Disclosures

• Rear Admiral (RADM) Riggs has no relevant financial or non-financial interests to disclose.

• Disclosure will be made when a product is discussed for an unapproved use.

• This continuing education activity is managed and accredited by Accreditation Council for Pharmacy Education (AffinityCE) in collaboration with Association of Military Surgeons of the United States (AMSUS).

• AffinityCE and AMSUS staff as well as Planners and Reviewers, have no relevant financial or non-financial interests to disclose.

• Commercial Support was not received for this activity
Learning Outcomes

At the conclusion of this activity, participants will be able to:

1. Review the Market Construct concept and Integrated Health Care System Delivery model.
2. Recognize and define what it means to be a High Reliability Organization.
3. Interpret health care optimization of the DHA.
4. Define Direct Support Roles as they relate to a successful transition.
5. Recognize the framework for Clinical Quality Management for Health Care Delivery in DHA.
6. Identify strategies that mitigate medical cyber security risks and ensure medical cyber security.
Agenda

- Highly Reliable Organizations
- Market Construct & Integrated Health Care System Delivery
- Healthcare Optimization
- Direct Support Roles
- Total Learning Architecture
- Clinical Quality Management
- Medical Cybersecurity
- Closing
High Reliability Organization

Rear Admiral Mary C. Riggs
Assistant Director, Healthcare Administration
What is an HRO?

A high reliability organization (HRO) manages risk and regulates operations, while focusing on improvements that advance the organization toward zero harm.
How is the DHA Improving Care?

The Military Health System (MHS) began the HRO transformation in 2014 to propel improvements to **access to care, quality of care, and patient safety**. The practices of the Services and National Capital Region (NCR), prior and ongoing, have laid the foundation for an enterprise HRO cultural change.
DHA’s Priorities

- **Optimize Outcomes (Medically Ready Force)** – We use all of the health and administrative specialties in our arsenal to optimize the health readiness of the force, so that they are ready for deployment, they are fit to fight, and they are ready to win.

- **Continuous Learning (Ready Medical Force)** – Practice every day in our medical centers, our hospitals, our clinics – as they provide the platform for clinical competency and currency of practice, leading to the superb casualty care our service members receive in the field... it’s our obligation to continuously learn, to minimize risk, and work towards zero preventable harm.

- **Improve Patient Satisfaction** – Balancing what we see as important clinical outcomes with those that our patients say are important, usually, quality of life outcomes. Done well, our patients gain collective trust in our the military healthcare system, and become advocates for it.

- **Improve Staff Satisfaction** – In order to remain competitive, we must attract and retain superior talent. To that end, our staff must feel fulfilled with their work. With great outcomes, a cohesive and ready medical team, and truly satisfied patients, we will become the organization of choice for those in the healthcare professionals field.
Expanding Patients’ Access to Care

• Established a 24/7 Nurse Advice Line
• Adjusted referral requirements in January 2018 to make it easier for patients to get access to urgent care
• Expanded access to mental health and substance use disorder treatment services in September 2016

Enhancing Transparency with the Public

• Began publicly sharing data on the quality and safety of care delivered at MTFs on Health.mil in December 2014
• In December 2017, the MHS started sharing performance data via the Hospital Compare website - Leapfrog
• Now MHS is working on providing performance data to help patients make informed health care decisions

Improving Safety and Quality of Care through Clinical Process Improvement

• Developed a Post-Traumatic Stress Provider Prescribing Tool that can track and report to MTF leaders the PTSD prescribing practices at their facility. Since FY17Q1, the number of Prescriptions for Benzodiazepines for Beneficiaries Diagnosed with PTSD has decreased from 1,922 to 824.
• Piloted an induction of labor care pathway at Naval Medical Center San Diego. When using this pathway, the team saw:
  • a two percent decrease in unplanned NICU admissions
  • time from admission to delivery decreased by an average of four hours
  • chorioamnionitis infections in labor decreased five percent
Illustrative Clinical Community Accomplishments

Behavioral Health Clinical Community (BHCC)
- Implemented enterprise-wide means to assess Post-traumatic Stress Disorder (PTSD) and Depression outcomes via Behavioral Health Data Portal (BHDP)
- Align with Clinical Practice Guideline (CPG) recommendation to reduce prescription of benzodiazepine (BZD) to PTSD patients over the last two years:
  - ↓ 42.9% number of prescriptions for BZDs for beneficiaries diagnosed with PTSD
  -  Collaboration with Pharmacy
- Piloting a project to address access to care and clinical workflow to improve outcomes in BH conditions, especially PTSD and major depressive disorder (MDD)

Women and Infant Clinical Community (WICC)
- Implementing comprehensive risk assessment and prompt treatment for postpartum hemorrhage (PPH “Bundle”)
- Induction of Labor (IOL) Care Pathway successfully piloted at Navy Medical Center San Diego (NMCSD) with reduction of complications; from 11 JUN 2018-10 OCT 2019:
  - ↓ 19.8 hours from admission to delivery
  - ↓ 3.4% Chorioamnionitis infection
  - ↓ 14.1% NICU admission
  - ↓ 14.5% IOL resulting in C-section
- Piloting a project to reduce venous thromboembolic events (VTE) with interventions that include updated risk assessment and improved post-discharge education
Clinical Community Accomplishments

Primary Care Clinical Community (PCCC)
- Pathway being implemented to promote non-pharmacologic treatments for pain and reduce rates of Long-term Opioid Therapy (LTOT)
- Collaboration with Pain Management and Pharmacy
- Piloting a project to improve asthma outcomes through re-education of care pathways, effective peer review, and electronic health record (EHR) workflow modification

Neuro-musculoskeletal Clinical Community (NMCC)
- Piloting Acute Care Concussion Pathway at four Military Medical Treatment Facilities

Oncology Clinical Community (OCC)
- Oncology next-generation Cancer registry contract awarded to meet National Cancer Registrars Association accreditation requirement

Dental Clinical Community (DCC)
- Piloting a project to decrease dental wrong-site surgery by improving management systems (human performance), work direction, and communication, such as using TeamSTEPPS team-based communication tools
- Collaboration with Surgical Services Clinical Community
Our DHA HRO Journey: Future Successes

How will you help DHA commit to becoming an HRO?
Clinical Communities
HRO Backup Slides
Clinical Communities Drive CPI

Clinical Communities are an MHS-wide network of multidisciplinary groups of health care personnel, working toward common goals in a particular care area. These communities, organized by high-volume, high-risk groups of interrelated care processes, house and align clinical specialties with the patient’s perspective across the care spectrum. Clinical Communities create, track, and share the conditions for high reliability (processes, standards, metrics, cost) at the point of care by identifying and resolving unwarranted variation, and fostering a culture of safety and innovation.

