

THE MILITARY HEALTH SYSTEM

OVERVIEW STATEMENT

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BEFORE THE

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Mr. Chairman, distinguished members of this committee, thank you for the opportunity to discuss the Military Health System. We have over 2.2 million members serving in the Active, Reserve, and Guard components with more than 251 thousand service members deployed overseas.

The Department is firmly committed to protecting the health of our service members and to providing world-class health care to over 9 million beneficiaries. The Fiscal Year (FY) 2008 Defense Health Program funding request is being finalized by the Office of Management and Budget, and will be submitted with the President's budget after February 6th.

As you know, the Department faces a tremendous challenge with the growing costs and long term sustainability of the Military Health System. Important changes in our great benefit program, TRICARE, are needed to ensure a superior benefit for the long term. We need the help and support of Congress to achieve this goal.

### **The MHS Strategic Plan – Keeping Warfighters Ready. For Life.**

In the past year, the Military Health System (MHS) took several more important steps in our multi-year transformation that will prepare our military forces and our military medical forces for the future. Our focus has been on developing greater joint capabilities and joint operations. I will outline a number of these initiatives today.

Our efforts have been guided by a vision of jointness, interoperability, greater efficiency, improved outcomes, and world class education, research, and medical care. We have refined our MHS Strategic Plan, itself a superb document, to provide a long-term perspective on the critical imperatives that will determine our success for the years ahead. This strategic plan was shaped by the recommendations contained in the Quadrennial Defense Review (QDR), Medical Readiness Review (MRR), and the Base Realignment and Closure Commission (BRAC) reports.

This plan – developed in concert with the Surgeons General, the Joint Staff and our line leaders – recognizes that our stakeholders, including this congressional body representing the American people, expect certain outcomes from the resources invested in military medicine.

- A fit, healthy and protected force
- Reduced death, injuries and diseases during military operations, and superior follow up care and seamless transition with the VA
- Satisfied beneficiaries
- Creation of healthy communities
- Effective management of health care costs

By measures developed both by our leadership, and by independent, external

organizations, we are excelling in our mission. Yet, we are hardly complacent. We recognize that we must build upon our successes to sustain this global, unique military medical system.

### **A Fit, Healthy and Protected Force**

Ensuring that every service member is medically protected and fit for duty is our primary objective. Together with the military commanders, we use a variety of tools to achieve this outcome.

Physical fitness and health promotion are critical elements in meeting the most basic health preparedness expectations of our commanders. We have also instituted an Individual Medical Readiness (IMR) metric to assess each service member's preparedness for deployment. Current health assessments and dental examinations and up-to-date medical vaccination records comprise some of the measures that are used to calculate the IMR of U.S. military forces.

The Department has programs to protect our service members against a variety of illnesses. The Department continues to view smallpox and anthrax as real threats that may be used as potential bioterrorism weapons against our soldiers, sailors, airmen and marines. To date, with vaccines we have protected almost 1.5 million Department members against anthrax spores and more than 1.1 million against the smallpox virus. These vaccination programs have an unparalleled safety record and are setting the standard for others in the civilian sector. Working closely with the Department of Health and Human Services, the Food & Drug Administration (FDA), we restarted the mandatory anthrax vaccination program, after it was again validated by the FDA as safe and effective against all types of anthrax exposure.

We are also ensuring our service members are medically evaluated before deployments, upon return and then again 90-180 days after deployment. These health assessments provide a comprehensive picture of the fitness of our forces, and highlight areas where intervention is indicated. For example, we've learned that service members do not always recognize or voice health concerns at the time they return from deployment. By reaching out to them three to six months later, we've found that about half of them report physical concerns, such as back or joint pain, and a third of them have mental health concerns. This allows the medical staff to provide education, reassurance, or additional clinical evaluation and treatment, as appropriate. Fortunately, as these clinical interactions occur, we have learned that only a fraction of those with concerns have diagnosed clinical conditions.

