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EVOLUTION OF TRICARE IN THE UNITED STATES CENTRAL COMMAND'S AREA OF RESPONSIBILITY: AN INTERAGENCY SUCCESS STORY?

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EVOLUTION OF TRICARE IN THE UNITED STATES CENTRAL COMMAND'S AREA OF RESPONSIBILITY: AN INTERAGENCY SUCCESS STORY?

INTRODUCTION

The delivery of quality healthcare at an affordable price is a challenge at any time, even within the borders of the continental United States. The challenge of delivering affordable quality healthcare to military beneficiaries outside the borders of the United States, particularly in remote and third world locations, is a daunting task. TRICARE is the instrument designated by Congress to provide health care worldwide to the members of the armed forces and their families. In the United States Central Command's (CENTCOM) area of responsibility (AOR) there are some of the remotest, inhospitable, and backward countries imaginable where, if healthcare exists at all, it does not meet the standard of western medicine. TRICARE was to remedy this problem for our service members and their families, but failed. From July 1999 through August 2001, the CENTCOM Surgeon's office, TRICARE Europe, and the Office of the Secretary of Defense for Health Affairs were engaged in an attempt to remedy the failed TRICARE system. During this two-year period, personalities, governmental politics, organizational culture, and process inertia stalled the effort to provide quality healthcare to our beneficiaries. It took the threat of personal intervention from the Commander in Chief of the United States Central Command via a "personal for" message to the Deputy Secretary of Defense for Health Affairs to galvanize the interagency process to successfully design and implement a solution that now provides quality health care at an affordable price to

members of the armed forces at remote CENTCOM locations. This paper is the story of the initially failing interagency process and the ultimately successful interagency process.

BACKGROUND

The Department of Defense, until 1963, had always provided healthcare to its members and their families through the direct care system, that is, through its own network of military hospitals and clinics.[1] In 1963, Congress started the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to ease the direct care burden on the military healthcare system.[1] Under CHAMPUS, family members of active duty military personnel and military retirees and their family members could utilize civilian medical services on a cost-sharing basis with the government. By the mid-1980s, it was well recognized that CHAMPUS was prohibitively expensive and that another way had to be found to lower healthcare costs while maintaining a high level of quality of care. From 1988 through 1994 several managed care demonstration projects were conducted on the west coast and Hawaii in an attempt to design an affordable system. These demonstration projects culminated in the establishment of TRICARE, the successor to CHAMPUS. TRICARE is a managed health care program that was designed to provide a standard benefit to the members of the armed forces, retirees, and their families. It is predicated on the availability of a network of healthcare providers and institutions near where military members reside. Additionally, the providers and institutions must be willing to participate. This system, it was believed, would work worldwide.

[1] TRICARE History, available from www.triwest.com/beneportal/tricare_program/tricare_history.htm

THE PROBLEM

In the CENTCOM AOR there is very little direct military care available for beneficiaries and TRICARE Europe was to be the instrument to fill the gap, particularly in countries where we have only a handful of people stationed. Unfortunately, TRICARE was doomed to fail overseas, particularly in remote locations, due to its requirement for a robust network of participating healthcare providers and institutions and its unresponsiveness to the needs of beneficiaries in remote locations. TRICARE was unable to establish a network of healthcare providers and institutions in the CENTCOM AOR.[2] The failure was caused by two factors. First, the business practices of healthcare providers in the CENTCOM AOR are markedly different than those of their western colleagues. They were unfamiliar with the concept of managed care and therefore unwilling to participate. Second, TRICARE Europe, in the CENTCOM Surgeon's estimation, never committed the resources to educate healthcare providers in the CENTCOM AOR so that a network might be established.[3] The lack of a network of healthcare providers and institutions led to several unforeseen effects for military members and their families who sought healthcare in the CENTCOM AOR. First, military beneficiaries seeking care were on their own. They had to find and evaluate the capability of providers and institutions without any input from an accrediting organization. This was a situation that could, and did, lead many patients to receive sub-optimal care. Second, once a competent provider was found, local business practices, more often than not, required the beneficiary to pay for services in advance, and then file

