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System for Health: An Organizational and Cultural Change

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Abstract

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Army Medicine, to combat the rising cost of health care, the increasing rate of preventable diseases, and the diminishing pool of eligible military recruits due to health related issues, is transforming from a health care system to a System for Health. The focus is shifting from a disease-based model to a preventive model of care. Although Army Medicine is changing practices and implementing health-focused initiatives to facilitate this paradigm shift, barriers inherent in the organization remain and are hindering the transformation process. Institutionalizing this new paradigm requires eliminating the cultural, economic, and educational barriers by providing tools and appropriate resources, implementing methods for promoting healthy lifestyles, and leveraging education, research, and technology. Transforming Army Medicine from a health care system to a System for Health has the potential to positively influence Army Medicine, the Military Health System, and ultimately shape health care in the nation.

System for Health: An Organizational and Cultural Change

> Culture does not change because we desire to change it. Culture changes when the organization is transformed; the culture reflects the realities of people working together every day.
>
> —Frances Hesselbein[1]

On 12 March 2013, the Secretary of the Army launched the Army's Ready and Resilient Campaign (R2C), a campaign designed to guide the Army's efforts to "build upon physical, emotional and psychological resilience in our Soldiers, Families and Civilians."[2] Synchronizing with this initiative, Army Medicine is transforming from a health care system to a System for Health. The focus is shifting from a disease-based and reactive model to a preventive and proactive model of care. The System for Health is "not a program; rather it is an integration of multiple programs and initiatives aimed at changing the U.S. Army's DNA."[3] It is designed to maintain health through fitness and injury prevention, restore health through patient centered care, and improve health through informed choices.[4]

The transformation from a health care system to a System for Health is a significant paradigm shift for Army Medicine. This transformation is essential for Army Medicine to provide "responsive and reliable health services and influences Health to improve readiness, save lives, and advance wellness in support of the Force, Military Families, and all those entrusted to our care."[5] In the current constrained fiscal environment and with shrinking personnel resources, this paradigm shift is needed to assist Army Medicine to meet its mission and continue providing ready and resilient forces to combatant commanders. The System for Health initiative is vital to the survival of Army Medicine and ultimately to U.S. National Security.[6]

To operationalize this concept and provide a strategic framework for transforming Army Medicine from a health care system to a System for Health, Army Medicine released the Army Medicine 2020 Campaign Plan.[7] The campaign plan recognizes that "a Soldier interacts with a health care provider for an average of 100 minutes" in a year but "engagement in the Life Space, the time not spent with a provider, is where the biggest impact on health can be made."[8] Although the campaign plan provides a strategic roadmap for effecting necessary organizational change, there are many barriers to such change inherent in the Army Medical system.

Integrating, synchronizing, and coordinating the relevant internal and external systems and working toward a common end-state will assist in transforming Army health care to a System for Health. This paradigm shift has the potential to transform Army Medicine, the Military Health System (MHS), and ultimately shape health care delivery in the United States.[9] Thus, this paper will discuss the facilitators that are assisting the transformation from a health care system to a System for Health, identify the barriers that are hindering the transformation, and provide recommendations for addressing those barriers.

Background

The MHS provides medical support for the full spectrum of military operations and provides health care for over 9.6 million eligible Department of Defense (DoD) beneficiaries.[10] It is the largest global health system in the U.S., and employs over 146,000 military and civilian personnel.[11] Of the 9.6 million eligible beneficiaries, retirees and family members constitute 56 percent of that population.[12] At 3.95 million, Army beneficiaries constitute 41 percent of those eligible for care in the MHS, more than any of the other Uniformed Services.[13]

The military population is a reflection of American civilian society and as such, the beneficiaries served by the MHS reflect similar health status and rates of occurrence of common medical conditions as the U.S. population.[14] Likewise, Army Medicine faces the same predominant challenges as the civilian health care system: an unsustainable rise in health care costs, an aging population, and increases in chronic diseases resulting from poor lifestyle choices. Furthermore, Army Medicine faces the additional challenge of a shrinking staff. Secretary of Defense Hagel recently proposed reducing the Army from 520,000 to 440,000 personnel.[15]

Although the U.S. spends more money on health care than any other nation, it does not represent the healthiest population in the world. According to the Institute of Medicine in 2011, 30 percent of health care spending is wasted and does not improve health.[16] The MHS is not exempt from these fiscal challenges. Health care costs for the DoD have more than doubled in the last decade, from $19 billion in 2001 to $45 billion in 2008, and represent eight percent of total DoD spending compared to 4.5 percent in 1990.[17] The ever-increasing portion of the defense budget that goes toward health care costs instead of DoD security priorities threatens operational readiness, health care benefits for our service members and their families, and thus ultimately threatens national security.