- Place patient interests at the center of health care delivery
- Align to MHS Quadruple Aim, High Reliability Organization (HRO) Domains of Change, and MHS HRO Guiding Principles
- Prioritize readiness
- Serve as primary mechanism to:
  - Improve patient outcomes
  - Eliminate preventable harm and waste
  - Improve performance and innovation
  - Maximize value
  - Develop MHS process standards
  - Reduce unnecessary variability
  - Embed learning and safety culture across all care sites

A Clinical Community is not:
- A specialty group
- A product line
- A diagnosis
- An integrated practice unit
Key Functions of MHS Clinical Communities

MHS-level Clinical Communities provide leadership and guidance to Clinical Communities at each level of the DHA, coordinate with the Services, and collaborate across the spectrum of care.

- Drive Continuous Process Improvement
- Promote Patient Engagement
- Promote Staff Engagement
- Develop Care Pathways
- Develop Measures, Analysis, and Evaluation
- Inform MHS Clinical Policy
- Identify Research Requirements and Evidence-Based State of the Art Practices

- Enable MHS-wide Knowledge Sharing and Learning
- Provide Clinical Guidance to Inform MHS GENESIS Workflows
- Support Development of Measures Used for QPP
MHS-level Clinical Communities

2018 Launched Clinical Communities
- Dental
- Behavioral Health
- Neuromusculoskeletal
- Primary Care
- Women and Infant

2019 Launch of New Clinical Communities
- Cardiovascular
- Complex Pediatrics
- Critical Care/Trauma
- Military-Specific Care
- Oncology
- Surgical Services
BHCC Initiative: BHDP Adoption in 5+3

- BHDP is the means through which the MHS obtains self-reported patient data, aggregates population behavioral health data, and enables outcome-informed treatment
- Without consistent and comprehensive use of BHDP, the MHS is unable to reliably monitor behavioral health outcomes
- BHCC is working with the transitional Intermediate Management Organization to increase BHDP adoption so behavioral health outcomes can be evaluated
BHDP: PTSD Outcomes by Market for Fiscal Year (FY) 2019

Percent of Patients with Positive Outcomes (Improvement or Remission) over First Six Months of Treatment

**No patients from COAST MS or JAX Markets qualified for this outcome cohort in the measurement period due to insufficient BHDP Adoption Rate in all MTFs**
BHDP: Depression Outcomes by Market FY2019

Percent of Patients with Positive Outcomes (Improvement or Remission) over First Six Months of Treatment

**No patients from COAST MS or JAX Markets qualified for this outcome cohort in the measurement period due to insufficient BHDP Adoption Rate in all MTFs.**
BHCC: PTSD Prescriber Tool

- Disseminated VA/DoD guideline information paper discouraging BZD therapy for PTSD

**Performance Data**

Number of Prescriptions for BZDs for Beneficiaries Diagnosed with PTSD

![Graph showing number of prescriptions for BZDs from FY17Q1 to FY19Q4](image)
WICC Initiative: IOL Care Pathway

• Care pathway developed to reduce variation in medications, dosage of medications, and interventions used for IOL to reduce maternal and/or fetal risk
• Currently being piloted at NMCSD

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Better Health</td>
<td>Average Time from Admission to Delivery for IOL</td>
<td>23.6 Hours St dev = 12.2</td>
<td>21.5 Hours P-value = 0.002</td>
<td>19.8 Hours P-value = 0.000</td>
<td>25.2 Hours P-value = 0.026</td>
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<tr>
<td>Better Health</td>
<td>Chorioamnionitis</td>
<td>7.1% St dev = 1.3%</td>
<td>7.5% P-value = 0.392</td>
<td>3.4% P-value = 0.001</td>
<td>20.1% P-value = 0.000</td>
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<tr>
<td>Better Health</td>
<td>Endometritis</td>
<td>2.0% St dev = 0.7%</td>
<td>3.4% P-value = 0.035</td>
<td>2.0% P-value = 0.515</td>
<td>10.0% P-value = 0.000</td>
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<tr>
<td>Better Health</td>
<td>PPH</td>
<td>4.6% St dev = 1.1%</td>
<td>5.8% P-value = 0.179</td>
<td>3.5% P-value = 0.169</td>
<td>12.9% P-value = 0.000</td>
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<td>Better Health</td>
<td>NICU Admissions (Babies Born at NMCSD) Related to IOL</td>
<td>17.8% St dev = 1.9%</td>
<td>16.4% P-value = 0.261</td>
<td>14.1% P-value = 0.044</td>
<td>23.6% P-value = 0.029</td>
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<tr>
<td>Better Health</td>
<td>IOL Resulting in C-section</td>
<td>20.4% St dev = 2.0%</td>
<td>20.2% P-value = 0.520</td>
<td>14.5% P-value = 0.004</td>
<td>37.2% P-value = 0.000</td>
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<tr>
<td>Better Health</td>
<td>1+ Unanticipated Outcomes Associated with IOL</td>
<td>30.8% St dev = 2.3%</td>
<td>27.3% P-value = 0.090</td>
<td>20.6% P-value = 0.000</td>
<td>47.9% P-value = 0.000</td>
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</tbody>
</table>
PCCC Initiative: Stepped Care Model for Pain Clinical Pathway

- **Problem Statement:** LTOT lacks evidence of efficacy and is accompanied by considerable evidence of significant harms of overdose, death from overdose, and increased risk of suicide in pain management. Risk for overdose and death significantly increase at a range of 20-50 Morphine Equivalent Daily Dose (MEDD). Cognitive-behavioral therapy and behaviorally-based treatments for pain are safe and demonstrate effectiveness, but widespread uptake is limited by a shortage of trained providers.

