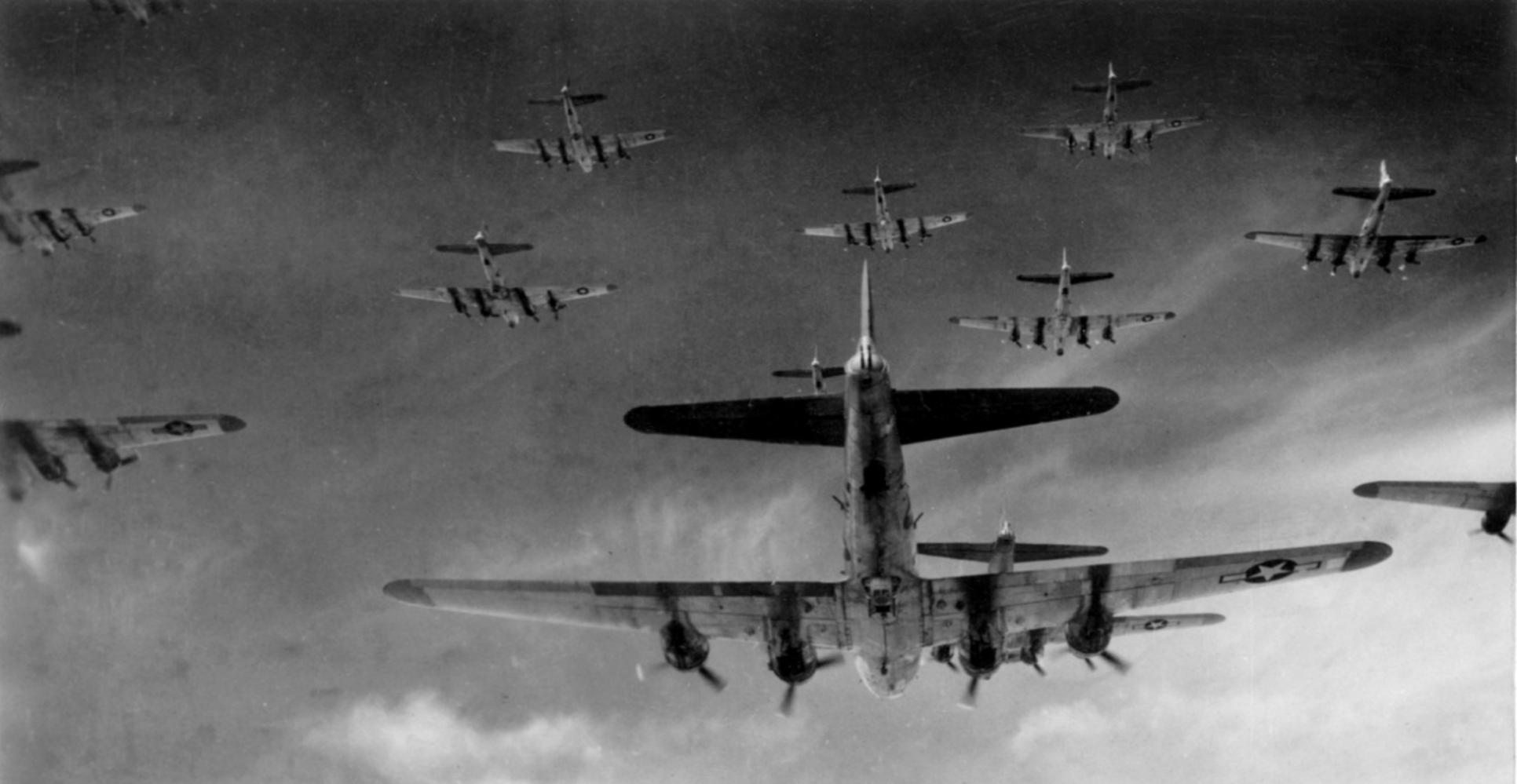


Military Health System: *HIT Transformation*

Lt Gen Douglas J. Robb
Director, Defense Health Agency
July 2014





“We have just fought a war with a lot of heroes flying around in planes. The next war may be fought by airplanes with no men in them at all... take everything you’ve learned about aviation in war, throw it out the window, and let’s get to work on tomorrow’s aviation.”

General Hap Arnold after WWII

(0-398) 102- 13 APR 45 (100-67 18500) (NEUMUNSTER) (C.M.F.)

The "Why..."



...the "Why Not"



If You Remember Nothing Else...



- **We have a shared mission**
- **We are a joint team**
- **We are moving forward...together**

“Medically Ready Force...Ready Medical Force”

A Changing World



“We are only beginning to see the dramatic shifts underway that will define our future and shape our interactions in the world ... and require our national security institutions to adapt and to adjust...”

We will need to more efficiently match our resources to our most important national security requirements. We can do things better. We must do things better – and we will.”

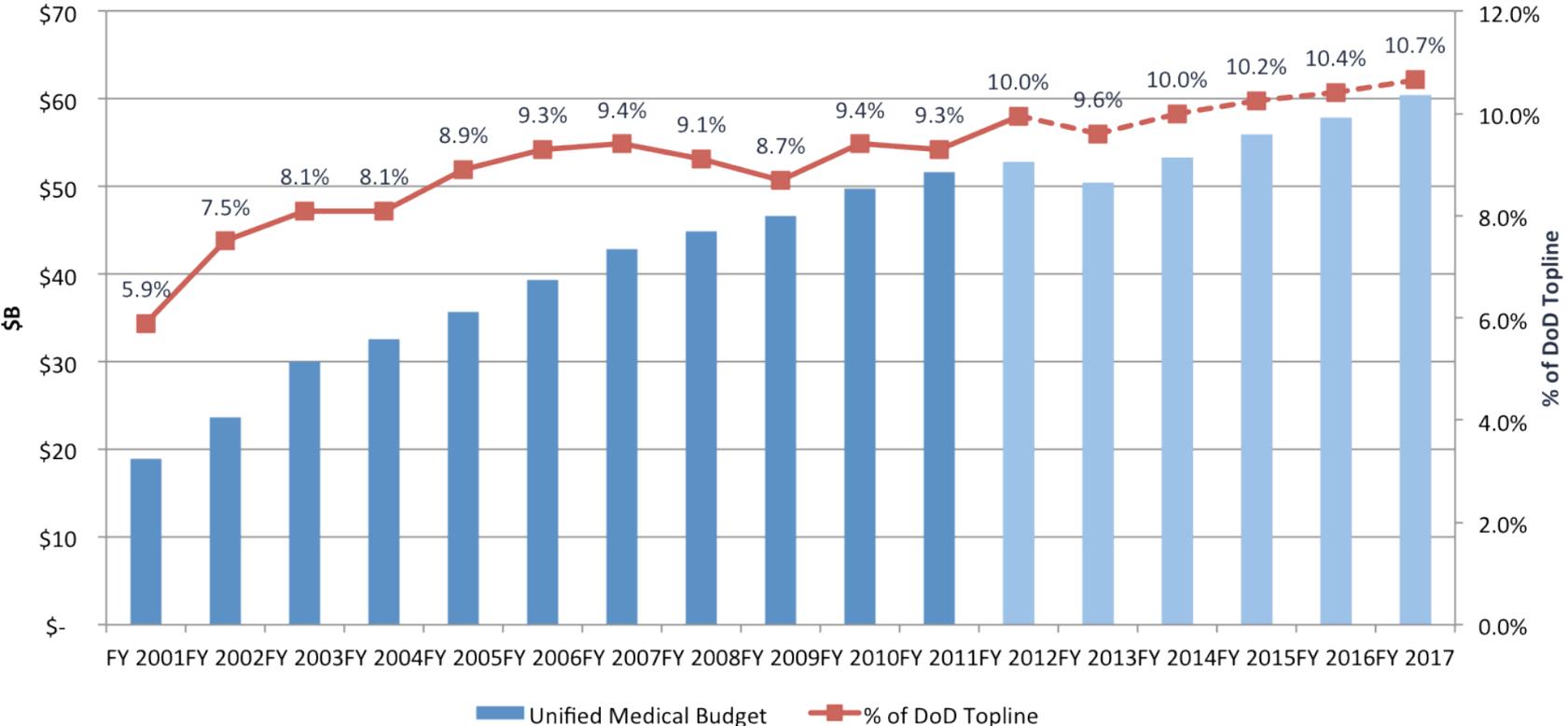
**Secretary Hagel
Center for Strategic & International Studies
November 2013**

