THE MILITARY HEALTH SYSTEM

TESTIMONY

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BEFORE THE

SENATE VETERANS AFFAIRS COMMITTEE

UNITED STATES SENATE

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MEETING THE HEALTH CARE NEEDS OF RETURNING

SERVICE MEMBERS AND NEW VETERANS

NOT FOR PUBLIC RELEASE UNTIL

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Thank you, Mr. Chairman, for the opportunity to speak to you today on behalf of the Assistant Secretary of Defense for Health Affairs regarding the health care needs of returning service members and new veterans.

The Department of Defense, and the military health system in particular, is committed to protecting the health of our Service members, providing world-class healthcare to more than 9 million beneficiaries, and, seamlessly coordinating the transition of Service members' medical care to the Department of Veterans Affairs (VA) whenever necessary.

Over the last several years, our two Departments have made significant strides in coordinating and developing common health care and support services along the entire continuum of care. Both agencies have been making concerted efforts to work closely to maintain and foster a more effective, aligned federal healthcare partnership. The Global War on Terrorism poses a challenge to both departments, as the severity and complexity of wounds, and the increased survival rates yield increasing demands on our system for long term rehabilitative care for our wounded, injured and ill combat veterans. We owe much to them for their sacrifice to our nation, and we are committed to work together to ensure they get the very best that our health systems can offer, and keeping their associated bureaucratic burdens to a minimum.

In April 2003, a DoD-VA Joint Executive Council (JEC), chaired by the Under Secretary of Defense for Personnel and Readiness and the Deputy Secretary

of the Department of Veterans Affairs, was established to jointly set strategies, goals and plans to better align and coordinate the health and benefit services of the two Departments. The JEC meets quarterly to review progress against the mutually developed plans.

The VA/DoD Joint Strategic Plan reflects common goals from both the VA Strategic Plan and the Military Health System (MHS) Strategic Plan – and specifically articulates the shared goals and objectives developed and ratified by DoD/VA leadership. Three weeks ago, Dr. David S. C. Chu, Under Secretary of Defense for Personnel and Readiness, and Mr. Gordon H. Mansfield, Deputy Secretary, Department of Veterans Affairs, directed additional joint initiatives to improve alignment, leverage shared resources, and improve delivery of care to our returning combat veterans.

The spectrum of DoD-VA collaboration and sharing activities encompasses clinical services, education and training, research and development, patient administration, and information/data technology sharing. Before providing an overview of these activities, I'd like to briefly highlight the Departments' response to the recent findings of inadequate administration of support services, care coordination, and disability processing. The Department is strongly committed to taking corrective actions to improve performance in these areas. Secretary Gates has formed an Independent Review Group (IRG) to advise him on actions that need to be taken, each Military Department has undertaken a focused review of

these matters, and the Under Secretary of Defense for Personnel and Readiness Dr. Chu, has convened a working group to assess ways to improve policies and programs based on the results of these ongoing reviews. DoD is also cooperating with the President's Commission on Care for America's Returning Wounded Warriors and is participating actively in the Interagency Task Force on Returning Global War on Terror Heroes.

DoD's collective focus is centered on five major program areas:

1. ***Facilities*.** DoD's medical facilities, outpatient housing, medical barracks, and the full spectrum of hotel services provided by the Department are being assessed to ensure standards of quality our Service members and families expect and deserve are met.

2. ***Case Workers/Case Managers and Family Support***. Practices for case management, including care coordination, case-manager-to-patient ratios, family support models, and related support services are being assessed to ensure our wounded and ill Service members get needed support throughout their healthcare delivery and rehabilitation, regardless of whether their care is delivered in DoD or VA facilities. In some instances, patients will continue to obtain care in both systems. For that reason, establishing case-management protocols and systems that seamlessly support all configurations of care in both systems is a high priority.

3. ***Disability Determination Processes***. Medical, personnel, and disability-benefit determination experts within and outside the DoD are actively involved in an effort to develop and recommend a streamlined process that minimizes delay while providing fair, consistent, and timely determinations for all Service members.

