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Graduate Management Project

Federal Health Care Partnerships:
Their Potential for Improving
the U.S. Coast Guard Health Care System

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In Partial Fulfillment of the
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Master of Healthcare Administration

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April 3, 2000

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ABSTRACT

TRICARE Prime Remote (TPR) was designed to address deficiencies in health care benefits for service members assigned to remote locations. Through involvement in the Alaska Federal Health Care Partnership (AFHCP), the four U.S. Coast Guard (USCG) clinics in Alaska have reduced costs, improved the quality of health care, and overcome some access problems in spite of their geographic isolation. In the wake of the implementation of TPR, are AFHCP-type programs viable options for improving health care for other remote USCG clinics outside Alaska?

This retrospective, descriptive business case study uses a cost benefit analysis method called the “balance-sheet” approach to tabulate who bore the costs and who reaped the benefits from these AFHCP initiatives at Alaskan USCG clinics in Fiscal Years 1997 through 1999. The balance-sheet approach facilitates evaluation of quantifiable and unquantifiable changes in cost, quality, and access factors as a basis for program evaluation. The analysis finds the AFHCP has yielded significant benefits for USCG clinics in Alaska. A total of 16 other remote USCG clinics are identified as potential sites for partnership involvement. Moreover, partnership initiatives could potentially benefit all USCG clinics, regardless of location.

The USCG Health Services Program has no formal strategic plan. As a result, its business strategy lacks focus and is reactive in nature. To clarify the applicability of federal health care partnerships to the Coast Guard health care system and optimize the benefits of partnering with other federal health care agencies, leaders in the Coast Guard’s Health and Safety Directorate should embrace strategic management as an organizational behavior and develop a comprehensive strategic plan which considers further involvement in federal health care partnerships.

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CHAPTER 1: INTRODUCTION

The combined departments of the Executive Branch of the United States (US) Government annually spend billions of taxpayer dollars on health care for millions of federal beneficiaries. There are intense political and economic pressures on federal agencies providing or funding health care benefits to reduce rising operating expenses. However, to keep pace with the unrelenting effects of inflation in health care, new requirements, and beneficiaries' demands, these agencies must submit ever-larger annual budget requests. In response, Congress has mandated reforms intended to force improvements in efficiency.

In the past few years, many Executive Branch departments providing health care to federal beneficiaries implemented initiatives to increase efficiency and improve quality. A few examples are mentioned here. The Department of Veterans Affairs (DVA) streamlined its health care operations and governance structures by creating Veterans Integrated Service Networks (VISNs) (Kerrigan, 1999). The Department of Defense (DOD), through the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)), expanded use of the Interfacility Credentials Transfer Brief to speed transfer of provider credentials between facilities and standardize credentials procedures across its health care system (S. C. Joseph, personal communication, July 11, 1994). The Department of Health and Human Services (DHHS) instituted new rules and programs to reduce waste, fraud, and abuse (Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997, 1997). The United States Coast Guard (USCG), an agency of the Department of Transportation (DOT), upgraded its health care information management systems and increased emphasis on formal education in health care administration.

Federal agencies have also cooperated across Executive departments to create efficiencies in the national delivery of health care. Veterans Administration and DOD sharing agreements have allowed sharing of reimbursable medical resources (DOD, 1995). These two departments have also increased purchasing power through such interagency initiatives as the Prime Vendor programs covering pharmaceutical, medical and surgical supplies, and equipment. The Health Care Financing Administration (HCFA), a DHHS agency, and DOD recently began the “Medicare Subvention” demonstration program, commonly known as TRICARE Senior Prime, to coordinate interagency funding of health care for dual-eligible federal beneficiaries over 65 years of age (News Release, 1996).

However, one of the most unique approaches to interagency cooperation in the federal health care sector is not a national initiative. It is a regional endeavor called the Alaska Federal Health Care Partnership (AFHCP or “Partnership”), a consortium of units of the federal agencies responsible for providing health care to federal beneficiaries in the state of Alaska. By coordinating their operations and resources, partner units have cut costs, increased access to services, and improved quality of care. The AFHCP not only saved over \$16 million since its inception in 1995, but also helped its member organizations execute their individual missions more effectively. In the spirit of true partnership, each AFHCP agency both contributed to and benefited from the Partnership’s success. Member units, their locations, and their parent agencies are shown in Table 1.

Table 1

Member Units, Locations, and Parent Agencies of the Alaska Federal Health Care Partnership

Member Unit	Location	Parent Agency
Bassett Army Community Hospital	Fairbanks	US Army
Troop Medical Clinic	Anchorage	US Army
Army Medical Detachment	Fort Greely	US Army
Alaska Native Medical Center	Anchorage	US Indian Health Service ^a
DVA Health Care System Office	Anchorage	DVA
354th Medical Group	Fairbanks	US Air Force
3rd Medical Group	Anchorage	US Air Force
Coast Guard Clinic	Kodiak	US Coast Guard
Coast Guard Clinic	Juneau	US Coast Guard
Coast Guard Clinic	Sitka	US Coast Guard
Coast Guard Clinic	Ketchikan	US Coast Guard

^a The Alaska Native Medical Center is also overseen by the Alaska Native Tribal Health Consortium (ANTHC), a quasi-federal entity under the Indian Self-Determination and Education Assistance Act.

There are many aspects of the AFHCP worthy of study. However, this research effort will focus on the Partnership's positive impact on the four USCG primary care clinics in Alaska.

Conditions Which Prompted the Study

The smallest denominator of Coast Guard organization is the individual unit or operating facility (OPFAC). The Coast Guard operates hundreds of OPFACs. Each OPFAC may have

between one person and several hundred active duty personnel assigned. To maintain fitness for duty of these personnel and meet the health care needs of their dependents, the Coast Guard assigns each OPFAC to a Primary Management Site (PMS)¹. The PMS may be either an USCG clinic (a health care facility staffed with at least one medical officer) or an USCG independent duty health services technician (IDT) assigned to a large OPFAC. If the PMS is an IDT, then the IDT must be supported by an USCG clinic. A PMS is responsible for providing or overseeing primary health services (medical, dental, pharmacy, and administrative) and/or helping coordinate health care for all Coast Guard beneficiaries affiliated with the OPFACs within a designated geographic area of responsibility (AOR). Independent duty health services technicians are authorized to treat only active duty personnel. Not all beneficiaries receive health services directly from the PMS. Depending upon the size and location of the OPFAC, sources of primary health care for USCG beneficiaries are:

1. IDTs;
2. private health care providers;
3. DOD Military Treatment Facilities (MTFs); and
4. USCG clinics.

Whether beneficiaries are seen by the PMS or not, the USCG clinic is often an arbiter in any OPFAC's health care support system.

¹ This term is specific to the Pacific Maintenance and Logistics Command (MLC). The Atlantic MLC prefers the term Clinic Support Activity. However, the term Primary Management Site more accurately describes the function and will be used in this study for both MLCs.

The USCG has 29 primary care clinics. Clinics vary in size, staffing, and scope of practice. Most offer a mix of primary health services. Some clinics support no IDTs in their AOR, others support several IDTs. In addition to the four Alaskan clinics already mentioned, there are 25 other clinics located within the continental United States, Hawaii, and Puerto Rico. These clinics are typically located in areas with a relatively high concentration of USCG active duty personnel or where USCG operations require the presence of operational medical assets.

Like the four sites in Alaska, many USCG clinics are remote (i.e. greater than 50 miles from a DOD referral MTF capable of providing most types of specialty care such as orthopedics, dermatology, obstetrics/gynecology, mental health, etc.) and/or support OPFACs located far from large metropolitan centers and adequate health care services. These isolated locations often lack reasonable access to affordable, quality health care for USCG personnel and their families. Ostrom (1999) elaborates on the difficulties both providers and patients face in rural health care settings. She states the cost of living is higher in remote areas and that provider profitability is threatened by low payer reimbursements (which are often based on lower costs in metropolitan areas). She adds that one of the ways providers cope with these low reimbursements is to increase patient co-payments. In many such locales, the USCG has entered contracts for services with local private health care providers to address the problem.

The DOD Military Health System (MHS) is charged with maintaining the military medical readiness of active duty personnel of the armed services and caring for other statutorily entitled beneficiaries such as dependents of active duty personnel, and retirees and their dependents. In 1994 the MHS implemented TRICARE, its managed care reform plan intended to improve economic efficiency, quality of care, and access to services for its beneficiaries. TRICARE is a tripartite benefit plan consisting of a low-cost health maintenance organization option ("Prime");

a fee-discounted preferred provider option (“Extra”); and a full-fee indemnity coverage option (“Standard”), the original dependent health care benefit plan known as CHAMPUS (Civilian Health and Medical Plan of the Uniformed Services). Military Health System beneficiaries may select one of the three options, but if they desire the benefit-rich Prime plan, they must formally enroll to receive it. As an element of the MHS, the USCG health care system and its beneficiaries have been affected by the implementation of TRICARE. In some instances, TRICARE has been a windfall for USCG beneficiaries, particularly those residing in areas where the Prime benefit is available. However, according to the Coast Guard’s Chief of Health Systems Management, “[TRICARE is] the DOD’s square peg in the Coast Guard’s round hole” (T. Goldman, personal communication, September 3, 1999). That is, TRICARE has done little to improve access to affordable, quality health care for the many USCG beneficiaries residing in geographically separated areas where there are few health care providers, let alone availability of the Prime plan. A survey by the Coast Guard in early 1999 found that more than 50% of all USCG beneficiaries reside outside the 40 mile catchment area of any MTF and 31% of all OPFACs are not in an area where the Prime plan is available (S. Wood, personal communication, September 15, 1999).

With implementation of the TRICARE Prime Remote (TPR) program on October 1, 1999, the MHS attempted to resolve some of the health care problems facing remotely assigned military personnel. Personnel that live and work more than 50 miles from a MTF are considered remote. TRICARE Prime Remote is intended to reduce bureaucracy and improve access to health care by identifying local private health care providers and establishing referral and payment procedures with them.

However, TPR has some shortfalls. First, TPR does not create providers, especially specialists and tertiary facilities, where there are none; it focuses solely on existing providers. Second, because it attempts to establish relationships with existing providers, TPR may threaten the stability of some hard-won contracts the USCG already has in place in these remote locations. Third, TPR does not cover active duty family members in remote areas². Non-active duty beneficiaries must still use the original Standard health care benefit or, if referred by a MTF retaining clinical oversight, have their care funded through the MHS's supplemental health care program (TRICARE Management Activity [TMA], 1999). Therefore, from the Coast Guard's perspective, TPR is largely a symbolic program without substantive benefits in some locales. Due to a near-total lack of available specialists and tertiary care facilities where some USCG clinics and their beneficiaries are located, there has been no real reduction in members' costs, improvement in quality of care, or better access to care (K. Meyer, personal communication, October 1, 1999; R. Perkins, personal communication, September 14, 1999).

Problem Statement

The USCG has OPFACs in diverse locations that create difficult challenges for the health care system. Through involvement in the AFHCP, the four remote USCG clinics in Alaska have reportedly reduced costs, improved the quality of health care, and overcome some access problems in spite of their geographic isolation. The USCG needs to evaluate these successes and determine if the benefits of involvement in similar partnerships could benefit other remote USCG clinics outside Alaska, if any.