Poor lifestyle choices of many of the aging military beneficiary population are increasing the risk for a variety of health problems and further contributing to the rise of health care costs. Dr. Littman and colleagues conducted a study evaluating weight change following U.S. military service and reported that veterans tend to exhibit a similar or greater prevalence of excessive weight or obesity compared to non-veterans.

They found that 31 percent of veterans became obese soon after their service ended.[18] In addition, Dr. Das and colleagues conducted a cross sectional analysis of 1,803,323 veterans being treated at the Veterans Administration and reported that 68% of females and 73% of males were overweight.[19] Exceeding recommended body mass index or being obese greatly raises the risk for a variety of chronic diseases and other health problems requiring costly long-term health care management.

Furthermore, poor life style choices in the general U.S. population, primarily the youth, are negatively affecting military recruitment. Over the past 30 years, childhood obesity rates have tripled and the proportion of potential recruits who failed their physicals each year because they were overweight rose by 70 percent.[20] The Army's Accessions Command estimates that approximately 27 percent of all Americans between the ages of 17 and 24 years are unable to join the military because they are either unable to meet the height and weight standards or are medically unfit.[21] This decreasing pool of eligible recruits for military duty is threatening the strength of the Force as well as national security.

Army Medicine, the MHS, and the U.S. health care system cannot continue on their current trajectory. Their current shared health care model, which is better suited for acute care issues, is antiquated, inefficient and increasingly costly. The current model was suitable in the past when communicable diseases and acute care issues were the primary focus. Today, however, health care has evolved into a dynamic, technological, and highly complex system. Patients are demanding, educated, and often more informed than the physician regarding their diagnosis. Recognizing these inefficiencies, Army Medicine has taken steps toward transforming from a health care system to a

System for Health. The focus is pivoting from sick care to preventive care and aiming to positively influence the "Life Space" of Army Medicine beneficiaries in an attempt to reduce acute care cost and to positively influence the lives of potential Army recruits.

Opposing Views

Despite the compelling evidence in the literature regarding the benefits of preventive measures and their potential cost savings, there is still a broad debate over whether preventive health services save money.[22] Louise Russell, a research professor, evaluated the cost effectiveness of preventive measures and reported, "the evidence does not support the commonly accepted idea that prevention always, or even usually, reduces medical costs – although it sometimes does."[23] Joshua Cohen and colleagues acknowledged some preventive measures do save money, however "the vast majority reviewed in the health economics literature do not."[24]

Determining cost effectiveness of preventive services is complicated. Many studies include higher cost screening tests or preventive services delivered in a clinical setting.[25] Army Medicine, however, is implementing low-cost preventive strategies to promote healthier lifestyles in beneficiaries' Life Space and at the workplace. A review of 47 peer-reviewed studies found that workplace wellness programs were effective in achieving behavioral changes and reducing health risks."[26]

Other arguments against prevention are based on the idea that it is difficult to change individual behaviors and changing behavior is outside the physician's role.[27] Donald Seldin, a well-respected physician, argued during a presidential address "medicine is a narrow discipline... and its goals are the relief of pain, the prevention of disability, and the postponement of death."[28] He further argued that the attainment of health and happiness was "not solely as a matter of medicine, but for individuals and

their communities."[29] However, the last decades have disproved these assertions. Smoking rates have decreased through the years and obesity rates have increased, both demonstrating a change in habit or lifestyle.[30] Many service members, upon joining the military, change their behaviors in ways that can be either positive or negative from a wellness standpoint. Furthermore, as medicine continues to evolve the important role of health care providers in preventive services is becoming more relevant and pronounced.

