

Statement of
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Commissioner, President's Task Force
to
Improve Health Care Delivery For Our Nation's Veterans

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**Biography of Sue Schwartz, DBA, RN
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Sue Schwartz is Deputy Director of Government Relations, Health Affairs at the Military Officers Association of America (MOAA) where she follows health care reform legislation and its potential impact on the military health services system and serves as co-chairman of the Military Coalition's Health Care Committee. In November 2000, Dr. Schwartz joined the staff at MOAA after leaving the National Military Family Association (NMFA) as the Associate Director, Government Relations

Dr. Schwartz has over 19 years experience as a registered nurse in a variety of health care settings, holding positions of staff nurse, Operating Room Educator, Operating Room/Post Anesthesia Care Unit Director, and Quality Improvement Director. Her consultative experience with Allegiance Health Care, Inc., emphasized cost reduction through supply logistics and clinical activities reengineering. She has served as a commissioner on the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans and is a member of the Office of the Secretary of Defense's TRICARE Beneficiary Panel.

Her education preparation includes: DBA from NOVA Southeastern University, MBA from Auburn University, Montgomery, MSA from Central Michigan University, BS from Springfield College and ADN from Bristol Community College. Dr. Schwartz is a certified operating room nurse (CNOR) since 1989, receiving the Association of Perioperative Registered Nurses (AORN) scholarship awards in 1990, 1991, 1997 and 1998. In addition, she is a member Beta Gamma Sigma, a national business honorary.

A spouse of an active duty Marine officer, she resides in Northern Virginia.

The Military Officers Association of America, does not receive any grants or contracts from the federal government.

Mr. Chairman and distinguished members of the subcommittee, thank you for this opportunity to share my views as a commissioner on the final report of the President's Task Force (PTF) to Improve Health Care Delivery for Our Nation's Veterans. It has been a privilege to serve as a commissioner and have the opportunity to assist in honoring our nation's obligation to those who currently serve and those who have served our nation in uniform.

Since the work of the commission has ended, I am here today to ask the Subcommittee's support to enable implementation of our recommendations. As the Subcommittee is well aware, other commissions have worked to the same effort in the past, only to have their recommendations sit on the shelf. Successful implementation will require congressional authority and additional funding.

I would like to highlight some of our recommendations with the hope that Congress, the Administration and both the VA and DoD will continue to move forward with greater collaborative effort to enhance the delivery of quality health care to beneficiaries who have earned these benefits through service to their country in uniform.

What distinguishes this report from others is it focuses on the importance of senior leadership's commitment as the key to sustaining collaboration. Over the past two years, there has been a flurry of interest in collaboration activities between the two agencies based in part on the attention focused on the issue by the President and the creation of the PTF. In addition, recent Congressional interest such as the FY 2003 National Defense Authorization Act (NDAA) (P.L. 107-314) was also important, as it codified the Joint Executive Counsel (JEC) and provided an additional framework for collaboration activities.

Recently the JEC has made strides forward, laying the groundwork to institutionalize additional collaborative, and joint venture efforts. The infrastructure is now in place to further these efforts, and steps are being taken to "institutionalize" collaborative activities. As the PTF report says, "What is needed is the will to change." Continual Congressional oversight will keep both agencies focused on this goal, making sure that "the will" does not wane.

Leadership at the top and empowerment at the local level are critical in order for collaboration efforts to succeed. In visits to several joint ventures, I was impressed with the ability of the staff to overcome numerous obstacles at the local level and their commitment to make these ventures succeed. Unfortunately, this resulted in an over-reliance on personal commitment rather than leadership guidance or the provision of recognition and reward. Without support from the top and empowerment at the grassroots, the recommendations of this commission are unlikely to come to fruition.

The goal of providing a seamless transition to veteran status for retirees or for those separating from military service is significant for many reasons and will rely on collaboration for success. As soon as an individual enters the armed services, both agencies have a stake in his or her health status. Therefore, in order to provide quality health care, that information must be shared between the VA and DoD.

We have learned from the 1st Gulf War that a better job must be done to collect, track and analyze occupational exposure data. Without this information, benefits determinations cannot be adjudicated fairly, nor can the causes of service related disorders be understood. This April, DoD initiated an enhanced post-deployment health assessment process for active duty and reserve service members deployed in support of Operation Iraqi Freedom. The outcome of this project will be a marker to determine if this PTF recommendation is being heeded.

In order for this assessment program to be effective in the long run, this information and any other health status data must be shared electronically between both agencies. VA and DoD will have to finally take steps to develop an interoperable bi-directional electronic medical record (EMR). Just as leadership is the key to the success of overall collaboration activities, the EMR is the lynchpin to a seamless transition. The technology exists, but again, “the will” must be there to move forward.

Another recommendation that is significant is “the one-stop shopping” process to facilitate separation or retirement. Offering one discharge physical, providing outreach and referrals for a VA Compensation and Pension examination, as well as following up on claims adjudication and rating is not only more cost effective in terms of capital and human resources. It is the right thing to do -- to ensure that servicemembers receive the benefits they have earned and deserve.

The government has been talking about development of an electronic DD 214 for many years. It is 2003, when will the DD 214 be in an electronic format? Whatever start-up costs this would incur would be paid back many times over in efficiencies gained. Again, this is not just a matter of conserving resources. It is the right thing to do -- to remove barriers that hamper a veteran's ability to complete the benefits determination process.