- Conducted by DHA, in coordination with the PCCC and Pain Management CSS

- Goal is to **address opioid prescribing/addiction through standardized management of chronic pain**

<table>
<thead>
<tr>
<th>Quadruple Aim Category</th>
<th>Measure (Quarterly Data)</th>
<th>Baseline</th>
<th>Target</th>
<th>Gap</th>
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</thead>
<tbody>
<tr>
<td>Better Care</td>
<td>Percent Active Duty Service Member taking LTOT</td>
<td>0.16%</td>
<td>0.144%</td>
<td>10%</td>
</tr>
<tr>
<td>Better Care</td>
<td>Percent ADSM co-prescribed opiates and BZDs</td>
<td>0.17%</td>
<td>0.153%</td>
<td>10%</td>
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<tr>
<td>Better Care</td>
<td>Of those ADSM prescribed opioids, percent with greater than 90 MEDD</td>
<td>0.11%</td>
<td>0.099%</td>
<td>10%</td>
</tr>
<tr>
<td>Better Care</td>
<td>Percent ADSM taking LTOT who receive Naloxone</td>
<td>11.78%</td>
<td>12.96%</td>
<td>10%</td>
</tr>
</tbody>
</table>
PCCC: Baseline Performance and Target Goals
PCCC: Baseline Performance and Target Goals
Market Construct and Integrated Health Care System Delivery

Mr. Christopher Priest
Principal Deputy to the Deputy Assistant Director, Healthcare Operations
DHA Markets will integrate, standardize, and optimize care delivery and readiness support in specific geographies.

**What is a Market?**
A group of MTFs in a geographic radius that operate as a system: sharing patients, providers, functions, budget, etc., across facilities in order to improve the delivery and coordination of health services to drive value for beneficiaries.

**What is the Market Construct?**
A criteria-based and data-driven model that expands on the existing eMSM concept in order to drive process standardization, reduce variability, and generate efficiencies within markets and across the MHS.

**Market Responsibilities**
As there is demand for many specialties across the market, this offers opportunity for aligning healthcare demand and supply.

Approximately 80% of all US-based MTFs will be managed as part of a market.
Market Construct and Integrated Health Care System Delivery – Defining Markets Based on Operational Complexity

**K-means Clustering Analysis**

**Readiness Data**
- Support for Ready Medical Force generation
- Support for Medically Ready Force

**Health Services Delivery Data**
- Access, quality and experience of care for the beneficiary population

**Administrative Operations Data**
- Management & oversight of MTFs through QPP
- Delivery of shared administrative functions
- Facilitation of external partnerships
- Integration of direct and purchased care

*Data Pending

**Market Functional Complexity**

**DHA Market Reporting Structure**

- Large Markets
- Defense Health Region Indo-Pacific
- Defense Health Region Europe
- Small Market & Stand Alone Office
- Small Markets
- Stand-alone MTFs

*Data Pending
Market Construct and Integrated Health Care System Delivery

- monitors overall performance of the DHA and markets as an integrated healthcare system pursuing the Quadruple Aim
- manages QPP execution
- develops COAs for senior leader decision-making
- creates POAMs to guide OPORD development
- analyzes threats to, and opportunities for, improving market integration

1. MARKET INTEGRATION

2. DAD Healthcare Operations

3. Healthcare Optimization

4. TRICARE Health Plan

5. Monitor, Shape, QPPs, Service Δ Requests

6. Leverage Contracts, Manage the Benefit

7. Service A, MILPER Realign, QPP

8. Decisions

9. Compliance & Operations

10. Clinical Safety, Quality, GME

11. Data Support, QPP Planning

12. Lab

13. Pharmacy

14. Patient Admin

15. OPORDs, Inspections

16. Service Readiness Commands

Asst Dir Healthcare Administration

DAD Medical Affairs

Decision Briefings

J5
Healthcare Optimization

Ms. Gina Julian
Chief, Healthcare Optimization
DHA Approach to Healthcare Optimization

- The 2017 NDAA, Sections 704 and 709, catalyzed needed direct care optimization efforts
- DHA Healthcare Optimization’s approach to achieve goals:
  - Establish **enterprise standards** and processes in DHA policy
  - Conduct direct care **outreach**: coach, educate, and sustain
  - DHA leadership holds Markets and MTFs **accountable** for compliance and performance
Enterprise Standards and Processes

- The DHA codified healthcare optimization standard processes in policies
  - DHA-Interim Procedures Memorandum (DHA-IPM) 18-001, dated 26 January 2018, established standard appointing processes, provider productivity standards and central referral management processes; it encouraged but did not require centralized appointing
  - DHA-Procedural Instruction (DHA-PI) 6025.03, dated 26 January 2018, established criteria for expanded hours in primary care and urgent care
  - DHA-PI 6025.11, dated 9 October 2018, established primary care empanelment capacity standards, processes for dis-empanelment, and identified approved leadership adjustments
Standardized MTF Processes in DHA Policy

- Goals are to support a medically ready force and a ready medical force through access to high quality and standardized processes including:
  - Increased/optimized capacity and Knowledge, Skills and Ability (KSA)
  - First Call Resolution to meet patients’ needs the first time they call
  - Optimized appointment availability and expanded operating hours/days
  - No “One Visit – One Problem” experience
  - Increased convenience by leveraging secure messaging, virtual care, and nurse-run clinics
  - The sole authority to disempanel beneficiaries to the network resides in the DHA Director
  - Better integration between direct and purchased care through a streamlined and customer-focused specialty care appointing process
  - Implemented processes to make obtaining care easier, seamless, and consistent from one MTF to the next
Direct Care Outreach

