STATEMENT OF

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UNDER SECRETARY OF DEFENSE

FOR

PERSONNEL AND READINESS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

JUNE 17, 2003

Not for publication

Until released by Committee on Veterans Affairs

United States House of Representatives

## Introduction

Mr. Chairman, I am pleased to be invited here today to discuss with you and the members of the Committee the Department of Defense's views on the report of the President's Task Force to Improve Health Care Delivery for Our Nations Veterans.

First, let me express my deepest appreciation for the impressive work of the President's Task Force. The co-chairs of the Task Force, Dr. Gail Wilensky and John Paul Hammerschmidt, have exemplified public service in their dedication to improving health care for our military and veterans. I commend them for their leadership and their thorough and creative analysis of the issues.

During the 24 months of the deliberations, we have worked closely with the members and staff of the Task Force to provide critical information on key areas of collaboration that have contributed to the recommendations in the Final Report. I have met monthly with Dr. Wilensky to ensure an ongoing dialogue on the findings of the Task Force. Consequently, DoD has been well informed on the direction of the Task Force and has already begun to implement many of the recommendations in the Final Report. We have likewise kept the Task Force informed on major initiatives and policy decisions regarding DoD/VA collaboration that have occurred through our Joint Executive Council.

One of the most important of these initiatives has been the development of a Joint Strategic Plan that identifies goals and objectives for DoD/VA collaboration in the areas of leadership oversight, health care, capital asset planning, contingency planning, information management and information technology, and transition planning. Through

this strategic planning process, we have launched a new era of DoD/VA collaboration, with unprecedented strides toward a new federal partnership that promises to transcend business as usual, and serve as a model for inter-agency cooperation across the federal government.

This Joint Strategic Plan is consistent with the recommendations of the Task Force in that it addresses the same key issues, recognizes both our common and unique mission requirements, and ensures accountability for results. This will become more evident as we review each of the major areas of recommendations outlined in the Final Report.

**Leadership**

DoD fully concurs with the recommendations regarding the need for leadership, collaboration and oversight. In April 2003, DoD and VA signed a charter that institutionalizes a Joint Executive Council structure. I am pleased that the report of the Task Force saw fit to praise the leadership of our two Departments in setting that Joint Executive Council structure. Through our VA/DoD Joint Executive Council, co-chaired by Dr. Leo Mackay and myself, we have established a forum for senior leaders from both Departments to provide support and oversight of all our collaborative activities between DoD and VA. Our Health Executive Council has been in place for sometime and has had many successes . Through its extensive work group structure, many opportunities for further collaboration have been identified and many obstacles to sharing have been removed. Building on the success of our Health Executive Council, the two Departments have also established a Benefits Executive Council, which is examining ways to improve information sharing, refining the process of records retrieval, and identifying procedures

to improve the benefits claims process.

## Seamless Transition

Our concern for the well-being of Servicemembers extends well beyond their time on active duty. DoD supports the recommendations of the Task Force to provide a seamless transition from active duty to veteran status. We have already made significant progress in ensuring pertinent medical data is transferred to the VA on Servicemembers upon their separation from active duty. Through our Federal Health Information Exchange, an exemplary model of collaboration between both Departments, DoD transfers electronic health information on separating Servicemembers to the VA. Currently, DoD sends VA laboratory results, outpatient military treatment facility pharmacy data, radiology results, discharge summaries, demographic information and admission, disposition and transfer information. By the end of this year, DoD will also send allergy information and consult results. To date, DoD has transmitted to VA information from 3.8 million records on 1.5 million discharged or retired Servicemembers. To further strengthen DoD/VA electronic medical information exchange, while leveraging departmental systems investments, we are working with our VA counterparts to ensure the interoperability of our electronic medical records by the end of FY 2005. To achieve this goal, DoD and VA will update our joint business case for an electronic health record with the development of an implementation plan in the last quarter of 2003. In addition, DoD and VA are moving forward jointly to improve the efficiency and accuracy of enrollment information through the creation of integration points that will permit VA to access the Defense Enrollment and Eligibility Reporting System (DEERS) in real time by the end of 2005, a key objective in the President's

Management Agenda. Together, these information technology initiatives will be significant steps to a seamless transition and will markedly enhance the continuity of care for our nation's veterans.