At your direction, we have implemented new health benefits that extend TRICARE coverage to members of the Guard and Reserve. We implemented the TRICARE Reserve Select (TRS) health plan for Reserve Component personnel and their families as mandated in the NDAA for FY 2005, and then amended in the NDAA for FY 2006. We are now working on the new program mandated by the NDAA for FY 2007. Today, over 34,000 reservists and their families are paying the premiums and getting

TRS coverage. We have made permanent their early access to TRICARE upon receipt of call-up orders and their continued access to TRICARE for six months following active duty service for both individuals and their families.

### **Reduced Death, Injuries and Diseases During Military Operations**

The performance of our military medical personnel on the battlefield and in our medical facilities in the United States has been extraordinary. Our investments in people, training, technology and equipment have paid huge dividends. We have established new standards in virtually every major category of wartime medicine:

- **Lowest Disease, Non Battle Injury (DNBI) Rate.** A testament to our medical readiness and preparedness, our preventive medicine approaches and our occupational health capabilities, we are successfully addressing the single largest contributor to loss of forces – disease.
- **Lowest Death to Wounded Ratio.** Our agility in reaching wounded service members, and capability in treating them, has altered our perspective on what constitutes timeliness in life-saving care from the “golden hour” to the “platinum fifteen minutes.” We are saving service members with grievous wounds that were likely not survivable even ten years ago.
- **Reduced time to evacuation and definitive tertiary care.** We now expedite the evacuation of Service members following forward-deployed surgery to stateside definitive care because of a change in the evacuation paradigm to employ airborne intensive care units. Wounded service members often arrive back in the United States within 3-4 days of initial injury.

Our successful efforts to prevent loss of life from battle injuries have consequences. Many of our wounded service members have worked heroically to regain their skills to the greatest extent possible. Of particular note, among the approximate 565 individuals who have had major limb amputations, approximately 10% have returned to active duty.

We continue to focus on the need for mental health counseling and family readjustment support for our service members after they return home. With this in mind and in consideration of the potential for physical health issues to arise once service members return, I directed a post-deployment health reassessment – a follow-up program that expands upon our previous efforts. We recognize that no one who goes to war remains unchanged. However, not everyone is affected in the same way and not everyone has mental health or readjustment issues. But some, a minority, do have health issues, and their health is our concern. This additional assessment includes a short questionnaire to be filled out by all Service members -- including Reservists and Guardsmen, three to six months after they have returned home and a face-to-face visit in most cases. Service members with health concerns are referred to a healthcare provider for evaluation and assistance. The intent of this program is to help determine the health status or personal situation of the service member with a focus on discovering any readjustment issues or

problems. To get to the heart of issues, counselors ask such questions as: “How are you doing”? “How is your family”? If things are not well, we want our service members to know that help is available. We believe that with this new disciplined and caring process, we can reach those who may need help and make a real difference in their recovery and reorientation to home life. As you know, there remains a common, perception by some in our country – a stigma – regarding those who seek mental health services. We believe that through this follow-on reassessment tool, we reduce this “stigma” as a barrier to needed care, and we have evidence that sigma is, in fact, being reduced across the military.

To ensure program success and smooth integration into existing processes, small scale implementation at high-deployment platforms began in June 2005. Lessons learned from that small scale implementation served to inform our program deployment, which began in January 2006. We continue implementation with units scheduled for return deployments and also based on the Services’ identification of highest needs. Implementation has continued to roll-out across the military departments. As of December 31, 2006, 186,574 service members have completed a post-deployment health reassessment with 28% of these individuals receiving a referral for additional evaluation.

### **Satisfied Beneficiaries**

Our beneficiaries continue to give the TRICARE program high marks in satisfaction. Overall satisfaction with the TRICARE health plan has risen significantly and consistently each year since 2001. Given the stresses of war during this time period, this is a remarkable achievement. The annual Outpatient Satisfaction Survey of military health system beneficiaries provides feedback that permits us to benchmark the satisfaction of beneficiaries with their outpatient experience at military treatment facilities against civilian health maintenance organizations. For the period of October 2005 through September 2006, military health system beneficiaries’ overall satisfaction with medical care in the outpatient setting was 6.11 compared with the national civilian benchmark of 6.18 (on a seven-point scale where 7 is *completely satisfied*). For the same time period, military health system beneficiaries’ overall satisfaction with the clinics at which outpatient services were provided was 6.02 percent compared with the national civilian benchmark of 6.13 percent.

