PRESIDENT'S TASK FORCE TO

Improve Health Care Delivery For Our Nation's Veterans

A Brief Guide to the Final Report

May 2003

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Preface

This document is extracted, for the reader's convenience, from the *Final Report* of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. Readers are strongly cautioned to form their conclusions only on the text of the full report, which places the importance of the findings of the Task Force in context. In addition, this document lists the recommendations of the Task Force for each of the issues reviewed.

The *Final Report* will be available online at *www.presidentshealthcare.org* until September 2003, when it will be available through the Department of Veterans Affairs website (home page *www.va.gov*).

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A Brief Guide to the Final Report

OUR COUNTRY OWES an enormous debt to those who have served in our Nation's Armed Forces. Providing enrolled veterans and military retirees with timely access to the full range of health benefits earned through service to their country is a central part of our national obligation.

For more than two decades, Congresses and Presidents have tried to increase collaboration and sharing between the Department of Veterans Affairs (VA) and Department of Defense (DOD) in order to improve the efficiency and cost effectiveness of health care delivery for beneficiaries. In May 2001, President George W. Bush signed Executive Order 13214 creating the President's Task Force (PTF) to Improve Health Care Delivery for Our Nation's Veterans. The PTF is comprised of 15 members appointed by the President, including two Co-Chairs.

The Task Force's Mission and Achievement

The President's charge to the PTF was to identify ways to improve health care delivery to VA and DOD beneficiaries through better coordination and improved business practices. In July 2002, the PTF presented preliminary findings in its *Interim Report*. The PTF's conclusions, together with a series of 23 specific recommendations for action, are presented in the group's *Final Report*. This document offers a brief overview of the final report, some context about the PTF's major areas of inquiry, and the text of each of the recommendations.

A Growing Dilemma

To gather information necessary for its *Final Report*, Task Force members visited numerous VA and DOD health care facilities around the country, conducted focus groups with beneficiaries, and met with many beneficiary organizations. Through this research, it became clear that there is a significant mismatch in VA between demand and available funding—an imbalance that not only impedes collaboration efforts with DOD but, if unresolved, will delay veterans' access to care and could threaten the quality of VA health care.

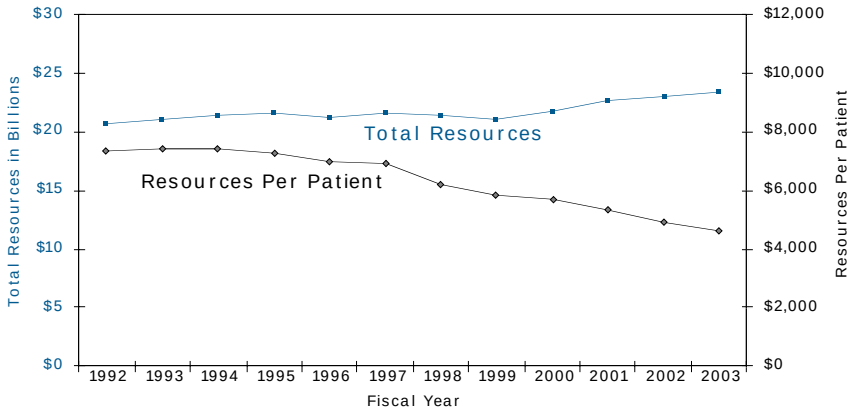
To its credit, VA has managed to cope within constrained resources over time by becoming a more efficient provider of care (see figure below). But increasing enrollee demand, combined with available funding, has forced significant reductions in per-patient expenditures beyond what could be expected from improved efficiency. PTF Members believe that even if VA were operating at maximum efficiency, it would be unable to meet its obligations to enrolled veterans with its current level of funding. A more focused and concerted effort must be made to bring funding and demand into balance.

As of January 2003, nearly a quarter-million veterans were on a waiting list of six months or more for a first appointment or an initial follow-up.

Theoretically, enrolled veterans have full access to the VA health care system. In reality, however, long waiting times for appointments with health care providers continue to be a problem for a significant number of veterans. In fact, as of January 2003, nearly a quarter-million veterans were on a waiting list of six months or more for a first appointment or an initial follow-up—clearly indicating that VA lacks either sufficient capacity or resources to provide the necessary care. The problem of not being able to meet demand is already serious—but it will only get worse if it is not addressed soon.