Through our Joint Strategic Plan, we are continuing our emphasis on improving access to benefits, streamlining application processes, eliminating duplicative requirements such as physical exams, and smoothing other business practices that complicate Servicemembers' transition from military to civilian status continuity of care to our nation's veterans.

In addition to enhancing and expanding the technical capability of DoD and VA information systems, an "Information Sharing Task Force" is being established under the VA-DoD Benefits Executive Council to develop a plan to automate the data collection process so necessary information is received in a timely and accurate manner.

In addition to these efforts, DoD and VA are collaborating to ensure that VA has visibility into the future health care needs of military personnel who will be depending on VA for their care in the future. DoD and VA have established a joint Deployment Health Working Group which has already enhanced collaboration and communication on identifying individuals who deploy, locations of deployment, environmental exposures during deployment and illnesses or injuries occurring during deployments. DoD and VA have also initiated a 20 year, prospective study of 140,000 military personnel to determine relationships of health outcomes to their military service. DoD is already providing VA daily information on personnel separating from active duty, which includes the assignment history, location and occupational duties. The DoD TRICARE on Line program has the individual Servicemember's pre- and post-deployment health

assessments and a significant portion of their medical history, including illnesses and injuries. This program is available electronically to DoD providers.

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**Remove Barriers to Collaboration**

DoD and VA have different missions and serve different populations. We have different care delivery strategies and benefits. Despite the differences in the two departments, we are working to remove barriers to collaboration and are confident we can overcome these challenges through our joint strategic planning process. We are actively eliminating policy and program barriers between DoD and VA and institutionalizing processes that promote collaboration and communication. Our success in joint contracting for pharmaceuticals is a model for overcoming barriers to collaboration. In fiscal year 2002, DoD/VA joint pharmaceutical procurement purchases totaled over $230M, and resulted in $379M in cost avoidance.

DoD concurs with the Task Force's recommendation for a single, common clinical screening tool that ensures reliable, electronic access to complete pharmaceutical profiles for VA/DoD dual users across both systems. The Pharmacy Data Transaction Service (PDTS) already allows DoD to build a patient medication profile for all beneficiaries regardless of the point of service. Since implementation in June 2001, over 210 million transactions have been processed and over 75,000 potential Level 1 (life-threatening) drug interactions have been identified involving beneficiaries using more than one pharmacy for prescription services.

Because of our many successes in the pharmaceutical arena, DoD has some concern with the Task Force's recommendation to develop a national core joint

formulary. We believe we are already achieving many of the goals of a national joint formulary through our on-going DoD/VA joint pharmaceutical contracting initiatives I previously highlighted. The primary goal of common formulary selections for both organizations is to leverage the buying power of both Departments to obtain the lowest price possible, where having a drug on both formularies given the differences in their patient population demographics is clinically appropriate. However, there are inherent differences between the two healthcare organizations and their pharmacy benefit programs. The most significant difference is that VA is essentially a closed system where VA patients are seen almost exclusively by VA providers who write prescriptions using only the VA formulary. TRICARE is essentially an open system in which patients may seek care from civilian providers who have no relationship to TRICARE, requiring DoD to have a much broader pharmacy benefit for DoD beneficiaries, including access to almost all FDA approved prescription drugs. The development of a national joint core formulary may result in either greatly expanding the drugs made available to VA beneficiaries or decrease the scope of drugs available to DoD beneficiaries. The FY2000 National Defense Authorization Act mandates many aspects of DoD formulary management, including how drugs will be selected for the DoD's Uniform Formulary, and the associated copays. A decision to establish a joint VA/DoD formulary would not relieve the DoD from complying with these laws. The Department is prepared to implement the DoD Uniform Formulary in conjunction with the new TRICARE Retail Pharmacy contract in FY04, ensuring the optimum combination of best pricing, beneficiary choice, and the tool needed to better manage the pharmacy benefit.

