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STATEMENT BY

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ON BEHALF OF
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COMMITTEE ON VETERANS AFFAIRS FIELD HEARING - HAWAII
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COL Arthur P. Wallace

Mr. Chairman and distinguished members of the Committee, on behalf of Major General Hawley-Bowland, Commanding General of Tripler Army Medical Center (TAMC) and Pacific Regional Medical Command who is visiting medical facilities in the Pacific Region, thank you for the opportunity to share information about the collaborative relationship and initiatives under the auspices of the Department of Defense (DoD) - Department of Veterans Affairs (VA) Joint Venture in Hawaii. I represent the largest military medical treatment facility in the entire Pacific Basin. TAMC's area of responsibility spans more than 52% of the entire Earth's surface and provides medical support to nearly 450,000 beneficiaries, including Active Duty Service Members of all branches of service; their eligible Family Members; military Retirees and their Family Members; Veterans; and many Pacific Island Nation Residents.

In 1991, Undersecretary of the Army and the Deputy Secretary of Veterans Affairs approved the

basic concept of a Joint Venture for Hawaii. What was initially conceived as a small veteran's hospital adjunct to the military medical center, is now a vast twenty million dollar sharing agreement spanning inpatient medical, surgical and psychiatric services, as well as outpatient specialty services and non-medical support, such as security, meals and housekeeping. Beginning in 1997, the VA began to relocate administrative and health care services to the TAMC campus. Construction and renovation to portions of the medical center infrastructure have resulted in both new and relocated veteran services on the Tripler campus, including an inpatient psychiatric unit, a new parking structure, the Center for Aging, the Ambulatory Care Clinic and renovation of the E-Wing of TAMC for both the Veterans Health Administration and Veterans Benefits Administration (VBA) administrative functions. The relocation of the Post Traumatic Stress Disorders (PTSD) Residential Rehabilitation Program (PRRP) from Hilo to TAMC has been a very successful initiative. The current PRRP program admits both Veteran and Active Duty patients as a cohort group, and provides a seven-week program of integrated treatment, including but not limited to PTSD symptom management, communication skills, anger management, relaxation training, behavior therapy, trauma focus therapy, adjustment counseling, substance abuse and relapse prevention treatment, and general health education. The relocation of the VA to the TAMC campus has resulted in increased workload for both TAMC and the VA Pacific Islands Healthcare System (VAPIHCS). We continue to move forward, using joint strategic planning sessions. New initiatives currently underway today include planned additions for a new facility for the Post Traumatic Stress Disorder (PTSD) Residential Rehabilitation Program in 2008, a shared Same Day Surgery Center in 2009, and a proposed inpatient tower at TAMC to consolidate nursing units.

A collaborative effort of this magnitude requires diligent planning and oversight. Both the VA and TAMC have dedicated staff to ensure the exploration and development of joint efforts. On a daily basis, VA patients represent a large part of our workload. For example, last month my hospital's average daily census was 151 patients. Approximately 33 of those patients, or 22%, were veterans. Additionally, 29% of our admissions from the emergency room were veterans. The VA-operated psychiatric ward averaged nine psychiatric veterans as patients per day. Over the years, additional clinical staff have been hired to accommodate the growing VA workload, forming a reliance on the reimbursement from the VA. We have also begun a new program of embedding VA providers into specialty clinics to add stability and increased workload to support the Graduate Health Education programs. These additions are now evident in our hospitalist program, in ophthalmology and in orthopedic surgery. There are plans to continue to evaluate other areas for expansion.

While reimbursement is essential to a successful DoD/VA partnership, it is not the primary motivation. For the military, caring for veterans represents a continuation of the services we provided when they were Active Duty. Our ultimate status will be as veterans. Another dimension of caring for the veteran is that the illnesses and surgeries associated with aging are very relevant to keeping Active Duty medical personnel trained and ready for our battlefield mission. We must remain competent caring for acutely ill patients. At Tripler we have a robust graduate health education program spanning 10 different medical specialties and training 220 individuals per year. Our graduate medical education occurs in Orthopedics, Radiology, Urology, Medicine, Obstetrics & Gynecology, Psychiatry, ENT, Pediatrics, Family Practice and General Surgery. We have found that these programs benefit from caring for the veterans population.

