Statement of

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to

Improve Health Care Delivery For Our Nation's Veterans

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Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. Along with your former colleague, John Paul Hammerschmidt, I was honored to co-chair this Task Force. Copies of the Final Report, along with a Brief Guide to the Report, have been delivered to the Committee, and I ask that they be made a part of the record of today's hearing.

At the outset, I note that this Final Report is indeed the work of a task force, not of any individual member or members. While John Paul and I were privileged to chair the Task Force, the final product is the work of the overall body and speaks for itself.

I also note that all of the work of the Task Force was carried out in a very open, very public manner. Anyone with an interest in what we were doing -- and I know that included staff of the Committee -- could attend our public meetings or, shortly after each meeting, find both all the briefing slides and a verbatim transcript of the meeting on the Task Force's web site. Now that the Final Report has been issued, it, along with last summer's Interim Report, is available on the Task Force web site which will be maintained as a stand-alone site though the summer and then will be placed on the VA web site.

As you know, the Task Force was established pursuant to Executive Order 13214 issued in May 2001. Along with the two co-chairs – originally former Congressman Gerry Solomon was the other co-chair until his untimely death in October 2001 – the President appointed thirteen other members. We were a diverse group, with backgrounds in medicine, VA and DOD affairs, information management, health policy, and various other disciplines and life experiences. Some knew VA or DOD well, while, for others, Federal medicine was a new enterprise. Over time, I think we worked together very effectively. One demonstration of our effort to forge consensus is that, of our 23 numbered recommendations which, with sub-elements,

comprise 35 specific recommendations – all but one was supported by the full Task Force.

The President identified improved cooperation between VA and DOD in delivering health care to those who served in the Armed Forces as one of his Administration's ten management improvements, and he established the Task Force to assist in that effort. The Task Force was given three specific missions:

- to identify ways to improve benefits and services for VA and DOD beneficiaries through better coordination of the activities of the two Departments;
- to review barriers and challenges that impede that cooperation and to identify opportunities to improve VA and DOD business practices so as to ensure high-quality and cost-effective health care; and
- to identify opportunities for improved resource allocation between VA and DOD so as to maximize the use of their resources.

As I will discuss later, as the Task Force carried out its focused work on collaboration matters, we realized that there were other issues, most notably those associated with the mismatch in VA between demand and available funding, that had to be addressed if we were to successfully deal with the primary mission of identifying ways to improve VA-DOD collaboration.

In the end, I believe that the PTF's work, as exemplified in our Final Report, adds important insights and direction on the collaboration issue. This issue is one that will continue; I do not believe that any of us on the Task Force supposed that we would have the final word, but I do believe that we have helped further the process. Our goal, from the outset, was to forge a set of recommendations that would be implemented.

Few are more aware than my co-chair, John Paul Hammerschmidt, of the challenges associated with fostering greater cooperation between VA and DOD. John Paul was the Ranking Member of this Committee when the original sharing legislation was enacted in the early 1980s and he worked on the issue until he left the Congress in 1993. The Task Force benefited greatly by his insights and perspective gained through his experience in the Congress and specifically on this Committee.

Since the Final Report speaks for itself and our work, I will not go into any detailed discussion of the specifics although, of course, I am very happy to attempt to answer any questions you may have. Instead, I will just highlight some of the more significant themes from the report.

As the Members of this Committee are only too aware, the history of VA-DOD collaboration is one of fits and starts. In the early days, after the enactment of the original Sharing Act, Public Law 97-174, back in 1982, there was a flurry of activity. However, that activity was focused almost exclusively at the local level and seemed to flourish in those locations where it was in the mutual interest of the local facilities involved.

Early in our deliberations, the Task Force identified senior leadership commitment as the linchpin of any sustained collaborative effort between VA and DOD. It was not until the mid-1990s that there was any focused leadership at the

national level and that interest was not sustained. Indeed, it has only been in the last two years or so that there has been a renewed attention at the national level on increased cooperation between the Departments, interest that I believe reflects the President's attention to the issue and the creation of the Task Force.