[2] Colonel D. Geiger, Director TRICARE Europe, interview by author, November 1999
[3] Colonel D. Kasperik, CENTCOM Surgeon, interview by author, November 1999

a claim with TRICARE. This often created a financial crisis for young enlisted members with families. Third, when a claim was filed, it was often rejected for technicalities, causing a delay in reimbursement to the beneficiary. The unresponsiveness manifested by TRICARE Europe resulted in delayed specialty referrals to Europe and the U.S., a cumbersome system for obtaining aeromedical evacuation, and frustration and anger among the beneficiaries.[4] Enter the interagency process.

THE SOLUTION: ACT I

Beginning in July 1999 and extending through May 2001, the CENTCOM Surgeon's office attempted to use the interagency process to craft a solution for the delivery of healthcare in the CENTCOM AOR. The agencies involved were CENTCOM, TRICARE Europe, and the Office of the Secretary of Defense for Health Affairs (OSD-HA). For CENTCOM the solution was simple. The TRICARE Europe mission was to provide health services to CENTCOM's beneficiaries that were on a par with the services being received by military members in Europe and the U.S. TRICARE Europe was unable to provide the necessary healthcare services to the beneficiaries and was therefore obligated to contract with a private, for profit, international healthcare provider to provide those services. TRICARE Europe was not willing to explore this avenue primarily due to funding and manning and OSD-HA stayed disengaged from the process because no one had yet brought the problem to their attention.

By the summer of 1999, it was becoming increasingly clear to the CENTCOM Surgeon's office that there was a real problem with the delivery of healthcare in the CENTCOM AOR. We began receiving complaints from the field about the quality of

[4] Lt Col J Bodin, Security Assistance Office Physician, Egypt, multiple conversations, Sept 1999-June 2001

care, the ability to get bills paid, and the responsiveness of TRICARE Europe to the needs of the beneficiaries. Staff assistance sessions by the Surgeon's office to visiting U.S. military delegations turned into TRICARE bashing sessions. TRICARE Europe was engaged via telephone conversations and email. They assured the CENTCOM Surgeon that they understood our concerns and would take appropriate steps to remedy the situation. Unfortunately, the CENTCOM Surgeon did not have the command authority to force TRICARE Europe to do his bidding. The complaints from the field were becoming increasingly strident and there was beginning to develop some one and two star level of interest within the command. This, of course, increased the pressure on the Surgeon to "do something".

Each November, CENTCOM invites each of its Security Assistance Officers (SAO) and their families from the AOR to a conference in Florida. During this time, the critical military issues are discussed, but there is also a great deal of time set aside for discussions concerning quality of life issues. The Surgeon thought this would be an ideal time to fully engage TRICARE Europe. TRICARE Europe was invited, at CENTCOM's expense, to come to Florida to present the solution to the problems being encountered in the AOR and to participate in a question and answer session with the SAO's and their spouses. TRICARE Europe sent two individuals to participate. In informal meetings prior to the presentation and the question and answer session, it became clear that personalities, politics, and organizational culture would significantly affect the outcome of the discussions. The Surgeon was a male Army O-6 physician in his 50s and the lead for TRICARE Europe was a younger female Air Force O-6 administrator who was TRICARE Europe's director. The Surgeon, unwittingly, acted exactly as he had been

conditioned to act. He was in charge, arrogant, and a bit condescending to the guests. He didn't feel that a non-physician would 'get' the issues and essentially told the guests what he expected and when he expected it be done. There wasn't any real negotiation, just direction. Naturally, the Air Force O-6 took exception to this approach. Neither party was able to overcome the personalities at work. TRICARE Europe is a service organization and should have been responsive to the needs of the customer, but could not overcome her aversion to the Surgeon's approach. Rather than search for common ground, TRICARE Europe offered organizational process/culture and governmental politics reasons why the Surgeon's goals could not be met. The excuses were the usual, there wasn't enough money, they weren't manned appropriately, and I don't work for you, I work for the EUCOM commander. Their focus was Europe where there was the medical infrastructure to make TRICARE work. They didn't/wouldn't understand what all of our fuss was about. However, they would look at our proposal and consider budgeting for the future after appropriate staffing within their organization.

