DEFENSE BUSINESS BOARD

**Report to the Secretary of Defense**

# Military Health System – Governance, Alignment and Configuration of Business Activities Task Group Report

Report FY06-5

- **Recommendations regarding the most rational model to support the strategic objectives of the Military Health System.**

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**September 2006**

# Military Health System – Alignment and Configuration of Business Activities Task Group Report

## TASK

In support of the Department's ongoing transformation efforts, and at the request of the Deputy Secretary of Defense, the Defense Business Board (DBB) formed this Task Group to 1) assess and provide an independent and objective assessment to the Department of Defense (DoD) for a Military Health System (MHS) governance framework in keeping with the Defense Enterprise Planning and Management Framework and 2) identify key best practices for delivery of the overall military health care mission.

The objective of this work was to provide actionable recommendations that would both continue to support and improve the enterprise healthcare mission including the efficient delivery of enterprise health benefits while meeting the Secretary's transformational goals and the Secretary's 2006-2008 priorities.

The Task Group was asked to (Appendix A):

1. Recommend how the Defense Enterprise Planning and Management framework and best practice enterprise models can help to facilitate development of an optimal organizational structure for implementing the MHS strategic vision and plan.

2. Recommend where application of industry best practices such as shared services or outsourcing could increase both efficiency and mission effectiveness, and

3. Consider which course of action would have the greatest potential for improving MHS performance and balance the needs of the war fighters with DoD beneficiaries.

Task Group Chairman: Henry Dreifus
Task Group Members: James Haveman, Barbara Barrett, Arnold Punaro, Atul Vashistha, Denis Bovin
Task Group Sponsor: Gordon England, Deputy Secretary of Defense
Task Group DoD Liaison: Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs
Task Group Executive Secretary: Lynne Schneider, DBB Deputy Director

## PROCESS

The Task Group received informational briefings and had several discussions regarding military and civilian efforts to improve military healthcare delivery within the Department. These discussions and interviews were held with key stakeholders including Health Affairs (HA), HA Transformation team, Surgeon Generals, Joint Chiefs of Staff, Service leadership, Task Force team members, Government Accountability Office, Veterans Affairs, Health and Human Services, and other stakeholder partners.

The Task Group also reviewed analyses and studies of the fourteen previously recommended models of Military Health System governance for the DoD enterprise. In researching private sector best practices, the Task Group reviewed research papers and articles, and interviewed private sector and public sector senior managers and CEO's for best practice ideas, concepts and implementation models. The Task Group presented their findings and recommendations to the full Board on September 6, 2006.

## RESULTS

During the September 6, 2006 meeting deliberations, the Board observed that with this Task Group effort, the Department has studied the consolidation of military medical health services (MHS) at least 16 times since 1948. The Board concluded that it is now time to reconfigure the way in which military medicine is delivered since it has grown into a significant strategic national asset, and accordingly it has achieved great efficacy in missions such as "health diplomacy" as a tool for winning the hearts and minds in global crisis. On the current path, costs to deliver this mission are unsustainable according to both internal and external reports. DoD can achieve benefits through configuring itself as a 21st century organization and adopting appropriate healthcare industry best practices and trends.

The Board acknowledged that the Base Realignment and Closure process and Quadrennial Defense Review have established important foundational steps for change, but further improvement of effort will come only through a re-configuration that drives unity of effort across the enterprise. Further, the President's Executive Order of August 2006 promoting quality and efficient healthcare will continue to drive the enterprise toward a new and forward-looking operational model.

The critical points deliberated among the Board members and the public focused on the DBB recommendation to establish a unified medical command. Concerns were raised that the proposed recommendations may require changes to DoD Title 10 legislation. However, the Board's review determined a unified command was not only feasible within Title 10, but in fact the Department may not be fulfilling its obligations under public law requiring consolidation of shared services. It also was clear to the Board that Service-specific operational mission needs such as battlefield and forward-deployed medicine (Level I and II) should remain organic and embedded within each Service.

