

THE MILITARY HEALTH SYSTEM

OVERVIEW STATEMENT

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BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

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Mr. Chairman, distinguished members of this committee, thank you for the opportunity to discuss the Military Health System (MHS). The MHS serves more than 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 healthcare to more than 9 million beneficiaries. The Fiscal Year (FY) 2008 Defense Health Program funding request is \$20.7 billion for Operation and Maintenance, Procurement and Research, and Development, Test and Evaluation Appropriations to finance the MHS mission. We project total military health expenditures, including personnel expenses, to be \$40.5 billion for FY 2008. This includes payment of \$10.9 billion to the Department of Defense Medicare Eligible Health Care Retiree Health Care Fund.

As you know, the Department faces a tremendous challenge with the growing costs and long-term sustainability of the Military Health System. We need important changes in our great health benefit program, TRICARE, to ensure a superior benefit for the long term. We need the help and support of Congress to achieve this goal. As a placeholder, our FY 2008 budget request assumes the second-year implementation of the user fees proposed in the FY 2007 President's Budget for a savings of \$1.9 billion, unless the Department of Defense Task Force on the Future of Military Health Care established by Public Law 109-452 recommends alternative acceptable savings measures.

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

In the past year, the MHS took several additional 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 to develop greater joint capabilities and joint operations. I will outline a number of these initiatives today.

We guide all of our efforts through 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 road map, to provide a long-term perspective on the critical imperatives that will determine our success for the years ahead. We shaped our strategic plan with the recommendations contained in the 2006 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 the following 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 healthcare costs

Our internal measures and those of independent, external organizations show 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**

Our primary objective is ensuring that every service member is medically protected and fit for duty. 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 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 we use 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. We are in the process of restarting the mandatory anthrax vaccination program, after the FDA published the Final Order confirming that the anthrax vaccine absorbed (AVA) is safe and effective for its labeled indication to protect individuals at high risk for anthrax disease.

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 have 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 have found that approximately half of them report physical concerns, such as back or joint pain, and a third of them have mental-health concerns. This additional evaluation gives medical staff an opportunity 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 the direction of Congress, 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, more than 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. Our FY 2008 budget request includes \$381 million to cover the costs of this expanded benefit.

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

Our military medical personnel have performed extraordinarily on the battlefield and in our medical facilities in the United States. Our investments in people, training, technology and equipment have paid major and historic dividends. We have established new standards in virtually every major category of wartime medicine:

- **Lowest Disease, Non-Battle Injury (DNBI) Rate.** As a testament to our medical readiness and preparedness, with 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 10 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. We changed our 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 563 individuals who have had major limb amputations, approximately six percent 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 everyone who goes to war changes. 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. This assessment also includes 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 through 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, some people in our country still stigmatize those who seek mental-health services. We believe that through this follow-on reassessment tool, we can reduce the stigma as a barrier to needed care. In fact, we have evidence that we are already reducing this stigma across the military.

We began small-scale implementation at high-deployment platforms in June 2005 to ensure program success and smooth integration into existing processes. Lessons learned from that small-scale implementation informed our program deployment, which began in January 2006. We are basing current implementation efforts on the Services’ identification of those with highest needs and on units scheduled for return deployments. We are rolling out implementation across the military departments. As of January 29, 197,385 service members have completed a post-deployment health reassessment. Twenty-eight percent of these individuals received 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 compared with the national civilian benchmark of 6.13.

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 to improve beneficiary satisfaction from our contract partners and ensured our contractors are financially rewarded for care delivered in the private sector. Through our new MHS 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' experiences.

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, and 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 make our patients partners in their healthcare. 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. We are primarily focusing these health-promotion activities on 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. The tobacco-cessation demonstration provides pharmacotherapy in addition to a telephone quitline, a Web-based educational tool, and individualized quit kits. The weight-management demonstration provides health/weight loss coaching, as well as telephone and Web-based educational and motivational information.

The alcohol-abuse pilot project employs Web-based tools to educate and assess participants' knowledge of alcohol abuse, attitudes 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. We will conduct the more important, longer-term follow-up of these results 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 occur in 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.

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, we selected a popular icon who is out of control, "That Guy," as an effective mechanism and a campaign theme to reduce binge drinking. We chose the second campaign theme, "Quit Tobacco. Make Everyone Proud," 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 starts on February 20, 2007, in two media markets: Seattle (at McChord Air Force Base and Fort Lewis) and San Diego (at San Diego Naval Base and Camp Pendleton).

Recently, we announced the 2005 DoD Health Related Behaviors Survey. We added questions that addressed deployment issues and were pleased to find that the self-reported information indicated our military personnel are coping with the rigors of conflict and separation from family and home.

Although we found that most personnel use such positive coping mechanisms as talking to friends or exercising to cope with stress, we want to focus on those who report using unhealthy behaviors to help cope with their stress. We are quite concerned that of personnel who were deployed last year 13.6 percent began using or increased their use of alcohol since being deployed; however, we are pleased that 17 percent stopped or decreased their alcohol use since deployment. We are also concerned that 10.3 percent began smoking or increased their cigarette smoking, 6.1 percent began using or used more smokeless tobacco, and 6.3 percent began or increased their cigar smoking.

However, 66.8 percent of the military personnel who were "smokers" in the past year made an attempt to quit during the last year. We are also pleased that 66.2 percent of military personnel indicated they were either "satisfied" or "very satisfied" overall with their current work assignment. Military personnel were notably and significantly less likely than civilians to use any illicit drugs in the past 30 days (4.6 percent versus 12.8 percent).