With this atmosphere, TRICARE Europe briefed the SAOs and their spouses. Instead of offering solutions, the TRICARE representative gave a gee-whiz TRICARE briefing that in no way reflected the realities in the field. They did offer to establish a CENTCOM only TRICARE service center located in Germany to handle issues coming out of the AOR, but never addressed the essential issues of access and payment. Once established, the service center was ineffectual. During the question and answer session the crowd was hostile to the point of rudeness, which only made the Director of TRICARE Europe more entrenched in her beliefs. The CENTCOM Surgeon realized that we were failing to convince TRICARE Europe that something needed to be done

now and not five years from now through the POM process. To this end, the Surgeon arranged a meeting with CENTCOM's three star Army Deputy Commander in Chief (DCINC) to take place prior to TRICARE Europe's departure. The hope was that three star visibility would persuade TRICARE Europe of the magnitude of the problem. The DCINC had not adequately been read into the problem, which turned out to be an organizational culture/political failure on the Surgeon's part. The Surgeon did not want to make waves, particularly with his reporting official. It's always much cleaner to fix the problem yourself and present the solution to the boss than it is to go to the boss for help because you failed. The meeting turned out to be a feel good session. The Surgeon did not adequately prepare the DCINC to ask the tough questions and TRICARE Europe painted a much rosier picture than existed. It was agreed that continued dialog and discussion was essential and that TRICARE Europe would present a plan, at some future date, addressing the concerns of the Surgeon. TRICARE Europe went home, and we were no closer to a solution than we had been in July.

To this point, CENTCOM or TRICARE Europe had not actively engaged OSD-HA. After the unsuccessful SAO conference, CENTCOM informally approached OSD-HA for help. They were less than responsive. To be fair, OSD-HA was involved in some extremely high visibility issues that were taking up all of their time and resources. CENTCOM's problems as compared to implementing TRICARE for Life, the prescription drug benefit, and the overseas dental program were mere blips on the radar screen to the staffers at OSD-HA. We were told that there simply wasn't the time or the money to address our issues and that we would have to work it out with TRICARE Europe.

The CENTCOM Surgeon's office also approached the contractor, International SOS, who was providing the kind of care we wanted in Pacific Command to see if they could provide a similar service in the CENTCOM AOR. International SOS was more than willing to talk to us and assured us they could provide what we were looking for. As was to be expected, it would take a great deal of money to make it happen. Money, that by law, had to come from the services via OSD-HA and TRICARE Europe.

It certainly seemed that we were at an impasse, but the action officers for CENTCOM and TRICARE Europe kept the lines of communication open despite the animosity that had been generated by the principals. The CENTCOM action officer worked closely with his counterpart at TRICARE to fix issues as they arose from the AOR. They would work in concert to get an overdue bill paid or arrange specialty referral or to arrange an emergency aeromedical evacuation. While none of these activities were in either job description, it was important to the quality of life of the beneficiaries. This quieted a lot of the complaints from the field, but it was not the optimal solution. It was an interagency work around at the action officer level, but it did not address the underlying system failure. To do this, the TRICARE Europe action officer developed a phased plan to implement the needed network of providers and institutions in the CENTCOM AOR. TRICARE Europe, time and money permitting, would send a representative to the countries that had the most pressing need, and try to develop a local network of providers and institutions. The plan was a good one, but was hampered by the time and money variable. It looked like it was simply going to take too long to set up an adequate healthcare network, but it was the only option that appeared to be available. Never the less, a trip by TRICARE Europe was planned to go to selective

countries in the AOR to begin the process. Before TRICARE Europe could launch the trip however, the USS Cole was the victim of a terrorist bombing and the trip was canceled because of force protection issues. Another trip could not be planned until the region was yet again reasonably safe for travel by non-combatants. In the meantime, the bombing of the USS Cole, changes in personnel at CENTCOM and TRICARE Europe, and a personal interest by the CINC served to change a failed interagency process into a successful interagency process.