- DHA policies distributed to Military Medical Treatment Facilities (MTFs) and Markets through traditional Service channels
- DHA conducts outreach activities by:
  - Incorporating enterprise standards and processes in existing formal training
  - Conducting Staff Assistance Visits (SAVs) to assess and support compliance with DHA healthcare optimization policies
  - Holding twice-weekly webinars with MTFs world-wide on DHA policies, healthcare optimization strategies, and standard processes
  - Using social media to communicate directly with MTF staff members to answer questions and discuss leading practices in standard process implementation
Current Status

- Increased percent of providers complying with appointment productivity standards IAW DHA-IPM 18-001 in Oct 19 compared to May 19
  - Primary Care: 17% up from 6%
  - Specialty Care: 21% up from 16%
- Expanded operating hours in Primary Care compared to 2017
  - 40% of appointments now available after noon as compared to 20%
  - 11% of appointments available after 1500 hours as compared to < 1%
- MTFs using DHA’s Template Optimization Tool* to better align appointment supply to meet patient demand signals by day, hour, and appointment type
- Carepoint Direct Access Reporting Tool scorecards are ready for release and measure compliance with DHA policies by Market/MTF/Clinic/Provider
- Variance remains in appointing and referral processes; solution is implementation of Integrated Referral Management and Appointing Centers (IRMAC)

* MHS Carepoint Portal: https://carepoint.health.mil/sites/PCAD
The Integrated Referral Management and Appointing Center (IRMAC) Platform

• The IRMAC is a low cost/high performance platform to support direct care optimization, eliminate variance, and enhance patient experience
  o Provides a single, reliable phone number for beneficiaries to book any primary or specialty care appointment with options for location of care
  o Reliant on product line optimization efforts as required in DHA-IPM 18-001
  o Allows the Market to capture high cost cases, even when access is limited
  o Maximizes KSA scores in support of a ready medical force
  o Decreases costly network deferrals to optimize return on MTF resources
  o Leverages appointing/referral staff economies of scale to reduce costs
  o Reduces wait times for specialty appointment booking
    - Pre-IRMAC: 11 day average from referral to scheduling a specialty appointment
    - Current: More than 95% of referrals now reviewed same-day with same or next-day appointing
Next Steps
Integrated Direct and Purchased Care Referral Management

- Centralized, integrated same-day referral disposition pilot projected to begin January 2020
  - Same or next-day appointing to MTF or network care by calling “One Number”
  - Process potentially can be replicated for VA and other partners

Six-Month Pilot Locations:
- National Capital Region
- NH Jacksonville
- Cannon AFB
- NMC San Diego
The Role of Direct Support for a Successful Transition

Col Sally Kellyrank
Chief, Healthcare Operations Support Division
Direct Support Roles for Successful DHS Transition

- 2017 NDAA, Section 702, updated in NDAA 2019, necessitated integrated system of readiness and health
- DHA Implementation Plan 3 delineates multi-year transition of Military Treatment Facilities (MTFs) from Military Departments (MILDEPS) to DHA
  - Risk-mitigated plan based on Implementation Plan 2
  - Covers 25 April 2019 through 30 September 2021
Direct Support Roles for Successful DHS Transition

• DHA assumed Authority, Direction and Control (ADC) of MTFs on 25 October 2019
• Memorandum of Agreements (MOAs) established MILDEP support of DHA
  – Retain existing communication, reporting structure, and established relationships with MTFs
  – MILDEPS will participate in Functional Capability (FC) working groups and oversight forums to provide expertise and ensure DHA policies/procedures are developing
• Direct Support to continue until all FCs have transitioned to the DHA
Direct Support Roles for Successful DHS Transition

• Collaborative Culture
  – Inter-service Collaboration / Informal Consortium
  – Active discussion on relevant topics / resolve issues at lowest level

• Capability Increases
  – Close coordination between HCO and MILDEP reps
  – Maintain continuous leadership engagement and buy-in

• Change Management
  – Communicate workflows, bridge knowledge gaps from old to new processes, early in transition
  – Prioritize issues; communicate to MTFs
DHA Total Learning Architecture (TLA)

ANITA L. FLIGGE, BRIG GEN, USAF, NC
Deputy Assistant Director, Education & Training

PAUL R. CORDTS, MD, MSS
Deputy Assistant Director, Medical Affairs (DAD-MA)
Disclosures

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Learning Outcomes

• At the conclusion of this activity, participants will be able to:

• Define the Military Health System (MHS) high level requirements that for an infrastructure that can enable lifelong blended, data driven training tailored to the individual and the educational and operational goals of the services and the MHS as a whole.
  
  – Are there existing systems/efforts that can be leveraged?
  
  – What needs to be acquired?

• Define the Science and Technology gaps that must be addressed for this infrastructure to be successful.

• Define the roles of Defense Health Agency (DHA) and the infrastructure requirements to support MHS Graduate Medical Education (GME)
DHA J-7 Mission and Vision

J-7 Education & Training
Strategic Plan FY2020-FY2024

Vision: A Unified MHS Learning Continuum
Mission: The J-7 Directorate leads the Military Health system in the development and sustainment of a “unified and ready” medical force

1. Optimize E&T Across the MHS
   1.1 Enhance Training Capacity and Delivery
   - Build efficient and effective capacity and capability to deliver high quality training across the MHS
   1.2 Align Training with Requirements
   - Deliver innovative strategies to evolve training to stay relevant to the MHS' requirements

2. Operationalize Learning Continuum Roadmap Across the MHS Enterprise
   2.1 Integrate Training in Support of a Medical Ready Force
   - Create synergies and streamline training to be comprehensive, consistent, and interoperable from policy to execution
   2.2 Enhance Professional Development
   - Enable increased access to training to develop the diverse roles needed to support the MHS

Values: R.I.S.E.