4. ***Traumatic Brain Injuries (TBI) and Treatment of the Severely Injured.*** Since the Global War on Terrorism began, DoD has been collaborating with VA on the full spectrum of combat wounds, injuries and associated illnesses, particularly those occurring as a result of improvised explosive devices. Both Departments are working together to identify best practices for providing and supporting highest quality acute and long term care for severely injured and ill servicemembers, as well as to determine the most effective means to screen, diagnose, and treat individuals who experience a TBI. Civilian TBI experts and researchers are important collaborators to both Departments in shaping how to apply available research outcomes in establishing an evidence-based, comprehensive program in both systems to detect, diagnose and treat this health risk to our servicemembers and veterans.

5. ***Post-Traumatic Stress Disorder (PTSD) / Mental Health***. The short-term and long-term mental health needs of our Service members and veterans are major priorities of both Departments. To further transition

support, a VA/DoD Mental Health Working Group was formed in 2003 under the Joint Executive Council to focus specifically on mental health initiatives and transition of care. DoD continues to critically evaluate its capabilities, policies and programs to ensure effective support for returning servicemembers and new veterans' mental health needs, including their families. This includes looking at improved methods of information sharing from VA medical records regarding mental health conditions and treatments for Reserve Component members that may contraindicate future deployments. With the renewed support of the line commanders and leaders, new approaches to reducing the stigma of seeking mental-health treatment will be explored. We will continue to pursue expanded opportunities for collaboration with VA to ensure the coordinated transition of veterans with mental-health needs.

Supporting all of these collaborative efforts, we will continue to grow, enhance, align, and integrate the technology infrastructure that supports both systems, enabling greater access to clinical and administrative information for the benefit of the people we serve.

The following provides greater detail on our comprehensive sharing initiatives:

Overall DoD-VA Sharing Efforts

As a result of the National Defense Authorization Act for FY 2003, VA and DoD have been actively collaborating on a wide spectrum of joint initiatives. Section 721 of that Act required that the departments establish, and fund on an annual basis, an account in the Treasury referred to as the Joint Incentive Fund (JIF). The JIF provides a means to eliminate budgetary constraints as a possible deterrent to sharing initiatives by providing designated funding to cover the start-up costs associated with innovative and unique sharing agreements. At the end of FY 2006, 47 JIF projects—accounting for $88.8 million of the $90 million in the fund—had been approved by the Health Executive Council out of a total of more than 200 proposals. The 2006 projects cover such diverse areas of medical care as mental-health counseling, Web-based training for pharmacy technicians, cardio-thoracic surgery, neurosurgery, and increased physical therapy services for both DoD and VA beneficiaries.

We also are jointly staffing a number of federal health facilities. These include:

- The Center for the Intrepid – opened in January 2007, provides a state-of-the-art facility in San Antonio, Texas, explicitly to rehabilitate wounded warriors. This follows the Walter Reed Amputee Training Center's example of on-site collaboration.
- Integrated DoD-VA operations in several locations, for example: North Chicago (Great Lakes Naval Station); New Mexico (Kirtland AFB); Nevada

(Nellis AFB); Texas (Fort Bliss); Alaska (Elmendorf AFB); Florida (NAS Key West); Hawaii (Tripler AMC), and California (Travis AFB).

- At the end of FY 2006, DoD military treatment facilities and Reserve Units were involved in sharing agreements with 157 VA Medical Centers, enabling improved visibility of medical needs in VA for reservists entitled to VA care after returning from combat operations.

Coordinated Transition

Coordinated transition involves effectively managing medical care and benefits during the transition from active duty to veteran status to ensure continuity of services and care. Efforts to date have focused on enabling Service members to enroll in VA healthcare programs and file for VA benefits before separation from active duty status. Additionally, the Department has been engaged with VA on initiatives and programs supporting coordinated transition focused on three general areas: 1) medical care and disability benefits, 2) transition to home and community, and 3) sharing Service member personnel and health information. The Joint Executive Council has established a Coordinated Transition Working Group to examine and make recommendations for improvement to the transition process.