“Medically Ready Force...Ready Medical Force”

Medical as Percent of DoD Budget



Continued cost increases within MHS are unsustainable over time



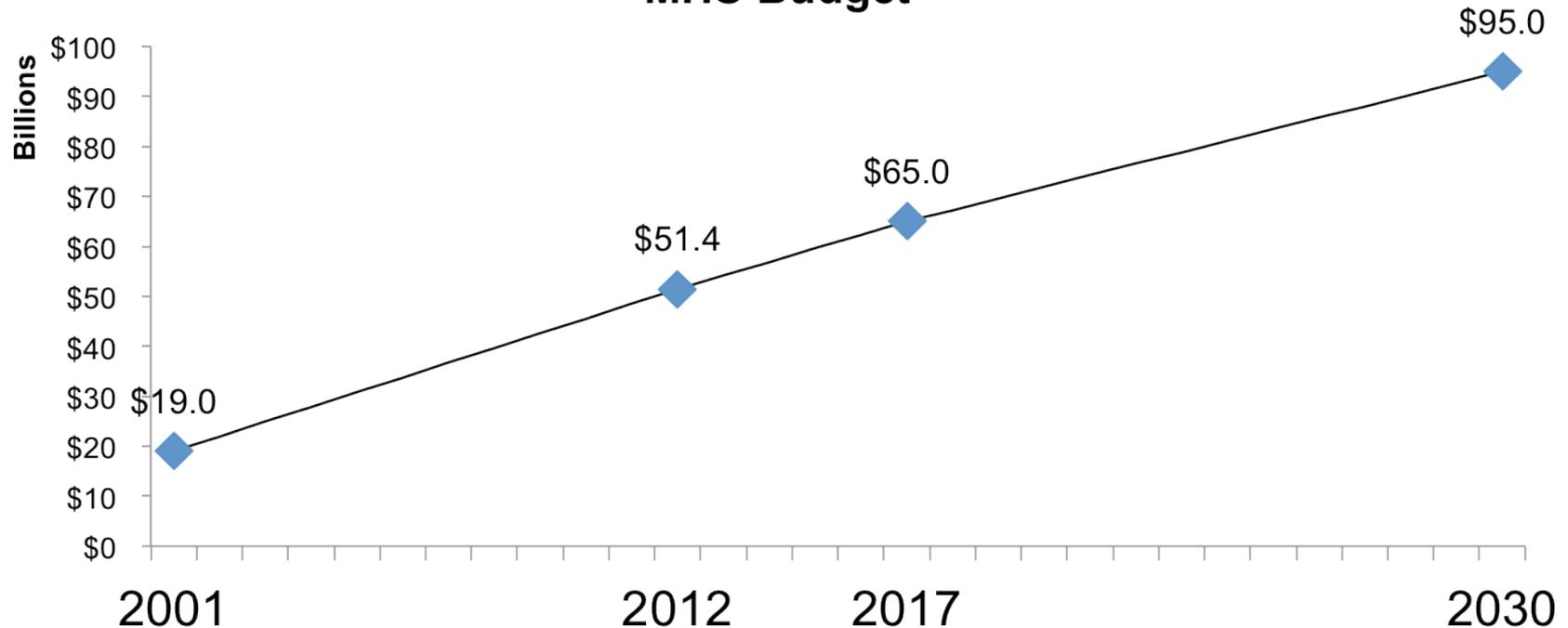
Includes Normal Cost contributions to the Medicare Eligible Retiree Health Care Fund (MERHCF)

“Medically Ready Force...Ready Medical Force”

DoD Health Care Cost Growth



MHS Budget



- 1. Increases in new eligible beneficiaries**
 - Increase of 500,000 beneficiaries since 2007
- 2. Expanded benefits**
 - TRICARE plans and prescription benefits
- 3. Increased utilization**
 - Existing users consuming more care (ER, ortho, MH)
 - 70% increase in AD outpatient purchased care FY05-FY10
- 4. Healthcare inflation**
 - Higher than general inflation rate

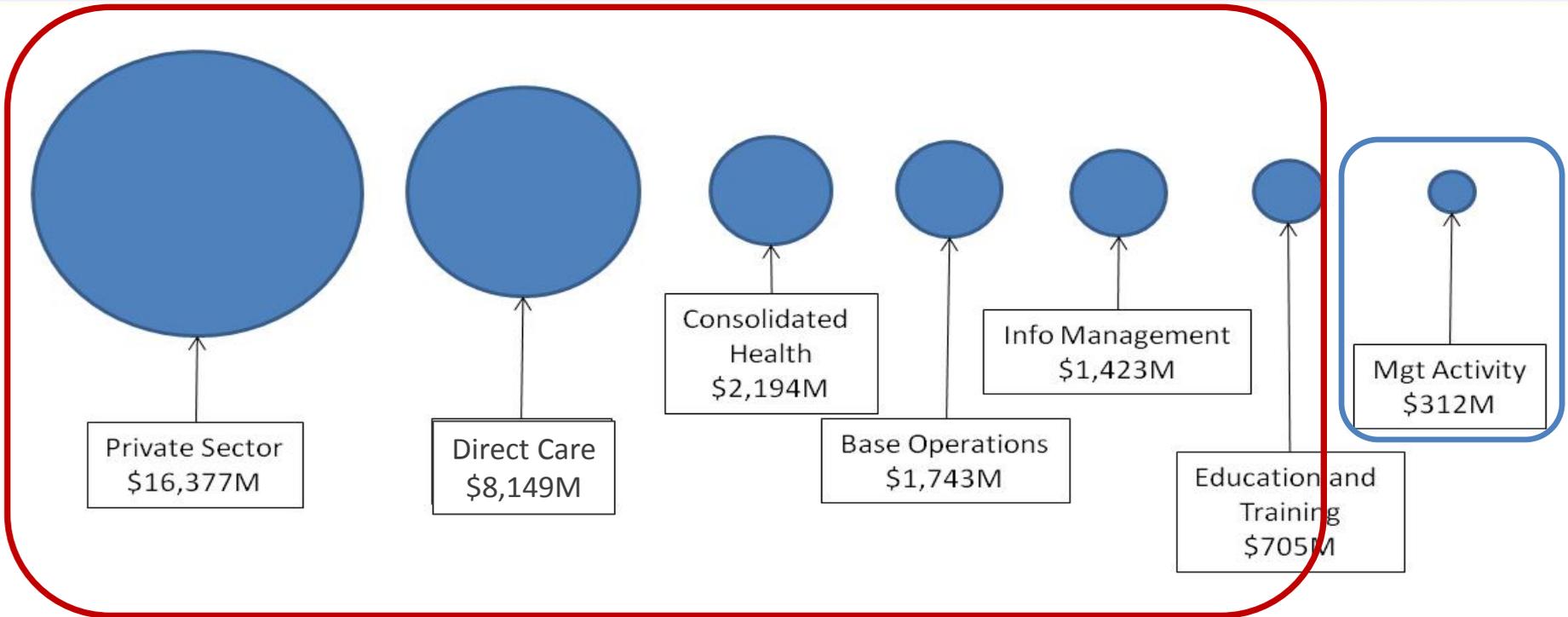
“Medically Ready Force...Ready Medical Force”