VA's Declining Per-Patient Expanditures, FY 1992–2003*

(Expressed in FY 2002 Dollar Terms)



*All resources, including collections

A key point to understand about this problem is that, while the overall number of veterans eligible for care in VA facilities is expected to decrease over the coming years, the actual number of beneficiaries seeking VA care is projected to grow. A variety of events over the past decade—economic, budgetary, and structural—has created increased demand for, and pressures on, the VA and DOD health care systems. With the rising cost of health care and insurance premiums, veterans have been seeking alternative ways to pay for their health care. This phenomenon, along with the absence of an outpatient pharmacy benefit under Medicare, appears to be causing a growing number of veterans to seek health care from VA.

Finally, legislative, administrative, and structural changes have increased demand for VA care. Following the passage of the Veterans' Health Care Eligibility Reform Act of 1996, VA's mission moved from primarily treating veterans with service-connected disabilities and indigent veterans to offering a comprehensive health benefit to all enrolled veterans. The Veterans' Millennium Health Care and Benefits Act, enacted in 1999, further increased demand by expanding benefits. Funding provided through the current budget and appropriations process for VA health care delivery has not kept pace with demand, despite efforts to increase efficiencies and focus health care delivery in the most cost-effective manner.

Task Force Recommendations

Perhaps the most fundamental part of the PTF's proposed solution is the primacy of leadership commitment to collaboration and sharing at all levels and the need to hold senior leadership of both Departments accountable for outcomes achieved. To that end, the PTF prefaces its more specific recommendations with this one:

- **The interagency leadership committee should, on an annual basis, report to the Secretaries on the status of implementing its collaboration and sharing initiatives and the recommendations in this Final Report, together with any other matters that the committee deems appropriate. Within 60 days after receipt, the Secretaries shall transmit the report, together with any related comments, to the President. (See Recommendation 1.1 in the PTF's *Final Report*)**

In the pages that follow are brief explanations of the PTF's findings in four major areas as well as its specific recommendations to the President.

Provide Clearer Leadership

Committed leadership is essential to achieve VA/DOD collaboration to improve health care to veterans, including military retirees.

VA and DOD leadership need to send a single, clear message about the expected end state of collaboration and sharing.

VA and DOD are already working to increase collaboration and sharing. Senior leadership of the Departments is clearly engaged, especially through the interagency leadership committee. It is the responsibility of the leadership of the two Departments, starting with the Secretaries, to continue to demand actions that will ensure the success of VA/DOD collaboration.

VA and DOD leadership need to send a single, clear message about the expected end state of collaboration and sharing. The goal is not collaboration for its own sake, but rather, to collaborate so as to improve access to quality health care and reduce the cost of furnishing services. Establishing formal accountability is a critical component of this collaborative approach; the PTF has identified specific recommendations for ways to improve the abilities of the Departments to provide unambiguous, sustained leadership and direction.

Recommendations

- **Congress should amend the fiscal year 2003 National Defense Authorization Act to create a broader charter beyond health care for the interagency leadership committee. Additionally, consideration should be given to using civilian experts as consultants to the committee to bring in new perspectives regarding collaboration and sharing. (Recommendation 2.1)**
- **The Departments should consistently utilize a joint strategic planning and budgeting process for collaboration and sharing to institutionalize the development of joint objectives, strategies, and best practices, along with accountability for outcomes. (Recommendation 2.2)**
- **The Departments should jointly develop metrics (with indicated accountability) that measure health care outcomes related to access, quality, and cost as well as progress toward objectives for collaboration, sharing and desired outcomes. In the annual report prescribed in Recommendation 1.1, the interagency leadership committee should include these results and discuss the coming year's goals. (Recommendation 2.3)**

Create a Seamless Transition

Providing timely, high-quality care requires effective information sharing. This happens only when VA and DOD can share information seamlessly throughout the course of an individual's service history, especially during the transition from military service to veteran or retiree status.

VA and DOD responsibility for an individual's health begins when he or she enters the Armed Forces. An important first step is to gather baseline medical information and capture it in an electronic medical record that DOD can later use to exchange appropriate information with VA in mutually understood and usable formats. As no such capability exists today, the two Departments must collaboratively develop appropriate electronic medical records that can function in an interoperable, bi-directional manner.

Information relevant to a service member's deployment, occupational exposures, and health conditions should follow the service member through his or her military career.

Information relevant to a service member's deployments, occupational exposures, and health conditions should follow the service member through his or her military career. Better recording, tracking, and reporting of occupational exposure data will improve the ability to understand the causes and origins of service-related disorders, assist in benefits determinations, and improve the overall health of veterans today and in the future.

Once an individual separates from military service, the process for determining eligibility for veterans' benefits, assessing health status, and receiving care through the VA health care system should be seamless, timely, and accurate. These goals can only be accomplished through systems that are standards-based and coordinated between VA and DOD. When an individual is separated from military service, he or she receives a DD214, needed to access benefits and services in the VA system. VA has identified untimely access to the service member's DD214 as a major factor delaying determination of benefits.