For Service members who transition directly from DoD military treatment facilities to VA medical centers, DoD and VA implemented the Army Liaison/VA Polytrauma Rehabilitation Center Collaboration program—also called “Boots on

the Ground"—in March 2005. This program is designed to ensure that severely injured Service members (primarily Army soldiers) who are transferred directly from a military treatment facility to one of the four VA Polytrauma Centers – in Richmond, Tampa, Minneapolis, and Palo Alto – are met by a familiar face and a uniform. A staff officer or non-commissioned officer assigned to the Army Office of the Surgeon General is detailed to each of the four locations, to provide support to the family through assistance and coordination with a broad array of such issues as travel, housing, and military pay. This coordination process has been working exceptionally well. However, this transition has not always worked as well when Service members are transferred to other locations around the country. In response, VA opened 21 new Polytrauma Network Sites in FY 2006 to provide continuity of care to injured Service members. The Department deeply values the sacrifices that these veterans and their families have made. With our VA colleagues, we are committed to doing all we can to improve our coordination and case management of Service members who transition to any VA facility.

VA also is placing personnel in our medical facilities. The Joint Seamless Transition assists severely injured Service members while they are still on active duty so that they can receive benefits in a timely manner. There are 12 VA social workers and counselors assigned at 10 military treatment facilities, including Walter Reed Army Medical Center and the National Naval Medical Center in Bethesda. These social workers ensure the seamless transition of healthcare,

including a comprehensive plan for treatment. Veterans Benefits Administration counselors visit all severely injured patients and inform them of the full range of VA services, including readjustment programs, educational and housing benefits. As of February 28, 2007, VA social worker liaisons had processed 7,082 new patient transfers to the Veterans Health Administration from participating military hospitals.

VA also partners with DoD medical facilities through a Cooperative Separation Physical Examination and Benefits Delivery at Discharge (BDD) program which began in 2004. The BDD program eliminates the disadvantage of previous procedures, in which Service members were required to undergo two physical examinations within months of each other. Under VA's BDD program, Service members can begin the claims process with VA up to 180 days before separation at any of the 131 DoD sites where local agreements have been established.

Finally, VA has placed liaisons in each of our three TRICARE Regional Offices in Washington, DC, San Antonio, TX, and San Diego, CA, providing an important communications and coordination link between the DoD and VA to better support our shared beneficiaries.

Within DoD, providing assistance and support to the families of wounded or ill servicemembers during this tumultuous time of transition continues to be a high priority. Thus, the Military Severely Injured Center (MSIC), established in

February 2005 within the Military Community and Family Policy Office, operates a hotline center which functions 24 hours a day, seven days a week. The center's mission is to identify and resolve policy and program gaps in support and augments and reinforces the support that each of the Service-specific programs — the Army Wounded Warrior Program, the Navy Safe Harbor program, the Air Force Helping Airmen Recover Together (Palace HART) program, and Marine4Life—provide.

Clinical Services

DoD and VA are working together on some of the most complex clinical matters emerging from the current war. We are developing joint Evidenced-Based Clinical Practice Guidelines that are means for disseminating throughout our systems the most current scientific and medical knowledge. These guidelines allow our organizations to provide fact-based state-of-the-art medical care that is easily transferable between the two medical care delivery systems.

Although our range of shared clinical activity spans most specialty areas, we are placing a particular focus in the following areas:

Mental Health. Mental-health services are available for all Service members and their families before, during, and after deployment. Service members are trained to recognize sources of stress and the symptoms of distress in themselves and others that might be associated with deployment. Combat-stress control and mental healthcare are available in-theater. In addition, before

returning home, we brief Service members on how to manage their reintegration into their families, including managing expectations, the importance of communication, and the need to control alcohol use.

