**THE ASSISTANT SECRETARY OF DEFENSE**

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

**HEALTH AFFAIRS**

JUL 18 2005

The Honorable John W. Warner
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

Section 721 of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005 requires the Secretary of Defense to submit an interim report on the Department of Defense Pilot Program for Health Care Delivery not later than 60 days after commencement of the program.

The interim report is forwarded for your information. It includes the Department's overall approach for conducting the pilot program, activities and actions conducted to date, action planned for the future, and results expected from the pilot program.

Fort Drum, New York and Yuma, Arizona have been selected as test sites. The Army Surgeon General has the lead for Fort Drum, and the Navy Surgeon General has the lead for Yuma. A health care summit was held at Fort Drum on April 12, 2004 to coordinate implementation of their pilot. A market analysis has been initiated to identify health care gaps in the Fort Drum market that will be used to identify test initiatives. A teleconference was held on April 21 to coordinate the Yuma pilot. A market analysis has also been initiated at Yuma, and a health care summit is planned for August.

Thank you for your continued support of the Military Health System.

Sincerely,

William Winkenwerder, Jr., MD

Enclosure:
As stated

cc:
Senator Carl Levin

**Section 721-Pilot Program for Health Care Delivery**
**Interim Report**

## I. Pilot Program Mandate and Background

Section 721 of the National Defense Authorization Act for Fiscal Year 2005 (NDAA for FY05), authorized the Secretary of Defense to conduct a pilot program at two or more installations for purpose of testing initiatives that build cooperative health care arrangements and agreements between military installations and local and regional non-military health care systems (TAB A).

The Congressional authorization included several specific requirements:

- Features of specific health care delivery arrangements.
- Potential opportunities for costs savings.
- Identification of barriers to and constraints on greater cooperation between Department of Defense (DoD) and private sector health care providers.
- Consultation with Federal, state, and local stakeholders.
- Criteria for selection of specific military installations as pilot programs.
- Period of performance for the pilot programs.
- Reporting requirements.

In response to the Congressional mandate, the Office of the Assistant Secretary of Defense, Health Affairs (OASD(HA)) assigned staff responsibility for the pilot program to the TRICARE Management Activity (TMA).

## II. Interim Report Objectives

The objectives of this interim report are to provide Congress with information about:

- The Department's overall approach for conducting the pilot program.
- Activities and actions conducted to date.
- Actions planned for the remainder of the pilot program.

- Results expected from the pilot program.

## III. Approach for Establishing and Conducting the Pilot Program

To implement Section 721, TMA developed a standard approach for the management and technical/methodological actions needed to establish and conduct the pilot program. This standard approach is described briefly in the subsections that follow.

- *Implementation and Guidance Memo.* The Assistant Secretary of Defense for Health Affairs, Dr. William Winkenwerder, signed a memo implementing Section 721 in the Department of Defense. This memo assigns specific responsibilities to the individual Services and OASD(HA)/TMA staff elements.

- *Identification of potential market areas for pilot programs.* TMA consulted with each of the Services to solicit nominations for Military Treatment Facility (MTF)-based market areas to use as test sites. TMA used the criteria listed in Section 721(d) (1-5) to assess each nominated market area and determine which nominated market areas met all or most of the listed criteria as a basis for selecting the test sites. TMA recommended the following two locations:

    - Fort Drum/Watertown, New York
    - Yuma, Arizona

- *Coordination with stakeholders.* In March, TMA met with House Armed Services Committee (HASC) staff members to discuss the overall progress of implementing the pilot program. From these discussions, TMA obtained feedback that influenced the direction of subsequent planning efforts.

  TMA staff developed and initiated a standard approach to stakeholder communications for each of the two selected markets. To initiate each project, TMA held conference call discussions with the key government stakeholders (e.g., MTF commanders and staff, staffs of intermediate commands, Service Surgeon General representatives, TRICARE Regional Offices (TROs), etc.). These initial discussions were designed to familiarize local and Service staffs with the intent of Section 721 and the potential implications for their activities. Further, these discussions were used to determine the existence of recent market analyses, and plan an initial on-site "Health Care Summit" meeting involving both government and non-government stakeholders.

After initiation of the pilot program, TMA has continued regular discussions with the various staffs and stakeholders involved through regularly scheduled conference calls. They are held approximately every other week.

- *Methodological Approach.* One aspect of the Congressional intent expressed in Section 721(f) (2) is the development of recommendations for a "model health care delivery system for other military installations." To implement this intent, TMA is using a relatively standard and consistent methodological approach that has been used by DoD and the Department of Veterans Affairs to implement changes or modifications to their respective systems for delivering health care. For purposes of the Section 721 pilot program, the broad outlines of this methodological approach are described briefly in the subsections that follow.

- Market Analysis. The analysis of each market consists of two components:

    - A detailed description of the market using data obtained from DoD and other data sources. This description includes information about the population of DoD Military Health System (MHS) eligible beneficiaries and their enrollment status, information about the current health care utilization of these beneficiaries, and a projected future demand for services, both direct (MTF-based) and indirect (non-MTF-based, i.e. contractor) care; and information about the current and projected future capacity (e.g., staff, space) of both the direct and indirect care systems.