- Respect.
  Strive to be fair and considerate in our dealings with each other and outside groups.
- Integrity.
  Endeavor to always do the right thing.
- Service.
  Always work to provide the finest service to our customers and partners.
- Excellence.
  Hold ourselves to the highest standards in everything we do.
MHS Education & Training Challenges

Lack of Complete, Enterprise level Readiness Data for MHS or Services
• Lack of ability to capture complete and integrated readiness data
• Lack of ability to identify education/training needs and provide offerings to medical force in a timely manner

Training Content is not Optimized or Standardized
• Content is primarily outdated (e.g. PowerPoint) and needs to be modernized
• Training courses are taught differently across locations and need standardization

Learning Data is Isolated throughout the MHS Continuum and Lacks Granularity
• Many learning experiences are not recorded or data is in disparate data repositories
• Learning experiences are often marked as completion only and discrete performance data is not captured
# TLA Progress to Date

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<tr>
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<th>Completed initial research to identify:</th>
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<tr>
<td></td>
<td>• Best practices, standards, technology, and complementary efforts that can be leveraged</td>
</tr>
<tr>
<td></td>
<td>• Lessons learned and best practices from learning science perspective</td>
</tr>
<tr>
<td></td>
<td>• Systems engineering lessons learned / infrastructure / interoperability that can be leveraged from past/current efforts</td>
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<table>
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<tr>
<th>02</th>
<th>Completed TLA Requirements Document</th>
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<tr>
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<td>• Version 1 of the High Level TLA Functional Requirements Document</td>
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<th>03</th>
<th>Completed a draft roadmap which consists of gaps to be resolved by DHA or S&amp;T efforts</th>
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<tbody>
<tr>
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<td>• Need for more granular performance data</td>
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Stepwise Approach to Data-Driven Training and Education

**Now**
- **Limited Readiness**
  - "Check the box"
  - Required Completions

**Near Term**
- **Role Based Readiness**
  - Leverage Existing Efforts (KSA project, ICTLS)
  - Course Completions
  - Sub-Course Completions
  - SME Provided / Organization Approved
    - Clinical & Readiness
      - Critical Tasks/Experiences
    - Standardized Metrics/Thresholds

**Future**
- **Individualized Readiness**
  - Course Completions
  - Sub-Course Completions
  - SME Provided / Organization Approved
    - Clinical & Readiness
      - Critical Tasks/Experiences
    - KSAs
    - KSA Standardized
      - Metrics/Thresholds

**Results**
- Annual Requirements for Credential / Certification Tracking

- Role based proficiency calculations
- Targeted training per role type
- Data driven training and education:
  - Media selection (e.g. 80% Sim, 20% Live)
  - Assessment selection
  - AAR selection
TLA Path Forward

Scope of Warfighter Journey
- Previous Training/Education
- Basic Training
- Home Station
- On the Job
- Deployed

Performance Metrics/Thresholds
- Key Performance Areas
- KSAs
- Competency Models
- Assessment Strategy

Data Strategy
- Training Effectiveness Models
- xAPI Selection
- xAPI Profiles
- xAPI Metadata

Training Delivery/Deployment
- Technologies for Deployment
- Training Content
- Optimal Spacing/Timing
- Performance Data Collection

Enterprise Data Aggregation/Storage
- Data Aggregation Strategy
- Data Exchange Library

Data Analysis & Visualization
- Data Visualization
- Training Effectiveness Evaluation
- Human Factors Analysis
Graduate Medical Education (GME)

• DHA transformation

• Progress

• Challenges

• Future
DHA Transformation

• GME is the primary force generator for the Services’ Medical Corps.

• DHA provides oversight of MHS GME programs.

• GME programs may be reshaped based on operational needs of the Services, as well as other tenets of NDAA17, Section 749.
NDAA17 Sections 702 & 749

• **Sec 702**
  – DHA via DAD-MA is responsible for policy, procedures, and direction of GME

• **Sec 749**
  – Develop oversight process to ensure:
    • Programs focus on operational medical force requirements and are conducted jointly to the extent practicable
    • Minimize [unwarranted] duplicative programs among the MILDEPs
    • Coordination of assignment of faculty, support staff, and students
    • Optimization of resources by appropriately using MTFs as training platforms
    • Reviewing and restructuring/realigning programs if/when necessary
DHA GME Responsibilities

- Provide oversight of DoD GME programs
- Administration of GME Advisory Boards
- Execution of all aspects of JSGMESB, except Service Selection Boards
- Policy development for DoD GME
- Analyze DoD GME data to develop initiatives and policies
- Tracking of all accreditation decisions and other metrics
- Preparation of all requests for information re: DoD GME
Service Responsibilities

- Title 10: recruit, train, equip, and organize

- Services will:
  - Recruit new Medical Corps officers
  - Decide how many and what type of specialties to train
  - Support GME with military faculty and support staff
Progress

• Oversight infrastructure
  – **Oversight Advisory Council (OAC)**
    • DHA Deputy Assistant Director - Medical Affairs
    • Service Medical Corps Chiefs
  – **Integration Advisory Board (IAB)**
    • DHA GME Director
    • Service GME Directors

• OAC primary duties
  – Focus on **Medical Force Readiness**
  – Review Service-specific training plans
  – Evaluate recommendations for policy, procedures, and direction of GME

• IAB primary duties
  – Draft recommendations for policy, procedures, and direction of GME
  – Develop **Joint Training Plan** by coordinating Service Training Plans
  – Review training plans and make proposals for **restructuring/realigning** programs *if/when necessary*
Evaluation of the Number and Size of GME Programs

• Each specialty is reviewed at least every other year
  – Operational training requirement = total number of new starts/year for the three Services combined
  – Total training capacity = total number of training positions/year available across all the programs in that specialty across the MHS

• Too little capacity in MHS for that specialty?
  – Expand existing partnerships, open programs, establish new partnerships

• Too much capacity in the MHS for that specialty?
  – Evaluate programs to determine if programs could be restructured or realigned
    • Operational, academic, and market criteria
    • Includes consideration of required program interdependencies
Challenges