² Health care services for dependents of active duty personnel in remote locations are available through TRICARE geographically separated unit (GSU) trial demonstration programs in Regions 1, 2, 5, and 11. There are plans to expand TPR in all Regions to include active duty family members beginning October 1, 2000.

Literature Review

Before examining the AFHCP and determining whether benefits, if any, realized by USCG clinics in Alaska could benefit any other remote USCG clinics outside Alaska, it is important to understand the Alaskan environment, the history of the Partnership, the authority under which it operates relevant to the USCG, and the Partnership programs involving the USCG. Background on the USCG health care system will also be reviewed as will current literature on program evaluation.

Alaskan Environment

The Alaska Division of Tourism (1999) reports background information on Alaska. The state of Alaska contains 586,412 square miles. By comparison, Alaska is two and a half times larger than the state of Texas and one-fifth the combined size of the contiguous 48 states. As of July 1998, Alaska's population was 621,400, about two-thirds the population of the city of San Antonio, Texas. Nearly half of the state's residents live in Alaska's most-populated city, Anchorage (population 258,782). Three hundred fifty air miles to the north, Fairbanks (population 83,928) is Alaska's second largest city. With 0.93 square miles for each person in the state, compared to 0.003 for New York, Alaska is by far the most rural of the 50 states. Aside from two roads connecting Anchorage and Fairbanks, there are no roads between the state's six most populated cities. The third through sixth most populated cities--Juneau, Ketchikan, Sitka, and Kodiak, respectively--can be reached only by air or sea. As one would expect due to the state's vastness and inherent travel difficulty, Alaska has the highest number of licensed private airplane pilots per capita of any state.

According to S. Yeager (personal communication, August 30, 1999), director of the AFHCP Project Support Office (PSO), Alaska presents significant challenges for health care

services. Air evacuation is the only practical means of patient transportation between cities. Year-round harsh, unpredictable weather conditions often make air evacuation impractical or even dangerous. There are no health maintenance organizations in Alaska mainly because the population base to support a comprehensive health care provider network is too small and dispersed. For the most part, primary care providers are available in all but the most remote areas, but specialists and tertiary care facilities are few and located mainly in Anchorage. Regarding provider-to-patient ratio, Alaska ranks next to last of the 50 states. Health care costs can be up to 200% higher than the national average.

Alaska Federal Health Care Partnership

History

Alaskan Natives and American Indians have populated Alaska since before recorded time. As the US Government encroached on the ancestral lands of these indigenous peoples, treaties were made in exchange for land, mineral rights, and more. Subsequent laws, Supreme Court rulings, and executive orders affirmed a federal responsibility to provide, among other things, health care services to federally recognized tribal governments. The Snyder Act of 1921 authorized federal appropriations to meet these obligations and the Indian Health Service (IHS), a division of the US Public Health Service, part of the DHHS, was established in Alaska (Trujillo, 1997).

World War II, and in subsequent years the Cold War, brought a substantial military population to Alaska. A US Coast Guard presence grew concomitantly with the growth of the commercial fishing, crude oil transportation, and pleasure boating industries in Alaska. As personnel left the military services, a significant veteran population grew and VA facilities arose to support them.

To exist in the harsh Alaskan environment, the federal agencies responsible for providing health care to these beneficiary populations learned to cooperate to support each other's beneficiaries and achieve their respective goals. In the 1980's the DOD, DVA, and IHS often worked together through resource sharing agreements. This informal cooperation was strengthened when the DVA decided not to build a new hospital in Anchorage. Instead, they entered into a joint venture in which the DVA would occupy a portion of the new 3rd Medical Group Air Force hospital completed at Elmendorf Air Force Base (AFB) in 1998. With the advent of the MHS's TRICARE program in 1994, all Alaskan MTFs formed a strong collaborative partnership dubbed the Alaska Regional Health Plan to jointly pursue OASD(HA) TRICARE objectives. Many cost-effective, informal interagency relationships were formalized as a result of increasing trust, success, and momentum in intragovernmental support. The next step was to work more closely together to acquire even more cost-effective care from non-governmental sources (AFHCP, 1997).

By combining their individually small beneficiary populations, federal facilities obtained discounted prices from private health care sources. This combined beneficiary population accounted for nearly 240,000 people--40% of the state's population. Greater economic power made the unified federal agencies a major force in the state's health care marketplace and allowed them to pool their respective talents and experiences to improve patient care. Two alliances formed. The first was in Anchorage consisting of the DVA, the IHS's Alaska Native Medical Center (ANMC), and the Air Force's 3rd Medical Group. This alliance was called the Alaska Federal Health Provider Network. A second parallel alliance formed in the Fairbanks area consisting of Bassett Army Community Hospital (BACH) at Fort Wainwright, the 354th

Medical Group at Eielson AFB, the DVA in Fairbanks, and the Tanana Chief's Conference (IHS) in Fairbanks (AFHCP, 1997).

After visiting DOD, DVA, and IHS facilities in 1994, Dr. Stephen Joseph, then Assistant Secretary of Defense for Health Affairs, expressed enthusiasm for such joint agency initiatives. Later that year, he met with representatives from the DOD, DVA, DHHS, and the USCG. These senior agency officials agreed to allow their respective Alaskan agencies to continue developing more initiatives. They viewed the Alaskan grass-roots effort as the best way to provide health care for Alaskan beneficiaries, acquire cost effective care, increase access, and perhaps provide a laboratory for further interagency cooperation in national health care reform (AFHCP, 1997).

The AFHCP Annual Report (1997) reported that in early 1995 leaders representing the agencies of the AFHCP met to determine the optimum governance and operating structures for a formal, overarching interagency organization. The heads of the various agencies/facilities formed a new governing body—the Executive Committee—and authorized the creation of a planning and execution group—the Planning Committee—to develop and, upon Executive Committee approval, implement programs. This formal, statewide interagency organization was called the Alaska Federal Health Care Partnership. In 1997, the execution function was segregated in a new AFHCP PSO in Anchorage with a staff of six employees funded by the various member agencies. The current organizational structure of the AFHCP is shown in Figure 1.

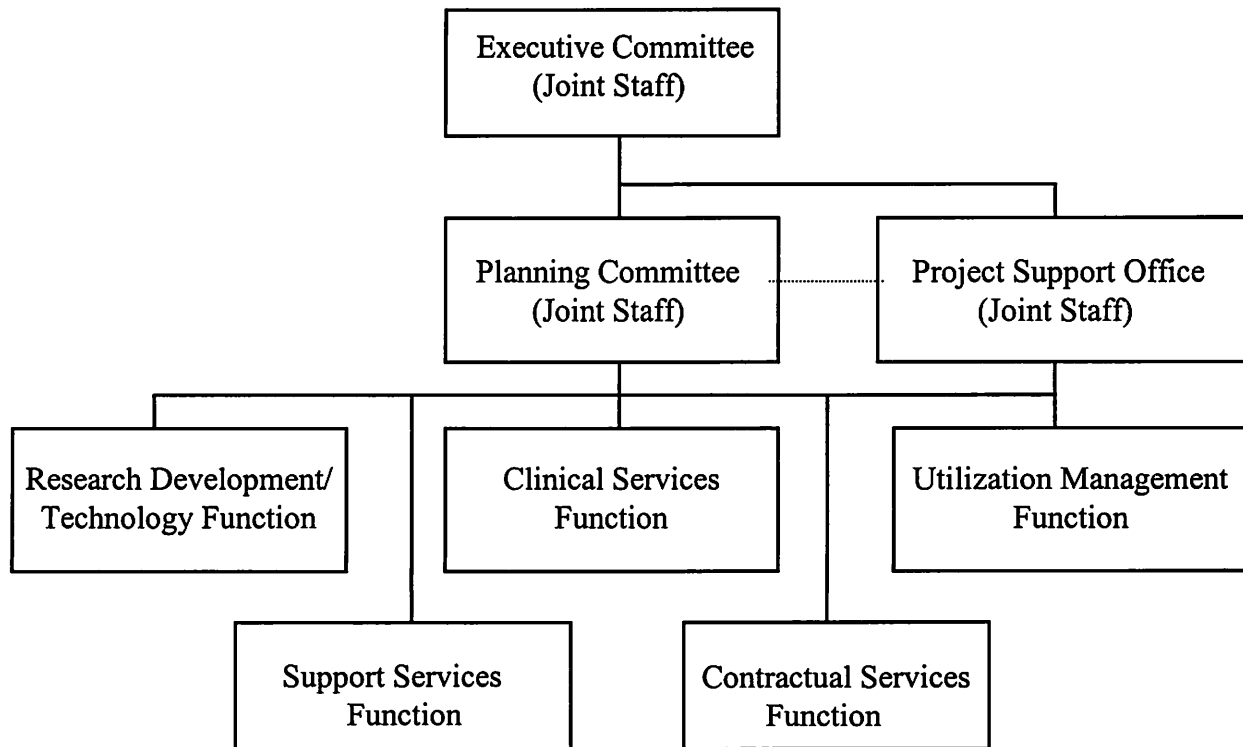


Figure 1. Organizational structure of the AFHCP

Kertesz (1996) accurately stated that the AFHCP has created a new economy in the once highly fragmented health care environment and predicted that Alaska's private health care organizations would inevitably be affected by the change. Indeed, the Partnership's "Alaska First" policy emphasizes its desire to work primarily with Alaska's private health care providers when possible versus transporting patients out of state to receive care. Another federal agency, the US Marshals Service, also began purchasing health care services through the AFHCP in 1998.

The Partnership's revolutionary approach has drawn attention outside of Alaska. The various parent agencies of the AFHCP members have lauded its accomplishments. Most notably, the Partnership received the prestigious Vice President's Hammer Award for Reinventing Government in 1997 (Office of National Performance Review, 1997). The list of

formal recognition also includes the Veterans Health Administration's Strategic Alliance Award (1997), the Federal Employee Team of the Year Award (1997), and the DHHS's Secretary's Award (1998) (S. Yeager, personal communication, August 30, 1999).

In summary, the AFHCP, established in 1995, was borne out of two main dynamics affecting health care delivery in Alaska. First, a history of mutually beneficial cooperation among federal health care activities in the largely rural Alaskan environment. Second, recognition that political and economic pressures for national health care reform require all federal health care providers to work more closely together to accomplish their individual organizational missions.

Operating Authority

The AFHCP is an interagency initiative without specific legislative authorization. It assumes its legislative interagency acquisition authority from the Economy Act (1999)³. Specific procedural rules on interagency acquisition are elaborated on in the Federal Acquisition Regulation (FAR), Subpart 17.5 (1997).

Economy Act. The Economy Act authorizes certain personnel within a federal agency to place an order for goods or services within that same agency or with another agency if:

1. the requested amounts are available;

³ The relationship between the DOD and VA is also governed by 38 USCS § 8111 ("Veteran's Administration and the Department of Defense Health Resources Sharing and Emergency Operations Act", Public Law 97-174) and, secondarily, by 10 USC § 1104 which authorizes the DOD to share health care resources with the VA. However, these Acts contain legislative guidance relevant to Coast Guard involvement in the AFHCP only when the USCG is operating as an entity of the DOD (U.S. Navy) pursuant to 14 USC § 3.

2. the ordering official decides the order is in the best interest of the US Government;
3. the agency or unit filling the order is able to provide or acquire via contract the ordered goods or services; and
4. the requesting agency decides that the order cannot be provided by contract as conveniently or inexpensively as by a commercial enterprise.