We are focusing more energy in the area of medical supplies and equipment. The Task Force report encourages VA and DoD to work with industry to establish a uniform methodology for medical supplies and equipment identification and standardization and to facilitate additional joint contracting initiatives. The report suggests that VA and DoD identify opportunities for joint acquisitions in all areas of products and services. We fully agree.

The benefits of joint national pharmaceutical contracts are difficult to replicate in the medical surgical supply arena, because there is no industry standard to identify these items. Our Defense Supply Center in Philadelphia has taken the lead in establishing a federal data synchronization workgroup to collaborate with industry in determining the data necessary to identify medical surgical products. A common identifier is essential to ordering, product comparisons, and documenting usage. Valid usage data will facilitate volume discount negotiations for DoD/VA national contract prices.

We are also working to facilitate collaboration in health care delivery. To simplify and standardize the process of encouraging sharing agreements between facilities, DoD and VA have instituted a new reimbursement methodology of a single regionally adjusted rate structure for DoD/VA medical sharing agreements. Using a single—but regionally adjusted--rate simplifies negotiations among facilities, clarifies reimbursement issues, accounts for local differences, and improves data analysis.

The Task Force Report addressed VA/DoD joint ventures, suggesting that they be used as test beds for future initiatives and that all future construction, where there is opportunity, be considered as a potential joint venture. DoD recognizes the value that joint venture facilities provide in increasing access to care and reducing costs. No joint

venture, of course, is completely like its predecessors, either in physical plant, location or patient clientele. Each is designed to meet the needs of the special circumstances that existed where it is built. Thus, there is no standard template to be used for all situations.

We can, however, create the common templates for many of our clinical systems, as is embodied in the test of the provider credentialing systems of DoD and VA. A joint pilot study is being conducted to evaluate the merits of integrating the Department of Defense Centralized Credentials Quality Assurance System (CCQAS) with the Veterans Administration Professional Review Program (VetPro) credentials system.

A current example of an emerging joint health care operation is North Chicago, Illinois. In lieu of a replacement hospital at Naval Hospital Great Lakes, the Navy will construct a Navy Ambulatory Care Center based on a family practice/primary care model. The nearby North Chicago VA Medical Center will provide inpatient services. This will require upgrading its surgical facility. The Navy Clinic will be sized to meet the projected workload, including specialty outpatient services required to support the unique requirements of the Naval Training Command.

Collaboration just between our two Departments will not address all the opportunities to collaborate in solving demand, access and funding issues associated with the delivery of health care. We think its time to discuss a new paradigm in sharing. DoD believes that a multiplicity of opportunities can be found at the local level of health care delivery to leverage DoD, VA and quality civilian health care institutions to provide the best quality and value for our beneficiaries. The University of Colorado project in Denver is one example of how both agencies and the private sector can benefit. DoD, VA and the University Medical Center all need updated health care facilities in the

Denver metropolitan area. As stewards of the federal dollar, we owe it to our taxpayers to aggressively seek out opportunities such as this to provide the highest quality care at less cost.

The National Defense Authorization Act of 2003 requires that VA and DoD better coordinate the benefits and services they provide to our military and their dependents, either while on active duty or after they have served our Nation. In order to accomplish this formidable task, the bill requires that the Departments establish three pilots where services, manpower and facilities will be shared (using common IT systems) to provide seamless care to our veterans and their dependents. We are actively working to identify sites, and developing our approach to accomplish this priority effort and will submit this information to the Congress by September 30, 2003.

Therefore, as part of our strategic planning efforts, we are establishing a Capital Asset Planning and Coordination Steering Committee to provide executive oversight and strategic direction for joint capital asset planning. This committee will provide strategic direction and serve as a clearinghouse for all capital asset planning activities between DoD and VA.

**Conclusion**

Mr. Chairman, our goal is to build a world-class partnership between DoD and VA, guided by the principles of collaboration, stewardship and leadership. The recommendations of the Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans will assist us in this accomplishing this goal.