A joint command structure would inherently reduce costs through eliminating redundant processes and consolidating personnel, resulting in a more efficient and effective healthcare system. Service-specific needs would still be addressed and implemented. Some participants at the public session stated that the current healthcare system already operates in a joint manner, especially in the non-battlefield echelons of care (Level III and above care facilities). There is not much more efficiency that can be achieved under the current separate-Services model. Therefore, a unified medical command would provide the forward "quantum leap" that would allow for a concomitantly more interoperable joint medical capability that can be more efficient and mission effective.

Following discussions and deliberation, the Board unanimously approved the proposed recommendations (Appendix B).

## KEY RECOMMENDATIONS

<u>Establish a Unified Medical Command Now:</u>

1. The Secretary of Defense should immediately approve and empower a Transition Team with quantifiable milestones for a January 2007 implementation (1 year ahead of schedule).

a) Augment the transition team with objective 3rd party experienced advisors from private sector industry leaders. These advisors would observe and provide insight in the implementation of the best practices. (We advise against using Defense consultants or Federally Funded Research and Development Center advisors.)

2. Move shared services, non-battlefield medicine (Level III care and above), and associated funding into this command.

    a) Begin with phased implementation of combining the management and execution of all direct care services (Level III and above), personnel, common requirements setting, logistics, education, training, information technology, contracting, facilities, research, development, testing and evaluation.

    b) Maintain organic battlefield medicine (Level I & II) and Service-specific medical capabilities and needs for mission continuity within Service control.

3. Re-align the current activities of the TRICARE Management Activity to function alongside the unified command and streamline its management functions to concentrate on policy and oversight of health plan management.

    a) Outsource the management activity once the agency has been re-aligned.

<u>Use the Existing Governance Framework:</u>

1. Continue to use current enterprise planning models and methodologies to maximize the enterprise outcomes.

2. Establish feedback loops for the civilian healthcare benefit management activities analogous to the Universal Joint Lessons Learned used by the military.

Adopt Best Industry Practices for Defense Medicine:

1. Combine like shared services across the medical community to include: common medical equipment, education and training, research and development, testing and evaluation, logistics, information management, information technology, establishing common requirements, etc.

2. Enhance the commitment and relationship with Veterans Affairs including shared clinic services and facilities, best evidence-based medicine and shared knowledge and technology in the delivery of service.

3. Align investment, manpower and resources to ensure implementation, accountability, and transparency.

    a) Converge education and training functions at Ft. Sam Houston (not just physical location) as well as at the National Capitol Region medical care in Bethesda to operate as a fully integrated unit (not three separate Services on three separate floors)

## CONCLUSION

The Board believes that a unified approach for the medical health mission will enhance the medical readiness of all forces and facilitate delivery of seamless operational medicine. Concomitantly, a unified approach also will improve the delivery of quality health services to all Defense health stakeholders, creating a better and continuously improving healthcare enterprise value.

Respectfully submitted,

Henry Dreifus
Task Group Chairman

Attachments:

Appendix A: Terms of Reference memo

Appendix B: September 6, 2006 Military Health System Task Group Final Presentation

# APPENDIX A

# (Terms of Reference)

DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

JUL 19 2006

MEMORANDUM FOR CHAIRMAN, DEFENSE BUSINESS BOARD (DBB)

SUBJECT: Terms of Reference – DBB Task Group on Military Health System Governance, Alignment and Configuration of Business Activities

Request you form a Task Group to give an independent and objective assessment and make actionable recommendations regarding the most rational model to support the strategic objectives of the Military Health System (MHS). The recommendations shall support both an optimal force health protection mission and efficient delivery of the enterprise health benefit. The Under Secretary of Defense for Personnel and Readiness, working with the Chairman of the Joint Chiefs of Staff, has developed a set of options configuring the MHS. These options, which include consideration of a Joint Medical Command, can serve as a basis for the evaluation.

The Task Group should deliver actionable recommendations with regard to the following:

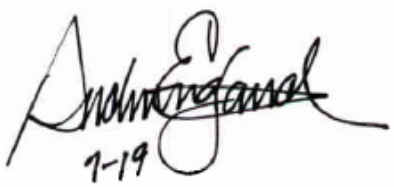
1. Recommend how the Defense Enterprise Planning and Management framework and best practice enterprise model can help to facilitate development of an optimal organizational structure in support of implementing the MHS strategic vision and plan.