The Economy Act authorizes agencies to enter into mutual agreements to obtain supplies or services by interagency acquisition, but may not be used by an agency to circumvent regulations regarding the proper use of funds. Nor does it exempt agencies from complying with regulations regarding certain uses of contractors. Finally, the Economy Act may not be used contrary to an agency's authority or responsibility.

FAR, Subpart 17.5. Subpart 17.5 of the FAR elaborates on the scope and application of the Economy Act. It starts by defining interagency acquisition as "a procedure by which an agency needing supplies or services (the requesting agency) obtains them from another agency (the servicing agency)" (p. 365). The FAR provides specific guidance on the type and detail of procurement analysis required to complete a valid Economy Act transaction. This analysis is called a Determination & Findings (D&F). The FAR requires a D&F suitable for the requesting agency's contracting officer to place the order with the servicing agency. Once the particulars of the order (i.e., description of goods or services, delivery requirements, funds citation and payment procedures, dispute resolutions provisions, etc.) are agreed upon, the agencies may either begin the exchange of goods or services, expand the use of an existing contract, and/or enter into a new contract. Finally, the agencies may opt to execute a formal Interagency Agreement (IA) stipulating the precise terms of the relationship.

Alaska Federal Health Care Partnership Agreement

Based on the Economy Act and FAR 17.5, the AFHCP executed a comprehensive multi-agency IA called the Alaska Federal Health Care Partnership Agreement (AFHCPA). The AFHCPA governs both individual operating agreements for professional health care services and sharing of health care resources between member agencies. The AFHCPA specifies that the interagency relationships shall not hamper access of federal beneficiaries to the health care agency or facility primarily responsible for their care nor diminish the quality of care. On the contrary, the intent of the AFHCPA is to expand the ability of each party to more effectively and efficiently meet its obligations to its respective beneficiaries. The AFHCPA also gives concise guidance on the responsibilities of the signatory parties, calculations of charges, reimbursement methods, and procedures for establishing new operating agreements and resource-sharing projects.

US Coast Guard

General

The Coast Guard is an agency of the DOT and has been given statutory authority for maritime missions including but not limited to: enforcement of federal laws and treaties; regulation of commercial and recreational vessel safety; search and rescue; and environmental protection. However, under 14 U.S.C. § 1 (1976), the USCG is also considered a military service and a branch of the armed forces. Thus, 10 U.S.C. § 1074, in effect, deems the USCG health care system as part of the MHS. This statute is cited in a Memorandum of Understanding between the DOD and the Coast Guard's Director of Health and Safety concerning USCG participation in TRICARE (1997).

Mission of the Health Services Program

According to the USCG Medical Manual (US Coast Guard, 1998), the mission statement of the Coast Guard's Health Services Program (HSP) is:

The Health Services Program supports Coast Guard missions by providing quality health care to maintain a fit and healthy active duty corps, by meeting the health care needs of dependents and retirees to the maximum extent permitted by law and resources, and by providing authorized occupational health services to civilian employees. (p. 1-1).

To guide that mission statement, the chief executive of the Coast Guard, the Commandant, has goals for the HSP to the Director of Health and Safety. Current goals include:

1. reducing the high out-of-pocket costs of health care in Alaska;
2. providing a TRICARE Prime benefit for families in locations far from MTFs;
3. getting members removed from paying providers directly;
4. obtaining portability of benefits regardless of relocation; and
5. increasing access to primary care for active duty members.

Interagency Cooperation

To help fulfill the HSP mission and meet the Commandant's priorities, the USCG Medical Manual (1998) requires the Director of Health and Safety to counsel and advise the Commandant on interdepartmental and interservice agreements related to the provision of health care for Coast Guard personnel, and "maintain[s] liaison with the Public Health Service, the Department of Veterans Affairs, the Department of Defense, and other Federal agencies and serve[s] on interservice boards and committees as appointed" (p. 1-1). This authority is further delegated to the commander of the Atlantic Maintenance and Logistics Command (MLC) and the commander of the Pacific MLC. Title 14 USC § 141 (1996) allows the USCG to assist and be assisted by

other federal agencies to the extent that it is helpful in the performance of its duties. This legislative language authorizes the USCG to cooperate with other agencies in mutually beneficial endeavors such as the AFHCP. The Chief of the Health and Safety Division of the Pacific MLC, a subordinate of the Pacific MLC commander, is the AFHCP signatory for the USCG. Finally, the heads of the various USCG clinics are charged by regulation to, “participate in health care initiatives with local/regional DOD delivery systems, under Headquarters and MLC guidance” (p. 1-14).

In addition to the DOD/USCG Memorandum of Agreement regarding TRICARE, there is another national interagency agreement between the Coast Guard and the DVA regarding how the DVA furnishes medical services to the USCG. The agreement is over 20 years old but remains in effect. There are also several, more specific, local VA/USCG medical services agreements in effect at a few clinics (A. Walker, personal communication, September 16, 1999).

Control of Clinics

Each clinic is under the technical control of one of the two MLCs, the regional offices responsible for non-operations functions of the USCG. The MLCs often assist the clinics in coordinating health care services for the OPFACs. Operational control of clinics is delegated to a local unit commander to ensure a clinic’s operations are integral to the Coast Guard’s local operational focus. This matrix relationship means that each clinic is accountable to its MLC’s Chief of the Health and Safety Division for its health care budget, beneficiary services, major procurements, contracts, etc., and to its local commander for its daily operations and administrative budget.

Programs Involving the USCG.

As stated in the AFHCPA (1998), the mission of the AFHCP is to “provide our beneficiaries ready access to customer oriented, quality, comprehensive, cost effective health care” (p. 1). To execute this mission, the Partnership has codified all its cooperative arrangements under the AFHCPA by formalizing sundry informal operating relationships, consolidating old interagency support agreements, and documenting new ones. The three primary Partnership project types that have involved the USCG are joint contracting, revenue recapture, and use of technology.

Joint contracting allows AFHCP units to pool their respective patient populations to achieve cost avoidance by taking advantage of large volume discounts from private health care providers and equipment and supplies vendors. The USCG is included in several AFHCP contracts.

Revenue recapture projects optimize the use of each facility’s excess capacity to reduce payments to non-government providers. In this way, patients using health care services outside of federal facilities are “recaptured” back into federal facilities under resource sharing agreements and money is saved. The USCG is provided services in several venues by specialists visiting from other AFHCP-affiliated health care facilities.

The use of technology has been a critical element of the Partnership’s success. Technology has, in effect, mitigated Alaska’s extremes in climate and distance. Two Alaskan USCG clinics are involved in using digital tele-radiology technology with 3rd Medical Group for clinical interpretation of radiographs (x-rays).

Program Evaluation

Veney and Kaluzny (1998a) defined evaluation as the collection and analysis of information by various methods. They stated that the various objectives of evaluation are to determine the relevance, adequacy, progress, effectiveness, impact, sustainability, or efficiency of a set of program activities. The object of efficiency evaluation is to determine whether program results could be obtained less expensively. Efficiency is most often assessed by comparing program costs to program outcomes.

There are three basic methods of cost to outcome evaluation: cost-utility analysis, cost-effectiveness analysis, and cost-benefit analysis. Of these three types, cost-benefit analysis (CBA) is the most theoretically sound method of economic evaluation, because it attempts to quantify, to the maximum amount practicable, a dollar value input per dollar value output relationship (Veney & Kaluzny, 1998b).

Cost-Benefit Analysis

There is a tremendous body of literature on methods of CBA, sometimes referred to as benefit-cost analysis. Elixhauser, Halpern, Schmier, and Luce (1998) reviewed 3,539 articles in the literature from 1991 to 1996 on the topics of CBA and cost-effectiveness analysis (CEA) in personal health services. They described the trends in the literature, reviewed characteristics of CBA and CEA studies, and classified studies into specific topic areas. Nearly 36% of the studies (1,265) reviewed were classified as commentary on CBA and CEA or articles addressing CBA or CEA methodology. The sheer volume of these articles demonstrates the wide variation in CBA and CEA methodology. These commentaries and variations in methodology highlight evaluators' disagreement over which cost and benefit elements to quantify, to what level of detail, and how to assign them.

The “Balance-Sheet” Approach to CBA. McIntosh, Donaldson, and Ryan (1999)

attempted to address such disagreements by advancing a method of CBA called the “balance-sheet” approach, originally proposed by Lichfield (1968) as a means of including unquantifiable benefits as important in CBA evaluation. Due to its uniqueness, Lichfield’s balance-sheet method has rarely been used since its introduction. The balance-sheet approach identifies who bears the costs and who reaps the benefits from any program change. Changes in quantifiable and unquantifiable costs and benefits are measured in units, in effect, reflecting the health care triad—dollars, access, and quality. Positive or negative changes in cost are listed in the left column of the balance-sheet. Positive or negative changes in benefit are listed in the right column of the balance-sheet. Table 2 gives a hypothetical example of the balance-sheet approach proposed by McIntosh et al (1999).

Table 2

Hypothetical Example of the Balance-Sheet Approach in Evaluating a One-Hour Increase in Outpatient Clinic Hours to Improve Patient Access

Costs (positive or negative)	Benefits (positive or negative)
\$250 - Increased revenues	Improved patient satisfaction
\$100 - Increased hourly staff wages	Earlier treatment of emergent conditions
\$25 - Increased supply consumption	Fewer after-hours visits to the ER
\$10 - Increased facilities support costs	Greater patient scheduling flexibility
Decreased staff satisfaction and endurance	

The balance-sheet approach facilitates consideration of the quantifiable and unquantifiable opportunity costs of change. As such, the balance-sheet approach provides the evaluator with a powerful decision-making tool which allows for comprehensive evaluation of all decision factors rather than using cost-benefit ratio as the sole decision criterion.

Purpose

The purpose of this research effort is to determine if the AFHCP programs involving the USCG clinics in Alaska are viable options for other remote USCG clinics outside of Alaska. There are two supporting objectives to this effort. The first is to assess and document the costs and benefits realized by Alaskan USCG clinics from their involvement in AFHCP programs. The second seeks to determine which, if any, of these programs can be implemented at which, if any, remote USCG clinics outside of Alaska.

Objective 1

Knowledge of the success of the AFHCP has become widespread. Some believe the future viability of federal health care will rely on broader implementation of such joint interagency partnerships (L. Naehr, personal communication, September 8, 1999). By identifying the costs and benefits of these interagency support activities, the USCG is provided with a better understanding of its current position in the federal health care environment and a theoretical framework for evaluating other partnership opportunities in the future.

Objective 2

The USCG health care system is both an integral part of the MHS and a system unto itself. The system relies on a variety of health care delivery modalities to create the health care support infrastructure necessary to support the organization's missions, its people, and their loved ones. By identifying gaps in and opportunities for improving that infrastructure and recommending

potential new solutions, the USCG health care system will be enhanced as will its ability to support the organization's missions and care for its beneficiaries.

CHAPTER 2: METHOD AND PROCEDURES

Ethical Considerations

The investigator considered ethical issues with this research effort. Data on patient populations and clinic staff composition were collected. However, neither patient-level nor provider-specific data was sought or used. Government contracts were reviewed during data collection, but all information contained therein was in the public domain and subject to disclosure under the Freedom of Information Act (1974). The potential for research bias, based on the researcher's former involvement as a member of the AFHCP Planning Committee briefly in 1996 and former assignment as clinic administrator of the Coast Guard's Kodiak clinic from April 1995 to May 1998, resulted in special attention by the researcher to maintain impartiality and objectivity. Due to the nature of the data and the intent of the study, the researcher found no other significant ethical concerns.