History of MHS Governance Studies



Year	COMMISSION AND/OR STUDY	CREATE UNIFIED SERVICE	ADD TO CENTRAL AUTHORITY	KEEP SEPARATE SERVICES
1948	HAWLEY BOARD		X	
1949	COOPER COMMITTEE		X	
1949	FIRST HOOVER COMMISSION	X		
1955	SECOND HOOVER COMMISSION		X	
1958	CONSULTANT TO PRESIDENT			X
1970	PRESIDENTIAL BLUE RIBBON PANEL		X	
1975	MILITARY HEALTHCARE STUDY			X
1979	DEFENSE RESOURCE MANAGEMENT COMMITTEE			X
1982	GRACE COMMISSION	X		
1983	SAIC REPORT TO CONGRESS	X		
1990	ASD(HA) JOINT WORKING GROUP		X	
1991	OSD OFFICE OF ADMINISTRATION AND MANAGEMENT		X	
2001	USD(P&R) RAND STUDY	X*		
2001	DEFENSE MEDICAL OVERSIGHT COUNCIL	X*		
2006	OSD(HA) OFFICE OF TRANSFORMATION	X*		
2006	DEFENSE BUSINESS BOARD	X*		
2006	JOINT UNIFIED MEDICAL COMMAND WORKING GROUP	X*		
2011	MHS TASK FORCE		X	

Governance Reform: *Influencing the Big Rocks*



Management Activities represent a small part of DoD's health care costs

Opportunities exist for a properly organized management HQ to effect change with shared services

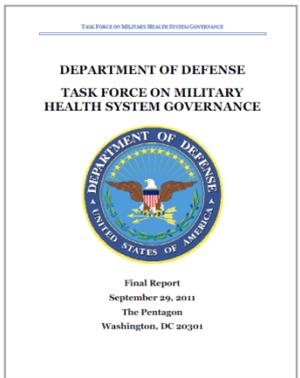
*Source: FY 2012 President's Budget position for DHP O&M

“Medically Ready Force...Ready Medical Force”

How We Got Here



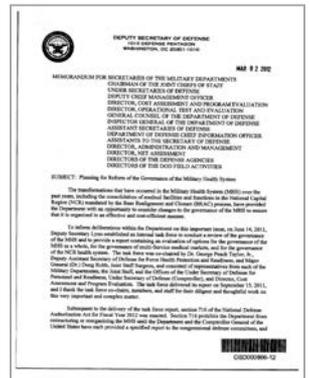
DoD Task Force on MHS Governance



September 2011

Recommended DHA model for MHS governance

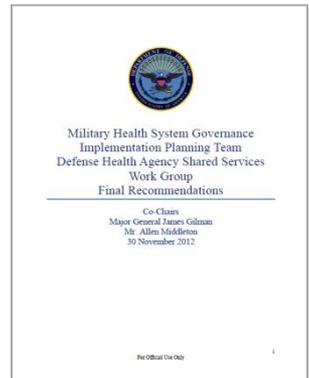
DEPSECDEF Planning Memo



March 2012

Directed planning for DHA implementation

DHA Planning WG Report



November 2012

Provided DHA and Shared Services implementation plan for DEPSECDEF approval

DEPSECDEF "Nine Commandments" Memo



March 2013

Directed implementation of DHA

"Medically Ready Force...Ready Medical Force"

MHS Reform: *What We Are Undertaking*



- Creating a more **globally integrated** health system – built on our battlefield successes
- Driving enterprise-wide shared services; **standardized clinical and business processes** that produce better health and better health care
- Implementing future-oriented strategies to create a **better, stronger, more relevant** medical force

DHA Vision & Mission



Vision

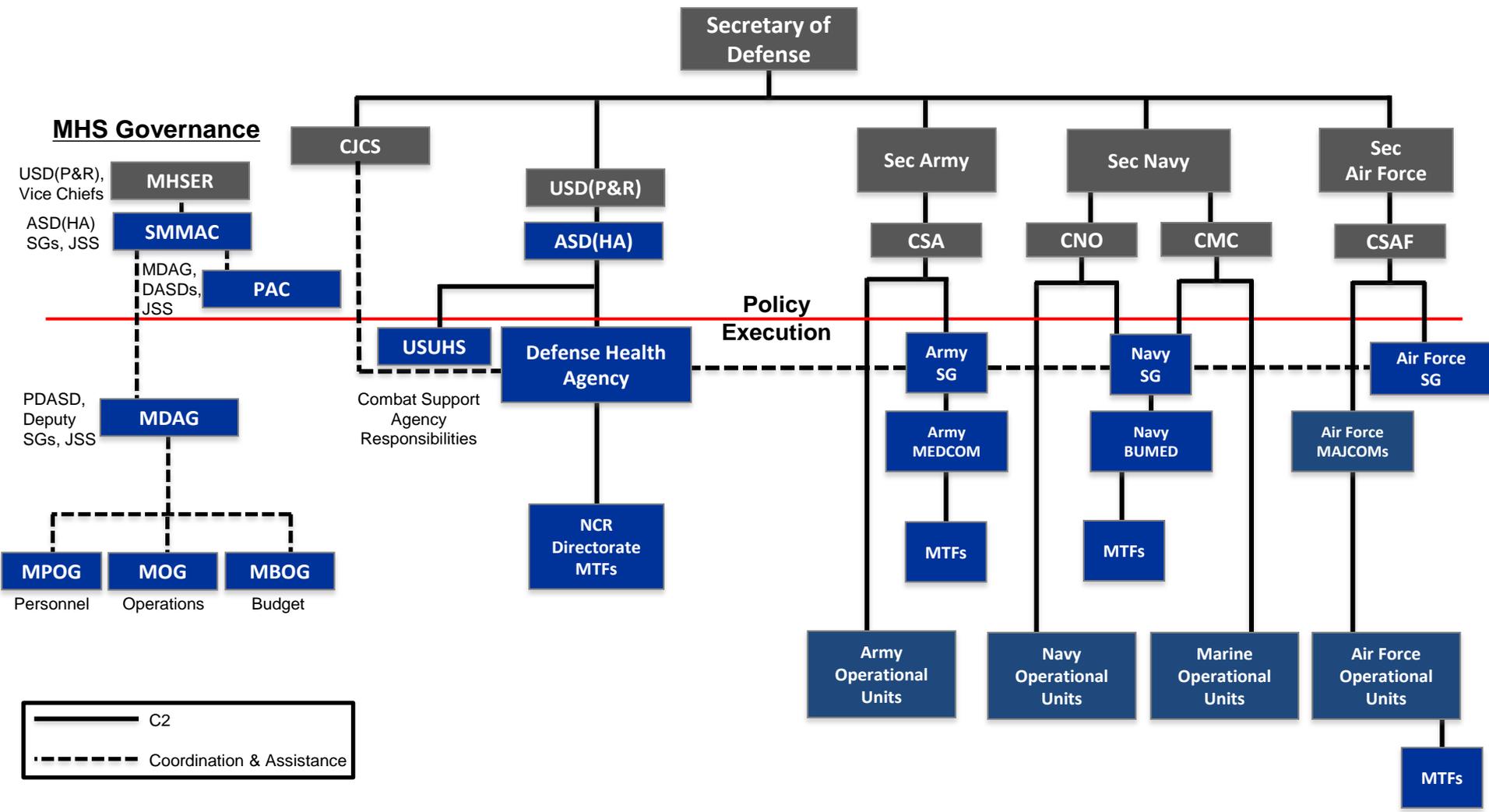
A joint, integrated, premier system of health, supporting those who serve in the defense of our country.

Key Mission Aspects

- A Combat Support Agency supporting the military services
- Supports the delivery of integrated, affordable, and high quality health services to beneficiaries of the Military Health System (MHS)
- Executes responsibility for shared services, functions, and activities of the MHS
- Serves as the program manager for the TRICARE Health Plan, medical resources, and as the market manager for the National Capital Region (NCR) enhanced Multi-Service Market
- Manages the execution of policy as issued by the Assistant Secretary of Defense for Health Affairs
- Exercises authority, direction and control over the inpatient facilities and the subordinate clinics assigned to the DHA in the NCR Directorate.

