

THE PRESIDENT'S COLUMN: BRAC AND EMERGENCY MEDICINE

By LTC. ROBERT A. DeLORENZO, MD, FACEP, USA

In my last column, I wrote about the changing environment of military medicine and how it affected emergency physicians. In keeping with the "change" theme, this column will focus on the Department of Defense's (DOD) Base Realignment and Closure (BRAC) plan. In addition to highlighting the proposed closures and realignments, I will speculate on the implications for military medicine in general and emergency medicine in particular.

mizing military value while reducing infrastructure footprint, maintaining or improving access to care, enhancing jointness, maximizing consolidation synergies, and examining outsourcing opportunities. The BRAC commission, in its deliberations, used a similar set of factors. The result is a list of medical treatment, training, research, and administrative facilities recommended for closure or realignment.



Abbreviations

AFB — Air Force Base
BAMC — Brooke Army Medical Center
BRAC — Base Realignment and Closure
ED — Emergency Department
EP — Emergency Physician
GME — Graduate Medical Education
NAS — Naval Air Station
NMC — Naval Medical Center
NS — Naval Station
WHMC — Wilford Hall Medical Center
WRAMC — Walter Reed Army Medical Center

BRAC Process

BRAC is a federal law passed by Congress as part of the fiscal year 2002 Defense Authorization Act. During the past 2 years, as part of the Act, the DOD has been gathering data on all installations, and in May of this year released the now well-publicized "BRAC list." Compared to previous BRACs (there have been four previous rounds since the late 1980's), this one moves particularly fast and is less subject to alteration by the presidential-appointed BRAC Commission. In fact, by the time you read this, the public hearings will have concluded and the Commission's recommendations will be transmitted to the President. After approval by the President, the Commission's recommendations become final a mere 45 working days after being sent to Congress for a straight up-or-down vote. Since this column is being written as the BRAC commission holds its hearings, it is possible there will be changes not reflected herein. News accounts of the hearings, however, suggest that few if any changes will greatly affect the medical infrastructure.

In deciding which medical facilities to recommend for closure or realignment, the DOD used several criteria including support for the warfighter, maxi-

DOD's Recommended Changes

DOD (Table 1) has recommended nine major realignments and consolidations. At least 10 hospitals will convert to outpatient-only clinics including the medical centers at Keesler and Andrews AFBs (Table 2). Even the venerable Armed Forces Institute of Pathology is recommended for outsourcing. Additionally, the BRAC commission itself added the service medical commands and office of the surgeons general to its list of possible realignment. Notably, these tallies do not include medical facilities (mostly clinics) located on bases and posts recommended for complete closure, such as the Naval Station, Groton, CT.

One outstanding feature of the BRAC recommendations is the creation of six medical research centers of excellence: a) trauma and battlefield health, San Antonio, TX, b) infectious disease, Bethesda, MD, c) aerospace medicine, Dayton, OH, d) biological defense, Fort Detrick, MD, e) chemical defense, Aberdeen Proving Ground, MD, and f) regulated medical product development and acquisition (e.g., vaccines), Ft Detrick, MD. By consolidating related but geographically scattered researchers under one roof, the DOD plans to enhance collaboration and reduce the considerable overhead associated with scientific endeavors.

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TIME TO STAND UP AND BE HEARD

BY COL  LINDA LAWRENCE, USAF, MC

For years we have been discussing the issues impacting emergency medicine – crowding, liability reform, reimbursement. Well Sept. 27 is your chance to stand up and be heard by joining your colleagues in a Rally on the West Lawn of the US Capitol. These issues affect us now – even in our military emergency departments. Think about the last time you had to transfer a patient and couldn't find the appropriate on-call specialist or there was no bed available in the local community to admit the patient your hospital couldn't keep due to lack of capability. Even if you don't think these issues affect you today, there is always tomorrow. Most military emergency physicians leave military practice sooner or later, and choose to continue to practice in civilian emergency departments. So, do plan to come out to the Rally if you're attending the ACEP Scientific Assembly.

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For those close by to DC – you don't even need to be attending to participate. You can still register for the rally or even show up that day.