Recommendations

- **VA and DOD should develop and deploy by fiscal year 2005 electronic medical records that are interoperable, bi-directional, and standards-based. (Recommendation 3.1)**
- **The Administration should direct HHS to declare the two Departments to be a single health care system for purposes of implementing HIPAA Privacy regulations. (Recommendation 3.2)**
- **The Departments should implement by fiscal year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process. Upon separation, DOD should transmit an electronic DD214 to VA. (Recommendation 3.3)**
- **VA and DOD should expand the one-stop shopping process to facilitate a more effective seamless transition to veteran status. This process should provide, at a minimum: 1) a standard discharge examination suitable to document conditions that might indicate a compensable condition; 2) full outreach; 3) claimant counseling; and 4) when appropriate, referral for a VA Compensation and Pension examination and follow-up claims adjudication and rating. (Recommendation 3.4)**
- **VA and DOD should expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces; and to conduct epidemiological studies to understand the consequences of such events. (Recommendation 3.5)**
- **By fiscal year 2004, VA and DOD should initiate a process for routine sharing of each service member's assignment history, location, occupational exposure, and injuries information. (Recommendation 3.6)**
- **The Departments should: 1) add an ex officio member from VA to the Armed Forces Epidemiological Board and to the DOD Safety and Occupational Health Committee; 2) implement continuous health surveillance and research programs to identify the long-term health consequences of military service in high-risk occupations, settings, or events; and 3) jointly issue an annual report on Force Health Protection, and make it available to the public. (Recommendation 3.7)**

Remove Barriers *To Collaboration*

VA and DOD can improve quality, access, and efficiency of health care delivery by pooling resources, eliminating administrative barriers, and implementing change.

Joint contracting for pharmaceuticals has been one of the bright spots . . . . But by most other measures, there is substantial opportunity for increased collaboration between the two Departments.

In the past, Congresses and Presidents have tried to improve the coordination of services and resources between VA and DOD. The first specific legislation, the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act (Public Law 97-174), was intended to encourage greater efficiencies and increase the variety and amount of health care resource sharing.

Since the enactment of that law in 1982, VA and DOD have had a mixed record in carrying out the mandates to improve collaboration and sharing. Joint contracting for pharmaceuticals has been one of the bright spots, with a total cost avoidance of $369 million in fiscal year 2002. But by most other measures, there is substantial opportunity for increased collaboration between the two Departments.

The reasons range from fundamental incongruities in organizational structure to administrative and logistical differences. For example, VA provides health care services through a system of 21 Veterans Integrated Services Networks (VISNs), each covering a certain geographic area of the country. Designed to allow each VISN to adapt to local needs, one result of this organizational structure is that there are significant differences among the VISNs in the way they deliver care and manage programs. Meanwhile, DOD's TRICARE system delivers health care services through a network of three Health Services Regions (consolidated in 2002 from a total of 12), each containing its own network of Military Treatment Facilities (MTFs). The net effect is that for the commander of an MTF in any one region to collaborate or share resources with VA, he or she must often interact with several different VISNs, each with its own policies and procedures.

The PTF identified other significant institutional barriers to collaboration in the ways VA and DOD—and the three Military Departments—develop and deploy their resource plans. These include the budgeting process, health care delivery plans, acquisition plans, and facility plans. The PTF developed a series of recommendations for removing barriers between VA and DOD and improving collaboration.

Recommendations

- **The Secretaries of Veterans Affairs and Defense should revise their health care organizational structures in order to provide more effective and coordinated management of their individual health care systems, enhance overall health care outcomes, and improve the structural congruence between the two Departments. (Recommendation 4.1)**
- **The Secretaries of Veterans Affairs and Defense, based on the recommendations of the interagency leadership committee, should provide significantly enhanced authority, accountability, and incentives to health care managers at the local and regional levels in order to enhance standardized and collaborative activities that improve health care delivery and control costs. (Recommendation 4.2)**
- **VA and DOD should integrate clinical pharmacy initiatives through the coordinated development of: 1) a national joint core formulary; and 2) a single, common clinical data screening tool by fiscal year 2005 that ensures reliable, electronic access to complete pharmaceutical profiles for VA/DOD dual users across both systems. (Recommendation 4.3)**
- **VA and DOD should collaborate on policy and program changes, through local sharing arrangements, which would permit prescriptions written by either VA or MTF providers to be filled for dual users by the other Department's pharmacies. (Recommendation 4.4)**
- **VA and DOD should work with industry to establish a uniform methodology for medical supplies and equipment identification and standardization and to facilitate additional joint contracting initiatives. VA and DOD should identify opportunities for joint acquisitions in all areas of products and services. (Recommendation 4.5)**