I am pleased that the PTF supported greater collaboration and sharing, not the integration of two systems with unique missions and varied populations. Efforts must be increased to improve DoD/VA coordination. However, these activities must enhance and maintain access to quality health care earned by each category of beneficiary. At a minimum, these activities must preserve or enhance benefits for all stakeholders. Collaboration activities should not be undertaken based solely on gaining government efficiencies that, if implemented, would come at the expense of beneficiaries.

Collaboration activities must remain beneficiary-focused and driven by a shared vision in both Departments of improving health care delivery for all stakeholders. This will not be without its challenges, as the vision must accommodate critical differences in cultures, missions, beneficiary populations, and benefit structures. As the JEC moves forward, development of beneficiary-focused collaboration that results in better management practices, resource use, accountability, and budget savings will continue to pose challenges.

The report highlights organizational barriers that hinder collaboration between these two behemoth organizations. One of the problems is that management structures and geographic responsibilities make it problematic at the local level for the two agencies to work together. The VA has 21 Veterans Integrated Service Networks (VISNs) who have a great deal of autonomy in setting policy, whereas DoD is decreasing the number of its regions from 12 to 3. Therefore, the DoD Lead Agents of the 3 TRICARE regions will have to work with multiple VISNs who each have their own way of doing business. It becomes even more difficult as Lead Agents lack autonomy over local military hospitals, which belong to the three individual military branches, and DoD's private care network is provided through Managed Care Support Contractors.

Given these challenges, the recommendations to develop "structural congruence" and joint budgeting are higher order objectives that have yet to be reached within the three military branches (there are myriad accounting systems within DoD). Making that happen will take years of leadership commitment and may require further legislative action.

In our deliberations on collaboration, we often asked, "Is the juice worth the squeeze"? In other words, collaboration is certainly a worthy goal, and would make those with green eyeshades happy, but is it a worthy enough goal to invest the time and energy it will take to change the management structures of these two agencies? Some in DoD would argue that the military system's readiness mission relies upon the autonomy of each service to exert command and control of its resources and its personnel system needs to remain intact. Others might ask whether collaboration is a worthy goal if it conflicts with DoD's current health care management and readiness model.

What will be needed is institutionalization of a framework to provide clear guidance and a blueprint for success, providing rewards and seed money. I would also suggest that each agency has its own work to do first. There are no short-term fixes to collaboration. The Capital Asset Realignment for Enhanced Services (CARES) and the Base Realignment and Closure (BRAC) process will afford an opportunity for the agencies to work together to identify underutilized facilities to match demand with infrastructure.

One of the goals of my organization, MOAA, is that TRICARE services be provided in BRAC areas. Permitting DoD beneficiaries to utilize VHA facilities, as TRICARE providers in BRAC areas would help accomplish that goal. The House version of this year's NDAA, H.R. 1588 SEC. 705, contains language that establishes a working group

to assist the 2005 Defense BRAC Commission evaluate accessibility to health care in BRAC areas, develop selection criteria/ recommendations and to provide a plan for the provision of services to beneficiaries impacted by closures. Should this provision be enacted, I would hope that the working group would take into consideration collaboration with the VA's CARES program. This would provide an opportunity for cooperation between the two agencies that should not be missed.

One caution in this area is the growing gap between demand and capacity in VA health care that made the "core funding" issue a significant challenge for the PTF. It became apparent that collaboration between the two agencies is severely hampered because of the VA's shortfalls in funding. VA's continuing "open enrollment" policy, increased costs for health care in the private sector; and a lack of a Medicare prescription drug benefit have driven increased enrollment. However, annual appropriations have not kept up with demand, and 250,000 veterans are on waiting lists of six months or more for appointments. As long as disable and indigent veterans are still waiting lengthy periods for care in VA facilities, meaningful collaboration will remain a challenge.

Much has been made about the fact that the PTF did not come up with a firm recommendation for care for the category 8s. As this was a consensus driven report, the commissioners could not all agree on the level of service guaranteed to be provided to those without service-connected disabilities whose incomes were above the means test. I hope this controversy does not overshadow our unanimous decision that those enrolled in categories 1-7 should be fully funded. Funding should be through either mandatory spending or some other modification to the current process.

The consensus of the commissioners is that first priority must be given to making things right for the veterans for whom the VA has traditionally provided care, those with service-connected disabilities, and the indigent.

To the extent that facilities are unable to meet VA's modest access standards, there is a need to be able to refer veteran beneficiaries to a non-VA provider, unless the veteran prefers to wait for a VA appointment. This recommendation would put veteran beneficiaries on the same footing as TRICARE beneficiaries. Under the DoD system, if a patient cannot be seen in the direct care system, an appointment with a civilian provider must be made in line with DoD's more stringent access standards. If the VA enrolls beneficiaries when they lack the capacity to care for them, they will be obligated to buy the care in the private sector. This recommendation will require a significant amount of additional funds and most likely would require legislative authority. But it offers one solution to cutting down the many months that our veterans endure as they wait for primary and specialty care.

Again, thank you for the opportunity to share these thoughts with you. We will look to the Subcommittee for your leadership to help in the implementation of these recommendations. I look forward to answering your questions.