For the past three years as a member of the Board of Directors we have worked hard to increase our advocacy and get the message heard – we need reform and NOW! We have three goals with the Rally. First – get our message out to our patients and get them engaged. Too many Americans assume we will be there when they need us and all will be fine. Time to wake up and smell the coffee and hopefully with a large attendance we will get the ear of the press who will carry our message across the newswires to many local stations far from DC. Second, we want Congress to hear us. Tied to the Rally will be a bill we plan to introduce to Congress – Access to Emergency Care Act 2005. In that bill there will be three focused “asks” – End boarding of “admitted” patients in our EDs, support emergency medical care as an essential public service and solve the professional liability crisis in emergency care. Third, we hope to energize all emergency physicians to get more involved in advocacy. This is just the beginning of our aggressive external campaign for reform. Later, in the fall, ACEP will be releasing the Emergency Medicine Report Card and early 2006 should bring the release of the IOM report on emergency care in America. These events present excellent opportunities to capitalize on what we will begin on Sept. 27.

Hopefully, you will join us in what is sure to be a memorable event and just the beginning of some exciting times ahead. For those of you on active duty like myself, I have obtained the opinion of legal counsel

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and this is an activity we CAN participate in even though we work for the government. Only restriction – don't wear your uniform. But you can come out as an emergency physician and let your presence be heard. Our numbers will speak volumes – the greater the number of us standing on the lawn the louder the message. I do hope to see you on the Capitol Lawn for what I promise will be an energizing and engaging event. Time we stop complaining and start pushing for solutions.

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*For more information about GSACEP, please call our office at 877-531-3044.
Our office hours are 0900 to 1700 EDT, or visit our website at www.gsacep.org*

GSACEP PLANS FOR ONLINE JOB BANK

For the last 28 years, GSACEP has been working diligently to serve military emergency physicians. After much discussion, the GSACEP Board of Directors has decided to begin work on an online job bank for GSACEP members. While we do not wish to encourage military emergency physicians to leave the military, we feel we should provide quality employment information for those who independently decide to stop serving in the military.

Once completed, the job bank will consist of a database of potential employers wishing to recruit former military emergency physicians. We also hope to compile a list of resources helping you select which type of practice you wish to be involved in. Lastly, the job bank will be designed in such a way that it protects our member's identity. It will be up to our member to disclose your personal information to a potential employer. If you are interested in placing an ad, please contact Bernie Carr at the GSACEP office: 877-531-3044.

We hope this new resource will become a valuable asset to our members who are concluding their service in the military. Look for this new service towards the end of this year.

GSACEP RECEIVES CHAPTER DEVELOPMENT GRANT

A grant proposal submitted by LTC John McManus, MC, USA, was approved by the ACEP Board of Directors for \$3625. The grant, Tactical and Basic Emergency Combat Casualty Care Educational Compact Disc for Deployed Military Physicians, will be officially announced at the ACEP Council luncheon in September in Washington, DC.

FREE CME FOR DEPLOYED PHYSICIANS

The Young Physicians Section of ACEP (YPS) and Government Services Chapter ACEP (GSACEP) have worked with ACEP in an effort to obtain free CME for the many service members currently deployed and unable to attend CME events. ACEP wants to provide all deployed emergency medicine physicians with a free subscription to Critical Decisions. If you are a deployed physician, please provide GSACEP with: full name, e-mail address, institution deployed to, e-mail address overseas, date deployed and anticipated return date. (Contact carr@gsacep.org)

GSACEP will send this information to ACEP who will send Critical Decisions via e-mail. Once the soldier has read the issue, there is a way for him/her to complete the CME via the Internet or to print the CME questions, answer them, and mail them back to ACEP for CME credit.

GSACEP AT SCIENTIFIC ASSEMBLY 2005 IN WASHINGTON, DC



This is a big year for GSACEP with Col Linda Lawrence, MD, FACEP, running for re-election to the ACEP Board of Directors, and LTC Marco Coppola, DO, FACEP, running from the floor for Vice-Speaker. Come celebrate with us at GSACEP's annual reception. Only GSACEP members and guests are invited. The reception is on Tuesday, Sept. 27th, from 1800 to 1930, at Farragut Square, Grand Hyatt. There will be a bar and buffet provided, thanks to Sonosite, our sole sponsor.