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 twofold: 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. We are using evidence-based clinical-practice guidelines and educational resources developed jointly by the Departments of Defense and Veterans Affairs in both the military treatment facility and managed care support contractor disease-management programs.

On September 1, 2006, the MHS 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 for fiscal year 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.

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 such diverse areas 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 healthcare 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.

AHLTA – DoD’s comprehensive, global electronic medical record and clinical data repository – significantly enhances our effort to create healthy communities and increase patients’ personal engagement in their own healthcare. 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. This gives 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. In addition, AHLTA offers clinical reminders for preventive care and clinical-practice guidelines for those with chronic conditions.



In November 2006, we successfully completed worldwide deployment of AHLTA, which began in January 2004, at all 138 DoD Military Treatment Facilities. Our implementation-support activities spanned 11 time zones and included training for 55,242 users, including 18,065 healthcare providers. DoD's Clinical Data Repository is operational and contains electronic clinical records for more than 8.7 million beneficiaries. AHLTA use continues to grow at a significant pace. As of the end of January 2006, our providers had used AHLTA to process 38,647,198 outpatient encounters, and they currently process more than 113,400 patient visits per workday.

Additional components to AHLTA are yet to be unveiled, including a new inpatient module. Last month, at the American Health Information Community meeting, VA Secretary Nicholson and I announced that DoD and the Department of Veterans Affairs will collaborate to develop a joint inpatient electronic health record system for active duty military personnel and veterans. This is a groundbreaking decision.

The DoD and VA are a federal information-sharing success story. Because of our sharing of clinical data, we are already decreasing redundant tests and procedures for our patients, and reducing errors that are inherent to a paper records system.

AHLTA contains the largest computable and structured medical data repository in the world. As you know, we are leading the nation in standards adoption and interoperability.

Before the end of this decade we will be using AHLTA as a central research and planning tool, leveraging its computable health data to improve patient outcomes through prevention, early detection, and proper intervention.

Our 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, our resources are limited. Military commanders, defense leaders and our elected officials rightly expect us to simultaneously manage healthcare costs and provide outstanding healthcare 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 be 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 led 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 common-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, Maryland, 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 healthcare costs utilizing a variety of initiatives, much work remains to be done. We continue to use a number of proven means to reduce healthcare costs in our system. These include:

- Obtaining significant savings for pharmaceuticals at our military treatment facilities 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 percent to 40 percent less at military treatment facilities and mail-order when compared to retail.
- Implementing the new TRICARE pharmacy formulary. We estimate savings of more than \$500 million in just the past two years due to key formulary-management changes and decisions.
- Contract strategies. Effective TRICARE contracting strategies have reduced administrative costs, and our effort to further enhance the next generation of the TRICARE contract is well underway. Once 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 military treatment facility 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.

In support of the Secretary of Defense initiative to relieve stress on operational forces by returning military billets to a war-fighter role, we embarked on a thorough analysis of our medical force structure. The Medical Readiness Review was an integrated approach to analyzing our force composition and defining an optimal balance of uniformed personnel and civilians. As a result of this analytical process, we are now leveraging military-to-civilian conversions as an effective tool to reduce costs and sustain operational readiness while continuing to provide high-quality, accessible healthcare.

We are carefully evaluating proposed conversions for potential impact. Only those opportunities that will not increase costs and will not degrade quality of or access to care are selected for implementation. Since the beginning of this initiative, the Congress has required that the Service Secretaries certify that conversions will not negatively impact their mission. This certification process has been delayed by successive FY 2007 Continuing Resolutions, in which funding for planned conversions has not been provided. Inadequate or delayed funding impedes our ability to certify and execute the conversions and puts projected savings at risk. It also has the potential to impact access to care if funds are not available to hire qualified staff to replace the departing service member.

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 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 the fall 2006, we began the Innovations Investment Program, designed to identify the best practices in place at select military treatment facilities or best practices utilized by private-sector healthcare 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 healthcare 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 age 65 and over), 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 healthcare. 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 the Congress took no action last year to change TRICARE co-payments, the underlying problem continues unabated. In 2006, our proposals were estimated to reduce military healthcare 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. Military health care costs continue to increase substantially. The FY 2008 President's budget request includes a legislative proposal that aligns TRICARE premiums and co-payments for working age retirees (under age 65-years) with general health insurance plans. The Department may modify or supplement this request after it considers recommendations from the Department of Defense Task Force on the Future of Military Health Care that 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 on which it will make recommendations 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 to better manage the long-term cost structure of our program. Failure to do so will harm military healthcare 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. We began this monthly transmission of electronic pre- and post-deployment health assessment data to the FHIE data repository in September 2005. More than 1.5 million pre- and post-deployment health assessments on more than 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 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 VA. DoD implemented a policy entitled "Expediting Veterans Benefits to Members with Serious Injuries and Illness." This policy provides guidance for collecting and transmitting critical data elements for service members involved in a medical or physical evaluation board. DoD transmitted pertinent data to the VA from October 2005 through May 2006; thereafter transmissions were discontinued while enhancements to the security were, and continue to be, explored.

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. When the VA receives these data directly from DoD before service members separate, it eliminates potential delays in developing a benefits claim. This process ensures that the 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 MHS 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; 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 medical professionals 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 the 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.

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