- **The interagency leadership committee should identify those functional areas where the Departments have similar information requirements so that they can work together to reengineer business processes and information technology in order to enhance interoperability and efficiency. (Recommendation 4.6)**
- **VA and DOD should implement facility lifecycle management practices on an enterprise-wide basis. This should be accomplished by aligning business rules, eliminating statutory barriers, and adopting best practices. (Recommendation 4.7)**
- **VA and DOD should declare that joint ventures are integral to the standard operations of both Departments. Through the interagency leadership committee, the Departments should articulate policy requiring that: 1) all major initiatives of each Department be designed and tested for effectiveness and suitability in joint venture sites; 2) lessons learned from successful joint ventures be shared with other joint venture sites and also throughout the health care delivery systems of the two Departments; and 3) all proposed VA and DOD facility construction within a geographic area be evaluated as a potential joint venture. (Recommendation 4.8)**
- **VA and DOD should work together to identify and address staffing shortfalls, develop consistent clinical scopes of practice for non-physician providers, and ensure that their provider credentialing systems interface with each other. (Recommendation 4.9)**

Address the Mismatch *Between VA Demand and Resources*

Collaboration can address only minor fluctuation in capacity and demand. The more important problem is that demand for access to VA health care services far outweighs available funding. This mismatch must be resolved.

The mismatch in VA between demand for access and available funding is too large to be solved by collaboration alone.

The measures described in the preceding pages might help overcome modest or temporary capacity shortfalls or surges in demand, and standardized information systems and medical records will provide lasting improvements in health care delivery to veterans. However, the mismatch in VA between demand for access and available funding is too large to be solved by collaboration alone. Moreover, the PTF is concerned that this mismatch affects the delivery of timely health care and impedes efforts to improve collaboration between VA and DOD.

In recent years, as a growing number of veterans with incomes above VA's means test threshold with no compensable service-related disabilities (Priority Group 8, formerly Priority Group 7) have entered the VA health care system, funding has not kept pace with demand. The result is that today, many veterans in VA's traditional constituency—veterans with service-connected disabilities and indigent veterans—have been unable to obtain health care within VA's established access time frames.

This situation is unacceptable. Congress and the Executive Branch must work together to provide full funding to meet demand, within VA's access standards, for today's Priority Groups 1–7. The Task Force recommends that VA be held accountable for meeting its established access standards; when appointments cannot be offered within the standard, the Department should be required to offer an enrolled veteran an appointment with a non-VA provider. Congress and the President must also resolve the status of Priority Group 8 veterans.

Recommendations

- **The Federal Government should provide full funding to ensure that enrolled veterans in Priority Groups 1 through 7 (new) are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal. (Recommendation 5.1)**
- **VA facilities should be held accountable to meet the VA's access standards for enrolled Priority Groups 1 through 7 (new). In instances where an appointment cannot be offered within the access standard, VA should be required to arrange for care with a non-VA provider, unless the veteran elects to wait for an available appointment within VA. (Recommendation 5.2)**
- **The present uncertain access status and funding of Priority Group 8 veterans is unacceptable. Individual veterans have not known from year to year if they will be granted access to VA care. The President and Congress should work together to solve this problem. (Recommendation 5.3)**

Conclusion

Enrolled veterans and military retirees should have full and timely access to the health care services that Congress has authorized for them. Various approaches to fulfilling this obligation have been suggested, including better collaboration and sharing between VA and DOD, improved processes for transition from military service to veteran status, and enhanced funding. A number of commissions, advisory panels, and government study groups convened since 1991 have looked at these issues and provided recommendations.

There has been little disagreement on the need to improve collaboration and sharing across the two Departments. The structures needed to organize and implement collaboration and sharing are now in place, and current leadership has demonstrated a commitment to furthering this goal. What is needed is the will and focus to implement and sustain change.

A major recommendation of the PTF's *Final Report* is that, in addition to improving various administrative and functional activities in VA and DOD, the Federal Government should provide full funding to ensure that enrolled veterans who form VA's traditional constituency are provided comprehensive benefits, according to VA's established access standards.

For some veterans, VA may be their only health care option. As more and more veterans with incomes above VA's means test threshold and no compensable service-related disabilities choose to receive their health care in VA medical facilities, VA faces the challenge of providing quality care for its traditional population, especially those with disabilities that are the result of military service.

Our Nation's commitment to those who have served should not waver. Improving health care delivery to our Nation's veterans will require action by the President, Congress, VA, and DOD. The recommendations made in the PTF's *Final Report* provide a place to start in fulfilling the obligation to those who have sacrificed to defend our country.

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