Assumptions

The research effort relied on several assumptions. First, it was assumed that relevant, accurate information about the true costs and benefits of USCG participation in the various AFHCP programs could be found. It was also assumed that there are practical opportunities to apply similar initiatives beneficially at some USCG clinics in locations outside Alaska. However, the researcher understood that there may not have been full disclosure by data sources of the true costs and benefits of the AFHCP in hopes of preserving the stellar reputation of the organization. Similarly, the researcher understood that there may not have been full disclosure by data sources of the true needs of non-Alaskan USCG clinics for fear of creating errant impressions, potentially resulting in embarrassment to the USCG or its members. Finally, it was

assumed that AFHCP-based initiatives are viable options for meeting some non-Alaskan USCG clinics' needs without adversely impacting their current health care delivery operations.

Objective 1

Data Sources

The primary sources of data to support the first objective were the staff and documents of the AFHCP PSO, the Health and Safety Division of the Pacific MLC, the four Alaskan clinics, and personal knowledge. The data collected were background information and financial and utilization figures regarding USCG involvement in AFHCP programs. Data on resultant changes in access to and quality of care from USCG participation in the AFHCP were also sought from these sources. The period under study was Fiscal Year 1997 (FY97) through FY99 (October 1, 1996 through September 30, 1999). This three-year period was selected for three reasons:

1. Prior to FY97 there was little organized data collection about AFHCP initiatives;
2. It allowed for definitive endpoints for accounting purposes; and
3. It covers a majority and the most mature period the Partnership has been operating.

Method and Procedures

The first step in the analysis was to identify which of the many AFHCP initiatives involved the Coast Guard, how, and to what extent. That data was obtained from the sources using a variety of means such as site visits, on-site and telephone interviews, official records, and electronic transmission of raw data contained in internal documents such as spreadsheets and reports. Any manipulations or calculations based on the sources' data are explained in the applicable Results section. The CBA balance-sheet approach described by McIntosh et al (1999) was applied. The balance-sheet assumed a Coast Guard perspective in assigning who bore the costs and who reaped the benefits from AFHCP programs at the Alaskan clinics. Changes in

quantifiable and unquantifiable costs and benefits were listed to reflect changes in the health care triad—dollars, access, and quality. Positive or negative changes in USCG resources (i.e., costs) were listed in the left column of the balance-sheet. Positive or negative changes in effects on patients' well-being (i.e., benefits) were listed in the right column of the balance-sheet. Cost and benefit factors were quantified in measurable units when practicable. Otherwise these factors were listed narratively. To improve the format proposed by McIntosh et al (1999) and enhance clarity of the data presented, positive costs and benefits were identified with a positive sign (+) and negative costs and benefits were identified with a negative sign (-). One balance-sheet was created for each AFHCP initiative benefiting the USCG. All available data for the study period was aggregated on that balance-sheet. Not all program types were present in each clinic in each FY. Any known missing data was identified in footnotes to the various balance-sheets. Other cost and benefit factors of USCG involvement in the AFHCP were described and presented separately.

Psychometrics

Validity

Validity describes whether a measure accurately assesses the values it purports relevant to a stated goal (Veney & Kaluzny, 1998c). The impetus of Objective 1 was to be inclusive of as many variables as possible, not just quantifiable ones, to describe the degree of success the AFHCP has had in achieving the HSP mission in Alaska. This inclusiveness of quantifiable and unquantifiable, objective and subjective data allowed a broader assessment of goal attainment. Therefore, validity of the methods for this objective was higher than using monetary data alone.

Reliability

A measure is considered reliable to the extent that its repeated application to the same phenomenon yields the same value (Griffith, 1995). This objective's reliability was dependent on the depth and quality of the data supplied by the sources, whether and how the researcher quantified costs and benefits, and the researcher's determination of how best to categorize costs and benefits. Factors which may have been reasonably expected to impact source data quality were accounting practices (i.e., variations in cost allocation strategies, data collection methods, etc.) and human factors (i.e., calculation errors, subjective opinions). Economic evaluations of health care services are contentious. This study employed a somewhat unorthodox CBA methodology. Therefore, there was room for varying interpretations of what constitutes quantifiable versus unquantifiable costs and benefits, how best to quantify them, and how to assign them to the balance-sheet.

Objective 2

Data Sources

The primary sources of data to support the second objective were the staff and records of the Health and Safety Divisions of the Pacific and Atlantic MLCs. These sources provided objective geographic, demographic, and administrative data on the USCG clinics in their respective AORs as of the end of FY99. Senior staff of each MLC Health and Safety Division also provided subjective insight into current and future operations of the HSP and information about their own MLC AORs.

Method and Procedures

An assessment of the relevance and potential of federal health care partnership initiatives at remote (greater than 50 miles from a major DOD referral MTF) non-Alaskan USCG clinic

locations was performed through review of objective geographic, descriptive, and population data about all USCG clinics provided by the staffs of the MLCs. The greater than 50-mile distance standard was chosen as a proxy because that is the required distance for TPR eligibility for remotely assigned personnel.

Based on the data provided, all USCG clinics were segregated according to MLC (Pacific or Atlantic) AOR. The distance between each clinic and the nearest major DOD referral MTF and the name and/or location of that MTF was noted. Clinics more than 50 miles from a major DOD referral MTF were identified as remote.

Next, the total number of active duty and dependent beneficiaries affiliated with the OPFACs in each remote clinic's AOR, including OPFACs overseen by IDTs supported by that clinic, was summed. This number was termed the "AOR population." Of those beneficiaries, the number of beneficiaries actually receiving primary care at the clinic was summed. This number was termed the "care population." By dividing a clinic's care population by its AOR population, the number of beneficiaries actually receiving primary care at the clinic was expressed as a percentage of the total number of beneficiaries in the clinic's AOR. This percentage is, in effect, a measure of population concentration in each clinic AOR. For example, if a clinic's AOR population was 1000 and its care population was 600, then the population concentration was 60%. A higher number indicates greater concentration of beneficiaries receiving their primary care at the clinic. Because the individual clinic is the hub of Coast Guard health care delivery for its AORs, this measure is useful as a determinant of the potential success of interagency revenue recapture initiatives which rely on the presence of clinical facilities.

Information about pharmaceutical, medical, and surgical supplies procurement processes for the clinics was also assessed. The hierarchies for these procurement and supply processes

were reviewed and described. These relationships were also considered useful as a determinant of the potential success of interagency joint contracting initiatives.

Objective geographic, demographic, and administrative information from the MLCs was supplemented with interview data collected from the senior staff of the respective Health and Safety Divisions of the MLCs. Interview questions focused on:

1. current challenges facing the MLCs;
2. problems common to the clinics in their AOR;
3. clinics with unique issues and what those issues are;
4. future goals for their AOR; and
5. perspective of the potential for federal health care partnerships to improve health care in their AOR.

Psychometrics

Validity

Here the issue is whether the method employed was an accurate measure of the appropriateness of a potential AFHCP-based solution. The method employed relied on subjective interpretation of objective information and interviewees' opinions regarding the state of the HSP in their AOR. Interviewee perspective was a critical variant. The researcher might well have elicited disparate answers from personnel at different levels in the organization.

Reliability

The reliability of this objective relied heavily on the objective geographic, demographic, and administrative data provided by the MLC and the subjective views of interviewees and the researcher. The results of this research method used by others may be similar, but not identical. Sources which might have contributed to low reliability are: incorrect perceptions, incomplete

information, or personal biases of those interviewed about the state of the HSP. Other sources of low reliability included varying interpretations of: clinic descriptions, patient population information, patient utilization and referral patterns, and interpretations of interviewees' input.

CHAPTER 3: RESULTS

Objective 1

Joint Contracting Initiatives

Statewide Air Ambulance Services

Neonatal, pediatric, and adult air ambulance services were provided for the USCG throughout the state of Alaska via an AFHCP contract with Providence Lifeguard in FY97, FY98, and most of FY99. On June 1, 1999, a new vendor, Aeromed International, part of the Yukon-Kuskokwim Health Corporation, began providing air ambulance services for pediatric and adult patients. Providence Lifeguard remained the vendor for neonatal air ambulance services statewide. The terms of the contracts called for a 50% discount for air ambulance services for all AFHCP beneficiaries (L. Anderson, personal communication, January 26, 2000). Table 3 shows the balance-sheet evaluation for all statewide air ambulance services for all USCG clinics for FY97 through FY99.

Table 3

Balance-Sheet Evaluation: Statewide Air Ambulance Services

Costs (positive and negative)	Benefits (positive and negative)
(+) \$74,603 in cost avoidance (50% discount) ^a	(+) Quicker transport to sources of definitive
(+) In some cases, avoided use of a USCG HC-130 aircraft (\$5,336 per hour to operate) ^b	care for an average of 10 patients per year
(+) Not required to draft or review Request for Proposals or award contract	(+) Lower patient mortality and morbidity likely
(-) Training required for USCG personnel to learn proper procedure for accessing services	(+) Improved patient and family satisfaction

Note. Source: B. Thomas, Pacific MLC representative to AFHCP Planning Committee (personal communication, September 24, 1999).

^a An additional \$36,000 could have been saved through better-informed use of the contract.

^b Unable to determine which cases, because no such data was kept by the USCG.

Pharmaceutical, Medical, and Surgical Supplies

The USCG was part of the DOD's nationwide Prime Vendor purchasing contracts for pharmaceutical, medical, and surgical supplies (R. Rist, personal communication, September 22, 1999). However, these Prime Vendors' prices were sometimes higher than prices under regional contracts (D. Pratt, personal communication, September 24, 1999). This was true in Alaska as well. To ensure the least expensive procurements, Alaskan clinics sometimes used a contract the AFHCP established with Johnson and Johnson Health Care Systems in FY97 to purchase pharmaceuticals and a few medical and surgical supplies (T. Palmer, personal communication,

March 3, 2000). The terms of the contract called for a 1% discount on all purchases and a 5% discount on all purchase growth from one calendar year to the next (L. Anderson, personal communication, January 26, 2000). Table 4 shows the balance-sheet evaluation for these purchases for all clinics for FY97 through FY99.

Table 4

Balance-Sheet Evaluation: Pharmaceuticals, Medical, and Surgical Supplies Contract

Costs (positive and negative)	Benefits (positive and negative)
(+) \$891 in cost avoidance	None (aside from indirect positive benefit of
(+) Not required to draft or review Request for	lower government expenditures)
Proposals or award contract	
(-) Process variation in ordering resulted in less	
staff efficiency	

Note. Source: C. Jackson, staff member of AFHCP PSO (personal communication, January 19, 2000).

Revenue Recapture Initiatives

Visits by USAF Specialty Providers

There were several thousand USCG health care beneficiaries on Kodiak Island. Neither the Coast Guard's Kodiak clinic nor the local community hospital could accommodate all of their health care needs. Travel and per diem to receive non-elective medical care was an entitlement for active duty dependents assigned with their sponsor outside the continental US. Therefore, the USCG provided or paid for the trips when medical travel was required. These

beneficiaries were usually transported to 3rd Medical Group at government expense via a bi-weekly USCG HC-130 transport aircraft sortie for specialty care. Rather than paying the travel and per diem expenses for these patients, the Coast Guard arranged to have 3rd Medical Group specialty care providers visit Kodiak periodically to see patients. Table 5 shows the balance-sheet evaluation of visits by USAF specialty providers to the Kodiak clinic for FY97 through FY99.