Facilitators to Change

Transitioning from a health care system to a System for Health is an organizational and cultural change for Army Medicine. Organizational change is not easy and according to John Kotter, an expert in leadership and change, many organizations fail to transform due to common errors.[31] Based on these common errors, Kotter developed an eight-stage process to assist organizations with the transformation process.[32] The first four steps in the transformation process: establishing a sense of urgency, creating a powerful team, developing a vision and strategy, and communicating the changed vision "help defrost a hardened status quo… ."[33]

Army Medicine is defrosting the status quo. The leadership has successfully created the sense of urgency by communicating the sobering statistics of the rising cost of health care, the alarming increase in the rate of preventable diseases, and the disturbingly small number of eligible military recruits. To combat these challenges and to transform the organization from sick care to health care, a coalition team was established and a clear and simple vision was created: "Strengthening the health of our Nation by improving the health of our Army."[34]

The Army Medicine team, to operationalize the transformation, created a System for Health framework that focuses on maintaining health through fitness and prevention, restoring health through patient-centered care, and improving health through influencing choices in the Life Space.[35] The vision and strategy are being communicated and repeated in multiple forums such as web sites, webinars, public radio, newsletters, and a variety of social media outlets.[36] Army Medicine leaders are embracing fitness and prevention programs and are leading by example. All of these actions are contributing to organizational and ultimately cultural change.

Steps five through seven in Kotter's eight-stage process for organizational change focus on introducing new practices and removing barriers to change.[37] Army Medicine is changing practices and restoring health by introducing two significant practices: converting the Army primary care clinics into Patient Centered Medical Homes (PCMH) and implementing the Performance Triad.

The PCMH is a "team-based model, led by a physician, which provides continuous, accessible, family-centered, comprehensive, compassionate and culturally-sensitive health care in order to achieve the best outcomes."[38] The patient and the primary care team work together to create mutual goals and obtain maximum health. In the civilian sector, PCMHs have resulted in fewer emergency room visits, lower health care costs, and decreased referrals to specialists.[39] Similarly, a study evaluating the effectiveness of a military PCMH showed an increase in access to care, decrease in emergency room utilization, increase in population health, and an increase in staff satisfaction.[40]

The Performance Triad program is improving health by focusing on three pillars: nutrition, sleep, and activity. The program is designed to train the squad leader on the pillars of health, who in turn will train the members of his or her squad. This training is incorporated into unit physical training with the intent of incorporating healthy habits into the soldier's lifestyle. To validate the effectiveness of the Performance Triad, pilot programs have been initiated at Joint Base Lewis McChord, Washington; Fort Bliss, Texas; and Fort Bragg, North Carolina.[41]

Currently, PCMHs and the Performance Triad are showing promise. The PCMHs have had favorable outcomes and, although it is too soon to tell the benefits of the Performance Triad, its introduction is being received favorably by soldiers enrolling in the program and by the staff who are assisting with the program.[42] Although these programs are facilitating the shift from sick care to preventive care many barriers inherent in the Army and the Army Medical system remain and hinder progress toward a System for Health.

Barriers to Change

Army Medicine is changing the status quo and has introduced some new preventive health practices however, many cultural, economic, educational, and research barriers remain in the organization. These barriers need to be integrated or removed before positive organizational change can transpire and a System for Health can be institutionalized.

Cultural

A cultural barrier inherent in the military system is the transient nature of the Army medical staff. This constant relocating of health care professionals prevents a strong provider and patient relationship - a key element in providing comprehensive

patient care - and diminishes the health care providers' ability to effect lifestyle changes. Patients are continuously starting over with their new provider, which can be frustrating for the patients who have to re-tell their medical history several times. Likewise, it is frustrating for providers because they are unable to establish the crucial historical viewpoint and maintain continuity of care. Jeffrey Alexander and colleagues, in a random telephone survey of 8,140 patients, reported that the "patient-physician relationship is an important factor in patients taking a more active role in their health and health care."[43] The authors also reported that the "higher perceived quality of interpersonal exchange with physicians, greater fairness in the treatment process, and more out-of-office contact with physicians were associated with higher levels of patient activations."[44]

Despite the essential role the primary care provider plays in preventive medicine, Military health care consumers, and Americans in general, undervalue the roles and responsibilities of primary care providers, creating another cultural barrier.[45] An analysis conducted in 2010 reported that the salary for primary care physicians is lower than other types of physicians but the return on investment is higher for primary care services.[46] Army Medicine is changing this perception. Converting the primary care clinics to PCMHs is increasing the visibility of primary care providers and underscoring the importance of their role in health care.[47]

A cultural characteristic regarding healthcare that is embedded in both American culture and as well in military culture, is the expectation of instant gratification and the focus on symptom relief. Health care consumers are impatient and many would prefer a pill or a procedure rather than being educated on behavior and lifestyle changes.