2. Recommend where application of industry best practices such as shared services or outsourcing could increase both efficiency and mission effectiveness.

3. Recommend which of the proposed courses of action has the greatest potential for improving MHS performance and most appropriately balances the needs of the warfighters with those of DoD beneficiaries. Alternatively, if a novel structure would yield optimal performance, propose that structure.

Dr. William Winkenwerder, Assistant Secretary of Defense (Health Affairs) will be the DoD Liaison. Mr. Dreifus will be the Task Group Chairman and Ms. Lynne Schneider, Deputy Director of the DBB, will be the Task Group Executive Secretary. The Task Group will present a final report no later than September 6, 2006.

The Task Group will be operating in accordance with the provisions of P.L. 92-463, the "Federal Advisory Committee Act," and DoD Directive 5105.4, the "DoD Federal Advisory Committee Management Program." It is not anticipated that this Task Group will need to go into any "particular matters" within the meaning of Section 208 of Title 18, U.S. Code, nor will it cause any member to be placed in the position of acting as a procurement official.



# APPENDIX B

# (Task Group Final Report – September 6, 2006)

# Task Group
# on
# Military Health System (MHS)
# Governance, Alignment
# and
# Configuration of Business Activities

September 2006

DBB Task Group
Henry Dreifus (Task Group Chairman)
James Haveman
Barbara Barrett
Atul Vashistha
Arnold Punaro
Denis Bovin

Kelly Van Niman (DBB Executive Director)
Lynne Schneider (DBB Deputy Director)
Ryan Bates (DBB Staff Assistant)

DoD Sponsor
Mr. Gordon England, Deputy Secretary of Defense

DoD Liaison
Dr. William Winkenwerder (Assistant Secretary of Defense (Health Affairs))

# SCOPE & TERMS OF REFERENCE

1. Recommend how the Defense Enterprise Planning and Management framework and best practice enterprise model can help to facilitate development of an optimal organizational structure in support of implementing the MHS strategic vision and plan
2. Recommend where application of industry best practices such as shared services or outsourcing could increase both efficiency and mission effectiveness
3. Recommend which of the proposed courses of action has the greatest potential for improving MHS performance and most appropriately balances the needs of the war fighters with those of DoD beneficiaries

# STUDY PROCESS

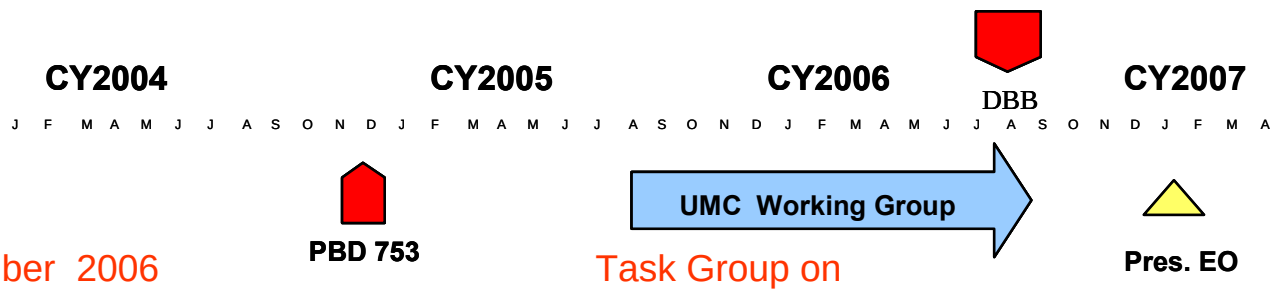
- Discussion and interviews with stakeholders including Health Affairs (HA), HA Transformation team, Surgeon Generals, Joint Chiefs of Staff, Service Leadership, Task Force team members, GAO, Veterans Affairs, Health and Human Services, and Stakeholder Partners
- Reviewed the history, reports, and studies on military healthcare delivery
  - Presidential Archives, Congressional Research Service, MITRE, McKinsey, Rand Studies, and others
- Discussion and interviews with private sector best practice providers and research on implementation of best practices in healthcare delivery including:
  - Schaller-Anderson
  - Henry Ford Health System
  - Mayo Clinic
  - Accenture