“Medically Ready Force...Ready Medical Force”

MHS Organizational Overview

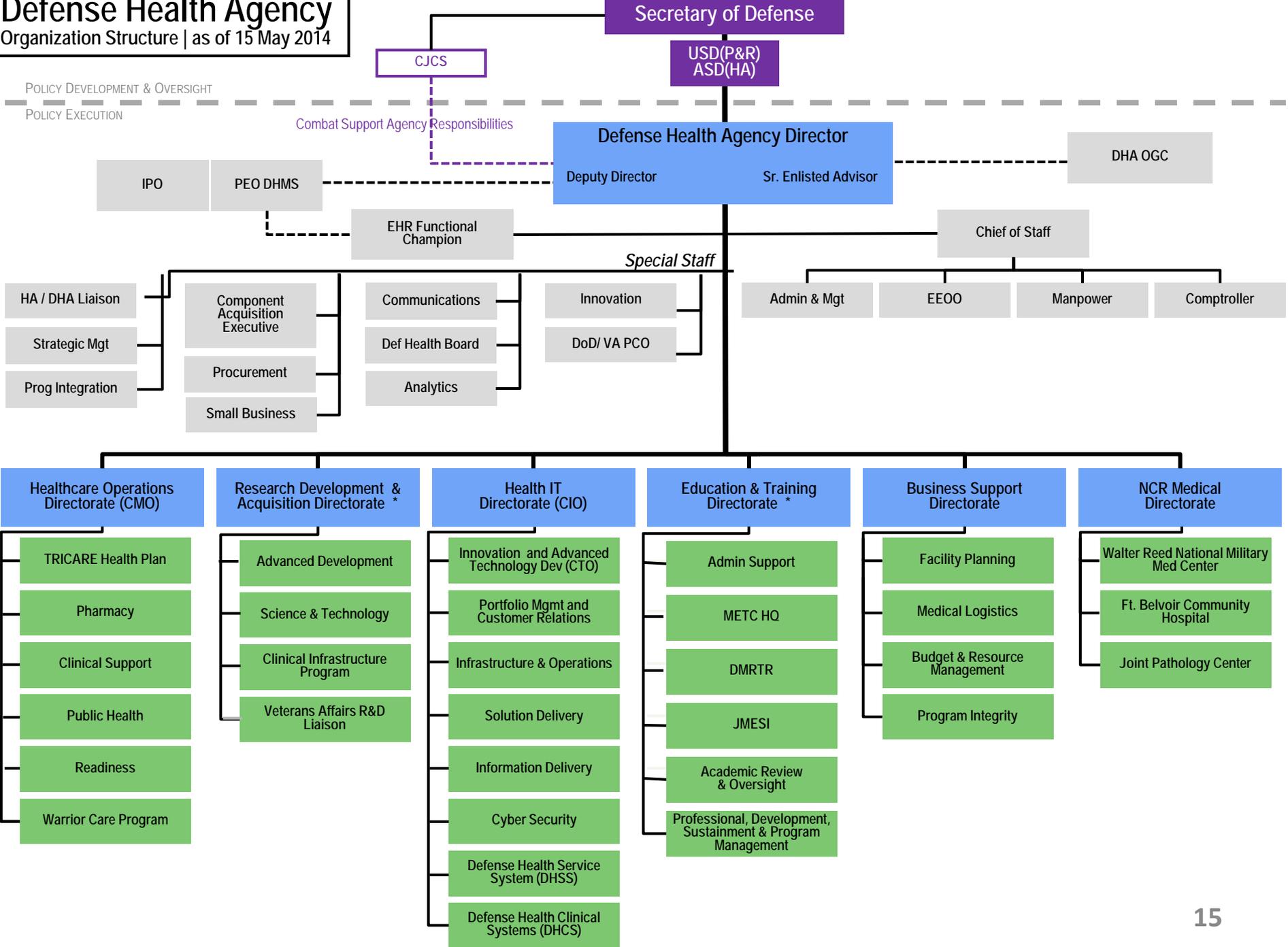


“Medically Ready Force...Ready Medical Force”

Defense Health Agency

Organization Structure | as of 15 May 2014

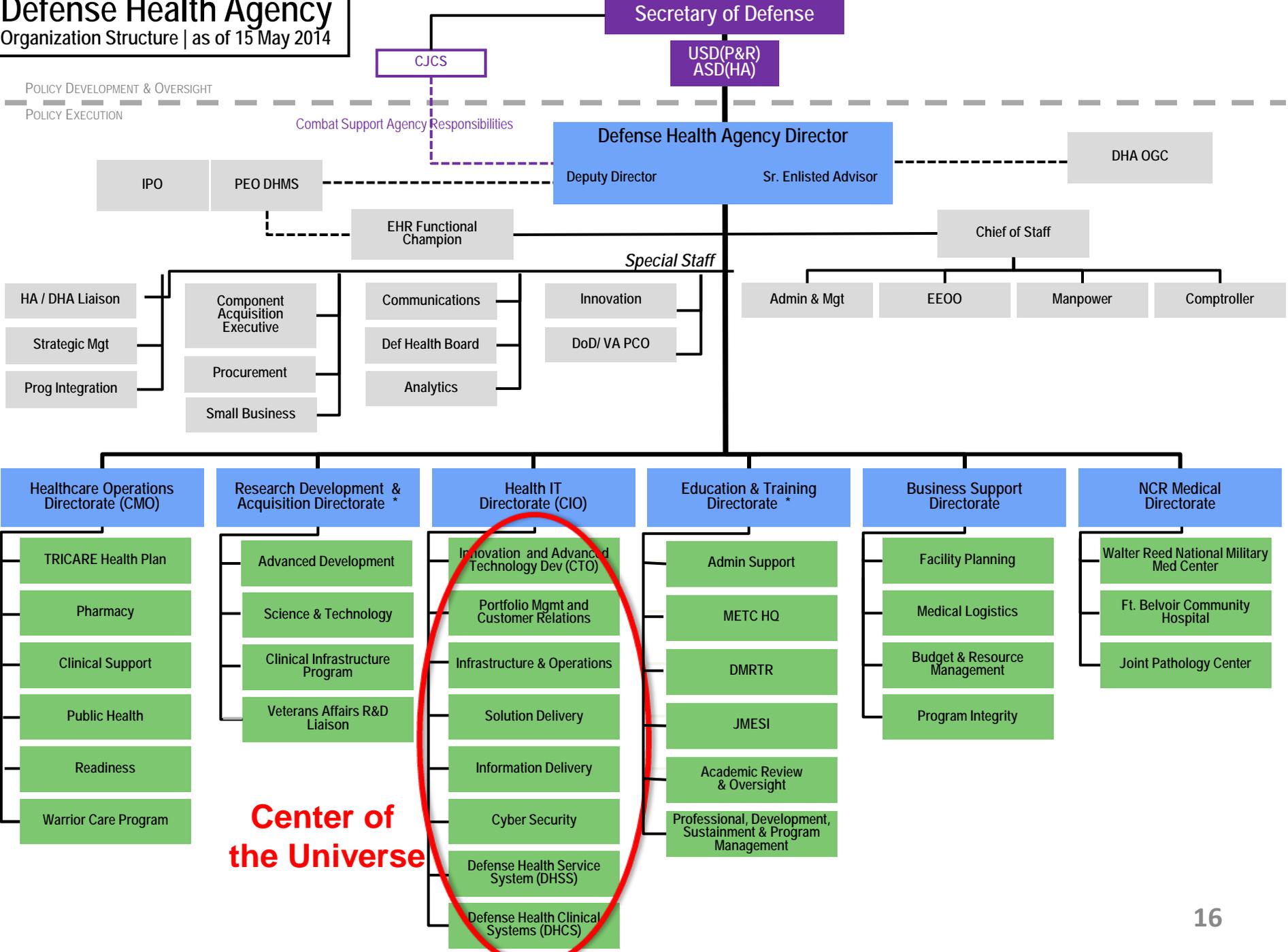
POLICY DEVELOPMENT & OVERSIGHT
POLICY EXECUTION



