



DEPARTMENT OF THE ARMY  
HEADQUARTERS, U. S. ARMY MEDICAL COMMAND  
2050 WORTH ROAD, SUITE 10  
FORT SAM HOUSTON, TEXAS 78234-6010

REPLY TO  
ATTENTION OF

MCHO-CL-C (40)

JAN 08 2001

MEMORANDUM FOR Medical Treatment Facility (MTF) Commanders and Deputy  
Commanders for Clinical Services (DCCS)

SUBJECT: Recommendations to Improve Soldier Health Care

1. The fiscal year 2000 U. S. Army Medical Command (MEDCOM) Inspector General (IG) Soldier Health Care Special Assessment found that adequate medical care is being delivered to our soldiers and that it has improved since the last survey in 1996. The IG reports, however, that there were numerous examples of documented or perceived shortcomings within the system. As a result of the IG report and the input of many active duty and retired health care providers, a list of suggested changes were compiled. I encourage all MTF commanders to review the following recommendations and evaluate any opportunity to improve soldier health care within the Troop Medical Clinic (TMC) setting. These recommendations, although not mandatory, will improve the delivery of care to our most important customer, the soldier.

2. Recommendations:

a. Battalion Aid Stations. On those posts, camps, stations with table of organization and equipment (TO&E) units, organic battalion aid stations need to be utilized to the maximum extent possible to triage soldiers. Typically, soldiers can be seen quickly, evaluated appropriately by the assigned physician assistant (PA) and provided the proper standard of care before being returned to duty. Those soldiers requiring further evaluation or care would be referred to their TMC or to the MTF as required. Certain support should be provided to the battalion aid stations in the form of:

(1) Limited Class VIII supplies to include over the counter (OTC) medications; and,

(2) Automation Support. This would allow capture and analysis of data on those soldiers treated. Although funds for new computer hardware are not available, innovative ways of reutilizing older automation support should be explored.

b. TMC Staffing Requirements. Morning sick call at any TMC represents a 'surge' of patients which should be properly anticipated and adequately staffed. TMCs should be open early each morning to meet the influx of patients following their morning accountability formations. Professional staffing requirements should be based upon

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average daily census at each TMC Solutions to meet the staffing requirements for TMCs include:

(1) Hiring additional Civil Service or contract providers (Physicians, Nurse Practitioner (NPs), and/or PAs) to work during peak patient periods; and/or,

(2) Require MTF primary care physician providers (Family Practice (FP), Pediatrics, Internal Medicine (IM)) and NPs from other clinics) to work at the TMCs in the early morning hours to assist with the large volume of patients.

c. Algorithm Directed Troop Medical Care (ADTMC), Health Services Command (HSC) Pamphlet 40-7-21. Algorithm Directed Troop Medical Care should be utilized at all TMCs as a screening/triage tool.

d. Sick Call Business Hours. TMCs should be open for business at a reasonable time each morning to handle the surge of soldiers reporting from their units. Since most unit accountability formations occur between 0500-0600 each morning, the TMCs might need to adjust their opening time accordingly. This would require that sufficient professional and ancillary support personnel be available at this time with all functional areas within the TMC up and running. Suggestions to make the system work more effectively include:

(1) Priority for Sick Call. Active duty soldiers should have priority for sick call. Other categories of beneficiaries should wait until after all active duty soldiers have been seen;

(2) Leader Sick Call. Special hours should be developed to handle the medical needs of senior noncommissioned officers and officers who are unable to make the normal sick call; and,

(3) After Hours and Weekend Sick Call. Additional methods need to be developed to meet the medical needs of our soldiers and improve their access to care during off-duty hours.

e. Consultant Referrals. The high volume of morning sick call at TMCs necessitates that patients be seen quickly, but appropriately. When cases present that are questionable or beyond the scope of training for the providers at the TMCs, specialty consultants should be readily available to provide advice or second opinions. In many cases, this can be handled telephonically by the on-call physician. Those specialties that are most frequently called, Orthopedics, General Surgery, Obstetrics-Gynecology, Dermatology and Internal Medicine should be available to give advice or to accept patients for further evaluation.

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f. Facilities. All TMCs must be adequate to handle the large number of soldiers seen each day. This includes:

(1) Adequate room and seating in waiting rooms to handle the early morning surge;

(2) Sufficient areas to screen patients and obtain vital signs;

(3) Properly equipped and functional examination rooms with a minimum of two rooms per provider, when possible;

(4) Adequate areas for minor surgical procedures or patient holding; and,

(5) All areas should provide the appropriate privacy for all soldiers being treated.

g. Minimal Care Facilities. All MTF's should have a minimal care facility available to care for soldiers who live in the barracks or have no one to care for them at home. Staffing should be sufficient to handle normal levels of soldiers, but there must be contingency plans in place for acute outbreaks of infectious diseases.

h. Self-Care Program. All MTFs/TMCs should have a Self-Care Training program in place. Soldiers having attended this training could obtain certain over the counter (OTC) medications to treat minor, self-limiting conditions.

i. Chaperone Policy. Each MTF must have a policy on the use of chaperones. TMCs should have adequate chaperones available during all clinic hours, especially during the sick call surge.

j. Soldier Accountability.

(1) To increase accountability of soldiers presenting for sick call, all TMCs should institute positive in/out processing procedures utilizing electronic date/time stamps.

(2) TMCs should notify units immediately of any soldiers referred for hospitalization or additional care.

k. Profiles. The issue of what constitutes a valid and acceptable profile was high on the list of complaints to the MEDCOM IG. Suggestions that may help this situation include:

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(1) Each MTF should develop mandatory, periodic classes for all providers on what constitutes a valid positive profile and the use of DD Form 689 (Individual Sick Slip) and DA Form 3349 (Physical Profile).

(2) A central point of contact (POC) within each MTF or TMC should be established that Unit Commanders and First Sergeants (1SGs) could call with questions or concerns regarding profiles.

I. Soldier Health Care Directorate. Create a directorate led by an individual with extensive TMC and TO&E experience to act as the interface with the MTF Commander/DCCS and TMCs. Duties would include:

(1) Conduct regularly scheduled meetings between MTF and TMCs to address Soldier Health care issues and TMC support;

(2) Ensure that TMC standard operating procedures are complete and up-to-date;

(3) Conduct regular routine staff assistance visits looking at all aspects of Soldier Health Care;

(4) Serve as the POC for coordination of borrowed military manpower working at TMCs;

(5) Provide orientation briefings to all new company level commanders and above, to include 1SGs, on Soldier Health Care issues;

(6) Coordinate Health Promotion campaigns directed at soldiers; and,

(7) Coordinate medical training and 91W transition/sustainment.

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3. My point of contact for questions concerning the above recommendations is LTC Louis Smith, Clinical Services Division, Office of the Assistant Chief of Staff for Health Policy and Services, Headquarters U.S. Army Medical Command, Commercial (210) 221-6525 or DSN 471-6525.

FOR THE COMMANDER:

A handwritten signature in black ink, appearing to read "William T. Bester". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

WILLIAM T. BESTER  
Brigadier General, AN  
Deputy Chief of Staff for  
Operations, Health Policy  
and Services