The GSACEP Board of Directors will meet on Wednesday, September 28 from 1000 to 1130 AM at the Renwick Room of the Grand Hyatt. All members are invited.

GSACEP will participate in the joint chapter booth again at Scientific Assembly. The booth is located in the main ACEP area.

TALKING PAPER ON DISCONTINUATION OF AMINOGLYCOSIDE EAR DROPS FOR OIF/OEF CASUALTIES

Background:

Landstuhl Regional Medical Center (LRMC) Otolaryngology Department cares for 99% of all OIF/OEF casualties with otologic injuries sustained by IED blasts. Significant numbers of these casualties have tympanic membrane ruptures. These types of injuries may cause membrane tears which lead to direct communication through the tympanic perforation, to middle and inner ear.

Currently many corpsman and medics are treating these casualties with eardrops

containing aminoglycoside. Aminoglycoside exposure to the inner ear has been proven to be toxic and has been reported to cause cochlear/vestibulopathies. The American Academy of Otolaryngology, Head/Neck Surgery has strongly recommended that otic drops containing aminoglycoside **not** be used in any type of surgery or in patients with tympanic perforations

All three service consultants recommend discontinuing the use of aminoglycoside ear drops in theater for these casualties. Medics should be advised to use quinolone

ear drops containing dexamethasone instead(like ciprodex). When these are not available, aminoglycoside ear drops should still not be used due to risk of further harm to our warfighters.

Recommendation:

AFMSA/SGOC work with CENTCOM/SG to develop effective means of communicating this to the medics in theater. Three services modify their curriculum for medic training to include this information.

Another major feature of BRAC is the establishment of two "supercenters" for graduate medical education (GME) in San Antonio, TX and Bethesda, MD. The former will be a joint Army-Air Force venture, while the Army and Navy will run the latter. Both centers will be huge by current DOD standards and if com-

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ments by military medical leaders at face value, will rival such academic giants as Johns Hopkins University in size and scope. To provide a sense of scale, consider the San Antonio Military Regional Medical Center's nearly \$1 billion in planned (and fully funded) patient care, research and support construction. This mammoth upgrade will begin as soon as 2006 and should be complete several years later. A new emergency department (ED) is part of the plan and is being designed for an annual census of 80,000 – 100,000. A similarly sized construction project is expected for the new Walter Reed National Military Medical Center.

Lastly, but perhaps just as significantly, the BRAC plan establishes a joint training location for all enlisted training. This massive shift of medical technician training will effectively double the size of Fort Sam Houston, TX, and create the world's largest school of allied health. It is not by coincidence this all-service enlisted school will be co-located with the new San Antonio Military Regional Medical Center with its robust medical education and research missions.

Implications for Military Medicine

The true impact of BRAC is at once far-reaching and uncertain. There are no doubt the closures and realignments will reshape military medicine for years to come. In fact, BRAC can be seen as part of a larger DOD effort to focus on the warfight, reduce infrastructure footprint, and increase efficiency in general. Viewed in this light, the creation of centers of research excellence, consolidation of educational missions, and elimination of smaller facilities become important components of a larger military transformation.

It is easy to focus on the hospital closures and draw negative conclusions for the future of military medicine. Without doubt, there will be fewer inpatient facilities (and consequently, fewer EDs) after BRAC. This will reduce assignment opportunities and

decrease practice variety for all medical specialties including emergency medicine. With over two-thirds of the hospital closures (including two medical centers - Wilford Hall and Keesler), the Air Force is most affected. Combined with the prior decision to eliminate most GME at David Grant Medical Center, Travis AFB, CA, a reduced commitment to military medicine is suggested. However, it is important to keep such downsizing in perspective. For example, prior years have seen the closure of two large Army Medical Centers (Fitzsimmons and Letterman) as well as several smaller Army and Navy hospitals.

Opportunities and Risks for Emergency Physicians

BRAC affords tremendous opportunities for the military emergency physician (EP). Perhaps the greatest benefit of BRAC will be an increase in joint staffing and training opportunities. The joint supercenters in San Antonio and Bethesda afford unprecedented integration for Army-Air Force and Army-Navy staffs, respectively. These jointly run medical centers will have jointly staffed EDs. Both EDs will train large numbers of medical students and off-service residents; the ED in San Antonio will be a Level I trauma center and host to one of the largest residencies in the military. Emergency physicians with an academic interest will find boundless opportunities in these new medical centers.