# OBJECTIVES, END, WAYS AND MEANS

- End: Provide a continuously improving aligned health mission that applies best evidence-based medicine for stakeholders including:
  - Enhancing the medical readiness of all forces for all missions
  - Deliver seamless operational medicine
  - Continuously improve the delivery of quality health services stakeholders for dependents, retirees, and mobilized reserves
- Ways: Improve the effectiveness of defense healthcare and its infrastructures through unity of efforts and elimination of redundant or conflicting services and structures
- Means: Apply an aligned outcome and mission “service excellence” based focus that parallels industry best practices

# BACKGROUND

- A Program Budget Decision (#753) signed by the Deputy Secretary of Defense Dec 2004 for a Unified Medical Command by FY08
- Unified Medical Command working group formed Aug 05 and chartered by the USD (P&R) and Joint Staff Oct 05
  - Focus was "developing recommendations for two specific commands"
    - A single Joint/Unified Medical Command responsible for all market areas
    - A Joint/Unified Medical Command responsible for operational/deployed medicine
- The work group's final recommendation was for a Unified Medical Command (SOCOM-like model APR 06)
- Joint Staff Action for a go-forward review May-Jul 06 is pending



# BACKGROUND

Recent Course of Events:

- Presidential Executive Order signed August 22, 2006 *Promoting Quality* and *Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs* has a deadline for adoption of January 2007
  - Increases Transparency In Pricing. Federal agencies must share with beneficiaries information about prices paid to health care providers for procedures
  - Increases Transparency In Quality. Agencies must share with beneficiaries information on the quality of services provided by doctors, hospitals, and other health care providers
  - Encourages Adoption Of Health Information Technology (IT) Standards. Agencies must use improved health IT systems to facilitate the rapid exchange of health information
  - Promotes Quality And Efficiency In Health Care. Federal agencies shall develop and identify approaches that facilitate high quality and efficient care

# OBSERVATIONS

- DoD medical community has collaboratively developed a Military Health System Strategic Plan under the leadership of Health Affairs
- The DoD Medical Community has adopted this plan which is consistent with the Defense Enterprise Planning and Management Framework
- The MHS Strategic Plan is founded on three pillars:
  - Provide a medically ready and protected force and homeland defense for communities
  - Create a deployable medical capability that can go anywhere, anytime with flexibility, interoperability and agility
  - Manage and deliver a superb health benefit

# OBSERVATIONS (continued)

- MHS has developed core processes through which it will accomplish this mission:
  - Manage and Deliver the Health Benefit
  - Deploy Medical Capabilities
  - Provide Medically Ready and Protected Force and HLD (homeland defense) for Communities
- MHS Core processes have identified the links between the What, How and Who – including shared services such as education and training, R&D, facilities, common medical equipment, etc.

# NEW REALITIES, OLD PERSPECTIVES

## Previous DoD Studies and Recommendations:**

| YEAR | COMMISSION AND/OR STUDY | CREATE UNIFIED SERVICE | ADD TO CENTRAL AUTHORITY | KEEP SEPARATE SERVICES |
|---|---|---|---|---|
| 1948 | HAWLEY BOARD | | √ | |
| 1949 | COOPER COMMITTEE | | √ | |
| 1949 | FIRST HOOVER COMMISSION | √ | | |
| 1955 | SECOND HOOVER COMMISSION | | √ | |
| 1958 | CONSULTANT TO PRESIDENT | | | √ |
| 1970 | PRESIDENTIAL BLUE RIBBON PANEL | | √ | |
| 1975 | MILITARY HEALTH-CARE STUDY | | | √ |
| 1979 | DEFENSE RESOURCE MANAGEMENT COMMITTEE | | | √ |
| 1982 | GRACE COMMISSION | √ | | |
| 1983 | SAIC REPORT TO CONGRESS | √ | | |
| 1990 | ASD/HA JOINT WORKING GROUP | | √ | |
| 1991 | OSD OFFICE OF ADMINISTRATION AND MANAGEMENT | | √ | |
| 2001 | USD P&R RAND STUDY | √* | | |
| 2006 | OSD HA/OFFICE OF TRANSFORMATION | √* | | |



