Leading the Defense Health Agency: A Conversation with Lieutenant General Douglas Robb, M.D., Director, Defense Health Agency

Across the country, health care systems are focusing on ways to reduce variation in care, improve patient safety, and more effectively use health information technology to improve clinical decision making and outcomes.

The Military Health System (MHS) isn't immune to such changes. In fact, within the military, there are additional imperatives for designing an integrated health system that involve more joint operations as a way to meet the Department of Defense's (DoD) aims of achieving readiness, improving the health and care for people it serves while also managing its costs. With the creation of the Defense Health Agency (DHA), DoD has taken a step in this direction. This agency is the starting point for comprehensive enterprise-wide reform. It is a leading example of how DoD seeks to modernize and integrate its system of care and, thereby, create a stronger, better and more resilient military health system for the future.

How is the DHA changing the way DoD delivers health care? What are some of the key challenges the military faces in restructuring a system as complex as the Military Health System? How is DHA transforming its health information technology portfolio? Lieutenant General Douglas Robb, M.D., director of the Defense Health Agency, joined me on The Business of Government Hour *to explore these questions and much more. The following is an edited excerpt of our discussion, complemented with additional research.*
— Michael J. Keegan

On the Mission of the DHA

I could give you the formal mission statement, but I'd like to describe it more plainly: The DHA is a combat support agency that supports the military services. Simply put, the combat commanders and the services are my customers.

Our job in the DHA is to help ensure that warfighters get what they need from us. We took on a host of responsibilities in the form of "shared services." We need to deliver common services to the Army, Navy, and Air Force and do so in the same way, across the MHS. This includes health information technology (HIT), medical logistics, hospital and clinic construction and maintenance, public health services, TRICARE health care benefits the military provides to service members, their families and to retirees, etc. There are 10 shared services we've identified under the DHA portfolio. The DHA also is responsible for health care delivery in the National Capital Region—at Walter Reed National Military Medical Center, and Fort Belvoir Community Hospital—and we serve as the market manager for the entire region.

The impetus for creating DHA was straightforward. In the combat theater, we function as a joint team in every phase of operations—and we need to coordinate the delivery of care in a more effective way. The imperative that drives the DHA is DoD's need to apply this joint approach to its peacetime operations. There are far more similarities than there

are differences in these two types of operational status, and we need to take advantage of this fact. Our goal is not just to improve efficiency, but to fully support readiness, health improvement, and solid health care delivery.

There is a saying inscribed on the wall as you walk into my office. It says "Medically ready forces….Ready medical forces." That's the mission of the MHS overall, and it's our responsibility in the DHA. And it's what I come to work every day to focus on and talk about.

On Challenges

I'll highlight a few key challenges DHA faces:

Building the plane as we're flying it. The DHA as an agency is still in IOC—initial operating capability mode. This means that, although most of the basics are up and running, we're still implementing pieces of the agency to get it fully operational. Managing an agency while simultaneously building and shaping what it will look like requires everyone to work together in a coordinated fashion.

Standardization and integration. One of the DHA's main goals is to standardize and reduce variation across the services to provide more joint and integrated care and support to our warfighters and our other beneficiaries. For me, that means often doing things three different ways and bringing everyone to the table to agree on one way to do them in the future. As you can imagine, this is not easy to achieve—but it is what makes the DHA's role so critical in the future of the MHS.

Challenging budget environment. Finally—and there's no real way around it—we're in a tough budgeting environment. Between sequestration and budget cuts, everyone in DoD has to refocus and re-evaluate how we spend our resources. Now, I'm proud to say that we at the DHA are leading the charge, delivering dollars more in savings than we were expected to in the first year. This requires making some hard choices. But, they are necessary choices.

On the Strategic Priorities of the Military Health System

My boss, Jonathan Woodson, MD, assistant secretary of defense for health affairs, an incredible leader and a tremendous strategic thinker, has outlined six strategic priorities.

- Modernize MHS management with an enterprise focus (and this is what we are doing at the DHA).
- Define and deliver the medical capabilities and manpower needed in the 21st century; (this involves figuring out what we have learned from the past 13 years of warfighting, and using this knowledge to shape the force and the infrastructure for the future).
- Invest in and expand strategic partnerships; (i.e., we are working closely with the private sector, other government agencies, academic institutions and this type of collaboration is only going to grow).
- Balance DoD's force structure.
- Transform the TRICARE health program
- Expand our global health engagement strategy.

On Moving to a Shared Services Model

The armed services have unique missions, no doubt about it. But, 80 percent of what we do is the same. Each Service teaches the same surgery techniques, we all take x-rays and we can all use the same checklists to prepare to treat patients. There's no reason for us to use eight different scalpels, four different x-rays, and twenty different common operating procedures. Working together to come up with single, shared solutions allows us to become more effective, more efficient, and more integrated.

The benefit of the shared services model is that now we will all train, deploy, and fight the same fight. Now, we can take Navy operating room technicians and place them in an Army facility where they will use the same machines, and receive the same training as the Army, Navy and Air Force personnel with whom they'll work, side by side as part of a joint staff. This ensures more consistent, higher quality, and more integrated care all over the world. Of course, the savings generated by buying

one of something instead of three of something is obvious. By bringing everyone to the table and choosing the best options, we can eliminate redundancy and waste and more effectively leverage our buying power in the market.