Other big opportunities resulting from BRAC include faculty and staff positions at the co-located enlisted medical training center in San Antonio. The current Army combat medic program is headed by a Colonel-level EP and assisted by two mid-grade EPs. Army EPs have held other faculty positions in the school including the physician assistant and cardiovascular-respiratory specialist programs. In the future joint school, equivalent Air Force and Navy positions can be expected to become available to the education-focused EP.

The joint medical research laboratories, particularly the trauma and battlefield health, chemical defense and biological defense labs will provide outstanding opportunities in a broad array of military-relevant topics. EPs in at least two services currently serve in all these areas and BRAC-driven enhancements will work to expand the opportunities.

Despite the many opportunities created by BRAC, there will likely be some offsets, too. Most obvious is the closures of EDs as nine hospitals convert to clinics (Table 2). Most of the facilities were staffed, at least in part, by military EPs. Their closure will reduce

practice opportunities and limit some geographic assignment preferences. The consolidation of NMC-Bethesda and WRAMC, and BAMC and WHMC will reduce some opportunities (even as others are created). Counteracting these negative trends are some potential expansion opportunities not directly related to BRAC. As part of the greater military transformation, thousands of troops in South Korea and Europe will return to bases and posts in the U.S. Among others, Forts Bragg, NC, Hood, TX, Bliss, TX, Campbell, KY, and Stewart, GA are each likely to expand by at least one brigade of about 5,000 troops. Accompanied by 5 – 10,000 family members, the military EDs can expect to see an increased census and thus, an increase in staffing needs. Combined with possible joint billets at co-located bases (e.g., Fort Lewis and McChord AFB, WA; Fort Carson and USAF Academy, CO; and Fort Bragg and Pope AFB, NC) these new opportunities may partially counteract the EDs lost in the BRAC process.

Summary

BRAC affords tremendous opportunities for military emergency physicians. Joint hospital opportunities will increase, as will joint training and research billets. These new opportunities will help to offset the few ED closures planned under BRAC. The resourceful and flexible EP will continue to find exciting and varied opportunities in military medicine.



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Table 1
Major Realignments (Relocations)

1. Walter Reed National Military Medical Center, Bethesda, MD
Close current WRAMC and re-establish new joint facility on grounds of National NMC-Bethesda
2. San Antonio Military Regional Medical Center, San Antonio, TX
Close current WHMC and merge inpatient services at BAMC, keeping some ambulatory services at new facility on grounds of WHMC

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3. Joint Enlisted Training Center at Fort Sam Houston, TX

Move virtually all enlisted medical training from NS Great Lakes, IL, Sheppard AFB, TX, NMC San Diego, and NMC Portsmouth to Fort Sam Houston (San Antonio), TX

4. Joint Center of Excellence in Aerospace Medicine Research, Wright-Patterson AFB, OH

Move the USAF School of Aerospace Medicine, Brooks City-Base, TX, and the Naval Aeromedical Research Laboratory, NAS Pensacola, FL to Wright-Patterson AFB, OH

5. Joint Center of Excellence in Chemical Defense Research, Aberdeen Proving Ground, MD

Consolidate all chemical defense medical research labs

6. Joint Center of Excellence in Biological Defense Research, Fort Detrick, MD

Consolidate all biological defense medical research labs

7. Joint Center of Excellence in Infectious Disease Research, WRAMC (Forest Glenn), MD

Consolidate all infectious disease research labs

8. Joint Center of Excellence in Battlefield Health and Trauma Research, Fort Sam Houston, TX

Consolidate all battlefield health and trauma research labs

9. Joint Center of Excellence in Regulated Medical Products and Devices, Ft. Detrick MD

Consolidate all research & development on regulated products (e.g., vaccines)

Table 2

Hospital Closures (Conversions to Clinics)

1. Army

Fort Eustis, VA
Fort Knox, KY

2. Navy – Marines

Naval Station Great Lakes, IL
Marine Corps Air Station Cherry Point, NC

3. Air Force

USAF Academy, CO
Andrews AFB, MD
MacDill AFB, FL
Keesler AFB, MS
Scott AFB, IL
McChord AFB, WA (Clinic will close)

4. Other Closures

Armed Forces Institute of Pathology

Please Save These Important Dates in 2006!