    - An assessment of the current and potential performance of the market. "Performance" of the market can be further refined into specific areas:

        - The degree to which available supply satisfies demand for services.

        - The degree to which the characteristics of the delivery system reflect the standards and criteria defined in (but not limited to) the MHS Strategic Plan.

- Developing options for improved service delivery. Options are operational courses of action with the potential to address service/benefit delivery issues identified in the market analysis, such as capacity/demand imbalances, or other performance plan-related improvements. Options may include (but are not limited to) the following generic types of actions:

    - Direct vs. purchased care tradeoffs (i.e., "make vs. buy").

    - Channeling/focusing demand.

- Reallocating existing resources/capacity.
- Adding resources/capacity.
- Combinations of the above.

The options developed for each of the pilot program market areas may include a spectrum or continuum of approaches, including options that at one end are very DoD resource-intensive, and at the other end leverage available private sector resources to a significant degree, with mixed approaches in between. Any options identified will be critically and analytically assessed for their ability to address, wholly or in part, the issues identified in the market analysis.

- Assessing feasibility of implementation. The assessment of the options determines the *desirability* of their implementation, i.e., their ability in an unconstrained environment to improve health care delivery in the market. However, not all desirable options may be feasible because of barriers or constraints on implementation imposed by, statute, policy, regulation, contractual obligation, and the timely availability of resources, schedule, or other factors. The set of options will be assessed against these barriers and constraints to ascertain their *feasibility*, and initiatives to be tested during the pilot program will be developed based on this feasible set.

This methodological approach provides a standard framework to integrate any existing work, and readily compare the results from each of the two pilot test sites. TMA staff and analytic resources are being used to provide timely support when local or Service resources are unavailable, or when using them would be less efficient.

## IV. Summary of Activity

In addition to the development of the implementation and guidance memo, and the coordination meeting with Congressional staffs, a number of actions have taken place for each of the two pilot program market areas, Fort Drum and Yuma. The current and planned status of each market area is described in the subsections that follow:

### Fort Drum Market Area

Before its selection as one of the two pilot program locations, the local staff at Fort Drum had been extensively involved in detailed planning to address ongoing concerns regarding effective health care delivery in the Fort Drum/Watertown market area. Fort Drum clinic does not have inpatient capability, and relies on two private sector community hospitals to provide the bulk of the inpatient care needed by local DoD beneficiaries. Planning was also occurring to support the ongoing deployment and return

of Fort Drum-based forces to/from Afghanistan and Iraq, and in support of other Global War on Terrorism (GWOT) contingencies.

TMA initiated a series of conference calls with local Fort Drum staff, and other agencies (e.g., North Atlantic Regional Medical Command, Army Surgeon General, TRICARE Regional Office-North, etc.) to familiarize local and Service staffs with the intent of Section 721 and the potential implications for their activities. These discussions identified that Fort Drum staff had recently completed an extensive market analysis in support of their facility master plan, and had initiated dialogue with their community providers, including but not limited to Samaritan Medical Center and Carthage Area Hospital.

Fort Drum hosted a North Country Health Care Summit on April 13, 2005, and included representatives from the TMA, TRO-North, the commander, and staff of Guthrie Army Health Center at Fort Drum, Carthage Area Hospital, Samaritan Medical Center, HealthNet, the Army Surgeon General's office, and the Army's North Atlantic Regional Medical Command. The following goals were established for the Summit:

- To identify and discuss the demand for health care services generated by Fort Drum soldiers and their family members, and that of the greater community.
- To place this health service demand in context with other medical markets which include a military treatment facility.
- To identify and discuss the supply of health care services within the local medical market, and the degree to which that supply can satisfy the estimated demand now and in the future.
- To creatively consider ways to improve and enhance the delivery of services within the local market for the benefit of both the Fort Drum and the non-military local population.

The discussion at the Summit generated several possible areas in which the pilot program might improve overall health care delivery through improved arrangements and agreements. These areas include (but are not limited to) the following:

- Centralizing support functions, e.g., scheduling.
- Aggregating billing and\or pooling federal support funding.
- Identifying available joint funding and grants.
- Monitoring patient satisfaction in more consistent ways.

- Improving communication within the market.
- Identifying protocols, processes, formats.
- Developing administrative liaisons between institutions.
- Developing a shared Electronic Medical Records program.
- Engaging in joint recruiting efforts.
- Centrally coordinating the emergency response in the area.

During the Summit, the participants reached a preliminary consensus on creating a new collaborative organization: the North Country Health Care Consortium. The participants concluded that a more comprehensive market analysis was also needed, since the DoD-specific analysis produced by Fort Drum was too narrowly focused. The participants addressed roles and responsibilities, while recognizing that more definition of these roles would be necessary. Finally, the participants recommended three areas for immediate action:

- *Create a structure and formal arrangement for long-term collaboration.* The Fort Drum MTF took the lead on this action. It has since initiated joint planning actions with Samaritan and Carthage Hospitals, brokered consensus for the bases of understanding within the Consortium, developed an agreed-upon charge for the organization, and identified and has begun to include other stakeholders.