The Task Force found that the current leadership focus within the two Departments to VA-DOD collaboration is very effective. We heard from and met with some of the key VA and DOD officials on a number of occasions. The Task Force was pleased with the activity of the Joint Executive Committee, chaired by VA Deputy Secretary Dr. Leo Mackay and DOD Under Secretary Dr. David Chu, as well as with the Health Executive Committee, chaired by Dr. Roswell and Dr. Winkenwerder. This level of leadership commitment must be sustained.

The effort of the Congress to solidify the statutory underpinning for this effort, most recently in H.R. 1911 as passed by the House in late May, is an important element in seeking to institutionalize the needed leadership but, frankly, it cannot be seen as enough by itself. I strongly urge your Committee and the other committees and subcommittees that deal with VA and DOD to maintain vigilant oversight of the two Departments and insist that they continue the current level of attention to VA-DOD collaboration.

It is also vital that the field-level managers of the two Departments come to understand the commitment of the top leadership to improved collaborative efforts between VA and DOD. Once field managers begin to see that increased success in undertakings between the Departments is recognized and rewarded, it is likely that there will be a much more sustained and consistent effort throughout the Departments.

Before I turn to some of our specific recommendations on collaboration issues, I stress one key, underlying principle of our work: the goal of improved collaboration between VA and DOD is not collaboration for the sake of collaboration, but rather that, through such activity, VA and DOD can improve timely access to quality health care and reduce the overall costs of furnishing services.

As directed in the Executive Order, the Task Force identified a number of process, institutional, and organizational barriers to improved collaboration, and our report provides specific recommendations to address these barriers. In addition to these departmental process issues, the Task Force members quickly focused on what their work would mean to the individual veteran. Specifically, they asked what should the Task Force recommend to make the transition from military service to veteran status seamless to the individual.

Early on, we decided it was important to get input from the field – from the VA medical center directors and military treatment facility commanders and their staffs engaged in the day-to-day challenge of delivering quality health care to their beneficiaries. As delineated in Appendix E of the Final Report, Task Force members and staff made a concerted effort to visit both joint venture sites and a number of co-located VA and DOD facilities.

We rapidly came to the conclusion that providing timely, high-quality health care requires effective information sharing. When you talk with clinicians at joint venture sites, you are quickly struck by the inability of the VA and DOD electronic

medical record systems to readily share data. The frustration of providers is often palpable. I well remember at one of the joint venture sites I visited how delighted the staffs were that their IT experts had developed a way to display both the VistA and CHCS medical records on the same desktop so the provider could at least have access to the full medical record on one computer. This was important enough to the local leadership that they invested scarce facility resources that were intended to fund other activities to accomplish this IT collaboration. And, while this was an important step, it was clearly only a first step. The Task Force quickly identified the electronic medical record as one of our focus areas.

As we researched the electronic medical record issue further, we found that the issue was not technology – the technology exists today -- but rather the will and the leadership commitment to overcome institutional "rice bowls" and make it happen. The development and use of electronic medical records that can share data would not only foster collaboration in the delivery of health care services but also reduce medical errors and attendant costs.

As a result, development and deployment in real time of interoperable, bi-directional, standards-based electronic medical records is the centerpiece of the PTF's seamless transition recommendations. VA and DOD responsibility for an individual's health begins when the service member enters the Armed Forces. It is important to gather baseline medical information in an electronic medical record that DOD can later use to exchange appropriate information with VA in mutually understood and usable formats. Subsequently, information relevant to deployments, occupational exposures, and health conditions should follow the service member throughout the military career. As discussed in greater detail in the report, DOD's personnel tracking systems are also a vital component in correlating subsequent health problems to exposure to occupational hazards during military service and need to be adequately resourced.