ED Director's Course—March 19th
Wyndham St. Anthony Hotel
San Antonio, TX

Joint Services Symposium —3/20-3/22
Wyndham St. Anthony Hotel
San Antonio, TX

Watch the GSACEP website for
further information.

New Members

Welcome! Please make sure that you register your e-mail address at our website, www.gsacep.org. If you don't, you won't receive breaking news from GSACEP.

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THE BALANCED SCORECARD IN MILITARY MEDICINE PRACTICE

By LTC ROBERT A. DeLORENZO, MC, USA

Introduction

The military health system (MHS) is comprised of all the service medical departments of the Army, Navy, and Air Force, as well as that portion of the Tricare managed care system that is controlled by the government. The deployable medical assets, fixed medical treatment facilities, and all of the medical infrastructure of the military, to include most of us, can be considered part of the MHS. Like all large organizations, the MHS needs a system of management. In the late 1990s, the Office of the Assistant Secretary of Defense for Health Affairs, in conjunction with the three surgeons general, flowed the lead of the Department of Defense by adopting a management tool called the Balanced Scorecard (BSC). (For those interested in the fundamental concepts of the balanced scorecard please read the appendix entitled “The Balanced scorecard – A Primer.”)

The chief benefits of using the BSC relate primarily to organizational alignment and focus. In particular, the BSC can focus a healthcare entity’s strategy, improve decision-making, help management set priorities, and improve accountability. Leaders at all levels, and certainly this includes all military emergency physicians, should have a basic appreciation for the BSC and how it fits with the MHS mission. The BSC validates what we do on a daily basis in the emergency department (ED), in line units, and in other military settings. It offers the opportunity for junior and mid-level medical managers (captains through colonel, or the naval equivalent) to understand the motivations and directives of senior leaders and help position their service, department or unit to best serve the organization.

Making Sense of the Balanced Scorecard in the MHS

The MHS is one of the largest healthcare organizations in the world with 9 million beneficiaries and an annual budget of \$21 billion. To fully appreciate the mission and scope of the MHS and understand the role of the individual in executing the larger mission, it is useful to review the MHS mission statement:

“To enhance DoD and our nation’s security by providing health support for the full range of military operations and sustaining the

The EPIC

MHS Strategy Architecture Figure 1



health of all those entrusted to our care.” In turn, the MHS vision statement is: “A world-class health system that supports the military mission by fostering, protecting, sustaining and restoring health.” Together these two statements are used to build the MHS strategy architecture (Figure 1). The learning and growth perspective forms the base of the strategy and focuses on the military personnel and support systems. The military GME system, USUHS, the various military medical research laboratories, the military unique curriculum, and other elements of the training and research base directly reflect this foundation. The internal perspective is characterized by three themes: readiness (for war and military contingencies), quality (healthcare), and efficiency (budget and productivity). Many junior and mid-grade medical officers are focused on this perspective in their daily jobs of patient care and running the ED.

The customer’s perspective is represented by the military service members the MHS serves. It is important to reflect that a critical population we serve – beneficiaries and retirees – are not explicitly present on the strategy map. This lack of strategic focus