The military health system also administers the TRICARE Inpatient Satisfaction Survey to assess beneficiary satisfaction with inpatient care (military treatment facility and network). For the period of July 1, 2005, to September 30, 2005, 79 percent of beneficiaries who received care from military treatment facilities were very satisfied with their care as compared with the civilian benchmark of 81 percent. Eighty-one percent of beneficiaries who received care from network facilities were very satisfied with their care.

We added financial incentives for improving beneficiary satisfaction for the contractors, and ensured contractors are financially rewarded for care delivered in the private sector. Through our new military health system governance and strategic plan, we are focusing on the effectiveness and efficiencies of military treatment facilities and

adding performance-based management and patient-centered care initiatives to transform our patients' experience.

We have also enhanced our beneficiaries "online" capabilities and unveiled a new "TRICARE Online" web portal in November 2006. This online service allows beneficiaries to more easily enroll, make appointments, obtain pharmacy refills, check the status of their TRICARE claims, perform online health assessment for specific disease risk and more. To our knowledge, there is no medical system in the world that arranges for a greater number, or percentage, of its appointments via the Internet than does ours.

### **Creation of Healthy Communities**

We have the internal ability to expand upon two major initiatives in the coming years: increasing the use of evidence-based medicine, and increasing the patient-provider partnership in sustaining health.

We need to do more to bring our patients along as partners in their health care. We are increasing the services available to specific populations – seeking to stem the adverse effects of alcohol abuse, tobacco usage, and obesity. The DoD has developed and implemented a series of demonstration and pilot projects to address the key health behaviors associated with premature and preventable death identified in the 2002 Health Related Behavior Survey. Known as the "Health Lifestyles Initiatives," these projects address the increase in tobacco use, obesity, and alcohol misuse and abuse among beneficiaries, both active and non-active duty identified in the survey. These health promotion activities are primarily aimed at disease prevention and the adoption of healthy behaviors while testing the effectiveness of comprehensive benefits not currently covered by TRICARE. The tobacco cessation and weight management demonstrations are comprehensive behavioral interventions that provide pharmacotherapy in addition to a telephone quitline, a web-based educational tool, individualized quit kits for tobacco cessation and health/weight loss coaching, telephone and web-based educational and motivational information for weight management.

The alcohol abuse pilot project employed web-based tools to educate and assess participants' knowledge of alcohol abuse, attitude towards alcohol use and abuse and current alcohol use. Preliminary results of the pilot study show that participants had a significant reduction in binge and heavy drinking as well as real reductions in the number of drinks per occasion. The more important, longer term follow up of these results will be conducted in year two of the project.

The 2002 DoD Survey of Health Related Behaviors Among Military Personnel indicated that rates of cigarette use, heavy alcohol use, and overweight had all risen since 1998, and that these three health threats are particularly focused among our young enlisted population. To respond to these threats, TRICARE has undertaken counter-marketing campaigns to encourage quitting tobacco and reduction in binge drinking among the young enlisted population. We are also conducting three demonstration projects to determine the most effective healthcare interventions for smoking cessation, alcohol education, and behavioral weight loss.

Both counter-marketing campaigns use themes developed from focus group research among our young enlisted population. Since humor and emphasis on everyday negative consequences appealed to the target audience, a popular icon who is out of control, “That Guy”, was selected as an effective mechanism and a campaign theme to reduce binge drinking. The second campaign theme, “Quit Tobacco. Make Everyone Proud”, was chosen because target audience members had a favorable response to appeals that use their position as role models, particularly to children, as a motivation to quit using tobacco. The alcohol counter-marketing campaign is currently being tested at four military installations. The initial test rollout of the anti-tobacco campaign is scheduled for February 2007.

We will also be introducing targeted disease management programs to engage our patients by offering tools and technologies that can reduce hospital admissions, visits to the emergency rooms, and poor quality of life. Our approach to disease management is two-fold: (1) keep the well healthy with a focus on healthy lifestyles, disease prevention, and health promotion and (2) maintain an active disease management program for high risk beneficiaries with specific chronic disease conditions. Evidence-based clinical practice guidelines and educational resources developed jointly by the Departments of Defense and Veterans Affairs are used in both the military treatment facility and managed care support contractor disease management programs.