Table 5

Balance-Sheet Evaluation: Visits by USAF Specialty Providers

Costs (positive and negative)	Benefits (positive and negative)
(+) \$116,969 in patient travel and per diem saved	(+) Improved patient and family satisfaction
(+) Increased availability of USCG HC-130 aircraft for other operational commitments	(+) Decreased out-of-pocket costs for patients
(-) \$15,639 for provider travel and per diem spent	(+) In-service training for clinic staff provided by specialists
(-) Man-hours required to help develop requirements and coordinate visits	(+) Opportunity for immediate referral of emergent cases during specialists' visits
	(-) Longer patient referral intervals ^a

Note. Source: T. Palmer, clinic administrator of Kodiak clinic (personal communication, February 3, 2000).

^a Longer patient referral intervals were the result of some patients having to wait for a sufficient number of referrals to justify a visit by the specialist or accommodate the specialist's schedule.

DVA Audiology Program

Under an AFHCP operating agreement with the DVA, the clinics in Alaska were visited by a DVA audiologist from Anchorage who performed screening and diagnostic audiology services for USCG beneficiaries. In exchange, the clinic provided an exam room and consumable medical supplies at no cost so the audiologist could also see DVA beneficiaries in the clinic. The DVA paid all travel and per diem expenses for their provider. This program began in FY98 and operated at varying frequencies at all four clinics. Table 6 shows the balance-sheet evaluation of VA audiologist visits FY98 and FY99.

Table 6

Balance-Sheet Evaluation: DVA Audiology Program^a

Costs (positive and negative)	Benefits (positive and negative)
(+) \$28,894 in patient travel and per diem costs saved ^b	(+) Improved patient and family satisfaction
(-) Staff man-hours required to help develop requirements for, draft, review, and sign operating agreement	(+) In-service training for clinic staff provided by audiologist
(-) Lost one clinic exam room on day of visit	(+) Opportunity for immediate referral of emergent cases during audiologist's visit
(-) Minimal costs for consumable medical supplies	(-) Longer patient referral intervals ^c

Note. Source: C. Jackson, staff member AFHCP PSO (personal communication, January 19, 2000).

^aData includes all of FY98 and only 1st and 2nd quarter of FY99.

^bThough not included in the analysis, the DVA realized a \$38,997 savings under this program by not having to transport their beneficiaries to Anchorage for care.

^cLonger patient referral intervals were the result of some patients having to wait for a sufficient number of referrals to accumulate to justify a visit by the audiologist or accommodate the audiologists schedule.

Use Of Technology InitiativesTele-Radiology Program

Only two of the four USCG clinic locations in Alaska, Kodiak and Ketchikan, operated

ray machines. Their capabilities were limited to basic radiographic examinations; they did not perform mammography, fluoroscopy, or any invasive or contrast imaging studies. For years these clinics used a contract with Virginia Mason hospital in Seattle to interpret their radiographs. Radiographs were mailed back and forth via the US Postal Service. In FY98, the AFHCP helped coordinate the installation of and connections for digital tele-radiology units at Kodiak and Ketchikan. The equipment was purchased and installed for the USCG using federally appropriated funds from the Akamai Telemedicine Project in Hawaii. Operations began in early FY99. After completing the x-rays, the USCG technician converted the films to a digital file and transmitted them electronically to a staff radiologist at 3rd Medical Group who interpreted them. The radiologist returned his report electronically to the originating clinic's provider via the Composite Health Care System (CHCS). This entire process usually took less than one business day. The operating agreement between 3rd Medical Group and the USCG stated that the USCG compensated 3rd Medical Group at 85% of the current CHAMPUS Maximum Allowable Charge (CMAC) for professional interpretation of x-rays, not including Technical or Global charges. To date, there have been no charges to the Coast Guard, but billing is forthcoming (C. Marcus, personal communication, March 3, 2000). Table 7 shows the balance-sheet evaluation of the tele-radiology program at the Kodiak and Ketchikan clinics for FY99.

Table 7

Balance-Sheet Evaluation: Tele-Radiology Program^a

Costs (positive and negative)	Benefits (positive and negative)
(+) \$1001 in private interpretation costs saved ^b	(+) Improved patient and family satisfaction
(+) Digitizing equipment provided and installed at no cost	(+) 6-20 day quicker turnaround time for interpretation
(+) Data transmission used pre-existing USCG wide-area network	(+) Nearly immediate x-ray interpretation for emergent cases ^c
(-) Staff man-hours required to help develop requirements and coordinate installation	(+) Direct consultation between primary care physician and radiologist on complex cases
(-) X-Ray machine down-time to install new digitizing equipment and train x-ray technician	(-) Slight loss in image quality occurred during the analog to digital conversion which resulted in negligible degradation of quality of care.

Note. Sources: T. Palmer, clinic administrator at Kodiak clinic (personal communication, February 3, 2000 and March 6, 2000); S. Heverly, clinic administrator at Ketchikan clinic (personal communication, February 9, 2000), and D. Vandenberg, chief radiologist at 3rd Medical Group (personal communication, February 7, 2000).

^a Initiative began January 1999 at Kodiak and July 1999 at Ketchikan

^b \$860 at Kodiak and \$141 at Ketchikan. See Appendix B for calculation of savings.

^c The USCG provider need only call ahead to 3rd Medical Group to notify radiologist

Other Cost and Benefit Factors

There were some general cost and benefit factors of USCG involvement in the AFHCP not directly related to any specific initiative. These factors were included in the evaluation.

Cost Factors

The USCG had to commit resources to participate in the AFHCP. It had personnel assigned to both the Executive Committee and the Planning Committee. In FY97 through FY99 the Executive Committee met an average of twice annually while the Planning Committee met quarterly. The USCG paid the travel and per diem costs for its representatives to attend these meetings in Anchorage, Alaska. The total travel and per diem costs from FY97 through FY99 were \$23,400, not including the opportunity costs of the members' lost productivity (B. Thomas, personal communication, September 24, 1999).

The partner agencies of the AFHCP were asked to help fund the establishment, capitalization, and non-salary operating expenses of the PSO. The USCG contributed \$1000 (0.3% of total PSO budget) toward these expenses in FY97 through FY99.

Partnership agencies routinely shared personnel to cover critical staffing shortages across the federal facilities. In fact, there was an operating agreement within the AFHCPA describing interfacility provider credentials and privileges for that purpose. In FY97, the Kodiak clinic authorized one of its staff nurses, certified in operating room nursing, to work for two weeks in the operating rooms at BACH in Fairbanks to bridge a critical nurse shortage there. The Army paid for the travel and per diem expenses for the nurse, but the salary cost and opportunity cost of not having the nurse on staff at Kodiak during that time were borne by the Coast Guard.

Benefit Factors

Not all miscellaneous factors of USCG involvement in the AFHCP were costs. One benefit of the USCG nurse working at BACH was that she maintained competency in her specialty. The AFHCP had contracts with local private health care providers for inpatient and outpatient care and urology, cardiology, and radiation oncology services. While the USCG was not a direct participant in these contracts, it benefited by 3rd Medical Group's involvement in them. The USCG clinics referred most of their patients to 3rd Medical Group for specialty care. Third Medical Group may have further referred USCG beneficiaries to one of these private health care contractors in Anchorage. If so, 3rd Medical Group paid the contractor the AFHCP-contracted rate and billed the USCG at that rate.

In FY99, two staff members from the Kodiak clinic were invited to participate in Partnership-coordinated medical education initiatives in Anchorage. First, the Quality Assurance Coordinator (QAC) from the Kodiak clinic participated via teleconference in weekend preparation sessions with other Partnership QACs studying to gain certification as a Certified Professional in Healthcare. Second, a physician's assistant from the Kodiak clinic attended a seminar on pediatric urology and gained knowledge as well as continuing medical education credits (D. Strother, personal communication, January 19, 2000).

Objective 2

Identification of Remote Clinics

Pacific MLC

Table 8 lists all clinics in the Pacific MLC AOR, the nearest major DOD referral MTF to that clinic, and the distance from that clinic to that MTF. Remote clinics are those more than 50 miles from a major DOD referral MTF.

Table 8

USCG Pacific MLC Clinics, Nearest Major DOD Referral MTF, and Distances Between

USCG Clinic	Nearest Major DOD MTF	Distance (miles)
Humboldt Bay, CA	Travis AFB, CA	305
Petaluma, CA	Travis AFB, CA	62
Alameda, CA	Travis AFB, CA	53
San Pedro, CA	Camp Pendleton, CA	83
Astoria, OR	Fort Lewis, WA	152
North Bend, OR	Fort Lewis, WA	351
Port Angeles, WA	Bremerton Naval Base, WA	80
Seattle, WA	Fort Lewis, WA	40
Honolulu, HI	Tripler Army Medical Center, HI	2
Kodiak, AK ^a	Elmendorf AFB, AK	270
Juneau, AK ^a	Elmendorf AFB, AK	540
Sitka, AK ^a	Elmendorf AFB, AK	570
Ketchikan, AK ^a	Bremerton Naval Base, WA	780

Note. Sources: D. Parker, staff member of Pacific MLC Health and Safety Division (personal communication, September 16, 1999).

^a AFHCP members included for comparison.

Atlantic MLC

Table 9 lists all clinics in the Atlantic MLC AOR, the nearest major DOD referral MTF to that clinic, and the distance from that clinic to that MTF. Remote clinics are those more than 50 miles from a major DOD referral MTF.

Table 9

USCG Atlantic MLC Clinics, Nearest Major DOD Referral MTF, and Distances Between

USCG Clinic	Nearest Major DOD MTF	Distance (miles)
New London, CT	Groton Naval Submarine Base, CT	5
Boston, MA	Newport Naval Clinic, RI	75
Cape Cod, MA	Newport Naval Clinic, RI	70
Cape May, NJ	Bethesda Naval Medical Center, MD	125
Elizabeth City, NC	Portsmouth Naval Base, VA	65
Washington, D.C.	Walter Reed Army Medical Center, D.C.	10
Clearwater, FL	MacDill AFB, FL	30
Yorktown, VA	Portsmouth Naval Base, VA	40
Mobile, AL	Keesler AFB, MS	60
Portsmouth, VA	Portsmouth Naval Base, VA	10
Borinquen, PR	Roosevelt Roads Naval Hospital, PR	20
Miami Beach, FL	MacDill AFB, FL	290
Miami, FL	MacDill AFB, FL	280
Traverse City, MI	Great Lakes Naval Training Center, IL	355
New Orleans, LA	Keesler AFB, MS	80
Baltimore, MD	Bethesda Naval Medical Center, MD	35

Note. Sources: L. Hooper, staff member of Atlantic MLC Health and Safety Division (personal communication, September 24, 1999).

Table 8 shows that, aside from the Alaskan clinics, the following seven Pacific MLC clinics are remote: Humboldt Bay, Petaluma, Alameda, San Pedro, Astoria, North Bend, and Port

Angeles. Table 9 shows the following nine Atlantic MLC clinics are remote: Boston, Cape Cod, Cape May, Elizabeth City, Mobile, Miami Beach, Miami, Traverse City, and New Orleans.

Populations and Population Concentration

Table 10 shows the AOR population, care population, and population concentration for each of the seven remote Pacific MLC clinics. Table 11 shows the AOR population, care population, and population concentration for each of the nine remote Atlantic MLC clinics.