Physicians may believe it is more likely that a patient will comply with taking medications than with recommendations regarding diet and exercise and so they provide the patient with the easier solution.[48] The increase in direct-to-consumer advertising for pharmaceutical therapy and surgical procedures may also be reinforcing the expectations for immediate and simplistic solutions for health problems and thus devaluing disease prevention.[49]

Economic/Metrics

The current health care benefit available to military beneficiaries, the metrics used to evaluate provider productivity, and patient satisfaction are not aligned with the principles of the PCMH, creating barriers to organizational change and System for Health integration. The provision of high quality care is one of the DoD's greatest benefits to service members and their families. It is also expensive and - at its current rate - unsustainable. Active duty military personnel and their family members are accustomed to receiving free or low cost health care. Currently there are no financial incentives for military beneficiaries to live a healthy lifestyle; the health care system is available and inexpensive. Other insurance policies, such as life and car insurance, are based on behavior and provide financial incentives to act with prudence. For example, age, tobacco, and medical history can raise or lower life insurance premiums and getting speeding tickets, reckless driving, or having an accident all have the potential to increase driver's premiums. Convenient and low-cost military health care, although an excellent benefit, is creating a potential barrier to organizational change.

Mismatched economic incentives are creating additional barriers to System for Health integration. Provider productivity metrics are misaligned with the principles of the PCMH. According to Kotter, the beneficiary-focused strategy will fail unless the

organizational structures are modified and are aligned with the strategy.[50] Current provider productivity metrics are designed to measure productivity based on sick visits and treatment, not health outcomes or prevention activities, creating a perverse incentive. The system is rewarding providers for providing more interventions and over specialized care, not for doing a better job of keeping patients healthy.[51]

The patient satisfaction survey distributed to patients is also misaligned with the principles of the PCMH and the System for Health. Patient satisfaction is a key determinant of quality of care and an essential metric in evaluating health care and provider performance.[52] It is widely recognized that there is a need for rigorous methods to elicit patients' views on the care they receive.[53] Currently, questions on the patient satisfaction survey focus on the principles of the previous model of care and are not measuring the desired outcome of the changed model of care, such as addressing all of the patients' problems, discussions on preventive care, and communication between patient and provider.[54] These mismatched economic incentives and metrics impede successful prevention activities and hinder organizational change.

Education, Research, and Technology

The education and training health care providers currently receive are also potential barriers to organizational change. Physicians in the Army graduate from accredited civilian educational programs or may have matriculated from the Uniformed Services University of the Health Sciences. Allied health professionals may also have graduated from a civilian program or may have matriculated from the Army Medical Department (AMEDD) Center and School, the Academy of Health Sciences. The Academy of Health Sciences is one of the largest medical education and training

campuses in the U.S., producing medical professional graduates ranging from nurses and physician assistants to physical therapists and dieticians.[55]

Currently, medical educational programs do not align with the organizational vision of Army Medicine or the elements of a System for Health. The expectation is that military health care providers will function in a PCMH working in teams, with other medical disciplines, and focus on treating the whole patient to include addressing preventive measures and healthy lifestyle habits. Despite changes in teaching methods, there has been minimal change in the basic structure of medical education since 1910.[56] The current medical educational system is designed to teach students how to function in an acute care model setting, focusing on diagnostic testing, pharmaceutical therapy, and intervention. Educational classes focusing on prevention of heart attack, stroke, and hypertension are limited.[57]

In addition to provider education, there are multiple systems and programs available to military beneficiaries focusing on health, prevention activities, and resilience in the Army and in Army Medicine such as the Army Wellness Centers, the Army Substance Abuse Program, Soldier 360, Comprehensive Soldier and Family Fitness, and the aforementioned Performance Triad. Moreover, the Army Special Forces have their own resiliency and prevention program, the Tactical Human Optimizations and Rapid Rehabilitation and Reconditioning ($THOR^3$) program.

Many of these programs are working toward promoting an injury-free, healthier, and more resilient population and although there is anecdotal evidence supporting the benefits of their use, high-level, evidence-based research validating their effectiveness is lacking. Furthermore, many of the programs are not fully integrated with each other or

with the Army Medical system. The lack of sound research validating their effectiveness and the lack of system integration are creating inefficiencies and duplications of effort that create barriers to organizational change.