After returning home, Service members are provided easy and direct access to mental healthcare services following a continuum of care model. Same-day appointments and daily walk-in appointments are available in military mental health clinics, and behavioral healthcare providers are integrated into primary care clinics in both the DoD and VA. TRICARE also is available for six months after return for Reserve and Guard members and TRICARE Reserve Select programs are available for continuing health insurance coverage for Reserve and Guard members and their families after the six-month transition period. To facilitate access for all Service members and family members, especially Reserve Component personnel, the Military OneSource Program—a 24/7 referral and assistance service—is available by telephone and on the Internet. In addition, we provide face-to-face counseling in the local community for all Service members and family members. We provide this non-medical counseling at no charge to the member, and it is completely confidential. For clinical care, family members can access mental health services directly in the TRICARE network. Up to eight sessions are available without a referral from a primary care manager and without pre-authorization requirements from TRICARE.

The Periodic Health Assessment (PHA) was added to the continuum of

assessments in February 2006. This annual requirement for all deployable assets of the Department includes a robust mental health section that complements the deployment health assessment process, allowing the opportunity for assessment, referral to care, and treatment outside the deployment cycle.

To supplement mental-health screening and education resources, we added the Mental Health Self-Assessment Program (MHSAP) in 2006. This program provides Web-based, phone-based, and in-person screening for common mental health conditions and customized referrals to appropriate local treatment resources. The program also includes parental screening instruments to assess depression and risk for self-injurious behavior in their children, along with suicide prevention programs in DoD schools. Spanish versions of the screening tools are available, as well.

Traumatic Brain Injury (TBI). The Department is working on a number of measures to evaluate and treat Service members affected or possibly affected with traumatic brain injury (TBI). For example, in August 2006, a clinical practice guideline for management of mild TBI in-theater for the Services was developed and fielded. Detailed guidance was provided to Army and Marine Corps line medical personnel in the field to advise them on ways to deal with TBI. The clinical practice guideline included a standard Military Acute Concussion Evaluation (MACE) tool to assess and document TBI for the medical record. TBI research in the inpatient medical area is also underway.

A program to integrate the outstanding work completed in TBI by the military departments has been initiated to establish a comprehensive DoD program, and experts from VA are included in this effort. This comprehensive program will provide system-wide common protocols and procedures to identify, treat, document, and follow up on those who have suffered a TBI while either deployed or in garrison. In addition, it will address TBI surveillance, transition to non-DoD care, long-term care, education and training, and research.

DoD has also modified the questions asked during the Post-deployment Health Assessment, the Post-deployment Health Reassessment, and the Periodic Health Assessment to help identify individuals who may have suffered a TBI.

Administration and Logistics

The DoD/VA Health Executive Council worked with industry to synchronize data on approximately 16,000 items from 17 manufacturers and more than 160,000 items from Prime Vendor distributors. A contract was awarded for a data synchronization pilot study to determine the best purchase of medical items from the healthcare industry. We continue to make progress on joint procurement activities. As of September 2006, there were 77 joint National contracts, 7 Blanket Purchase Agreements (BPAs) and 46 medical/surgical shared contracts.

Both Departments face a challenge familiar to health organizations, insurers, employers and individuals across the country – the rising costs of healthcare. One area – pharmacy – is particularly noteworthy. Nearly 6.7 million

beneficiaries use our pharmacy benefit, and in FY 2006, our total pharmacy cost was more than $6 billion. Our partnership with VA on joint contracting for prescription drugs is part of this solution, and our collective purchasing efforts have saved DoD more than $ 784 million in FY 2006.

Occupational Exposures

DoD and VA have collaborated on a number of recent projects related to occupational and environmental exposures. Projects related to chemical warfare agents and depleted uranium are two examples. DoD undertook a wide-ranging initiative to identify all exposures to chemical and biological agents from World War II to the present. To date, DoD has provided more than 19,000 names of test participants to VA. As part of this effort, DoD declassified the medically-relevant information from test records and identified the records of approximately 6,700 soldiers who were involved in testing of chemical agents, placebos, and/or pharmaceuticals in Edgewood, MD, during the period of 1955-75. DoD provided the names of these individuals, the dates of the tests, and the types of exposures to VA. VA and DoD collaborated on writing a letter to veterans to explain the history of the testing program and to provide information about the availability of VA healthcare. VA started mailing notification letters in June 2006.