* Unified Joint Command

**Source: RAND 2001

# ANALYSIS OF PREVIOUS DEFENSE HEALTH STUDIES*

- Past re-organization objectives:
  - Improve medical readiness through better planning, training, and operational systems
  - Ensure quality of care
  - Control costs through better coordination of resource management decisions and service delivery
  - Establish clear command and control of the medical system
- Reasons for considering MHS reorganization have changed little over the years:
  - Improving cost management
  - Better integration of health-care delivery
  - More effective administrative processes
  - Sustained attention to readiness
- Eleven of the past 14 studies since 1948 have recommended more centralized control/unification of command

*Source: RAND 2001

# WHY NOW?

- The citizens of the United States and the Government increasingly view military medicine as a strategic national asset in time of need, and “health diplomacy” is succeeding in winning the hearts and minds in global crisis (hurricanes, tsunami’s, earthquakes, etc.)
- Costs to deliver this mission are unsustainable. Duplication and incompatibility of equipment and facilities, etc. is inefficient and results in loss of buying power
- BRAC has already begun to force elements of the enterprise together physically – it is now time to consider how to best realign the processes and manpower
- DoD can achieve benefit through adopting health care industry best practices and trends
- Solving this now in a planned way rather than reacting to a budget cycle or crisis will better serve the enterprise
- Underlying recognition that defense healthcare culture is ready for change

# INDUSTRY PERSPECTIVES

- Consolidation of shared services becoming prevalent in industry to bring scale economies to discrete practice areas resulting in reducing costs and demonstrated savings
- Consolidated purchasing power is successfully being leveraged by industry - e.g. Consortia of health providers use review boards (comprised of hospitals and clinics) and are moving to common equipment, supplies, formularies, etc.
- Applying best evidence-based medicine is helping to control supply expenses for drugs, devices and resources
  - Review processes and increased transparency are providing situational awareness for clinicians to help maximize the utility of resources

# INDUSTRY PERSPECTIVES

- Industry moving toward "outcome-based medicine" which is service-driven vice practice-driven in its approach
  - Accommodates regional and demographic differences, use of internal v. outsourced services, etc.
  - Provides for better resource planning, budgeting and execution
  - Industry is re-educating and re-training physicians in evidence-based medicine
- Clinical information technology is key to achieving favorable outcome-based medicine
  - High performance providers invest in clinical information technology with the notion that careful implementation of clinical information technology contributes to better clinical decision-making and improves compliance with leading medical practices*

* Source: Accenture 2004

# RECOMMENDATIONS

Use the Existing Governance Framework:

- Support the MHS strategic plan including the linking of shared services to core processes and continuous monitoring of performance outcomes
- Establish feedback loops for the civilian healthcare benefit management activities analogous to the Universal Joint Lessons Learned used by the military
- Continue to use current enterprise planning models and methodologies to maximize the enterprise outcome (Appendix A)
- Business Transformation Agency and TRICARE Management Activity should establish a Memorandum of Agreement to ensure Armed forces Health Longitudinal Technology Application (AHLTA) and other related medical finance and logistics systems comply with the DoD Enterprise Architecture process and interoperability standards
  - The Director of TRICARE Management Activity should bring information technology capital investments through the Investment Review Board Process and the Defense Business Systems Management Committee

# RECOMMENDATIONS

Adopt Best Industry Practices for Defense Medicine:

- Combine like shared services across the medical community:
  - To include: Common medical equipment, education and training, research and development, testing and evaluation, logistics, information management, information technology, establishing common requirements, etc.
  - Enhance the commitment and relationship with Veterans Affairs including shared clinic services and facilities, best evidence based medicine and shared knowledge and technology in the delivery of service
- Align investment, manpower and resources to ensure implementation, accountability, and transparency
  - To include: Converging education and training functions at Ft. Sam Houston (not just physical location) and National Capitol Region medical care in Bethesda to operate as a fully integrated unit (not three separate Services on three separate floors)