THE SOLUTION: ACT II

The bombing of the USS Cole underscored some of the concerns CENTCOM had been expressing about the availability of quality health care in certain third world host nation countries. Western medicine generally does not exist in Yemen, and, in fact, it would take over 12 hours for the first U.S. physician to arrive at the scene. This was much too late to be of help during the critical post trauma period. Never the less, even the most remote third world countries have capable physicians, usually expatriates from Europe that take care of the elites of that particular nation. Had there been a western trained surgeon identified in Yemen, the casualty outcome might very well have been different.[5] As it was, the injured were taken to the public hospital where they received questionable care. This was a failure of the current system.

At the same time that the USS Cole incident was unfolding and underlining the health delivery crisis, events at CENTCOM and TRICARE Europe occurred that made a solution seem much more attainable. At CENTCOM, a new Deputy Surgeon had arrived who, as luck would have it, was an Air Force O-6 administrator who was a close friend of the TRICARE Europe's director. The Deputy Surgeon took the lead in negotiations with

[5] Colonel D. Kasperik, CENTCOM Surgeon, interview by author, December 2000

TRICARE Europe. This fortuitous development made the TRICARE Europe Director much more amenable to considering CENTCOM's wishes although it didn't change the problem of personnel and money. The personality factor had been removed from the equation. To address the money issue, it was necessary to turn to OSD-HA for the needed funds. Engagement by both TRICARE Europe and CENTCOM both informally and through a meeting at OSD-HA failed to persuade them to allocate the necessary funds to obtain a contract to provide healthcare in CENTCOM's remote locations. Again, it seemed as if we were at an impasse except that one more factor emerged to allow CENTCOM to engage OSD-HA more aggressively. The CENTCOM Surgeon had been persuaded by the Cole incident that it was more important to obtain the health care needed than to not rock the boat with the upper echelons of CENTCOM. It probably helped immeasurably that he was a lame duck at this point and would be soon moving on to a more prestigious position and had already received his good performance evaluation. In any event, he gave the green light to the Deputy Surgeon to write and coordinate a "personal for" message from the CENTCOM CINC to the Assistant Secretary of Defense for Health Affairs with the implied threat that if action were not taken, the next engagement would be with the Secretary of Defense who, of course was the boss of both the CINC and the Assistant Secretary. This message was coordinated within CENTCOM and the CINC approved the content and wording. Before it was sent however, the message was purposely leaked to the action officers at OSD-HA to see if there might be movement before the political hardball really began. Not surprising, the back channel leak of the message had the intended effect. In just two months at the end of fiscal year 2001, money was found and a contract was let with International SOS to begin the

process of building the network of providers and institutions that CENTCOM had identified as a need two years earlier.[6] The contract is in place today, is working as intended, and will be expanded to the remainder of the CENTCOM AOR in 2003.[7]

CONCLUSION

As I struggled to find an appropriate subject to write about for course 5603, I decided that the most educational benefit I would receive would be writing something from my own experience and trying to draw some conclusions about the factors we have learned about the interagency process. While I didn't realize it at the time, many of the variables we studied played into the final outcome. Most notably, personalities, and to a lesser extent organizational culture, politics, and process determined the success or failure of achieving our goal of delivering quality healthcare to the beneficiaries of the CENTCOM AOR. Initial failure turned into success because of a unique blend of new personalities that addressed the issue, an event of magnitude that illustrated the issue, and the threat of intervention by an individual at the highest level. I learned that personalities do count, organizational culture/process and politics can be overcome, and to involve those with influence early in the process if the issue is of sufficient import. Finally, I learned not to wait until the issue was front-page news before aggressively seeking a solution. I will carry these lessons with me throughout the remainder of my career.

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[6] Colonel R. Hartley, CENTCOM Deputy Surgeon, interview by author, Dec 2001
[7] Lt Col Carol Hammes, CENTCOM TRICARE Action Officer, interview by author, Dec 2001