We continue to monitor the health affects of our Service members exposed to depleted uranium (DU) munitions. DoD policy requires urine uranium testing

for those wounded by DU munitions. We also test those in, on, or near a vehicle hit by a DU round, as well as those conducting damage assessments or repairs in or around a vehicle hit by a DU round. The policy directs testing for any Service member who requests it. More than 2,215 Service member veterans of Operation Iraqi Freedom have been tested for DU exposures. Of this group, only nine had positive tests, and these all had fragment exposures.

Testing continues for veterans exposed to DU munitions from the 1990–1991 Persian Gulf War. The 74 individuals with the most significant exposures to DU in a Department of Veterans Affairs medical follow-up program have been extensively studied with physical exams and laboratory analyses for over 12 years. To date, none have developed any uranium-related health problems. This DU follow-up program is in place today for all Service members with similar exposures.

Health Information Technology and Data Sharing

In the health information technology arena, DoD and VA have engaged in a number of important efforts to share essential clinical and management information in support of health care services to our wounded service members and all eligible former military members who seek care from VA.

The work of capturing and sharing relevant clinical information between the DoD and VA begins on the battlefield. With the expanded use of the Web-

based Joint Patient Tracking Application (JPTA), our medical providers should have improved visibility into the continuum of care across the battlefield, and from theater to sustaining base. DoD grants access to JPTA for VA providers who are treating Service members in VA. In addition, we are working with VA to explore ways to share relevant patient injury/wound trend data to assist VA in predicting and preparing for treatment of OIF and OEF combat veterans.

Since September 2003, DoD has provided a roster to VA periodically, which lists OIF and OEF veterans who have either deactivated back to the Reserve/National Guard, or who have separated entirely from the military. VA uses this roster to evaluate the healthcare utilization of OIF/OEF veterans. VA performed its most recent analysis related to 631,174 veterans in November 2006. Thirty-two percent of these individuals had sought VA healthcare at least once. The three most common diagnostic categories were musculoskeletal disorders (mostly joint and back disorders), mental disorders, and dental problems. These data are quite useful in VA's planning for allocation of healthcare resources.

Service members who have substantial medical conditions are evaluated in the Physical Evaluation Board (PEB) process to determine if they are fit to stay on active duty or if they should be medically separated. DoD provides the names of individuals who enter the PEB process to VA, to facilitate the transition of care and to assist in starting the paperwork to provide VA benefits. In 2005, DoD and VA signed a memorandum of understanding that stated that DoD would send

these data to VA. In October 2005, DoD delivered the first list to VA of names, current locations, and medical conditions. Since then, DoD has sent a list of names to VA periodically, which will continue in the future. Data on more than 16,000 individuals have been transferred to VA. The Veterans Health Administration and Veterans Benefit Administration plan to send letters to these individuals to inform them about the availability of VA healthcare and disability benefits, respectively.

The Federal Health Information Exchange (FHIE) enables the transfer of protected electronic health information from DoD to VA at the time of a Service member's separation. Every month, DoD transmits laboratory results, radiology results, outpatient pharmacy data, allergy information, discharge summaries, consult reports, admission, disposition and transfer information, elements of the standard ambulatory data records, and demographic data on separated Service members. As of February 2007, DoD had transmitted more than 182 million messages to the FHIE data repository on more than 3.8 million retired or discharged Service members. This number grows each month.

DoD expanded the breadth of data transferred under the FHIE in recent years. In September 2005, we began monthly transmission of the electronic Pre- and Post-Deployment Health Assessment information to VA, followed in November 2006 with monthly transmission of Post-Deployment Health Reassessments (PDHRAs) for separated Service members and demobilized

National Guard and Reserve members. Weekly transmission of PDHRAs for individuals referred to VA for care or evaluation started in December 2006. As of February 2007, VA has access to more than 1.6 million assessment forms on more than 681,000 separated Service members and demobilized Reserve and National Guard members.