Table 10

Remote Pacific MLC Clinics, AOR Populations, Care Populations, and PopulationConcentrations

USCG Clinic	AOR Population	Care Population	Population Concentration
Humboldt Bay, CA	490	403	82%
Petaluma, CA	1725	1711	99%
Alameda, CA	5896	5094	86%
San Pedro, CA	3173	1038	33%
Astoria, OR	1943	1375	71%
North Bend, OR	1060	756	71%
Port Angeles, WA	701	526	75%
Kodiak, AK ^a	2636	2573	98%
Juneau, AK ^a	888	529	60%
Sitka, AK ^a	581	512	88%
Ketchikan, AK ^a	595	595	65%

Note. Sources: D. Parker, staff member of Pacific MLC Health and Safety Division (personal communication, September 16, 1999).

^a AFHCP members included for comparison.

Table 11

Remote Atlantic MLC Clinics, AOR Populations, Care Populations, and PopulationConcentrations

USCG Clinic	AOR Population	Care Population	Population Concentration
Boston, MA	3883	2175	56%
Cape Cod, MA	2913	1528	52%
Cape May, NJ	3688	2958	80%
Elizabeth City, NC	4378	1751	40%
Mobile, AL	4189	1169	28%
Miami Beach, FL	2746	2265	82%
Miami, FL	2447	1146	47%
Traverse City, MI	4512	348	8%
New Orleans, LA	4604	1975	43%

Note. Sources: L. Hooper, staff member of USCG Atlantic MLC Health and Safety Division

(personal communication, September 24, 1999).

Pharmaceutical, Medical, and Surgical Supply Procurement

The Coast Guard used a tiered approach to procuring pharmaceutical, medical, and surgical supplies through DOD national Prime Vendor purchasing contracts. Clinics with pharmacists were responsible for supervising the pharmacy operations and pharmaceutical procurement processes of clinics without pharmacists in the MLCs. The pharmacy supervision AORs were different from clinics' geographic AORs. If a clinic without a pharmacist needed pharmaceuticals, it notified its supervising pharmacist who validated the order, requested the

items from the Prime Vendor, debited the requesting clinic's budget account, and arranged to have the items sent directly to the requesting clinic.

The Pacific MLC organized the medical and surgical supply hierarchy to parallel the pharmaceutical supply hierarchy. Medical and surgical supplies for all clinics were ordered through the clinics with pharmacists (R. Rist, personal communication, March 9, 2000).

In the Atlantic MLC, the pharmaceutical procurement process was similar to that in the Pacific MLC. However, each clinic ordered its own medical and surgical supplies regardless of whether or not it had a pharmacist on staff (L. Hooper, personal communication, March 9, 2000).

Input from the MLC Staffs

T. Slack, Chief of the Managed Care section of the Atlantic MLC, and G. Anderson, Chief of the Medical Administration branch of the Pacific MLC, were both familiar with the AFHCP and other interagency federal health care programs. These senior staff members from the two MLC Health and Safety Divisions were interviewed regarding:

1. current challenges facing their MLC;
2. problems common to the clinics in their AOR;
3. clinics with unique issues and what those issues are;
4. future goals for their AOR; and
5. perspective of the potential of federal health care partnerships to improve health care in their AOR.

Current MLC Challenges

Both Slack and Anderson felt the greatest challenge facing their MLCs is integrating TRICARE programs, such as TPR, with existing Coast Guard health care programs, such as the PMSs, contracts with local private providers, and non-federal supplemental care policies. The

challenge is to ensure that every active duty service member and his/her dependents have equity in and access to quality health care regardless of OPFAC (T. Slack, personal communication, February 3, 2000; G. Anderson, personal communication, February 3, 2000).

Problems Common to Clinics

The problem found to be most common in the clinics of both MLCs relates to the integration of TRICARE. The essence of the problem is the lack of staff knowledge about TRICARE benefits and the resultant inability to adequately transfer that knowledge to beneficiaries. In its efforts to ensure that every active duty service member and his/her dependents have equity in and access to quality health care, the Coast Guard has to tailor its health care programs and policies to fit the needs of each OPFAC. The result is multifarious programs and policies varying even between PMSs in the same clinic AOR. That potential for obfuscation, along with the confusion of similar variations in TRICARE, make keeping staff abreast of health benefits information, and passing that information on to beneficiaries, daunting (T. Slack, personal communication, February 3, 2000; G. Anderson, personal communication, February 3, 2000).

Clinics with Special Challenges

In the Pacific MLC AOR, the most challenging clinics are Kodiak, AK, and San Pedro, CA. Even in light of the success of the AFHCP visiting USAF specialists provider program in Kodiak, there is a lingering lack of specialty care for a relatively large care population. In San Pedro, the problem is the reverse; the clinic is not located near enough to the OPFACs and too much primary care is delivered outside the PMS (G. Anderson, personal communication, February 3, 2000).

In the Atlantic MLC AOR, the most challenging clinics are Cape May, NJ, and Borinquen, PR. Cape May is the Coast Guard's only basic training center and, with the military services experiencing considerable recruiting and retention difficulties, the training center is under pressure from OPFACs to rapidly graduate new recruits. This results in a demand on the clinic to process recruits quickly and make them medically fit for graduation and subsequent assignment to the OPFACs. In Borinquen, the challenge is to overcome beneficiaries' erroneous perceptions that, because Puerto Rico is a small country, that quality health care is unavailable (T. Slack, personal communication, February 3, 2000).

Future MLC Challenges

The Pacific MLC's future challenge is to examine and redefine the role of its clinics in the wake of TRICARE and the advent of TPR. As the TRICARE program grows and health care in the US evolves, there may be less reliance on USCG clinics to provide direct primary care services. Instead, to justify their existence, clinics may have to take more responsibility for the training of IDTs and expand their role as health benefits service centers (G. Anderson, personal communication, February 3, 2000).

The Atlantic MLC's future challenge is to keep pace with the development of DOD medical technology and infrastructure. The Coast Guard health care system relies on the DOD MHS, but constantly lags behind. Further, the Coast Guard must develop a plan for medical equipment upgrade (T. Slack, personal communication, February 3, 2000).

Potential of Federal Health Care Partnerships

Both Slack and Anderson believed strongly in the potential of federal health care partnerships to improve the HSP. Slack called the need for all federal health care agencies to share resources, design and deploy a uniform patient health record, and jointly report pertinent

public health data “the wave of the future.” Anderson believed partnerships are an “excellent opportunity” to address the needs of all federal health care agencies. He felt “there needs to be a paradigm shift, a different rulebook” for federal health care and proposed using the DOD’s TRICARE experience as “a case study for the future of [integrated] federal health care.” (T. Slack, personal communication, February 3, 2000; G. Anderson, personal communication, February 3, 2000).

CHAPTER 4: DISCUSSION

Objective 1

The researcher expected to find that USCG involvement in the AFHCP has proven to be tremendously practical and cost-beneficial to the clinics in Alaska. Indeed, all three types of AFHCP initiatives have resulted in significant improvements in the cost of, quality of, and access to health care for those four USCG clinics and the beneficiaries they serve. From FY97 through FY99, the Coast Guard saved or avoided costs totaling over \$220,000 while improving clinical support services, patient satisfaction, and access to services and speeding the delivery of definitive care. All of this was achieved with a monetary investment of less than \$40,000 and only a small investment in man-hours.

Objective 2

A total of five to seven remote clinics outside Alaska were expected to be identified as potential sites to consider for future AFHCP-like interagency partnerships. Because the Atlantic MLC's AOR is larger, more of those locations were expected to be identified in the Atlantic MLC than in the Pacific MLC. Indeed, a total of 16 clinics were identified as remote--seven clinics in the Pacific MLC and nine in the Atlantic MLC⁴.

⁴ Coincidentally, the development and establishment of the Northwest Federal Healthcare Partnership (NWFHP) paralleled this research study. The NWFHP serves federal beneficiaries in Washington State and Oregon. Federal partners include: TRICARE Region 11, DVA Veterans Integrated Service Network 20, Portland Area Indian Health Services, and the four USCG clinics in that area, including three identified as potential partnership sites: Astoria, North Bend, and Port Angeles.

Joint Contracting

The potential success of joint contracting initiatives is not dependent upon a clinic's remoteness nor its population concentration. On the contrary, the most important factor in entering joint contracts is the volume of demand available to leverage for greater discounts. That leverage is not restricted to federal health care providers in Alaska nor to remote clinics. Given modern shipping capabilities and the Coast Guard's tiered approach to procuring pharmaceuticals and medical and surgical supplies for its health care system, any clinic authorized to order items should be considered as a potential site for involvement in joint contracting initiatives.

Revenue Recapture

Revenue recapture programs accounted for much of the quantifiable monetary cost of USCG involvement in the AFHCP. However, nearly two-thirds of all savings and cost avoidance resulted from such programs. Of all AFHCP initiatives, these programs had the greatest direct impact on patients, their families, and the staffs of the clinics the specialists visited. These programs are more dependent on a clinic's care population and remoteness than on its population concentration. Because the travel and per diem expense for the visiting specialist should be at least cost-neutral with the savings, a sufficient number of referrals must accumulate to justify the trip. For many medical conditions, it is imprudent to wait too long before seeing a medical specialist; the quality of patient care may be degraded. For that reason, all potential visiting specialist programs must be carefully balanced with individual patients' medical needs. Accordingly, remote clinics with relatively large care populations and/or high population concentrations (i.e. Alameda and Cape May) are the best candidates for initial

consideration of revenue recapture initiatives. However, all USCG clinics, remote or not, should be considered potential sites.

Use of Technology

Use of medical technology, specifically tele-radiology, in the AFHCP has slightly reduced USCG costs, but has had a significant impact on the quality of care in Kodiak and Ketchikan. Providers have much better access to the services of a radiologist and can diagnose and treat their patients more accurately and quickly. The use of tele-radiology is only in its infancy, so more savings are sure to be realized over time. New medical technologies are emerging almost daily.

As with joint contracting, the potential success of medical technology is not dependent upon a clinic's remoteness. Depending upon the technology and the need it fills, any clinic can benefit. However, because of their lack of access to large metropolitan health centers and/or the extended time it takes to process results, the most remote clinics with correspondingly high population concentrations (i.e., Humboldt Bay and Cape May) are likely to benefit most from the use of technology and should be given priority.

Meeting the Commandant's Goals

Federal health care partnerships provide options for improving all of the Coast Guard's clinics. Partnerships have also helped meet the Commandant's goals for the entire HSP, particularly the first two.

Reducing High Out-of-Pocket Costs of Health Care in Alaska

Through AFHCP revenue recapture initiatives, dependents in Alaska have avoided some out-of-pocket costs. By increasing clinic access, revenue recapture and use of technology initiatives may help reduce out-of-pocket expenses in other non-Alaskan clinics with relatively

large care populations. The Alameda and Cape May clinics are the best candidates for initial consideration of revenue recapture initiatives, but all clinics could be considered potential sites.

Providing a TRICARE Prime Benefit Far from MTFs

Beneficiaries in a remote clinic's AOR population but not in its care population are the most likely to miss-out on the TRICARE Prime benefit. The shortcomings of TPR for these remote OPFACs will not likely be resolved by federal health care partnerships, because the functional unit of health care partnerships is the clinic facility not the OPFAC. That is, partnerships deliver care to clinics, not OPFACs. Unless beneficiaries travel through the AOR to the clinic, they will not access the partnership programs that improve health benefits.