Understandably, as the organization changes many processes and systems cannot be altered immediately. However, in the long-term, processes and incentives that continue to work against the vision and strategy need to be either integrated or eliminated. Otherwise, there is a risk of disempowering employees, who in turn will become frustrated and undermine organizational change.[58] Furthermore, this misalignment hinders organizational change and ultimately cultural change.[59]

The last step in Kotter's eight-step process "grounds the changes in the corporate culture and helps make them stick."[60] PCMHs, the Performance Triad, and other initiatives facilitating the System for Health must be firmly embedded in the organization and must be appropriately reinforced to change the culture.

Recommendations

Although Army medicine has a strategy for the way ahead and programs have been implemented to facilitate the transformation to a System for Health, barriers remain in the organization, hindering progress. Thus, to overcome these barriers, the focus should be on empowering staff, promoting a healthy lifestyle, leveraging education, and building partnerships.

Providing Tools and Empowering Staff

PCMHs need to be adequately funded. Failure to provide appropriate resources to support these programs inhibits the ability of health care staff to do their jobs, decreases employee satisfaction, and sends an implicit message that this program is

not important. More importantly, leaders lose the opportunity to reinforce the program and influence the culture.[61]

Converting some primary care provider positions to civilian positions, while ensuring that war-fighting capabilities are preserved will strengthen the patient-provider relationship, support the Secretary of Defense's proposal to decrease the size of the Army and align the PCMH concepts with Army Medicine's vision. Similarly, increasing tour lengths for uniformed health care providers will also promote a productive patient-provider relationship. These options will strengthen PCMH team cohesion and provide continuity of care, both of which have been shown to be associated with the delivery of high quality care.[62] Additional research shows an association between having the same health care provider and better health indicators, as well as better management of acute and chronic problems.[63] Another study reported that continuity of care resulted in more effective implementation of preventive activities reducing morbidity and mortality rates.[64] Furthermore, by converting the positions in an effort to increase continuity of care, leadership is demonstrating a commitment to the principles of PCMH and the philosophies of the System for Health, actions that will reinforce the embedding mechanisms and ultimately contribute to cultural change.

Increasing primary care physicians' income commensurate with the expanding scope of care in the PCMH and changing the way health care providers are incentivized will further highlight the important role of the primary care physician, influence health care delivery, and promote culture change. Performance measures that focus on value-based metrics and patient outcomes, as opposed to number of patient visits, will align the organization with the System for Health framework.[65] The metrics should reflect the

value of therapies that support the development and dissemination of prevention strategies and the preventive activities that fall outside clinic visits, such as coordination with other relevant clinics and organizations in the communities.[66] PCMHs should be measured on the larger Army Medicine system goals such as readiness, population health, access to care, quality of care, safety, efficiency, and patient and family centricity.[67] Health outcomes should be transparent to the Army community and the MHS as well as the broader medical community to facilitate dialogue and communicate best practices.

Adding additional allied health specialties such as occupational therapists, physical therapists, and dieticians to the PCMH teams will assist the primary care physician with educating patients in preventive measures and lifestyle counseling.[68] Currently, the PCMH model consists of primary care providers, nurses, pharmacists, behavioral health providers, and administrative staff.[69] Incorporating these allied health specialties will allow easier access to preventive care at lower cost. A recent study reported that the presence of allied health professionals in the primary care practice setting was strongly associated with overall technical quality of care.[70] The allied health professionals can assist in educating the patients and focusing on behavior modification and cognitive therapies. Implementing these services in the PCMH will further reinforce the System for Health philosophy to the staff and will reinforce the importance of preventive measures to the patients, contributing to altering their perspective on an "easy fix" and instilling recognition of the patients' role in their own health outcomes. Increasing the primary care provider's income and modifying the metrics to better reflect practice are reinforcing mechanisms that will contribute to culture change.

Revising the Patient Satisfaction Survey to better address the areas relevant to the goals of the PCMH and Army Medicine is an important step in evaluating the effectiveness of the change. The questions in the survey should focus on access to care, coordination of care, discussion of preventive measures, and patient-centered care. Furthermore, in order to increase survey responses and obtain immediate feedback, a computer should be made available to the beneficiaries to encourage survey completion before leaving the MTF.

Consumers of the military health care system are regularly surveyed regarding patient satisfaction after a health care visit; but more importantly, beneficiaries should be surveyed periodically, outside of a health care visit, to determine their perceptions of the health care system and to ascertain their expectations. This feedback can assist Army Medicine in positively shaping the system to meet the needs of the beneficiaries.