- *Conduct a whole market gap analysis.* The responsibility for this action was undertaken by TMA in coordination with the Army. The proposed analysis of market requirements, capabilities, and capacities, as well as the flexibility of these aspects, will result in a more complete understanding of the challenges facing the North Country. TMA as a whole is well suited to contribute to the pilot in this area and has begun this effort.

  TMA reviewed the market analysis prepared by Fort Drum staff and is in the process of completing a holistic market analysis for the North Country market.

- *Develop an operating mode or model for integrated service delivery within the "North Country."* Initially the local hospitals, together with the TRO, planned to develop a conceptual theory of operations for the Consortium and its members. However, it quickly became evident that competitive proprieties recommend that TMA, and not the individual hospitals, lead this area. Elements such as structure,

membership, legal status, voting rights and privileges, and funding, as well as how the operation of the Consortium would work, all must be considered and negotiated.

Yuma Market

For the Yuma market, Navy staff from both the Yuma clinic and the parent facility at NH Camp Pendleton has been included in the telephone conference calls regarding the Fort Drum pilot, and were represented at the Fort Drum Health Care Summit on April 13, 2005. Army staff from the Yuma Proving Ground's parent facility at Fort Irwin, California has also participated on selected conference calls.

One Yuma-specific conference call has also taken place for government staff only. The planning for an on-site meeting at Yuma is underway.

A holistic market analysis was delayed pending the release of the recent DoD Base Realignment and Closure (BRAC) recommendations. That market analysis will now be completed.

## V. Expected Results

There are four broad areas for which TMA expects to be able to report more specific results at the conclusion of the Section 721 pilot program in FY2007:

- Specific actions taken to improve the delivery of health care in the two pilot program market areas, and the results obtained. These results will include but not be limited to the cost avoidance or savings resulting from partnerships between DoD and the private sector, and the use of DoD health care providers in civilian community hospital settings.

- Options and results from each pilot program that appear to be generalizable to other markets.

- A description of the barriers and constraints precluding the implementation of options that are more desirable, based on access, quality and cost criteria, than those that are currently feasible. This description will be accompanied by an assessment of the potential performance improvements to be obtained by relaxation or removal of the barrier/constraint, and any recommendations for action in this regard.

- Recommendations for a model health care delivery system for other military installations.

**TABS**

A. Section. 721- DoD Pilot Program for Health Care Delivery (Ronald W. Reagan NDAA for FY05)

## CONGRESSIONAL LANGUAGE

Section 721 - Pilot Program for Health Care Delivery

(a) PILOT PROGRAM. – The Secretary of Defense may conduct a pilot program at two or more military installations for purposes of testing initiatives that build cooperative health care arrangements and agreements between military installations and local and regional non-military health care systems.

(b) REQUIREMENTS OF PILOT PROGRAM. – In conducting the pilot program, the Secretary of Defense shall –

(1) identify and analyze health care delivery options involving the private sector and health care services in military facilities located on the installation;

(2) determine the cost avoidance or savings resulting from innovative partnerships between the Department of Defense and the private sector;

(3) study the potential, viability cost efficiency, and health care effectiveness of the Department of Defense health care providers delivering health care in civilian community hospitals; and

(4) determine the opportunities for and barriers to coordinating and leveraging the use of existing health care resources, including Federal, State, local and contractor assets.

(c) CONSULTATION REQUIREMENTS. – The Secretary of Defense shall develop the pilot program in consultation with the Secretaries of the military departments, representatives from the military installation selected for the pilot program, Federal, State, and local entities, and the TRICARE managed care support contractor with responsibility for that installation.

(d) SELECTION OF MILITARY INSTALLATION. – The pilot program may be implemented at two or more military installations selected by the Secretary of Defense. At least one of the selected military installations shall meet the following criteria:

(1) The military installation has members of the Armed Forces on active duty and members of reserve component of the Armed Forces that use the installation as a training and operational base, with members routinely deploying in support of the global war on terrorism.

(2) The number of members of the Armed Forces on active duty permanently assigned to the military installation is expected to increase over the next five years.

(3) One or more cooperative arrangements exist at the military installation with civilian health care entities in the form of specialty care services in the military medical treatment facility on the installation.

(4) There is a military treatment facility on the installation that does not have inpatient or trauma center care capabilities.

(5) There is a civilian community hospital near the military installation with –

(A) limited capability to expand inpatient care beds, intensive care, and specialty services; and

(B) limited or no capability to provide trauma care.

(e) DURATION OF PILOT PROGRAM. – Implementation of the pilot program developed under this section shall begin not later than May 1, 2005, and shall be conducted during fiscal years 2005, 2006, and 2007.

(f) REPORTS. – With respect to any pilot program conducted under this section, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and of the House of Representatives –

(1) an interim report on the program, not later than 60 days after commencement of the program and

(2) a final report describing the results of the program with recommendations for a model health care delivery system for other military installations, not later than July 1, 2007.