Defense Health Agency

Organization Structure | as of 15 May 2014

POLICY DEVELOPMENT & OVERSIGHT
POLICY EXECUTION



Center of the Universe

Our Leadership Team



Lt Gen Douglas Robb
Director



Mr. Allen Middleton
Deputy Director



MG Richard Thomas
Director
Healthcare Ops



RADM Bruce Doll
Director
Research & Development



Mr. David Bowen
Director
Health IT



RADM William Roberts
Director
Education & Training



Mr. Robert Moss
Acting Director
Business Support



RDML Raquel Bono
Director
NCR Medical

“Medically Ready Force...Ready Medical Force”

10 Shared Services



- | | | | |
|---|-------------------------------|----|--------------------------------|
| 1 | Facilities | 6 | Budget & Resource Management |
| 2 | Medical Logistics | 7 | Procurement/Contracting |
| 3 | Health Information Technology | 8 | Public Health |
| 4 | TRICARE Health Plan | 9 | Medical Education & Training |
| 5 | Pharmacy Programs | 10 | Medical Research & Development |

 Achieved IOC as of Aug 8, 2014 or earlier

 Achieve IOC by October 2014

Shared Services Savings Update: First 5



Function	IOC	Forecasted FY14 Net Savings	Current Initiatives	Actual FY14 Net Savings to Date
Facilities	1 Oct 13	(\$18.4M)	• Facilities Demand Signal Management	\$0M
			• Facility Planning Standardization	\$0M
			• IO&T Standardization	\$0M
Medical Logistics	1 Oct 13	\$13.5M As of FEB14=\$0.5M	• Electronic Catalog (ECAT) ordering for orthopedic implants	\$.5M
			• Supply purchasing standardization	\$0M
			• Medical Equipment Information Assurance standardization	\$0M
Health IT	1 Oct 13	(\$33.1M) As of May 14=M	• Central IT Governance development • Portfolio Management standardization • Customer Relationship management process standardization	\$0M
			• BCA 1 – Re-engineering of IT Management	\$3.8M
			• BCA 2 – IT Infrastructure Rationalization	\$14.7M
			• BCA 3 – Portfolio Rationalization	\$13.3M
Health Plan	1 Oct 13	\$25.5M As of FEB14=\$17M	• Tricare Service Center closure	\$0M
			• Other Health Insurance (OHI) discovery	\$0M
Pharmacy	1 Oct 13	\$160.5M As of FEB14=\$54.8M	• Retail Rx to Mail Order/MTF conversion (including TFL pilot)	\$17.0M
			• Brand to generic conversions	\$4.3M
			• Formulary Management	\$33.5M
Total				\$79.8M

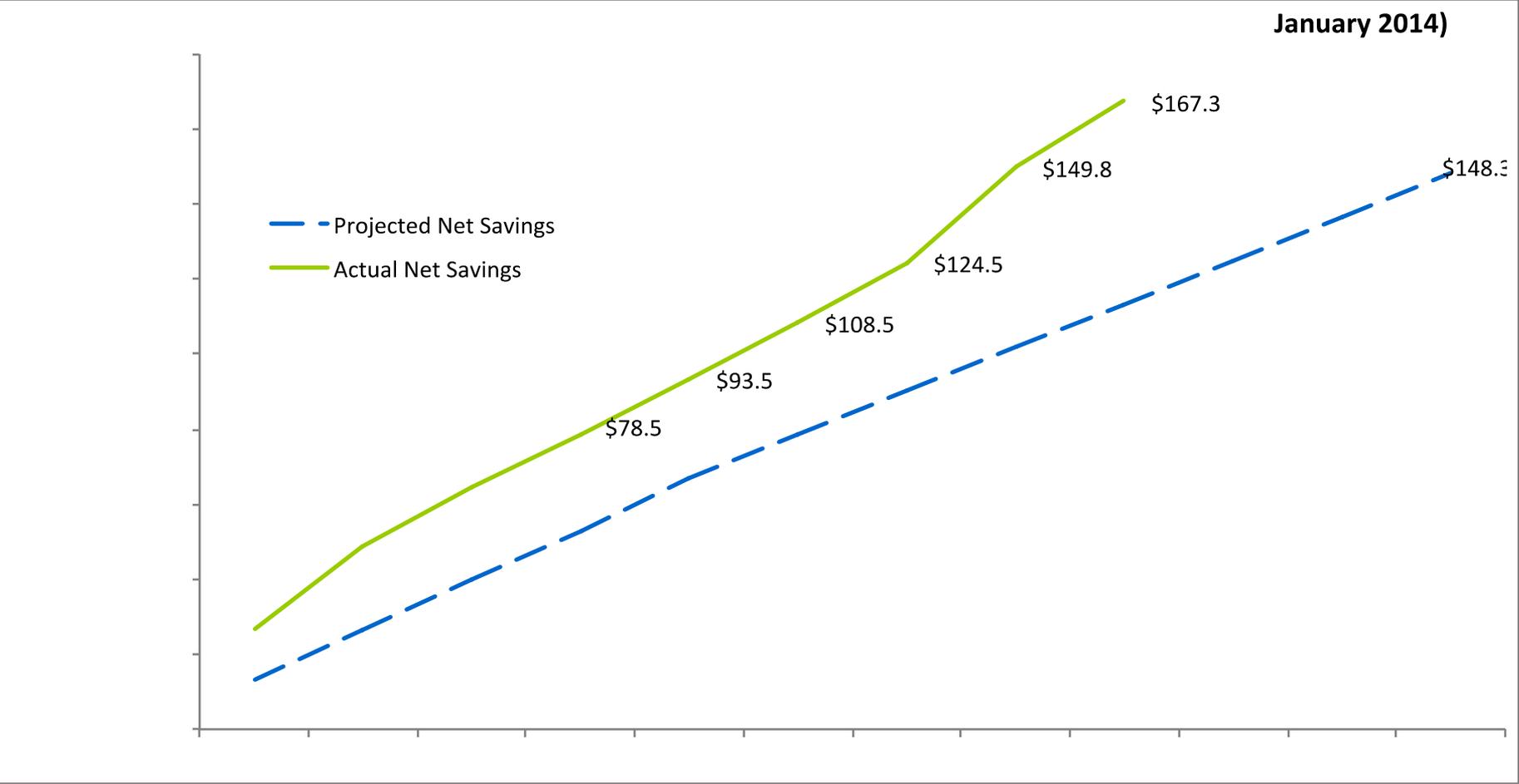
“Medically Ready Force...Ready Medical Force”

Shared Services Savings Update: Second 5



Function	IOC	Forecasted FY14 Net Savings	FY 14 Initiatives
Budget and Resource Management	1 Feb14	\$4.9M	<ul style="list-style-type: none"> • UBO Governance • Common Cost Accounting
Contracting	1 Mar 14	(\$2.9M)	<ul style="list-style-type: none"> • Strategic Multiple Award Task Order Development – Q Services • Strategic Multiple Award Task Order Development – R Services
Public Health	1 Oct14	(\$12.3M)	<ul style="list-style-type: none"> • Deployment Health Process Efficiency and Standardization • Streamlining Health Surveillance processes across the MHS
Med. Education and Training	8 Aug 14	(\$0.3M)	<ul style="list-style-type: none"> • Modeling and Simulation contract consolidation • eLearning software application rationalization
Research, Development, and Acquisition	1 Jun14	\$0M	<ul style="list-style-type: none"> • Redirection of Extramural Funding • Future DHA RDA structure development

FY14 Shared Services Savings: Actual vs Projected



“Medically Ready Force...Ready Medical Force”

DHA Progress to Date



- We have:
 - Built an A+ Team
 - Brought in 9 shared services...1 more to go
 - Established multi-service markets and business plans for each
 - Provided value to our leaders, our line commanders, and our customers by providing single points of contact

Health Information Technology (HIT) Directorate

Mr. David Bowen
Director

Vision & Mission



Vision

A premier system of health information technology, enabling integrated health care delivery for those who serve in the defense of our country, retirees, and their families.