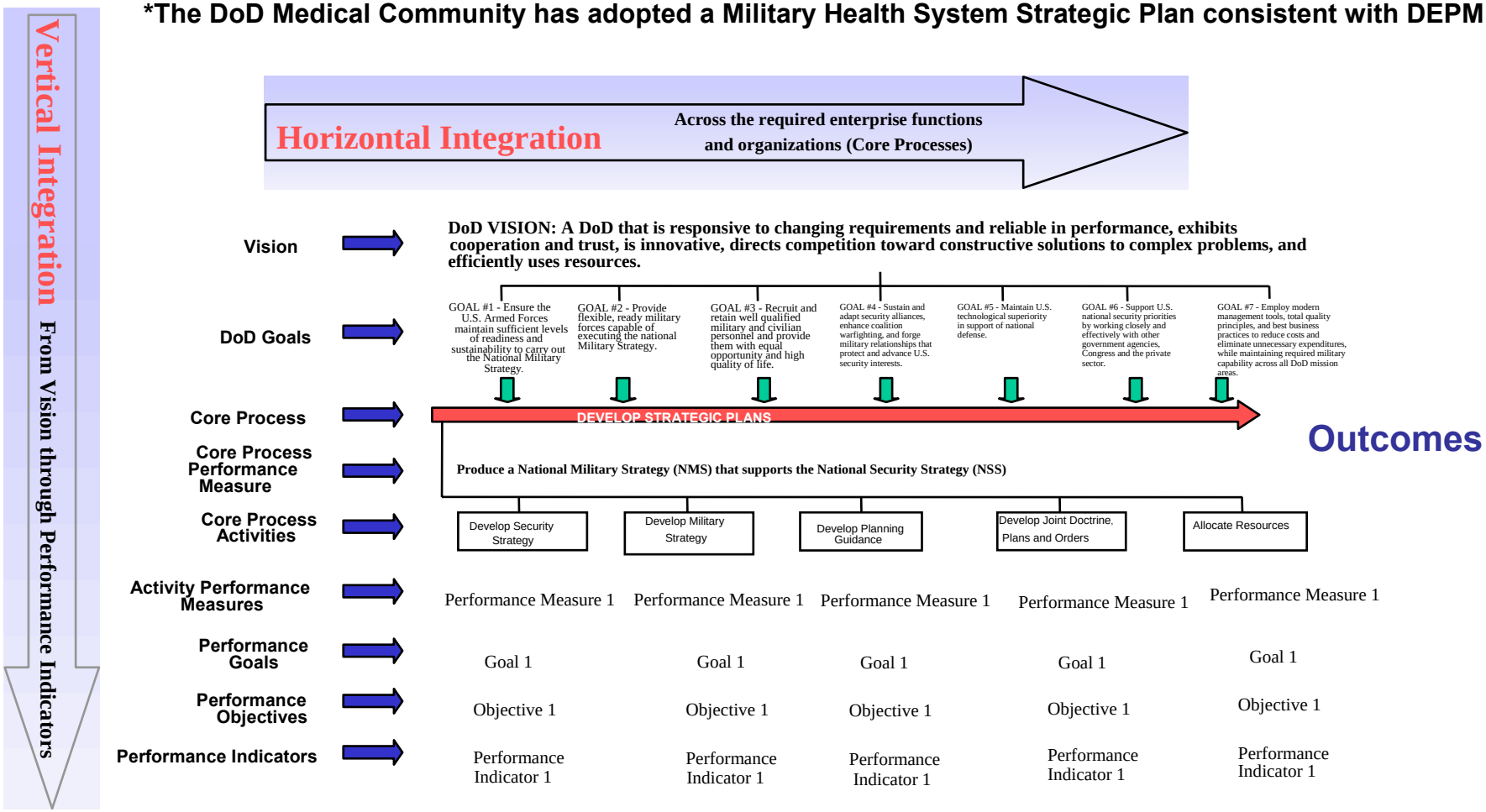
# RECOMMENDATIONS

## Establish a Unified Medical Command Now:

- Move shared services, non-battlefield medicines (Level III care and above), and associated funding into this command
  - Begin with phased implementation of combining the management and execution of all direct care services (Level III and above), personnel, common requirements setting, logistics, education, training, information technology, contracting, facilities, research, development, testing and evaluation
  - Maintain organic (battlefield Level I & II medicines) Service-specific medical capabilities for mission continuity within Service control
- Re-align the current activities of the TRICARE Management Activity to function alongside the Unified Command and streamline its management functions to concentrate on policy and oversight of health plan management
  - Outsource the management activity once the agency has been re-aligned
- Health Affairs must maintain policy control, budget accountability and oversight for all Medical Health Services activities
- Immediately approve and empower a Transition Team with 30-60-90 day milestones for a January 2007 implementation (1 year ahead of schedule)
  - Augment the transition team with objective 3rd party experienced advisors from private sector industry leaders. These advisors would observe and provide insight in the implementation of the best practices (We advise against using Defense consultants or Federally Funded Research and Development Center advisors)