Getting Members Removed from Paying Providers Directly

Beneficiaries are often required to pay private health care providers directly for care received outside a federal facility, because the federal facility may not have had access to provide that care. To the extent that revenue recapture and use of technology initiatives can be employed to increase access in a clinic, beneficiaries may be spared this requirement. Any USCG clinic, remote or not, can achieve greater access using partnerships.

Obtaining Portability of Benefits Regardless of Relocation

Portability of a level health care benefit is an issue addressed in the revision to the TRICARE Managed Care Support (MCS) contracts (version 3.0). This issue is germane to the application of partnerships to the extent that partnerships can serve to increase access to care in federal facilities through revenue recapture and the use of technology. In addition, joint contracting may help PMSs meet beneficiaries' durable medical equipment benefit. Again, any USCG clinic, remote or not, can achieve greater access using partnerships.

Increasing Access to Primary Care for Active Duty Members

The AFHCP revenue recapture initiatives have focused on specialty care rather than primary care. Coast Guard active duty personnel are currently receiving primary care mainly through PMSs, local private providers under contract, and some DOD MTFs. In locations without adequate primary care access for active duty personnel, local DVA or IHS facilities could be engaged in revenue recapture programs to expand primary care access for active duty personnel.

The Role of Strategic Management

Ginter, Swayne, and Duncan (1998) emphasize the importance of strategic management for modern health care organizations to succeed. However, the HSP has no comprehensive strategic plan for achieving its mission and addressing the Commandant's priorities (O. D. Cook, personal communication, September 27, 1999). Federal health care partnerships do not appear to provide direct solutions to the MLC's issues described by Slack (2000) and Anderson (2000) (i.e., integrating TRICARE programs, clinics with special challenges, redefining the future roles of USCG clinics, etc.). However, the HSP's mission, the Commandant's priorities, and many, if not all, of the MLC's issues could be addressed in a strategic planning process which considers the potential value of federal health care partnerships to the Coast Guard health care system.

Considerations for Involvement in Partnerships

Federal health care partnerships are rife with inherent potential problems, but offer great opportunities. The Coast Guard should be aware of these issues when considering any partnership involvement.

Potential Pitfalls

Because of the current appropriation and funding methodologies of the Executive Branch

departments and the manner in which funds are allocated to operating entities of those departments, there is a natural tension between the partners' loyalty to their respective parent agency and the partnership entity. Partnership initiatives often demand resources and must compete with a partners' other priorities. This is complicated by the fact that one partner's parent agency organization, regulations, and internal politics may conflict with those of other partner(s) or the partnership entity as a whole. As a case in point, the USCG would like the IHS and ANTHC to compel one of its facilities in Sitka, Southeast Alaska Regional Community Hospital, to work more closely with the USCG clinic in Sitka. The IHS and ANTHC partners are politically reluctant to do so, although the result would help Coast Guard beneficiaries.

The novelty of a new partnership may wear thin and the partnership may face a critical loss of momentum as it enters the mature phase of its life cycle. The AFHCP is at that critical juncture. The AFHCP has realized the relatively easy gains and, from an accounting standpoint, their savings have been accounted for and a new budget base established. The AFHCP must now begin to vigorously innovate and commit more resources to yield more savings. As mentioned, this approach tends to stress the relationship between individual partners and the partnership entity. Consistent with the balance-sheet approach methodology used in this study, cost-benefit ratio should not be the primary decision factor in partnership initiatives, but the fiscal reality is that it often is.

Relationships with the private business sector can become strained if the federal government's partnership practices are interpreted as unfair or harmful to free market competition (although the D&F document required by the FAR prevents that). Disgruntled private enterprises may attempt to invoke political action. Consequently, partnerships and the initiatives they spawn must be skillfully packaged for the private business sector. For example,

the term “cost recovery” is preferred to “revenue generation” when describing a new AFHCP initiative.

Assigning which federal-federal initiatives are partnership initiatives and which are not can be a source of confusion and consternation between the partners. In the AFHCP, it is often difficult to determine what constitutes a legitimate AFHCP initiative and which initiatives those are. Even the AFHCP partners do not agree. B. Thomas believes that “only those initiatives where there is clear and compelling evidence that it would not have been possible without the Partnership” qualify as partnership initiatives (personal communication, January 19, 2000). Others disagree. According to S. Yeager “any health care initiative that is federal-federal in Alaska” is a partnership initiative (personal communication, January 19, 2000). As a result, the partnership may erroneously take credit for initiatives it had little to do with producing. For example, using Yeager’s definition, national federal-federal programs in effect in Alaska such as the compensation and pension physical exams the DVA performs for active duty service personnel would be counted as an AFHCP initiative. There are many similar national and regional programs the USCG operates with the DOD and DVA that would confuse these distinctions.

The confusion about what programs to consider partnership programs complicates accounting for costs and savings at the agency level as well. Federal agencies’ resource and cost allocation methods often rely on historical data. The inability to segregate partner’s operations from partnership operations creates difficulties for partners’ resource managers.

Rates and prices established through a partnership contract may not necessarily be the lowest possible. The AFHCP PSO has contracts with several private health care providers in Anchorage. The contract rates are more than CMAC rates available to the DOD and DOT, so it

makes little economic sense for these AFHCP partners to use the contracts (B. Thomas, personal communication, February 28, 1999; R. Perkins, personal communication, February 28, 2000).

The AFHCPA is non-binding and does not restrain partner agencies from working independently with private providers nor does it supersede organizational commitments. This is a concern for the DVA which, due to a recent major expansion in beneficiary eligibility criteria, is under pressure to partner with the DOD to meet its goals. The DVA concern is that it will enter into partnerships only to have a DOD partner default due to readiness commitments or some competing national priority (J. Park, personal communication, February 14, 2000).

The lack of a unified federal fee schedule requires separate negotiations for reimbursements between partners. Regional variations in provider practices and sundry variations of reimbursement policy within an agency magnifies the problem of how much and by what mechanism to reimburse another federal agency. This can be a difficult issue for partners to surmount.

Turnover of personnel, particularly executives of the partner agencies, may adversely affect a partner's commitment to the partnership and may result in personality dependence for success. This has been a major challenge for the AFHCP.

As partnerships mature, of necessity, a PSO or equivalent must be established. Funding, staffing, leading, locating, and supporting this office may become a contentious issue.

Modes and rules for communications within and between partnership agencies, the PSO, and the various partnership committees and subcommittees can be confusing. The AFHCP has struggled with this issue as well.

It is important for the prospective partner agency to gauge how much motivation exists to form partnerships and the basis for that motivation. This organizational dynamic may become

the critical impetus that ultimately determines the success or failure of a partnership. In Alaska, there is a strong history of federal interagency assistance, a culture of community closeness and cooperation, and geographic and economic imperatives to work together. This may not be so in other locales.

The amounts of the CMAC rates for the locality code where a clinic is located must also be considered. If the CMACs are appropriate for the area, enough private providers may be enticed to participate in TRICARE programs such as TPR, perhaps negating the motivation to form a partnership.

Leaders must temper expectation with reality and a keen understanding of the local health care landscape. Partnerships will not work in all venues and situations. For instance, the AFHCP has had great difficulty entering contracts with private providers outside the Anchorage and Fairbanks areas. This is because there are no economic incentives for private providers, who have a monopoly on local health care, to enter into contracts which reduce their revenues.

Decision-makers should consider issues of equity between the partners. For example, USCG fiscal participation in the AFHCP is less than 1% of the total contribution and USCG beneficiaries are less than 5% of the entire Partnership population, yet the USCG gets an equal vote on matters before the Executive Committee. This is hardly fair for the other partners, but an advantageous arrangement for the USCG when deciding AFHCP strategic direction.

Potential Opportunities

With all their possible pitfalls, partnerships offer the USCG great opportunities for improvement beyond those already described. Leaders should weigh these opportunities in the decision to enjoin a federal health care partnership.

Partnerships can provide a bridge for TMA to enter into contracts with non-traditional federal providers such as IHS facilities. Such arrangements could emerge as an enhanced form of revenue recapture with the TRICARE MCS contractor as the intermediary. In this way, the USCG can gain access to excess capacity at local federal health care facilities and use TRICARE billing processes rather than USCG personnel to process claims for payment.

As with the AFHCP, partnerships can serve as a proving ground for ideas or programs under consideration for broader deployment. For instance, the AFHCP has been selected as a test site for the Government Computerized Patient Record (GCPR) program. This “proof of concept” application of federal health care partnerships is a valuable outlet.

According to S. Yeager, the main determinants of a partnership’s success are partners’ commitment and desire to collaborate (personal communication, January 19, 2000). Fortunately, these factors are entirely within the control of the partners.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

Conclusion

The desired utility of this research effort is to provide a framework for decision-makers to evaluate federal health care partnerships as a potential option for reducing Coast Guard health care expenditures, enhancing the quality of care, and improving access to services while meeting mission requirements in a fiscally austere environment. The analysis shows that partnerships with other federal health care organizations have the potential for helping USCG clinics, remote or not, achieve the Health Service Program's mission and some of the priorities directed by the Commandant, thereby improving the Coast Guard's health care system. Partnership programs have proven to be ideal solutions to difficult challenges even in the most hostile health care environment. If partnership initiatives can work in these environments, they can work even in metropolitan areas.

This study addresses whether partnerships can improve the Coast Guard's health care system. The answer is yes. The deeper issue is whether and how partnerships should be used to improve the Coast Guard's health care system. To answer that issue, Coast Guard decision-makers must understand the opportunities and threats in the environment in which the organization operates and the internal strengths and weaknesses of the organization itself. In short, to be successful at implementing partnerships decision-makers must adopt strategic management as an organizational behavior.

Because HSP Coast Guard decision-makers have not been guided by an overarching strategic plan, their management approach has historically been unfocused and reactive in nature. As one Army health care administrator aptly stated, "The theme for the Coast Guard's strategic approach to health care has been 'Just Hang On'" (C. Schreckhise, personal communication,

February 29, 2000). The lack of a coherent strategic plan obfuscates any determination of how truly applicable federal health care partnerships are in improving the Coast Guard's health care system.

Recommendations

To realize the optimum benefit from involvement in federal health care partnerships, the Coast Guard's Director of Health and Safety should adopt and encourage strategic management as a valued organizational behavior and initiate the development of a comprehensive strategic plan for health services in the Coast Guard. With such a strategic plan, the Director could proactively propose a well conceived, integrated strategic vision to the Commandant rather than reacting to dictated priorities.

The USCG contributed little to the establishment and operation of the AFHCP. Other federal benefactors performed most of the work. This has been a real boon to the Coast Guard. Even if required to contribute more toward the establishment of future partnerships, the Health and Safety Directorate should support the development of federal health care partnerships where there are unmet organizational needs and partners willing and committed to forging a new future for federal health care and the millions of beneficiaries served.

Future studies in this field should examine: the effect of partnerships on TRICARE MCS contracts; restructuring of funding for agencies engaged in partnerships; and the establishment of a unified federal reimbursement schedule.

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Definitions and Acronyms

Definitions:

3rd Medical Group – The Air Force hospital at Elmendorf AFB in Anchorage, AK.

Alaska Federal Health Care Partnership (AFHCP or Partnership) – A consortium of units of the federal agencies responsible for providing health care to federal beneficiaries in Alaska.