Recently several new initiatives have been undertaken under the Joint Incentive Program and the

Joint Demonstration Project. Development of several Joint Incentive Fund proposals totaling $4 million have been completed and funded including a state of the art computer-aided design/ computer-aided manufacturing system for orthotics and prosthetics with telemedicine capability, a chronic dialysis center for veterans and a joint pain management improvement project. All three of these initiatives will improve access to care to our joint beneficiaries and decrease wait times. We have submitted two additional Joint Incentive Fund projects - one for a joint sleep study lab and a second for an integrative medicine approach to pain management. These two projects are pending approval and funding at this time. The Hawaii Collaborative was also selected as one of eight sites to serve as a demonstration project. Our Joint Demonstration Collaborative proposes to meet the need of establishing a structure and process to jointly assess, execute, and evaluate improvements in Referral Management, Fee Authorization, and Document Management. The collaborative expects to garner benefits from these demonstration studies including transparent tracking of consultations and authorizations, as well as improved access to documents for information exchange between our organizations for improved continuity of patient care.

We continue to explore opportunities and initiatives that allow Tripler and VA to share staffing. In the past year, we've signed several new sharing agreements, including provision of Central Sterilization support for the Ambulatory Care Clinic, additions of VA specialists in ophthalmology and orthopedic surgery, provision of meals to the VA Center for Aging and several agreements supporting joint clinical research projects. We have also undertaken a joint approach in planning for pandemic flu response. Our dedicated staff continues to identify and develop new initiatives including joint decontamination support, joint purchase of medical supplies, evaluation of a VA transitional/subacute care unit and increased attention to the seamless transition between our organizations for our Warriors in Transition.

This year, the Department of the Army, through the Army Medical Action Plan (AMAP), has placed a lot of emphasis on care of our Wounded Warriors and a seamless transition from Active Duty military service and the Military Health System to care under the Veterans Benefits Administration and Veterans Health Administration. Our programs in support of returning Wounded Warriors and our ties between TAMC and VBA and VAPIHCS were well established even before the advent of the AMAP. We assigned Case Managers to all returning wounded and had specialized treatment programs such as our Soldier and Family Assistance Center at Schofield Barracks which provides a whole range of behavioral health and advocacy programs. We have had representation from VBA on our Patient and Family Assistance Team since inception and our Case Managers work daily with the VBA and VAPIHCS to foster a smooth transition to VA benefits including health care. We have also had VAPIHCS as a partner in our Multi-Service Market Management Office-sponsored Joint Executive Council and subordinate working groups. At these forums, we explore healthcare options for Veterans, past and future. One key group is the Behavioral Health Working Group which is taking a greater role in determining needs for PTSD and mild Traumatic Brain Injury (TBI) to serve the greater Hawaii market of eligible beneficiaries. Under the AMAP directive, Tripler has launched training of all military personnel on recognizing PTSD and mild TBI and to encourage self reporting and referrals of others returning from Operation Iraqi Freedom/Operation Enduring Freedom (OIF/ OEF). Additionally, our Social Workers, Case Managers, Psychiatric Nurses and Psychiatric Nurse Practitioners are taking more focused clinical training courses. We are also adding Neuropsychologists and other clinical staff to assist with diagnosis and treatment. This area of urgent need is an excellent opportunity for DoD and VA collaboration and we are already leaning

forward in our planning.

As with most merger type activities, there are barriers that impede unfettered, efficient coordination. I believe, however, most of our Joint Venture barriers are systemic in nature. These barriers include: (1) The separate VA and DoD healthcare information systems which make.data sharing difficult. We need interoperability of healthcare computer systems between DOD and the VA to coordinate patient care and conduct financial business. Our demonstration project addresses a portion of the identification and business processes that will support the joint revenue process. However, we cannot continue to conduct business without commercial-type claim processing software and support. Currently, development and release of the Charge Master Based Billing module has been put on hold indefinitely. As patients move between Tripler and the VA, the lack of an integrated, computerized patient record causes inefficiency and staff dissatisfaction.

(2) Lack of venture capital to invest in joint initiatives. We cannot pool our resources to spend for a common need. While the Joint Incentive Fund is one-step in this direction - and we have taken advantage of funding available through this program since its inception in 2004 - the application and reporting processes are time consuming and complex. Again, without truly dedicated staff, many good proposals do not come to fruition due to our inability to jointly address the requirements.

(3) Business processes associated with Joint Ventures are not well defined at the VA and DoD enterprise level and impair efficient coordination locally. National guidance must be developed based on the needs of sharing sites which considers cost analyses and feedback whenever possible. Some of these processes have financial implications that cause delays in billing and payment. When there are billing and payment issues, ultimately there are cash flow problems.

