDAA	National Defense Authorization Act
NPIC	National Perinatal Information Center
NSQIP	National Surgical Quality Improvement Program
PAG	Perinatal Advisory Group
PCM	Primary Care Manager
PCMH	Patient Centered Medical Home
P4I	Partnership for Improvement
PSI	Patient Safety Indicator



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