On September 1, 2006, the Military Health System implemented a new disease management initiative based on a consistent approach across all three managed care regions, focusing on asthma and congestive heart failure. The NDAA 2007 further mandates the MHS disease management program to address, at a minimum: diabetes, cancer, heart disease, asthma, chronic obstructive pulmonary disorder, and depression and anxiety disorders. In the future we intend to expand our disease management efforts to the four other mandated chronic diseases mentioned above. The MHS disease management services are designed to help patients and their families better manage their conditions.

High quality care is safe care, and part of building healthy communities includes taking steps to minimize preventable harm as patients receive healthcare services. Both healthcare professionals and informed, prepared patients have roles to play in creating a safe patient experience. In a joint endeavor with the HHS Agency for Healthcare Research and Quality (AHRQ), the MHS has introduced TeamSTEPPS (Team Strategies and Tools to Enhance Performance and patient Safety) to improve quality and patient safety. TeamSTEPPS represents more than 20 years of research and evidence on teams and team performance in diverse areas such as aviation, nuclear power, business and healthcare. Ineffective, inadequate communication is a major contributing factor for medical errors. TeamSTEPPS provides the tools to counter this problem area. Our goal is to share this important tool with every health care facility in America to help them create and continue team training systems. Facilities that have implemented the program are already observing improvements in patient safety.

Creating healthy communities and increasing the personal engagement of the patient in their own health care has been significantly enhanced by the deployment of AHLTA – DoD’s comprehensive, global electronic medical record and clinical data repository. AHLTA creates a life-long, computer-based patient record for each and every military health beneficiary regardless of their location, and provides seamless visibility of health information across our entire continuum of medical care, giving our providers unprecedented access to critical health information whenever and wherever care is provided to our service members and beneficiaries.

The system is secure, standards based, and patient centric, for use in our garrison based medical facilities and our forward deployed medical units. AHLTA provides our physicians with decision support and builds a single encounter document out of a team effort, linking diagnoses, procedures and orders into one record.

Worldwide deployment of AHLTA, which began Jan 2004, was successfully completed at all 138 DoD Military Treatment Facilities in Nov 2006. Implementation support activities spanned 11 time zones and included training for 55,242 users, to include 18,065 healthcare providers. DoD’s Clinical Data Repository is operational, and currently contains electronic clinical records for over 8.7 million beneficiaries. AHLTA use continues to grow at a significant pace. To date, AHLTA has processed 37,028,253 outpatient encounters and is currently processing over 113,000 patient visits per workday. The accomplishments associated with the successful implementation of AHLTA are truly remarkable. It stands today as one of the most comprehensive, sophisticated and promising electronic medical record systems in the world.

## **Effective Management of Healthcare Costs**

Sustaining a medically ready military force and providing world-class health services for those injured and wounded in combat remains our primary mission. Yet, resources are not unlimited. Military commanders, defense leaders and our elected official rightly expect us to simultaneously manage healthcare costs and provide outstanding health care to our beneficiaries. We are working hard to manage the MHS more efficiently and effectively with the resources we have. Let me highlight what we are doing.

The most comprehensive changes to our system in a generation will have been brought about by the Base Realignment and Closure decisions. The BRAC recommendations will improve use and distribution of our facilities nationwide, and affect healthcare delivery and medical training across the MHS. The consolidation of medical centers in the National Capital Area and San Antonio will improve operations by reducing unnecessary infrastructure, rationalizing staff, and providing more robust environments to support Graduate Medical Education. In some areas, we expect to significantly enhance care by providing services closer to where our beneficiaries reside, for example at Fort Belvoir, Virginia. By contrast, in smaller markets, MHS facilities will cease to provide inpatient services and instead focus on the delivery of high quality



ambulatory care.. The BRAC recommendations will bring most medical enlisted training programs to Fort Sam Houston. As a result, the MHS will reduce its overall technical training infrastructure while strengthening the consistency and quality of training across the Services.