(4) Other valid business process questions and issues related to the management of the TRICARE program. For example, do VA patients compete with TRICARE patients in DoD? For TRICARE Prime, this is not an issue because by law Prime patients have precedence. Should the medical treatment facility commander dedicate capacity to TRICARE eligible beneficiaries or commit resources to caring for VA patients? This has long been a point of contention with VAPIHCS, as they desire dedicated support from military MTFs. Lack of this dedication at Joint Venture sites undermines the premise of sharing and generates additional costs when access levels cannot be maintained resulting in sporadic need for high cost contracted support. The eligibility rules and associated entitlements for the VA's categories of veterans and dual eligible beneficiaries are complex and constantly changing. This complexity is compounded when such patients seek care at a joint venture site. We need to establish joint service units at these sites to not only help these patients understand and make informed choices but also to more efficiently evaluate the need for available resources and track their use.

(5) Lack of policy guidance for dual eligibility. We don't need to require patients to choose between an entitlement to a military medical retirement benefit and a VA benefit but we do need to have the authority to coordinate access to the respective benefit. If we do not, we have patients duplicating services by seeking care from both systems. This increases the costs of providing care to both DoD and VA, and also results in patient safety concerns.

(6) Neither DOD or VA has established accountability and responsibility for the success of joint ventures. Jointly we need to develop metrics and a business strategy that reflect good stewardship of the resources invested in both systems.

(7) Competition between the convenience of healthcare that is available locally and the Veterans Integrated Service Networks' (VISN's) regional investment in healthcare delivery services

produces a barrier to local coordination. For the VISNs it is an out-of-pocket cost when they pay DoD rather than use their own facilities. VISNs are structured and funded using a concept whereby satellite medical centers are supported by one or two flagship medical centers. In our case, Honolulu is a satellite center and their flagship facilities are in California at Palo Alto and San Francisco. Emergent care is provided at Tripler and, if necessary, within the local community. Non-emergent care is referred to the California facilities. The current VA resource allocation system does not provide additional dollars for VISNs to allow satellite centers to seek a significant amount of care from non-VA providers.

Despite the systemic barriers we confront, we continue to work together diligently to devise local solutions. Wherever possible, we have leveraged advances in technology to provide seamless flow of information. We have incorporated Pharmacy Bi-Directional Data Interchange, Common Data View through a program called "Janus" and Laboratory Interoperability. The Pharmacy Bi-Directional Data Interchange allows both DoD and VA providers to order and receive prescriptions from either information system. The common data view presents patient data (demographics, lab, pharmacy, etc.) on a common computer screen. Finally, the current laboratory interoperability allows lab orders and results to be communicated between both systems. We look forward to expanding this program in the near future. The common goal of these initiatives is to improve patient care by developing interfaces to allow the electronic sharing of pertinent patient information between the VA, DoD and other clinical data providers.

In terms of DoD/VA joint venture development, our future is now. We are ahead of most localities in that we are already one of the most functionally integrated joint ventures. Instead of two freestanding medical centers, we have only one emergency room; one inpatient medical, surgical, and psychiatric service; and essentially one major specialty outpatient service. We have integrated clinical services for psychiatric on-call support, hospitalist support, ophthalmology, orthopedic surgery, nephrology support and psychology services. However, this functional integration is just the beginning.

While we are ahead of most of the other joint venture sites in the nation in developing our sharing agreements and establishing policies and procedures, there are still opportunities for continued development of our joint venture. The two key determinants when developing opportunities for improved coordination are expansion of our patient care services to care for more patients and elimination of redundant overhead. We have worked diligently to develop initiatives for VA chronic dialysis, shared pain management resources and expanded orthotic/prosthetic support to veteran patients through the Joint Incentive Fund. However, additional opportunities for improved coordination and cooperation are numerous. Achieving these opportunities will be dependent upon obtaining needed policy, program, and resource support.

There is local VA and DoD top management support to make Tripler Army Medical Center a model joint venture site. In this respect, countless hours have been invested by both activities to improve our joint venture. In order to perpetuate sharing between VA and DoD entities, national initiatives applicable to all types of sharing should be developed, providing guidance and policy on dual-eligibility, authorization, and reimbursement. Venture capital monies should be allocated for developing proposals and procuring dedicated joint venture staff. Information systems must be evaluated for applicability to sharing, and solutions to systemic issues should be identified and resolved expeditiously. We must address and resolve the barriers described if we are to achieve our ultimate goal - high quality care for our respective beneficiaries in a seamless healthcare system.