Mission

Implement, manage, and sustain an integrated and protected medical information enterprise in order to ensure the ***right information*** is accessible to the ***right customers*** at the ***right time*** and in the ***right way***.

Goals & Strategies



Goals

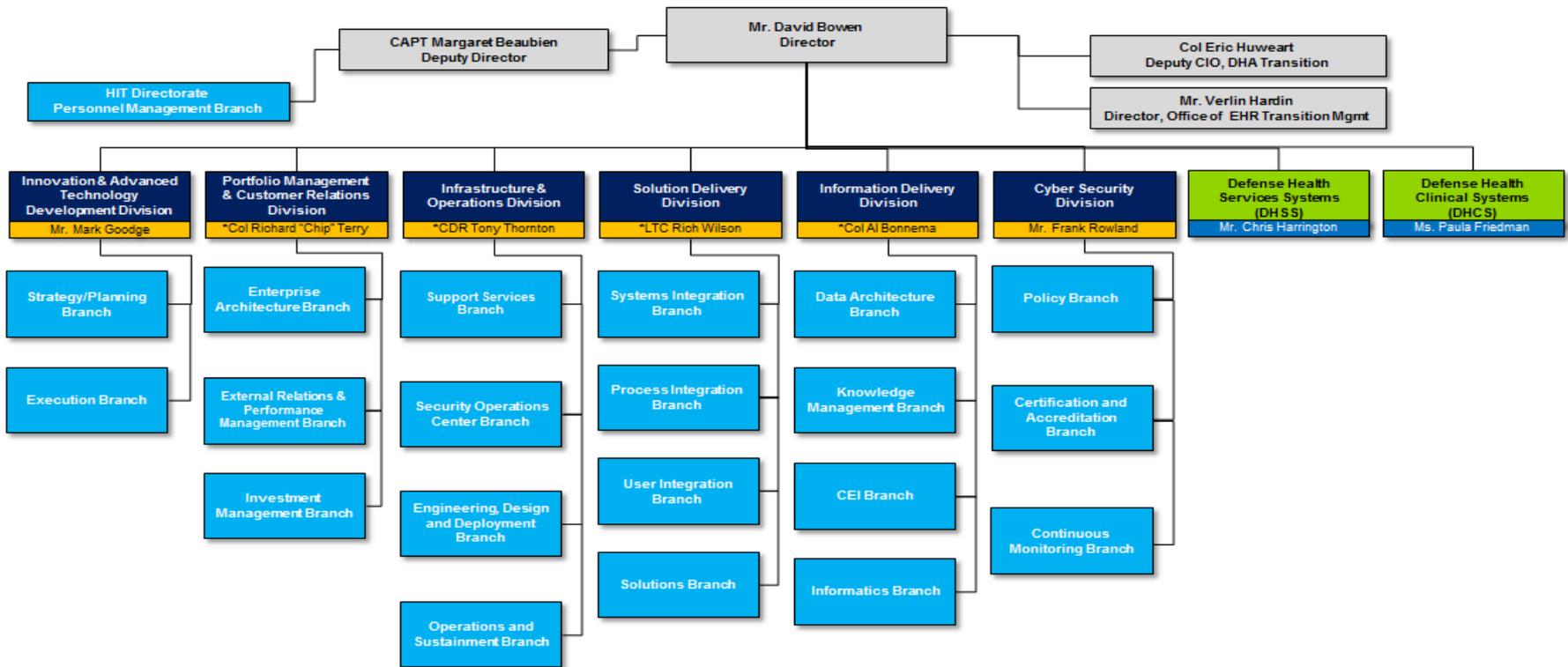
- Don' t Break Anything!
- Make our Business Case numbers
- Keep our Customers (the Services) happy
- Support the EHR efforts

Strategies

- Transform into functional organization – stand down existing commands
- Eliminate duplication and redundancies
- Reduce variability by means of standardization
- Leverage existing IT best practices
- Allocate resources to support EHR efforts

“Medically Ready Force...Ready Medical Force”

HIT ORGANIZATIONAL CHART



“Medically Ready Force...Ready Medical Force”

HIT Business Case: Savings Areas



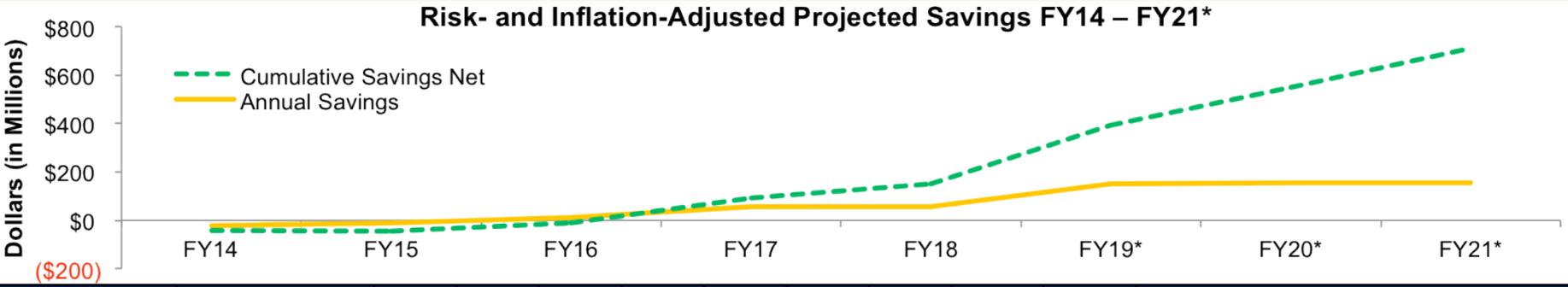
Our Business Case is driven by:

- Consolidating management and management resources across the Services
- Consolidating and standardizing our IT infrastructure: ***Datacenter to Desktop***
-
- Rationalizing our MHS HIT application portfolio

Projected Business Case Costs & Savings



Funding needs to be provided each year in order to produce net savings in FY16 and reach annual steady-state net savings in FY19



BCA	Category	FY14	FY15	FY16	FY17	FY18	FY19*	FY20*	FY21*	Total	Primary Drivers of Implementation Costs
#1: Reengineering of IT Management	Savings (\$M)	\$3.31	\$5.67	\$5.77	\$5.88	\$6.00	\$6.13	\$6.27	\$6.42	\$45.46	<ul style="list-style-type: none"> IT costs to invest in tools (portfolio management, EA) needed to support and automate reengineered business processes.
	Cost (\$M)	\$4.37	\$2.58	\$2.10	\$2.14	\$2.18	\$0.00	\$0.00	\$0.00	\$13.37	
	Net Savings (\$M)	(\$1.07)	\$3.09	\$3.67	\$3.74	\$3.82	\$6.13	\$6.27	\$6.42	\$32.09	
#2: Infrastructure Consolidation	Savings (\$M)	\$3.05	\$6.19	\$14.68	\$16.56	\$16.91	\$74.71	\$76.43	\$78.27	\$286.81	<ul style="list-style-type: none"> Contract support for transition planning and PMO (e.g., product line analysis, scheduling, risk management). IT costs for product line consolidation (e.g., additional servers, storage, bandwidth).
	Cost (\$M)	\$0.00	\$17.53	\$13.63	\$28.85	\$31.64	\$0.00	\$0.00	\$0.00	\$91.66	
	Net Savings (\$M)	\$3.05	(\$11.34)	\$1.05	(\$12.29)	(\$14.73)	\$74.71	\$76.43	\$78.27	\$195.15	
#3: Portfolio Rationalization	Savings (\$M)	\$0.00	\$21.33	\$40.24	\$66.21	\$67.60	\$69.08	\$70.67	\$72.37	\$407.50	<ul style="list-style-type: none"> IT costs for decommissioning and promotion of system to enterprise level (e.g., migrating/archiving data, increasing capacity of target system, hardware disposal, training, change management, BPR).
	Cost (\$M)	\$23.98	\$24.32	\$32.97	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$81.27	
	Net Savings (\$M)	(\$23.98)	(\$2.99)	\$7.27	\$66.21	\$67.60	\$69.08	\$70.67	\$72.37	\$326.23	
GRAND TOTAL NET SAVINGS	Annual (\$M)	(\$22.00)	(\$11.24)	\$11.99	\$57.66	\$56.68	\$149.93	\$153.38	\$157.06	\$553.47	
	Cumulative (\$M)	(\$22.00)	(\$33.23)	(\$21.25)	\$36.41	\$93.10	\$243.03	\$396.41	\$553.47	--	