# Defense Enterprise Planning and Management Architecture (DEPM)*

*The DoD Medical Community has adopted a Military Health System Strategic Plan consistent with DEPM



# HEALTHCARE INDUSTRY FINDINGS & TRENDS*

They must:

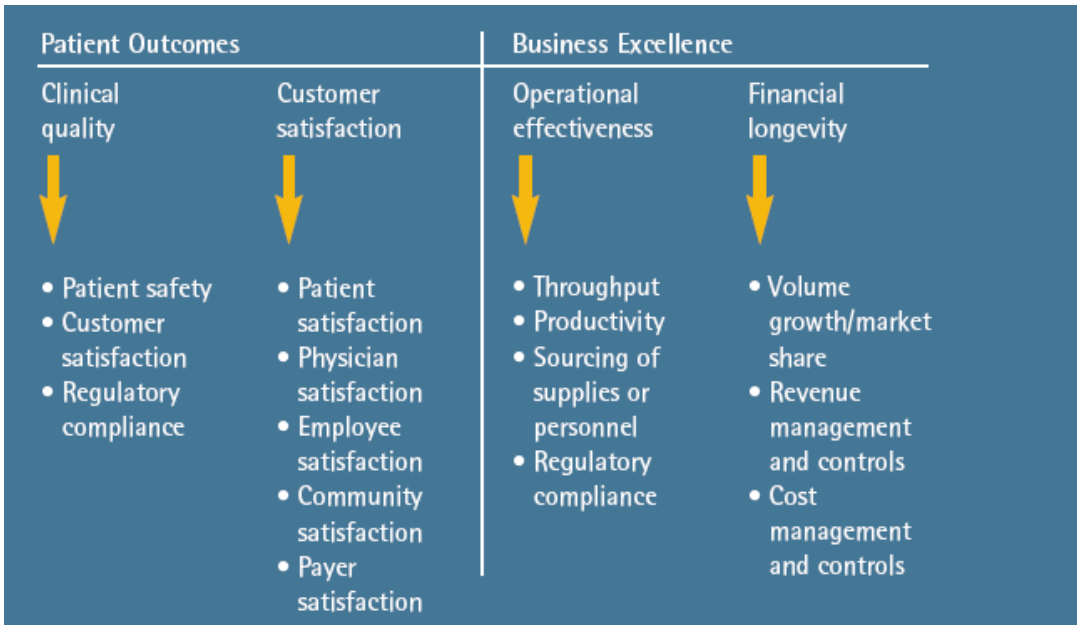
- Define and align a high performance vision with organizational strategic goals.
- Define key priorities and targets for high performance in terms of clinical quality, customer satisfaction, operational performance and financial longevity.
- Establish system-wide standards for measuring both functions and processes in a fair and consistent manner.
- Define timelines and implementation agendas.
- Establish and implement the supporting business processes, technologies, tools, incentives and a culture that enables the transition to high performance.
- Closely integrate business processes and information technology to ensure seamless and transparent data sharing.
- Monitor progress by analyzing the collected data and communicate results to the appropriate stakeholders.
- Make continual improvements as appropriate.

Only then can providers proceed to focus on the clinical quality and customer satisfaction that will deliver improved patient outcomes. And only then will they be able to develop the operational effectiveness and financial longevity that underpin business excellence and sustain high performance for the long run. All of this must be done with the benefit of technology.

*Source: Accenture 2004

# HEALTHCARE INDUSTRY FINDINGS & TRENDS*

- High-performance providers share a strategic vision, a willingness to embrace change and outstanding execution skills
- High performance in health-care is created by two core capabilities:
  - Generating improved patient outcomes
  - Sustaining business excellence




*These two core capabilities are interdependent and help to form a holistic approach*



*Source: Accenture 2004