• Volume of patients treated in the MTFs with the needed acuity and complexity

• Staffing of medical personnel and funding at MTFs to support GME programs

• DHA is actively working with Services, Veterans Affairs (VA), and civilian partners to address these challenges and others
Future

- Strengthen VA and civilian partnerships
- Reform business practices in MHS to sustain GME
- Reduce unwarranted duplication of GME programs
- Increased integration with professional military education
Clinical Quality Management

Col Todd W Poindexter
Deputy Branch Chief
Clinical Quality Management
An Opportunity Before Us

What led us to change

Three converging requirements provide opportunity to take actions to strengthen accountability, transparency, and standardization in CQM:

• High Reliability Organization (HRO) Mandate from the MHS Review
• NDAA 2017 and 2019
• Expiration and Revision of DoD Instruction (DoDI) and DoDM 6025.13
Transformation is Underway

DHA assumes authority, direction, and control of the MTFs through direct support of the Military Department (MILDEP) Medical Departments

ADC – Authority, Direction, Control – DHA assumes responsibility and accountability for the administration and management of MTF operations in accordance with governing law, regulations, policies, and procedures.

IOC – Initial Operating Capability – DHA assumes responsibility and accountability for the execution of day-to-day administration, management, and operations of MTFs through DS from the MILDEP Medical Departments for functional capability support, until conditions-based transfer of authority is reached.

FOC – Full Operating Capability – DHA assumes responsibility and accountability for the execution of day-to-day administration, management, and operations of MTFs with the MILDEP Medical Departments no longer providing DS to the MTFs for any functional capability, except for agreed-to MOUs/MOAs.

DS – Direct Support – A mission requiring a force to support another specific force and authorizing it to answer directly to the supported force's request for assistance (Source: JP 1-02 and JP 3-09.3).

- **Mission**: MILDEP Medical Departments provide DS to DHA for the MHS transition
- **Supported Force**: DHA
- **Supporting Forces**: MILDEP Medical Departments
Organize to be a Highly Reliable System

We will:

- Identify and employ the most advantageous practices from the Services and DHA
- Determine how we best work together
- Efficiently use resources for productive leverage
- Empower and support at the local level
Purpose of CQM

*An integrated framework of programs to improve quality of care*

- CQM provides *an organized structure for an integrated framework of programs* to objectively define, measure, assure, and improve the quality of care in the MHS.
- Through CQM, the MHS affirms its *unwavering commitment to quality of healthcare* for our beneficiaries, joint healthcare teams, and Combatant Commands across the globe.
CQM Structure and MHS CQM Programs

Promotes safety and prevents harm
Ensures qualified and competent staff
Objectively defines and measures the quality of care delivered

Mitigates risk in the clinical aspects of healthcare delivery
Accreditation: Ensures policy mandates are met;
Compliance: Ensures legal, ethical, and professional standards are met
Improves the quality of care and services delivered
DHA-PM 6025.13: Implementation Plan Timeline

**Phase 1: Training and Awareness**
- Volumes 1, 2, 7 Learning Webinars
- Communication plan development
- Develop Top-Changes, Risks and Mitigation Strategies

**Phase 2: Implementation**
- Volumes 3, 4, 5, 6 Learning Webinars
- Communication plan finalized
- Mitigation, risks completed for Top-Changes

**Phase 3: Sustainment**
- Volume 2 implementation guide (V1) released
- FAQ collection/response
- SharePoint Site developed and launched
- QSPAR (AF), Army forums
- Continued FAQ collection/response
- MTF Directors Toolkit development
- Coaching begins
- Office Hours begin
- Identify Navy Forum
- Development of learning evaluation plan
- Beginning standardizing CQM processes
- Continued FAQ collection/response
- MTF Directors Toolkit finalization
- Continued coaching
- Continued enabling expertise development
- Present at Navy Forum
- Finalize learning evaluation plan
- Share success stories
- Implement standardized CQM
- Begin standard CQM education/training implementation
- Share success stories
- Continuous improvement

**Timeline**
- October
- November
- December
- January
- February
- March
- April
- May
NDAA 2017 Transition Measures: CQM

DHA MTFs are currently performing the same as MHS as a whole in one transition measure (CLABSI), better than MHS as a whole in one transition measure (WSS), and worse than MHS as a whole in one measure (URFO)
**Improvement Focus: Advancement Toward High Reliability in Healthcare Awards Program 2019**

*The Advancement toward High Reliability in Healthcare Awards Program* aims to raise awareness, reward successful efforts, inspire learning, and communicate success throughout the MHS.

A total of **101 submissions were received** for the 2019 awards program including the following winning entries:

<table>
<thead>
<tr>
<th>Military Treatment Facility/TRO</th>
<th>Award Winning Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naval Health Clinic Hawaii</td>
<td>Using HRO principles to Improve Weight-Based Prescribing for Pediatric Patients.</td>
</tr>
<tr>
<td>Naval Medical Center Portsmouth</td>
<td>Enhanced Recovery after Surgery – Establishment of an Institutional Protocol</td>
</tr>
<tr>
<td>96th Medical Group Elgin Air Force Base</td>
<td>Improvement of Surgical Outcomes through Implementation of ERAS Protocol</td>
</tr>
<tr>
<td>Naval Hospital Pensacola</td>
<td>Improving Accuracy and Speed of Urine Drug Testing in Opioid Therapy</td>
</tr>
<tr>
<td>Brooke Army Medical Center</td>
<td>Implementing Standardized Comprehensive Behavioral Health Screening in Military Primary Care Clinics</td>
</tr>
<tr>
<td>Brooke Army Medical Center</td>
<td>MRI TIA Protocol Order Change Reduces Cost and Redundant MR Angiographic Imaging: Preliminary Results</td>
</tr>
<tr>
<td>Brooke Army Medical Center</td>
<td>NICU Enteral Feeding Protocol: Impact on TPN and Central Line Days</td>
</tr>
<tr>
<td>Brooke Army Medical Center</td>
<td>Successful Implementation of an Antibiotic Audit and Feedback Program at a Tertiary Military Medical Center</td>
</tr>
<tr>
<td>Naval Medical Center Portsmouth</td>
<td>Sustainment and Standardization of PeriOP Surgical Quality Improvements to Support a Medically Ready Force</td>
</tr>
<tr>
<td>U.S. Naval Hospital Guantanamo Bay</td>
<td>Sterile Compounding Program Optimization</td>
</tr>
<tr>
<td>USCENTCOM Military Treatment Facilities</td>
<td>Infection Control Improvements in Deployed Medical Treatment Facilities</td>
</tr>
<tr>
<td>MEDDAC Bavaria</td>
<td>Improving Medication through Trending Near Miss Errors</td>
</tr>
<tr>
<td>Naval Medical Center San Diego</td>
<td>Emergency Checklists- Improving Outcomes in Obstetric Emergencies</td>
</tr>
<tr>
<td>97th Medical Group Altus Air Force Base</td>
<td>Dental Readiness- Crossing Military Branch Barriers for Safe Expedient and Efficient Care</td>
</tr>
<tr>
<td>Naval Medical Center Portsmouth</td>
<td>Tissue Management Process</td>
</tr>
<tr>
<td>Keller Army Community Hospital</td>
<td>Pediatric Weight-Based Medication Dosing Errors</td>
</tr>
<tr>
<td>U.S. Naval Hospital Yokosuka</td>
<td>Blue Light Hazard Reduction Initiative Protects Patients and Staff</td>
</tr>
<tr>
<td>U.S. Naval Hospital Yokosuka</td>
<td>Master Privilege List Accuracy Visibility and Plasticity</td>
</tr>
<tr>
<td>Naval Medical Center Portsmouth</td>
<td>Short Term Opiate Prescribing and Intraoperative Therapy</td>
</tr>
</tbody>
</table>
Questions?
Medical Cybersecurity

Mr. Thomas “Pat” Flanders
Deputy Assistant Director Information Operations
Mr. “Pat” Flanders
Deputy Assistant Director Information Operations (DAD IO) and Chief Information Officer (CIO)
Defense Health Agency (DHA)

Mr. Flanders provides leadership for the continued development of an affordable, innovative, robust, and secure information technology environment in support of the MHS. Mr. Flanders is a computer scientist and Department of Defense certified acquisition professional with 29 years of system automation, personnel, finance, and logistics experience.
Medical Cybersecurity: Impact to Health Care?

• When compliance with cybersecurity requirements impacts health care operations, the Cyber Security Division (CSD) counsels MTFs on how to implement policy to support health care operations without incurring unacceptable risk
  – CSD involves multi-discipline SMEs, including Program Management Offices for centrally managed systems, Personnel Security, Cyber Operations Center (CyOC), and MEDCOI/D2D to determine acceptable considerations for implementation of cybersecurity controls

• Benefit
  – Practical risk-based decisions that support healthcare delivery without unnecessary LOE

(M1) – Optimize and Standardize Enterprise Business Processes
Medical Cybersecurity: When Cybersecurity Impacts Healthcare - how to get to yes?

• Do something *before* it happens
  - Bake cybersecurity into healthcare
  - Equate poor cyber behavior with poor clinical care
  - Make the right choice the easy choice
  - Bake healthcare into cybersecurity (gasp)

• *How?*
  - Plan ahead: What do providers need a year from now?
  - Poor Cyber = Poor Care: Cybersecurity is part of patient safety, even after treatment
  - Right Choice = Informed Choice: Arm yourself with knowledge
    https://info.health.mil/dadio/infosec/Pages/KnowledgeBase.aspx

Optimize Outcomes
Medical Cybersecurity: Answers at the Ready

• MTFs / Other Lines of Business (OLBs) / Markets request information/clarification on applicability of DHA/DoD/Federal/Service cybersecurity policies to daily health care operations
  – CSD reviews, engages with requestor (as needed)
  – Conducts comprehensive research
  – Posts all responses to the DHA CSD Knowledge Base for MHS wide visibility/benefit
  – 650+ FAQs to date, many of which were created in response to "Ask an Expert" submissions

• Benefit
  – Serves as a direct connection between MTFs and DHA that enables effective counseling of Cybersecurity Policy; Improve Readiness, Health, and Experience (M2), Enhance Value Through Strategic Partnerships (W5), Improve Readiness, Health, and Experience
Medical Cybersecurity: Cyber Operations Center

What we have:
– 24x7x365 Network Monitoring and Tier 2 Incident Response for malicious/adversarial behavior
– Protection, Detection, and Cyber Incident Response of DoDIN
– Coordinates Incident Response actions between DHA and DHMSM
– Implemented security tools to perform boundary protection

What we need from you:
– Notify when cybersecurity requirements impacts health care operations

What’s in it for you:
– A secure operating environment

(W5) – Improve Readiness, Health, and Experience
Medical Cybersecurity: CyberLOG

Centralized RMF Effort for Medical Devices

What we have:
– 25 CyberLOG counselors hired to work the CyberLOG PIPELINE list
– Medical devices prioritize by those most used across the enterprise
– Coordination with Service Agencies to prevent duplication

What’s in it for you:
– RMF completed once for the enterprise – instead of multiple times at each MTF using the medical device
– RMF maintained centrally vs multiple times at each MTF
– Central repository for medical equipment RMF status/documentation

(W5) – Improve Readiness, Health, and Experience
Medical Cybersecurity: Victories

- Assess & Incorporate (process and authorizations)
- Massive jump in Authorizations, time to approval
- Integrated CyberLOG process
How to Claim CE Credit

If you would like to receive continuing education credit for this activity, please visit:

amsus.cds.pesgce.com
MHS High Reliability Organization Mandate and Transformation

*High reliability is the framework against which the MHS will achieve an integrated system of readiness and health*

- A high reliability organization (HRO) manages risk and regulates operations, while focusing on improvements that advance the organization toward zero harm.
- The MHS began the HRO transformation in 2014 with improvements to **access to care, quality of care** and **patient safety**.
- High reliability is a culture that persists in a top performing health system and is nurtured by the people within that system.
- MHS personnel are leaders in identifying problems, driving improvements, and creating an environment where reliable care thrives.
- The MHS Transition of MTF authority to the DHA accelerates efforts to improve reliable, high-quality care across the enterprise.