The FHIE has been successful in improving data sharing as Service members' transition from DoD to VA care. In some communities, however, beneficiaries eligible for both DoD and VA care may obtain care from both systems. The Bidirectional
Health Information Exchange (BHIE) enables the real-time sharing of allergy, outpatient pharmacy, demographic, laboratory, and radiology data between DoD BHIE sites and all VA treatment facilities for patients treated in both DoD and VA facilities. As of January 2007, BHIE was operational at 14 DoD medical centers, 17 hospitals, and more than 170 outlying clinics. In the 3rd Quarter FY 2007, all DoD sites and all VA sites will be able to view allergy information, outpatient pharmacy data, radiology reports, and laboratory results (chemistry and hematology) on shared patients.

We have begun testing our ability to share inpatient information, and successfully completed initial testing at Madigan Army Medical Center (AMC) and VA Puget Sound Health Care System (HCS) in August 2006 – enabling access to inpatient discharge summaries from Madigan AMC's Clinical

Information System (CIS) and VA's VistA system. We implemented this functionality in November 2006 at Tripler AMC where we make emergency department discharge summaries available to VA on shared patients. We also installed this functionality at Womack AMC in February 2007. We plan further deployment in additional DoD sites in FY 2007. In the future, we will make additional inpatient documentation, such as operative notes and inpatient consultations available to VA.

We also began the exchange of important clinical information between each of our clinical data repositories. The Clinical Data Repository/Health Data Repository (CHDR) establishes interoperability between DoD's Clinical Data Repository (CDR) and VA's Health Data Repository (HDR). In September 2006, the CHDR interface successfully exchanged standardized and computable pharmacy and medication allergy data between William Beaumont AMC and El Paso VA HCS on patients who receive medical care from both healthcare systems. Exchanging computable pharmacy and allergy data supports drug-drug and drug-allergy order checking for shared patients using data from both DoD and VA.

In December 2006, DoD also began deployment and VA continued field testing at Eisenhower AMC and Augusta VA Medical Center (MC) and at Naval Hospital Pensacola and VA Gulf Coast HCS. During the 2nd Quarter FY 2007, the organizations implemented CHDR at Madigan AMC and VA Puget Sound HCS, Naval Health Clinic Great Lakes and North Chicago VA HCS, Naval

Hospital San Diego-Balboa and VA San Diego HCS, and Mike O'Callaghan Federal Hospital and VA Southern Nevada HCS. By July 2007, DoD will send out instructions to sites to allow remaining DoD AHLTA locations to begin using CHDR.

Finally, the Laboratory Data Sharing Initiative (LDSI) facilitates the electronic sharing of laboratory order entry and results retrieval between DoD, VA, and commercial reference laboratories for chemistry tests. LDSI is available to all DoD and VA sites with a business case for its use. Either Department may function as a reference lab for the other. We are currently testing the addition of laboratory anatomic pathology and microbiology orders and results retrieval using the Logical Observation Identifiers Names and Codes (LOINC) and Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) standards.

While the DoD and VA are pleased with this accelerated data sharing over the last several years, we remain interested in even more collaborative efforts in the information technology arena. Both federal health systems are proud of their successful deployments of enterprise-wide health information technologies, AHLTA and VistA, yet we both are seeking a new inpatient electronic medical record system. Consequently, we have embarked on a study to explore the potential for a joint inpatient system. This would offer several potential benefits. First and foremost, electronic sharing of inpatient data would enhance our ability to provide "seamless transition" of medical data for our severely injured and

wounded Service members to VA care. Second, there are potential cost efficiencies that would derive from joint-license procurements and joint-development activities. Finally, such an effort would likely proliferate opportunities for additional data sharing between DoD and VA. The Departments have embarked on a joint assessment that will recommend to DoD and VA leadership the best strategy for accomplishing these objectives.

Our efforts in enhancing DoD-VA collaboration over the last several years have been successful. Yet, we are not satisfied that we have achieved all that is possible. We have an aggressive plan to work through some of the greater technological and management challenges in the coming year. With the support of the Congress, we are confident we will be successful.

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