Area of Responsibility (AOR) – a unique geographic area assigned for management to an MLC or PMS.

Commandant – the ranking and chief executive officer of the Coast Guard.

Determination & Findings (D&F) – a document required by the Federal Acquisition Regulations to assess and ensure there are no conflicts of interest in executing an Economy Act transaction.

Economy Act – the federal legislative authority for federal agencies to work together to achieve efficiencies in government functions.

Executive Committee – a committee of leaders of the AFHCP partner agencies.

Federal Acquisition Regulations (FAR) – a compendium of regulations governing procurement processes for the US Government.

Health Services Program (HSP) – The infrastructure and processes used by the Coast Guard to provide health care services to its beneficiaries.

Maintenance and Logistics Command (MLC) – An intermediate level of regional authority between US Coast Guard headquarters and local units. MLCs oversee the non-operational functions of the Coast Guard from offices in Alameda, CA, and Portsmouth, VA.

Military Treatment Facility (MTF) – an acronym for any military medical facility. Applies to a free-standing clinic, small hospital, or medical center.

Operating Facility (OPFAC) – the smallest denominator of Coast Guard organization; an individual operating unit of the Coast Guard with personnel assigned.

Planning Committee – a committee of mid-level administrators of the AFHCP partner agencies empowered to innovate, propose, and execute AFHCP programs.

Primary Management Site (PMS) – a USCG clinic or independently assigned health services technician responsible for overseeing primary health services and/or helping coordinate health care for Coast Guard beneficiaries within an designated geographic area.

Prime Vendor – A type of DOD or VA contract for procurement of medical supplies.

Resource Sharing – sharing of health care resources (staff, equipment, and facilities) between health care institutions.

Strategic Plan – a comprehensive agenda for organizational action based on a thorough, systematic review of conditions inside and outside that organization.

TRICARE – world-wide military medical program for active duty, retirees, and family members. Consists of TRICARE Standard (fee-for-service), TRICARE Extra (PPO), TRICARE Prime (HMO), TRICARE Prime Remote, and TRICARE Senior Prime (Medicare at-risk HMO) programs.

TRICARE Prime Remote (TPR) – a TRICARE program to address deficiencies in health care for service members assigned to locations greater than 50 miles from a MTF.

TRICARE Management Activity (TMA) – a subordinate activity to OASD(HA). Manages all TRICARE activities on the national level.

Acronyms:

AFHCP – Alaska Federal Health Care Partnership

AFHCPA – Alaska Federal Health Care Partnership Agreement

ANMC – Alaska Native Medical Center

ANTHC – Alaska Native Tribal Health Consortium

AOR – Area of Responsibility

BACH – Bassett Army Community Hospital

CBA – Cost-benefit analysis
CEA – Cost-effectiveness analysis
CHAMPUS - Civilian Health and Medical Program of the Uniformed Services
CMAC – CHAMPUS Maximum Allowable Charge
D&F – Determination & Findings
DHHS - Department of Health and Human Services
DOD - Department of Defense
DOT – Department of Transportation
DVA - Department of Veterans Affairs
FAR – Federal Acquisition Regulation
HCFA - Health Care Financing Administration
HSP – Health Services Program
IA – Interagency Agreement
IDT – Independent Duty (Health Services) Technician
IHS – Indian Health Service
MCS – Managed Care Support
MHS – Military Health System
MLC – Maintenance and Logistics Command
MTF - (military) Medical Treatment Facility
NWFHP – Northwest Federal Healthcare Partnership
OASD(HA) - Office of the Assistant Secretary of Defense for Health Affairs
OPFAC – Operating Facility
PMS – Primary Management Site
PSO – Project Support Office
TPR – TRICARE Prime Remote
TRICARE - The DOD’s system-wide managed care program
USAF – United States Air Force
USCG – United States Coast Guard
VISN – Veterans Integrated Service Network

FY99 Tele-Radiology Program Data: Kodiak

Xray Series	CPT-4 Code	Quantity	FY99 CMAC	Discount Rate	3 MDG Charge	Extension	Potential Virginia Mason Charge	Extension	Savings
CXR	71020	200	\$13.13	0.85	\$11.16	\$2,232.10	\$12.54	\$2,508.00	\$275.90
KUB	74020	25	\$16.55	0.85	\$14.07	\$351.69	15.96	\$399.00	\$47.31
Skull	70260	1	\$20.63	0.85	\$17.54	\$17.54	19.76	\$19.76	\$2.22
Jaw	70110	1	\$15.36	0.85	\$13.06	\$13.06	14.82	\$14.82	\$1.76
Sinus	70220	21	\$15.42	0.85	\$13.11	\$275.25	14.82	\$311.22	\$35.97
Nasal	70160	6	\$10.50	0.85	\$8.93	\$53.55	9.88	\$59.28	\$5.73
C Spine	72050	21	\$18.64	0.85	\$15.84	\$332.72	17.86	\$375.06	\$42.34
L Spine	72110	11	\$18.65	0.85	\$15.85	\$174.38	17.86	\$196.46	\$22.08
LS Spine	72202	31	\$11.74	0.85	\$9.98	\$309.35	9.88	\$306.28	-\$3.07
T Spine	72074	3	\$13.42	0.85	\$11.41	\$34.22	12.54	\$37.62	\$3.40
Coccyx	72220	2	\$10.55	0.85	\$8.97	\$17.94	9.88	\$19.76	\$1.83
Ribs	71111	7	\$19.44	0.85	\$16.52	\$115.67	15.96	\$111.72	-\$3.95
Clavicle	73000	3	\$9.71	0.85	\$8.25	\$24.76	20.52	\$61.56	\$36.80
Shoulder	73030	25	\$10.95	0.85	\$9.31	\$232.69	10.26	\$256.50	\$23.81
Elbow	73070	28	\$9.31	0.85	\$7.91	\$221.58	8.74	\$244.72	\$23.14
Arm	73090	15	\$9.71	0.85	\$8.25	\$123.80	9.12	\$136.80	\$13.00
Wrist	73110	44	\$10.51	0.85	\$8.93	\$393.07	9.88	\$434.72	\$41.65
Hand	73130	42	\$10.51	0.85	\$8.93	\$375.21	9.88	\$414.96	\$39.75
Finger	73140	32	\$8.11	0.85	\$6.89	\$220.59	7.6	\$243.20	\$22.61
Acute Abdomen	74020	4	\$16.55	0.85	\$14.07	\$56.27	15.96	\$63.84	\$7.57
Pelvis	72190	4	\$12.94	0.85	\$11.00	\$44.00	12.16	\$48.64	\$4.64
Knee	73564	65	\$13.78	0.85	\$11.71	\$761.35	12.92	\$839.80	\$78.46
Tib/Fib	73590	12	\$10.10	0.85	\$8.59	\$103.02	9.5	\$114.00	\$10.98
Ankle	73610	32	\$10.51	0.85	\$8.93	\$285.87	9.88	\$316.16	\$30.29
Foot	73630	72	\$10.51	0.85	\$8.93	\$643.21	9.88	\$711.36	\$68.15
Foot/Ankle	73630	3	\$10.51	0.85	\$8.93	\$26.80	9.88	\$29.64	\$2.84
Hip	73520	17	\$16.16	0.85	\$13.74	\$233.51	\$15.20	\$258.40	\$24.89
Totals						\$7,673.18		\$8,533.28	\$860.10

Note. Sources: T. Palmer, clinic administrator at Kodiak clinic (personal communication, February 3, 2000); W. Cranston, Pacific MLC Health and Safety Division staff (personal communication, February 10, 2000). Savings equal the sum of the total Potential Virginia Mason Charges minus the sum of the total 3 MDG (3rd Medical Group) Charges.

FY99 Tele-Radiology Program Data: Ketchikan

Xray Series	CPT-4 Code	Quantity	FY99 CMAC	Discount Rate	3 MDG Charge	Extension	Potential Virginia Mason Charge	Extension	Savings
CXR	71020	25	\$13.13	0.85	\$11.16	\$279.01	\$11.22	\$280.50	\$1.49
CXR "B Reader"	71020	6	\$13.13	0.85	\$11.16	\$66.96	\$35.00	\$210.00	\$143.04
KUB			\$0.00	0.85	\$0.00	\$0.00	18.02	\$0.00	\$0.00
Skull			\$0.00	0.85	\$0.00	\$0.00	17.68	\$0.00	\$0.00
Jaw			\$0.00	0.85	\$0.00	\$0.00	13.26	\$0.00	\$0.00
Sinus			\$0.00	0.85	\$0.00	\$0.00	13.26	\$0.00	\$0.00
Nasal			\$0.00	0.85	\$0.00	\$0.00	8.84	\$0.00	\$0.00
C Spine			\$0.00	0.85	\$0.00	\$0.00	15.98	\$0.00	\$0.00
L Spine			\$0.00	0.85	\$0.00	\$0.00	15.98	\$0.00	\$0.00
LS Spine			\$0.00	0.85	\$0.00	\$0.00	8.84	\$0.00	\$0.00
T Spine			\$0.00	0.85	\$0.00	\$0.00	11.22	\$0.00	\$0.00
Coccyx			\$0.00	0.85	\$0.00	\$0.00	8.84	\$0.00	\$0.00
Ribs			\$0.00	0.85	\$0.00	\$0.00	14.28	\$0.00	\$0.00
Clavicle			\$0.00	0.85	\$0.00	\$0.00	18.36	\$0.00	\$0.00
Shoulder	73030	1	\$10.95	0.85	\$9.31	\$9.31	9.18	\$9.18	-\$0.13
Elbow	73070	1	\$9.31	0.85	\$7.91	\$7.91	7.82	\$7.82	-\$0.09
Arm			\$0.00	0.85	\$0.00	\$0.00	8.16	\$0.00	\$0.00
Wrist	73110	3	\$10.51	0.85	\$8.93	\$26.80	8.84	\$26.52	-\$0.28
Hand	73130	11	\$10.51	0.85	\$8.93	\$98.27	8.84	\$97.24	-\$1.03
Finger			\$0.00	0.85	\$0.00	\$0.00	6.8	\$0.00	\$0.00
Acute Abdomen			\$0.00	0.85	\$0.00	\$0.00	14.28	\$0.00	\$0.00
Pelvis			\$0.00	0.85	\$0.00	\$0.00	10.88	\$0.00	\$0.00
Knee	73564	2	\$13.78	0.85	\$11.71	\$23.43	11.56	\$23.12	-\$0.31
Tib/Fib	73590	1	\$10.10	0.85	\$8.59	\$8.59	8.5	\$8.50	-\$0.08
Ankle	73610	12	\$10.51	0.85	\$8.93	\$107.20	8.84	\$106.08	-\$1.12
Foot	73630	1	\$10.51	0.85	\$8.93	\$8.93	8.84	\$8.84	-\$0.09
Foot/Ankle			\$0.00	0.85	\$0.00	\$0.00	\$8.84	\$0.00	\$0.00
Hip	73520	1	\$16.16	0.85	\$13.74	\$13.74	13.6	\$13.60	-\$0.14
Totals						\$650.15		\$791.40	\$141.25

Note. Sources: S. Heverly, clinic administrator at Ketchikan clinic (personal communication, March 6, 2000); W. Cranston, Pacific MLC Health and Safety Division staff (personal communication, February 10, 2000). Savings equal the sum of the total Potential Virginia Mason Charges minus the sum of the total 3 MDG (3rd Medical Group) Charges.