*In a reliable MHS, the headquarters, Markets, and MTFs work together to track and manage risks to patients, support patients and staff, and consistently provide care free of harm.*
The MHS HRO Framework

Leaders and staff should embody the MHS HRO guiding principles in our work:

- Preoccupation with Failure: Empower each other's commitment to zero harm by proactively identifying and addressing systemic problems that can lead to harm.
- Sensitivity to Operations: Be mindful of people, processes and systems that impact patient care.
- Deference to Expertise: Seek guidance from the person with the most relevant knowledge, regardless of rank.
- Respect for People: Promote a just culture in which staff and patients are trusted, valued and relied on.
- Commitment to Resilience: Develop the tools and mindset to learn and improve from past mistakes.
- Constancy of Purpose: Foster a shared commitment to eliminating harm.
- Reluctance to Simplify: Work to understand the root cause of problems, and build and leverage connections to solve them.

These efforts are described against four domains of change:

- Culture of Safety: The shared commitment to safety and prevention of harmful incidents.
  
  MHS example: Personnel communicate as a team to ensure safe practices become second nature.

- Leadership Commitment: The prioritization of high reliability and its key practices by leaders.
  
  MHS example: Leaders leverage staff expertise for input, regardless of rank.

- Patient-Centeredness: The focus on patients' safety, quality of care and care experience, including patient and family engagement.
  
  MHS example: Providers make patient-specific health care decisions.

- Continuous Process Improvement: The advancement of innovation and spread of leading practices.
  
  MHS example: MHS Clinical Communities monitor performance and identify opportunities for improvement.
Services Capital Region Lay the Foundation MHS Clinical Communities Continue to Build

The practices of the Services, prior and ongoing, have laid the foundation for an enterprise HRO cultural change. Highlights include:

**AIR FORCE**
- Trusted Care
detailed the linkage of Organizational Culture, Leadership Commitment and Clinical Performance Improvement with a focus on zero preventable harm to patients

**ARMY**
- Initiated Integrated Behavioral Health and patient-centered metrics via the Behavioral Health Data Portal (BHDP) and advanced TeamSTEPPS patient safety training

**NAVY**
- Clinical Community experience of the Navy modeled Clinical Communities and Clinical Support Services for the MHS

**ALL SERVICES**
- Pharmacy’s Enterprise Activity was integrated into the Pain Management Step Care Model, Postpartum Hemorrhage AIM Bundle, and Opioid Use in Pregnancy
National Capital Region Lay the Foundation MHS Clinical Communities Continue to Build

The practices of the NCR, prior and ongoing, have also laid the foundation for an enterprise HRO cultural change. Highlights include:

1. **NCR’s Healthcare Resolutions of adverse events** was designated a DoD-wide program and spread to all Services.

2. The first four MHS Clinical Communities completed a Proof of Concept period in 2018 and were validated and expanded to **11 MHS Clinical Communities**.

3. The Clinical Communities led multiple improvement efforts in that time, such as developing a tool to monitor provider prescribing practices for patients with PTSD, piloting an Induction of Labor care pathway to achieve better outcomes in labor and delivery, and development of a Pain Management Stepped Care Model.
MHS HRO Journey: Notable Milestones

The DHA establishes the Patient Satisfaction Working Group to evaluate and resolve gaps in patient experience.

The Partnership for Improvement becomes operational. This team evaluates performance data and identifies areas for improvements.

The MHS begins publicly sharing data on the quality and safety of care delivered at MTFs. This data is available at Health.mil.

The former Secretary of Defense orders a performance review of MTFs across the MHS.

The MHS begins high reliability transformation with improvements to access to care, quality of care and patient safety.

The MHS enrolls the 40th MTF into the American College of Surgeons’s National Surgical Quality Improvement Program which supports improvement in MHS surgical care.

The MHS reviews and adjusts referral requirements allowing patients greater access to urgent care.

The MHS expands patient access to mental health and substance abuse disorder services.

The DHA publishes infection prevention and control policy to reduce hospital-acquired infections across the MHS.

The MHS develops a standardized Patient-Centered Medical Home model. With this model, primary care managers lead a team of providers in closely coordinating all patient’s needs, including specialty care. This improves continuity of care, patient-provider communication and access to care.

The MHS establishes four initial Clinical Communities to identify and drive improvement in critical areas of DoD care.

The MHS displays military hospital performance data on Hospital Compare at www.medicare.gov/hospitalcompare. This website helps patients find and compare information about hospitals across the United States.

The DHA reaches an important milestone, on its path to assuming medical management of all MTFs. This transition of MTF authority promotes reliability and improvement of care outcomes through standardization of certain health care and business processes.

The Walter Reed National Military Medical Center posts performance data on Leapfrog to help patients make informed health care decisions based on patient safety records.
Continuous Process Improvement Led by MHS Clinical Communities

Current Clinical Community initiatives include:

- Behavioral Health Treatment and Outcomes Monitoring
- Dental Wrong-Site Surgery Pilot
- Acute Concussion Care Pathway
- Cancer Registry Program
- Stepped-Care Model for Pain Clinical Pathway
- National Surgical Quality Improvement Program (NSQIP) operationalization
- Alliance for Innovation on Maternal Health (AIM) Postpartum Hemorrhage (PPH) Bundle

Communities Link to Operations, Performance, & Strategy

- Clinical Management Teams (CMTs) will oversee all operational aspects of clinical care. The MHS Clinical Communities and Clinical Supports Services (CSSs) will provide leading practice guidance to the CMTs.
- MHS Clinical Communities help identify core metrics that the MHS will use to evaluate MTF performance in key clinical areas