Important activities are underway at all facilities affected by BRAC, and the key to our success in BRAC is the creation of sound planning principles to shape these new structures in ways that are joint, interoperable, non-redundant, and effective. In November 2006, following many months of work lead by my office and the Joint Staff, the Deputy Secretary of Defense issued a policy that establishes new joint authority structures for a governance model that will serve our system well in aligning responsibility and authority throughout the military health system. We will consolidate and operate more jointly our large medical delivery markets, education and training, medical research and development, and critical back office-shared service functions that support the entire MHS.

Finally, the aging and overcrowded facilities at USAMRIID will be replaced with a cutting edge, modern research facility that will continue to produce medical countermeasures to the world's deadliest diseases. The new USAMRIID will serve as the cornerstone of the emerging National Biodefense Campus at Fort Detrick, Maryland, which is currently under development with the Department of Homeland Security and the National Institute of Allergy and Infectious Diseases. We are also planning for a replacement facility to support the U.S. Army Institute of Chemical Defense at Aberdeen, MD, the nation's premier center of excellence to identify and develop medical countermeasures for chemical warfare agents. The transformation of our physical infrastructure will help us meet the demands of the evolving war on terrorism and the potential threats we face today.

Despite our success in more efficiently managing health care costs utilizing a variety of initiatives, much work remains to be done. We continue to use a number of proven means to reduce health care costs in our system. These include:

- Obtaining significant savings at our MTFs and mail order venue when compared to the retail point of service. The acquisition price of brand name drugs, which represent the bulk of pharmaceutical expenditures in DoD, average 25 to 40% less at MTFs and mail order when compared to retail.
- Implementing the new TRICARE formulary. We estimate savings of over \$500 million in just the past two years due to key formulary management changes and decisions.
- Effective TRICARE contracting strategy that has reduced administrative costs, and our efforts to further enhance the next generation of TRICARE contract is well underway. Again, our Chief Financial Officer estimates several hundreds of millions of dollars in savings due to these new contracts.
- Further increases in Department of Veterans Affairs (VA) and the Department of Defense (DoD) sharing of facilities, capabilities, and joint procurements.

- The introduction of new prime vendor agreements to lower costs of MTF medical and surgical supplies. The MHS has aggressively negotiated preferential pricings with medical supply vendors across the country, and we project savings of \$28.3 million in 2007.

We continue to implement a Prospective Payment System in a phased, manageable way, and we incentivize local commanders to focus on outputs, rather than on simple, historical budgeting. We are confident this budgeting approach will ensure our hospitals and clinics remain high quality, highly efficient medical institutions in service to our patients.

Using our strategic planning tool – the Balanced Scorecard – we are identifying the most critical mission activities, and then using the Lean Six Sigma methodology to create a data-driven, decision-making culture for process improvement. The Service Surgeons General have aggressively incorporated this methodology into their business operations, and we are already witnessing the fruits of this engagement.

In Fall 2006, we began the Innovations Investment Program, designed to identify the best practices in place at select MTFs or best practices utilized by private sector health care firms and introduce them to DoD on a global scale. Our intent is to accelerate the introduction of these best practices, using a joint service, interdisciplinary team of experts to evaluate, validate and then implement proven approaches to better health care delivery. The evaluation phase is already underway, and we plan to begin substantive program changes in the coming year.

Finally, last year the Administration proposed to Congress changes in the TRICARE benefit to place the Defense Health Program on a sustainable financial footing. The Department of Defense has not altered the TRICARE benefit in the last 13 years, except when this benefit was enhanced through reductions in co-pays, expansions in covered services (particularly for military beneficiaries over age 65), new benefits for the Reserve Component, and other select benefit enhancements.

These benefit enhancements have come at a time when the private sector is shifting substantially more costs to employees for their health care. The twin effect of greater benefits for DoD beneficiaries, coupled with reduced benefits for those in the private sector has led to a significant increase in military retirees electing to drop their private health insurance and become entirely reliant on TRICARE for their health benefit.