Upon separation from military service, the process for determining eligibility for veterans' benefits, reviewing health status, and receiving VA health care should be timely, accurate, and seamless to the individual service member. A mandatory separation physical from DOD should set the stage, where appropriate, for a compensation and pension examination to determine the level of VA disability. When the individual separates, the DD214 should be immediately transmitted electronically to VA, not take weeks or months. The current transition process is often cumbersome, slow, and overly bureaucratic. The technology exists to make it reasonably seamless to the individual, and the Task Force felt strongly that, with continued leadership commitment, this was an achievable goal.

Earlier in my statement, I mentioned that many Task Force members and staff visited a number of joint ventures. The individual effort expended by local medical center directors and military treatment facility commanders and their staffs at these joint ventures is extraordinary, and they are clearly committed to overcoming a variety of obstacles. I also learned early on that, when you've seen one joint venture site, you've seen one joint venture site. They are all very different and, in many ways, still viewed as pilots. In addition, the separate strategic planning and management practices, personnel assignment processes, and standard IT capital investment programs of each Department generally have disregarded the needs of joint venture sites. The Task Force believed that VA and DOD should declare joint ventures to be integral to the standard operations of both Departments and made specific recommendations for action by the Joint Executive Committee,

including that all proposed VA and DOD facility construction within a geographic area be evaluated as a potential joint venture.

As I noted earlier, as the Task Force addressed issues set out directly in our charge, we invariably kept coming up against concerns relating to the current situation in VA in which there is such a mismatch between the demand for VA services and the funding available to meet that demand. It was clear to us that, although there has been a historical gap between demand for VA care and the funding available in any given year to meet that demand, the current mismatch is far greater, for a variety of reasons, and its impact potentially far more detrimental, both to VA's ability to furnish high quality care and to the support that the system needs from those it serves and their elected representatives.

The PTF members were very concerned about this situation, both because of its direct impact on VA care as well on how it impacted overall collaboration. Our discussion on the mismatch issue stretched over many months and, as anyone following the work of the Task Forces already knows, it was the area of the greatest difference of opinion among the members.

Although we did not reach agreement on one issue in the mismatch area – that is, the status of veterans in Category 8, those veterans with no service-connected conditions with incomes above the geographically adjusted means test threshold – we were unanimous as what should be the situation for veterans in Categories 1 through 7, those veterans with service-connected conditions or with incomes below the income threshold.

Our recommendations, if adopted, would represent a very significant change in how the government fulfills its commitment to these veterans who represent VA's historical constituency. Recommendation 5.1 calls on the Federal government to provide full funding so as to ensure that enrolled veterans in Categories 1 through 7 are provided the current comprehensive benefit within VA's established access standards. Recommendation 5.2 provides that, in instances where VA cannot offer an appointment to enrolled Category 1 through 7 veterans within its access standards, VA would be required to arrange for care with a non-VA provider. If these recommendations become law, service-connected and low-income veterans would get needed care from VA in a timely manner, with no use of waiting lists to manage access to care.

As to Category 8 veterans, the Task Force members had legitimate disagreements. Some members believed Category 8 veterans should be treated the same as Category 1 through 7 veterans; others believed that these veterans should have access to VA but on a pay-as-you-go basis; and still others believed that the Task Force had neither the information nor the authority to make such decisions.

While we were not in agreement on the specifics of how the issue of Category 8 veterans' access to the system should be resolved, the Task Force members did agree that the status quo is not acceptable. It is not clear what Congress intended for these veterans with the enactment of the Eligibility Reform legislation or whether VA's response to that legislation has been in keeping with that intent. To the extent there was uncertainly about the impact of providing this category of veterans with access to VA care, that would now seem to be at least partially addressed, as more specific information is becoming available on their demand for service. With such

information, it should be possible to engage in a full and open debate on the appropriate policy, and that was the recommendation of a majority of the members of the Task Force.

Mr. Chairman, that concludes my statement. I am happy to attempt to answer any question that you or the other members of the Committee might have, but note again that the Final Report is indeed the work of the entire Task Force and can and does speak for itself.