Incentives to Promote Healthy Lifestyle and Effect Change

Redesigning the health care benefit for military beneficiaries and empowering them through financial or other incentives can encourage beneficiaries to take responsibility for their health, make healthy choices, and save health care dollars.[71] The Army and Army Medicine have multiple programs to assist with maintaining and improving health and promoting a healthier lifestyle. However, the incentives for living a healthier lifestyle are primarily intrinsic to the person. The lack of internal motivation coupled with cultural expectations of instant gratification and ‘easy fixes’ are hindering Army Medicine from moving forward to a System for Health. Health care premiums can be raised and a discount could be offered on premiums or a monetary remuneration could be provided for those who meet personal health metrics such as a normal body

mass index, non-smokers, and for those enrolled in the Performance Triad or other wellness programs.

There is a plethora of literature supporting the success of financial incentives for changing health-related behavior.[72] In 1938, B.F. Skinner, a renowned psychologist, found behaviors that are rewarded tend to be repeated more frequently over time, while behaviors that produce negative consequences tend to be repeated less frequently over time.[73] A more current study evaluating the benefit of financial incentives and smoking cessation reported that financial incentives significantly increased enrollment in the smoking cessation program and increased tobacco cessation rates among smokers.[74] Another study, evaluating financial incentives and weight loss, reported that the group receiving a financial incentive lost significantly more weight over an 8-month intervention.[75] Financial incentives have also been shown to be effective in motivating people to adhere to an exercise program.[76]

Leveraging Education, Research and Technology

Although Army medicine is unable to directly influence medical education at the national level, it can implement changes in Army Medical educational programs, indirectly influencing national level education.[77] Recognizing that many of the professional and technical educational programs are limited by credentialing standards, some changes can be made to better align with the System of Health framework. Evaluating the current curriculum to identify opportunities to embed team building and multidisciplinary approaches to the course instruction will better prepare medical professionals to function in PCMHs and a System for Health framework. In addition, the medical programs should ensure that cost-effective preventive strategies, healthy

lifestyle choices and evidence-based alternative medicine are introduced alongside traditional treatment approaches.

Robust research and program evaluations need to be conducted on the multiple health and wellness programs in the Army and Army Medicine. The programs that are not producing desired outcomes and those programs that are creating duplication of effort should be either discontinued or combined. The systems that are effective and based on sound research methodology need to be integrated to create one system. Evidence-based practice can shape policy and generate funds. In this constrained fiscal environment, consolidating and streamlining efforts is essential.

Establishing an enabling information technology platform can provide transparency and allow relevant systems to communicate, thus streamlining care. The technology should also allow beneficiaries the capability to access their full health care records.[78] Allowing beneficiaries access to their records will empower and encourage them to take responsibility for their health.

Building and Strengthening Partnerships

A population-based approach working in a coordinated effort and integrating all military programs, as well as community programs and organizations is essential for institutionalizing the System for Health. Commissaries should be leveraged to make it easier and less expensive to provide healthy options to the military community. Introducing evidence-based wellness and health programs into the multiple military youth and family programs will instill healthy habits into the younger population. Army Medicine staff must continue developing and strengthening relationships with commanders and senior leaders to promote Army Medicine initiatives.

As Military Medicine undergoes the transformation and continues to remove the obstacles, leaders need to identify and communicate the short-term wins and capitalize on the momentum, steps included in Kotter's eight-stage process.[79] Tracking and communicating the wins across Army Medicine, such as PCMH certification and validation of the Performance Triad, will validate the changes and create synergy among the staff. This, in turn, will create more short-term wins and incrementally begin to solidify cultural changes. Furthermore, new programs and initiatives need to be evaluated, re-evaluated, and modified if needed to ensure they are aligned with the System for Health principles and are contributing positively to organizational and cultural change.

Conclusion

The transformation from a health care system to a system for health is an essential paradigm shift for Army Medicine. The rising cost of health care, the increasing rate of preventable diseases, and the diminishing pool of eligible military recruits due to health related issues is negatively impacting the Army and threatening national security. Although Army Medicine is changing practices and implementing healthy initiatives, much work remains to be done in eliminating the cultural, economic, and educational barriers hindering the transformation. Moreover, to sustain this transformation, Army Medicine personnel at all levels in the organization need to continue building and strengthening relationships with relevant military and civilian stakeholders and organizations. Army Medicine has the opportunity to positively influence Army Medicine, the MHS, and ultimately transform health care delivery in the nation.

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