Although no action was taken last year to change TRICARE co-payments, the underlying problem continues unabated. In 2006, our proposals were estimated to reduce military health care costs by more than \$11 billion over 5 years. Our estimates for cost growth through 2013 are not complete, but we are still witnessing sizable growth in the number of “TRICARE reliant” beneficiaries in our system, and the pressures on the defense budget grow. As directed in the NDAA for FY 2007, a Task Force on the Future of Military Health Care has been recently established with distinguished membership from within the Department, other federal agencies and the civilian sector. A key area

the Task Force will study and make recommendations on is “beneficiary and government cost sharing structure.” We believe this and the other recommendations they make will markedly benefit the MHS in the future.

Simply put, the Department and Congress must work together to allow the Department to make necessary changes to the TRICARE benefit affecting the long term cost structure of our program. Failure to do so will harm military health care and the overall capabilities of the Department of Defense – outcomes we cannot afford.

### **Sharing Initiatives with VA**

As we continue to seek ways to improve the healthcare for our beneficiaries, we constantly explore new avenues of partnership with the Department of Veterans Affairs (VA). We have established 504 sharing agreements covering 2,090 health services with the VA, and in FY 2006, 98 VA Medical Centers reported reimbursable earnings during the year as TRICARE Network providers. Every day we collaborate to further improve the healthcare system for our service members; we have substantially increased joint procurement, and we are working to publish jointly used evidence-based clinical practice guidelines for disease management to improve patient outcomes.

We are committed to working with the VA on appropriate electronic health information exchanges to support our veterans. The Federal Health Information Exchange is an important capability that enables the transfer of protected electronic health information from DoD to the VA at the time of a service member’s separation. We have transmitted messages to the FHIE data repository on more than 3.7 million retired or separated Service members. Building on the success of FHIE, we are now sending electronic pre- and post-deployment health assessment information to the VA. Monthly transmission of electronic pre- and post-deployment health assessment data to the FHIE data repository began in September 2005. More than 1.5 million pre- and post-deployment health assessments on over 623,000 individuals are available to the VA. In December 2006, we added weekly data pulls of post-deployment health reassessments for individuals referred to the VA for care or evaluation. DoD and the VA are also in the process of assessing our requirements for the potential joint development of an inpatient module for our electronic medical record.

Both the VA and DoD are committed to providing our service members a seamless transition from the MHS to the Veterans Health Administration. DoD implemented a policy entitled “Expediting Veterans Benefits to Members with Serious Injuries and Illness,” which provides guidance on the collection and transmission of critical data elements for service members involved in a medical or physical evaluation board. DoD began transmitting pertinent data to the VA in October 2005 and continues to provide monthly updates. We have provided information for 13,622 service members while they were still on active duty, allowing the VA to better project future workload and resource needs. Receiving this data directly from DoD before these service members separate eliminates potential delays in developing a claim for benefits by ensuring that

VA has all the relevant information to decide claims for benefits and services at the earliest possible time.

## **Conclusion**

Our military engagements in Iraq, Afghanistan and other locations, combined with our medical humanitarian missions and our “peacetime” health delivery mission have simultaneously tested the MHS. Our medics continue to exceed the expectations of all our stakeholders.

Yet, the critical concept that Military Health System leaders share is simple – we can never be satisfied with our accomplishments. The people we serve – our line commanders and civilian leadership; our service members and military families; and the representatives of the American people in the Congress – expect us to accomplish even more, and to build upon our successes.

And there is more work to do: Investments in medical technologies to protect and defend our military community against future threats is paramount; wise stewardship of limited taxpayer dollars to sustain a quality health system serving more than 9 million Americans; and the commitment to continued military and professional development of medics of all types – physicians, dentists, nurses, enlisted specialists, and administrators.

The expectations that so many people, in so many places, hold for this country’s military health system are very high. Our responsibility in the coming year – and years – is to continue to exceed these expectations. Our obligations are to those who follow us - today’s sergeants and corporals, lieutenants and captains, and civilians now rising through the system. With the assured support of the DoD leadership and of Congress, the MHS remains committed to sustaining and passing on this legacy of achievement and stewardship for the medical leaders of the future. On behalf of the MHS, I am grateful for the resources and encouragement you provide to all who serve, and look forward to working with you in the coming year.