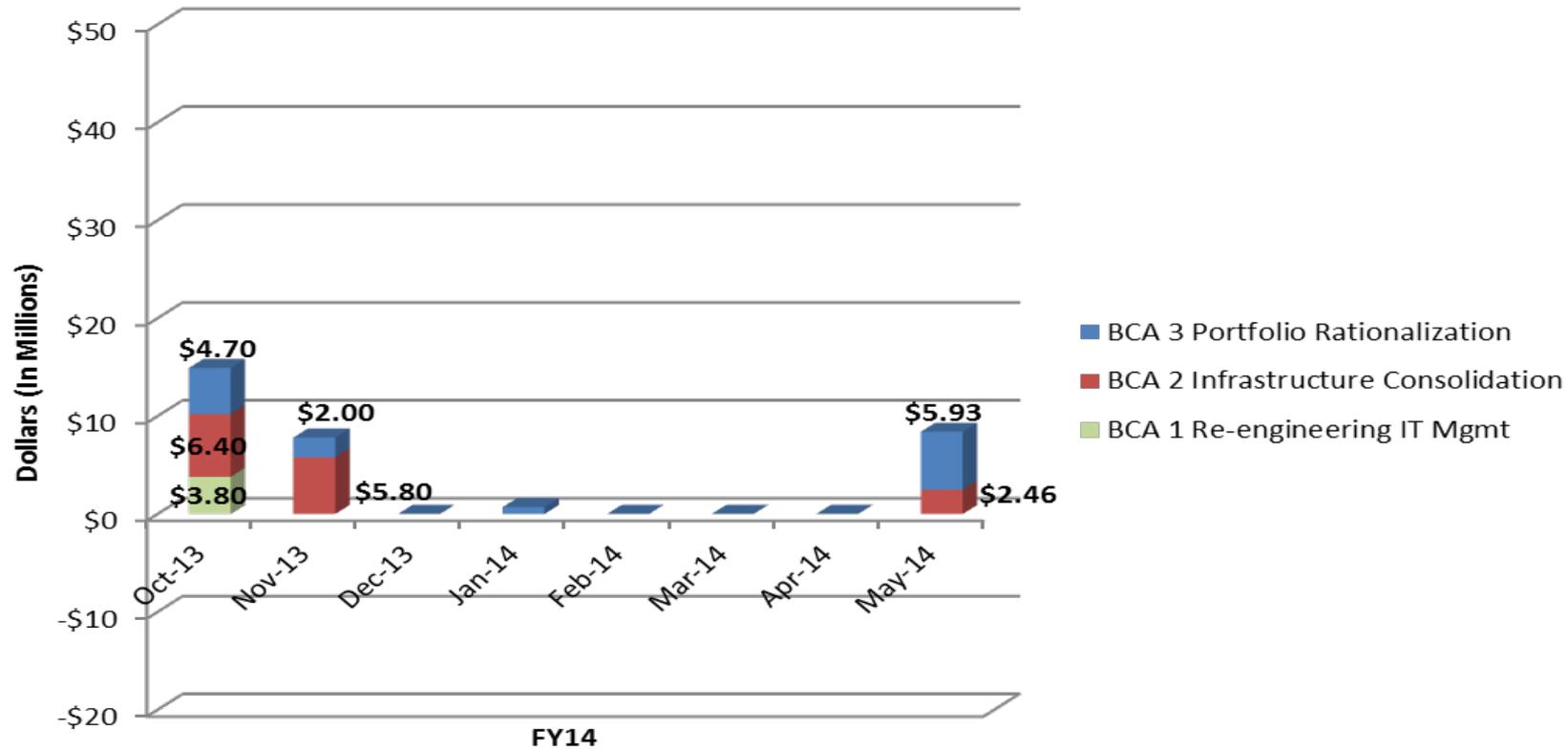
FY14 – FY18 Inflation Rates Source: http://comptroller.defense.gov/defbudget/fy2014/FY14_Green_Book.pdf

*FY19 – FY21 Inflation Rates are estimated

HIT BCA Current Year Savings



Reflects Components' Reported Savings & Costs through 28 Jul 14



“Medically Ready Force...Ready Medical Force”

IOC to FOC Initiatives



- Consolidate Management and management resources across the Services
 - Put “The Best” in leadership positions
 - Inventory and consolidate duplicative contracts
- Consolidate and standardize IT infrastructure; Datacenter to Desktop
 - **One Forest:** Active Directory and Enterprise Management
 - **One Network:** consolidate multiple networks
 - **One E-mail:** put everyone on the same e-mail system
 - **One Datacenter:** a single datacenter hosting strategy

IOC to FOC Initiatives



- Consolidate and standardize IT infrastructure;
Datacenter to Desktop
 - **One Web:** a single web hosting solution
 - **One Desktop:** a single desktop configuration and strategy
 - **One Help Desk:** a single help desk capability
 - **One AV/Comm:** a single AV/communications strategy
- Rationalize the MHS HIT application portfolio
 - Identify duplicative applications
 - Consolidate requirements, evaluate solutions
 - Decide on a single solution
 - Adapt the selected solution, decommission the others

Vision Status at FOC



- Manage IT functions “down to the desktop”
- Deliver standardized IT solutions (and contracts) in support of standardized clinical and business processes
- Facilitate communication, collaboration, and coordination with MHS PEOs
- Transition HIT funding into the DHA

Going Forward



- **We face significant challenges...**
 - How do we maintain a medically ready force and ready medical force as end strengths decrease?
 - How do we maintain and continue to build upon the lessons learned at war?
 - Getting our house in order – how can we best deliver care for the best value?
 - How do we improve the execution of the TRICARE health plan by addressing long-term systemic challenges?
- **Health IT offers value-added solutions to all of these challenges...no pressure!**

HIT Transformation

Final Thoughts



- This is a once-in-a-generation opportunity to shape the future of military medicine
- Readiness and quality of care will be enhanced and beneficiaries will receive the same level of care from a more efficient and effective organization.
- There are millions depending on us to get this right!