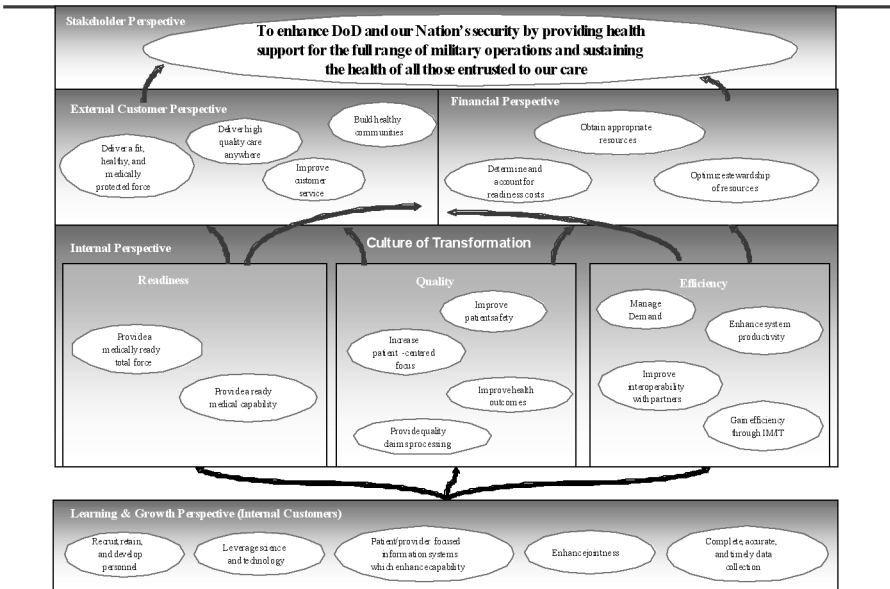
on our most frequent customer may help explain the ambivalence the system seems to have for retirees and beneficiaries. The financial perspective reflects cost-effectiveness, transparency, and accountability. In an era of budget constraints, cost concerns, in particular, seems to take special emphasis and at times seems to overshadow the other perspectives in the strategy map but is in reality only one portion of one component of the strategy map. Finally, the stakeholder perspective at the pinnacle is represented by the congress, the commander-in-chief, and ultimately, the American public. Interestingly, not represented amongst our stakeholders are the commanders, their unit members, and the servicemembers’ families we serve. This reminds us that ultimately we respond not to the market force of our customers (patients and military units), but rather to the political will of the civilian leadership in charge of the military.

With the architecture (Figure 1) established, the MHS strategy map is assembled, as depicted in Figure 2. Prominent on this map is the emphasis on people and personnel, systems, and customer focus. While not

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Strategy Map for the MHS

Figure 2



explicit, the left-hand portion of the map focuses on the chief business of the MHS, providing a capable medical force and sustaining a fit fighting force. At the top of the map, the stakeholder position is held by the MHS mission statement.

Utilizing the MHS Balanced Scorecard

With the strategy map in hand it is easy to identify the MHS priorities and drivers, even for personnel located relatively deep within the organizational chart. Collectively our priorities start with the readiness theme: personal readiness (e.g., weapons qualifications, physical fitness, etc) as well as medical readiness of the servicemembers in our care. It also encompasses training to provide a capable medical force. This latter component is the leverage needed by military GME, military medical centers, USUHS, and other institutions trying to justify their existence. Quality is the management theme for excellence in patient care – something we can all appreciate and strive for. The quality theme validates our effort to ensure all emergency patients in the military receive the best possible emergency medical treatment by board-certified emergency physicians. The cost-effectiveness theme represents everyone's efforts to achieve what the tired cliché implores: do more with less. While every leader needs to be cost conscious, not every aspect of this theme swings the budget ax. The renewed interest in third-party collections, for example, offers significant opportunity for those emergency departments able to capture this revenue stream.

One critical aspect of the BSC not discussed here is the use of metrics to measure and define success. While implicit in the design of the BSC, it is important to realize that accurate, valid data coupled with realistic and achievable benchmarks provide the feedback necessary to make the BSC work as a management tool.

Conclusion

Personnel at all levels can begin to think of their daily activities in terms of the MHS BSC. Customers, whether they are soldiers,

sailors, or airmen as part of a fit, healthy and medically protected force, or as beneficiary patients, can easily determine the outlines of benchmarks that define the MHS productivity and effectiveness. In short, the MHS BSC links all the components and perspectives into a unified strategy for the entire organization.

APPENDIX The Balanced scorecard – A Primer

The balanced scorecard (BSC) is a management approach to measuring all aspects of an organization's performance. The balanced scorecard was developed by Robert S. Kaplan and David P. Norton in 1992 when their concept was published in the Harvard Business Review.¹ A decade later, about 50 percent of Fortune 1000 companies use the technique, along with many departments and agencies of the US government.²