...the "Why Not"



BACKUP SLIDES

Multi-Service Markets



The Eight Largest Markets (and Service/Department Leads)



“Medically Ready Force...Ready Medical Force”

Enhanced Multi-Service Market (eMSM) Performance Overview



SIX ENHANCED MULTI-SERVICE MARKETS



- MHS eMSMs include Colorado Springs, Hawaii, the National Capital Region, Puget Sound, San Antonio and Tidewater
- eMSMs performance planning and execution is being carried out through two distinct, but intertwined workstreams – Five-Year Performance Plans and Quarterly Performance Reviews

FIVE-YEAR PERFORMANCE PLANS



- eMSMs reviewed five-year Business Performance Plans with MHS leadership throughout the month of April
- The Plans focused on each market optimizing MTF operations and becoming an Integrated Healthcare Delivery System, and identified opportunities to reduce Private-Sector costs, increase provider productivity and increase enrollment at Military Treatment Facilities (MTFs)

QUARTERLY PERFORMANCE REVIEWS



- The MHS has developed a set of metrics and targets to assess the success of the eMSMs. These measures are centered around the Quadruple Aim
- MHS leadership reviews eMSM performance quarterly to enhance accountability. If performance is below target, Service leads work with eMSMs to develop remediation plans
- The next quarterly review will be held in June

“Medically Ready Force...Ready Medical Force”

Overall Market Performance on FY14 Performance Measures: FY14 Q1 Review

Metric	Ambulatory RVUs per 100 Enrollees					Unfilled Appointments					No-Show Rate					Percent Retail Pharmacy					Total Purchased Care (\$M)				
Direction	Lower is Better					Lower is Better					Lower is Better					Lower is Better					Lower is Better				
Market	FY13 HQ	Q1	FY14 Goal	Distance to Goal	Trend	FY13 HQ	Q1	FY14 Goal	Distance to Goal	Trend	FY13 HQ	Q1	FY14 Goal	Distance to Goal	Trend	FY13 HQ	Q1	FY14 Goal	Distance to Goal	Trend	FY13 HQ	Q1	FY14 Goal	Distance to Goal	Trend
Colorado Springs	3,397	3,387	2,779	-17.9%	↔	18.6%	19.1%	13.0%	-32.0%	↓	5.3%	5.2%	5.0%	-4.7%	↑	43.4%	44.4%	40.0%	-9.8%	↓	248.4	243.3	317.0	30.3%	↑
Hawaii	3,149	3,193	2,850	-10.7%	↓	26.4%	25.8%	26.2%	1.4%	↑	7.2%	7.1%	5.4%	-24.4%	↑	30.3%	29.9%	28.2%	-5.6%	↑	82.9	83.9	79.5	-5.2%	↓
NCR	3,016	3,051	2,790	-8.5%	↓	28.6%	27.2%	21.4%	-21.2%	↑	7.0%	6.9%	5.3%	-23.3%	↑	44.0%	44.0%	36.9%	-16.1%	↔	603.9	607.0	609.0	0.3%	↔
Puget Sound	2,736	2,759	2,505	-9.2%	↔	24.3%	24.8%	25.0%	0.6%	↓	6.8%	6.7%	5.5%	-17.5%	↑	44.8%	43.3%	42.0%	-3.1%	↑	312.9	311.5	331.5	6.4%	↔
San Antonio	3,549	3,569	3,138	-12.1%	↔	24.7%	23.7%	20.0%	-15.5%	↑	6.9%	6.9%	5.0%	-27.5%	↔	39.5%	39.7%	32.0%	-19.3%	↔	320.2	315.1	434.6	37.9%	↑
Tidewater	3,006	3,011	2,750	-8.7%	↔	15.1%	15.3%	13.0%	-15.2%	↓	7.8%	7.5%	5.7%	-24.2%	↑	55.9%	55.6%	57.9%	4.2%	↔	528.9	530.0	508.8	-4.0%	↔
Ft Bragg	2,922	2,931			↔	11.5%	11.7%			↓	5.4%	5.3%			↔	57.7%	57.4%			↔	221.6	221.3			↔
San Diego	3,128	3,089			↑	19.4%	20.0%			↓	8.7%	8.7%			↔	49.0%	49.2%			↔	517.5	518.2			↔

Metric	Bed Days per 1000 Enrollees					ADPL (Sub for Occupancy Rate)				Number of Cases		IP/OP Case Breakdown (Percent IP)		Surgical IP CMI		ROFR				Prime Enrollment		
	Lower is Better					Higher is Better														Higher is Better		
Market	FY13 HQ	Q1	FY14 Goal	Distance to Goal	Trend	Reported Beds	FY13 HQ	Q1	Trend	FY13 HQ	Q1	FY13 HQ	Q1	FY13 HQ	Q1	FY13 Referred	FY14 Q1 Referred	FY13 Accepted	FY14 Q1 Accepted	FY13 HQ	Q1	Trend
Colorado Springs	285	282	331	17.3%	↑	47	38	38	↔	2,243	2,222	11.9%	11.2%	1.29	1.31	4,012	2,957	1,023	252	115,436	118,797	↑
Hawaii	221	202	205	1.8%	↑	233	157	155	↓	2,880	2,601	20.6%	23.3%	2.35	1.88	1,417	430	535	232	106,095	107,354	↑
NCR	306	307	278	-9.5%	↔	429	255	252	↓	5,527	5,930	14.6%	14.2%	1.85	1.77	11,022	2,844	3,608	1,122	215,818	216,025	↔
Puget Sound	269	261	285	9.0%	↑	295	145	141	↓	4,243	3,962	17.2%	18.8%	1.79	1.76	7,834	3,749	3,255	1,283	148,945	149,701	↔
San Antonio	400	400	405	1.2%	↔	425	246	245	↔	5,662	6,311	22.7%	22.2%	2.32	2.17	7,631	1,820	4,317	1,355	121,279	123,326	↑
Tidewater	228	232	211	-9.0%	↓	340	178	180	↔	4,956	5,194	18.8%	18.7%	1.55	1.54	25,733	10,364	15,059	5,001	160,012	162,252	↑
Ft Bragg	206	210			↓	172	80	81	↔	2,549	2,418	12.4%	11.4%	1.26	1.15	6,912	1,508	3,830	1,201	115,375	119,429	↑
San Diego	233	228			↑	323	199	196	↓	4,809	4,303	18.3%	18.8%	1.67	1.67	21,089	7,603	13,296	5,476	121,056	126,929	↑

Data pulled from M2 as of FEB 2014. All FY14 data reflect a rolling 12 months, including the first two Fiscal Months (FM) of FY14, except:

ADPL – Average of FY13 FM2-12 and FY14 FM1. Reported Beds from FY14 Performance Plans

OR Utilization – Reflects FM1-2 performance for FY13 and FY14

ROFR – Reflects referrals from first four FM of FY14

Prime Enrollment – Average enrollment over first five FM of FY14

See Appendix for additional notes on sources and methodology

- = Currently exceeding FY14 goal
- = Currently within 5% of FY14 goal
- = Currently greater than 5% off FY14 goal
- = Trend is favorable
- = Trend is neutral
- = Trend is unfavorable

Supported: MHS Strategy/Quadruple Aim

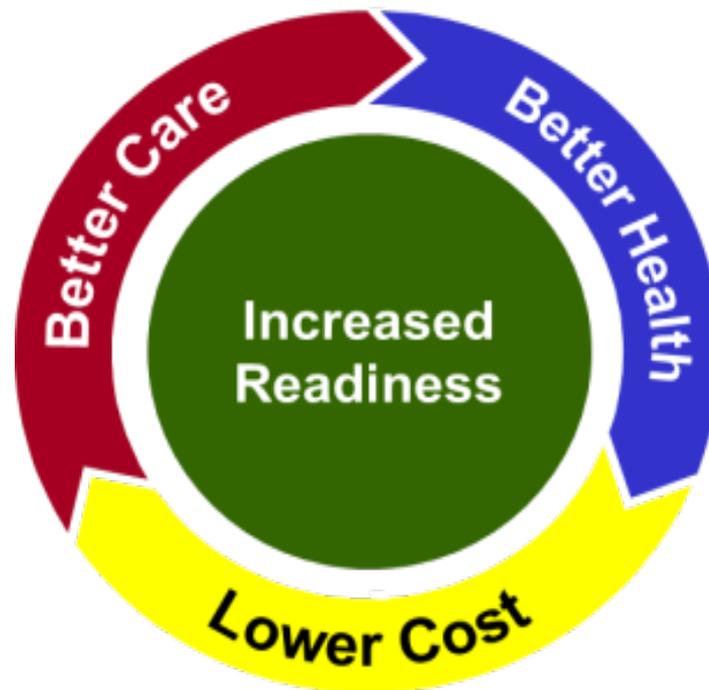
Supporting: DHA!

Increased Readiness

Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.

Better Care

Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.



Better Health

Reducing the generators of ill health by encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.

Lower Cost

Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.