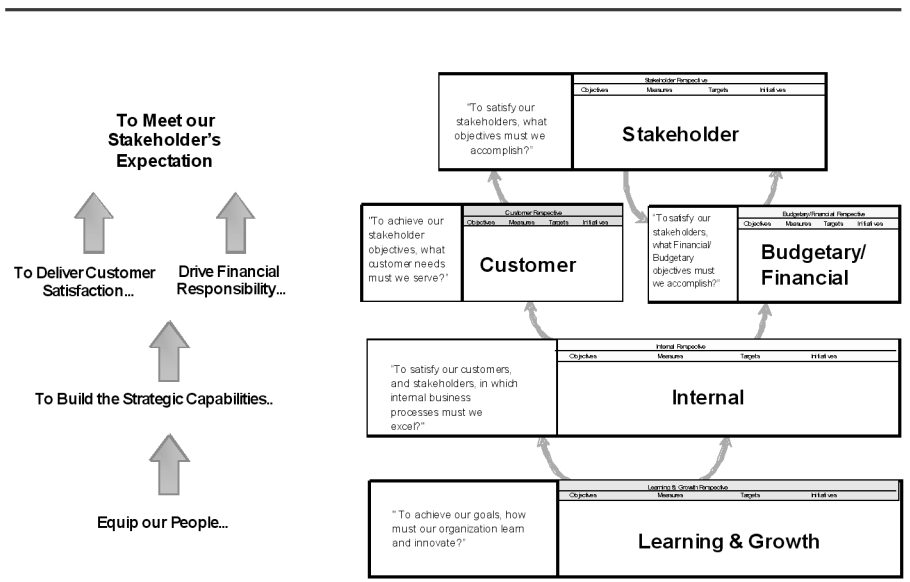
Fundamentally, the scorecard balances traditional financial measures of success with non-financial measures that ultimately affect organizational performance in the future. In the basic model, four perspectives, financial, customer, internal, and learning and growth are linked together as depicted in Figure 1. Each of these perspectives' measures is derived from the organization's vision, strategy and objectives.³

The BSC was originally intended for use in traditional for-profit enterprises and not

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Balanced Scorecard Framework

Figure 3



surprisingly finds its greatest application there. The company's vision and mission statements provide the foundation for developing a BSC.⁴ The vision and mission statements drive the company strategy, which the BSC will exploit in terms of the four perspectives and their inter relationships.

Organizations other than private, for-profit firms can also take advantage of the balanced scorecard. Both governmental and private nonprofit organizations make extensive use of the technique; however, financial performance is replaced by measures of effectiveness in providing services to constituents or the public.⁴ The four perspectives are described below.

Financial Perspective. In for-profit enterprise, the financial perspective gets the primary emphasis since it is the ultimate measure by which companies are measured. Indices of profitability are central to the financial performance of the company as measured in the BSC. Such measures

typically fall into three broad categories: a) revenue growth, b) cost management, and c) asset utilization.⁵ Together, cost management and asset utilization are sometimes categorized together as measures of productivity.

Customer Perspective. The Customer perspective represents those customer-focused areas where the company competes. Typical examples fall into five subcategories of which customer satisfaction is perhaps best known. The other subcategories are market share and customer acquisition, retention, and profitability.⁴

Internal Perspective. This aspect of the BSC pertains to the internal business processes of the company. While managers at all levels should be concerned with the internal perspective, typically it is middle and lower management that is immersed in the details. Four subcategories may be considered including operating, customer management, innovation, and regulatory and social

processing.⁴ In a traditional manufacturing process this may be conceptualized as the market identification, design, build, deliver, and post-sales service steps.⁵

Learning and Growth Perspective. The learning and growth perspective is concerned with personnel, organization, and support systems of the enterprise. The components of this perspective, therefore, are competencies, organization, and technology.³ Alternatively, these components may be viewed as employee capabilities, information technology, and motivation and alignment, respectively.⁵ The learning and growth perspective provides measures for a company's employees and their ability to help the enterprise remain profitable.

Strategy Map. The strategy map shows how each of the four perspectives drives one another and ultimately drive increased profits and improved shareholder value. Figure 3 depicts a very generalized form of a strategy map.

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Useful Website

Office of the Assistant Secretary for Health Affairs, U. S. Department of Defense (OSD (HA)), Washington, DC. www.ha.osd.mil.

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Trauma Care & Injury Control
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GSACEP CHAPTER OFFICE
6904 Colonial Road
PMB 42
Brooklyn, NY 11209

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