There are 10 shared services aligned under the DHA. Five of these shared services were implemented on 1 October 2013. The other five shared services will be implemented no later than 1 October 2015, the date for DHA Full Operating Capability (FOC).

Defense Health Agency Shared Services

	Shared Service Name
1.	Facility Planning (Oct. 1, 2013)
2.	Medical Logistics (Oct. 1, 2013)
3.	Health Information Technology (Oct. 1, 2013)
4.	TRICARE Health Plan (Oct. 1, 2013)
5.	Pharmacy (Oct. 1, 2013)
6.	Budget & Resource Management
7.	Contracting/Procurement
8.	Public Health (June 2014)
9.	Medical Education & Training Medical (June 2014)
10.	Research & Development (June 2014)

On Reining in Rising Health Care Costs

There are several factors that have contributed to rising costs in the military health care system: the increasing number of benefits offered and of beneficiaries using the system, and of course, health care inflation. The budget for the Military Healthcare System is about 10 percent of the top line of the DoD budget. Given such a significant investment, we have an obligation to provide the most effective and efficient health care we can while maintaining high quality.

Over the last year, we've done many things that have made a difference and have achieved up to millions of dollars in cost savings (or avoidance). The implementation of the sole community hospital reimbursement and the outpatient prospective payment system, for example, along with efforts to gain management and administrative efficiencies, have resulted in some serious savings.

On Transforming the Pharmacy Benefit

The DoD spends $7 billion annually on the TRICARE pharmacy benefit. This pharmacy program provides a worldwide pharmacy benefit to 9.6 million eligible active duty and retired members of the uniformed services and their families. The latest pharmacy contract (7 years, $62 billion) was awarded to Express Scripts, Inc., on April 18, 2014. We've pursued several cost-saving initiatives in this area:

- The TRICARE for Life Pharmacy Pilot, which started in March of this year, moves maintenance medication provision from the retail pharmacy locations to home delivery (pilot started March 2014).
- Leverage national contract purchases across the enterprise.
- Improve compliance in moving from prescribing brand name drugs to lower-cost generics.
- Conduct comprehensive reviews of the DoD uniform drug formulary to ensure the highest utilization of preferred products
- Permit electronic prescribing by civilian providers to military treatment facility pharmacies (pilot ongoing).

On Collaborating with the Defense Logistics Agency (DLA)

With the stand-up of DHA, the MHS has strengthened its partnership with DLA and is focusing closely on eliminating waste and reducing unwarranted variation across the DoD Medical Supply Chain. Specifically, by leveraging DoD's purchasing power as a health system, our partnership has led to the negotiation of national pharmaceutical and medical surgical supply contracts, made available through e-commerce solutions (prime vendor and electronic catalogues), resulting in significant discounts and savings for the MHS. These e-commerce solutions allow us to reduce government purchase card (GPC) usage for medical materiel and associated procurement inefficiencies and vulnerabilities.

On Transforming DHA Health IT Infrastructure

Our HIT infrastructure and systems are critical enablers; facilitating the free flow of information and supporting the core DHA mission of supplying a "Medically Ready Force…Ready Medical Force." Our MHS information technology systems support a broad range of activities, from clinical care to

"There is a saying inscribed on the wall as you walk into my office. It says "Medically ready forces….Ready medical forces." That's the mission of the Military Health System overall, and it's our responsibility in the Defense Health Agency."

— Lieutenant General Douglas Robb, M.D.

health benefit management. The transition from the TRICARE Management Activity to DHA is part of an effort to modernize MHS management—including the management of MHS health information technology—with an enterprise focus. Before the transition to DHA, HIT infrastructure and management were decentralized and managed within TRICARE Management Activity and separately within each of the three military services. When the DHA reached Initial Operating Capability on October 1, 2013, the HIT Directorate was one of the first shared services to begin operating.

Over the two-year period from October 2013 to October 2015, the HIT Shared Service will consolidate HIT assets from the Army, Navy, and Air Force to centralize HIT management and standardize IT infrastructure down to the desktop. It will also rationalize applications in the MHS portfolio to ensure that obsolete, underused or underutilized applications are not consuming our resources. Reforming the management of the IT infrastructure will, over time, give us the ability to manage *all* of health IT delivery all the way to the desktop. The end result will be an enterprise-wide, integrated IT environment with standardized infrastructure and applications that are accessible through the devices used by MHS end users. To support this transition of the bulk of health IT functions to the DHA, the services' chief information officers and their associated service IT management functions were transitioned into the DHA where they have been actively involved in all of the planning for the DHA's HIT shared service. Similarly, the IT management functions formerly under the TRICARE Management Activity have been subsumed by the DHA. Efficiency is a significant driver for enterprise consolidation and integration of HIT into a shared service.

MHS spends more than $2 billion a year on health IT. Establishing and investing in HIT as a shared service will allow the DHA to realize significant cost savings and present opportunities to improve the quality and coordination of care. Thus far in FY14, HIT has saved more than $24 million more than expected We have also been able to take 26 e-learning systems down to one. These are just two examples of the increased cost savings and improved efficiency the DHA has achieved.

On Pursuing Electronic Health Record Modernization

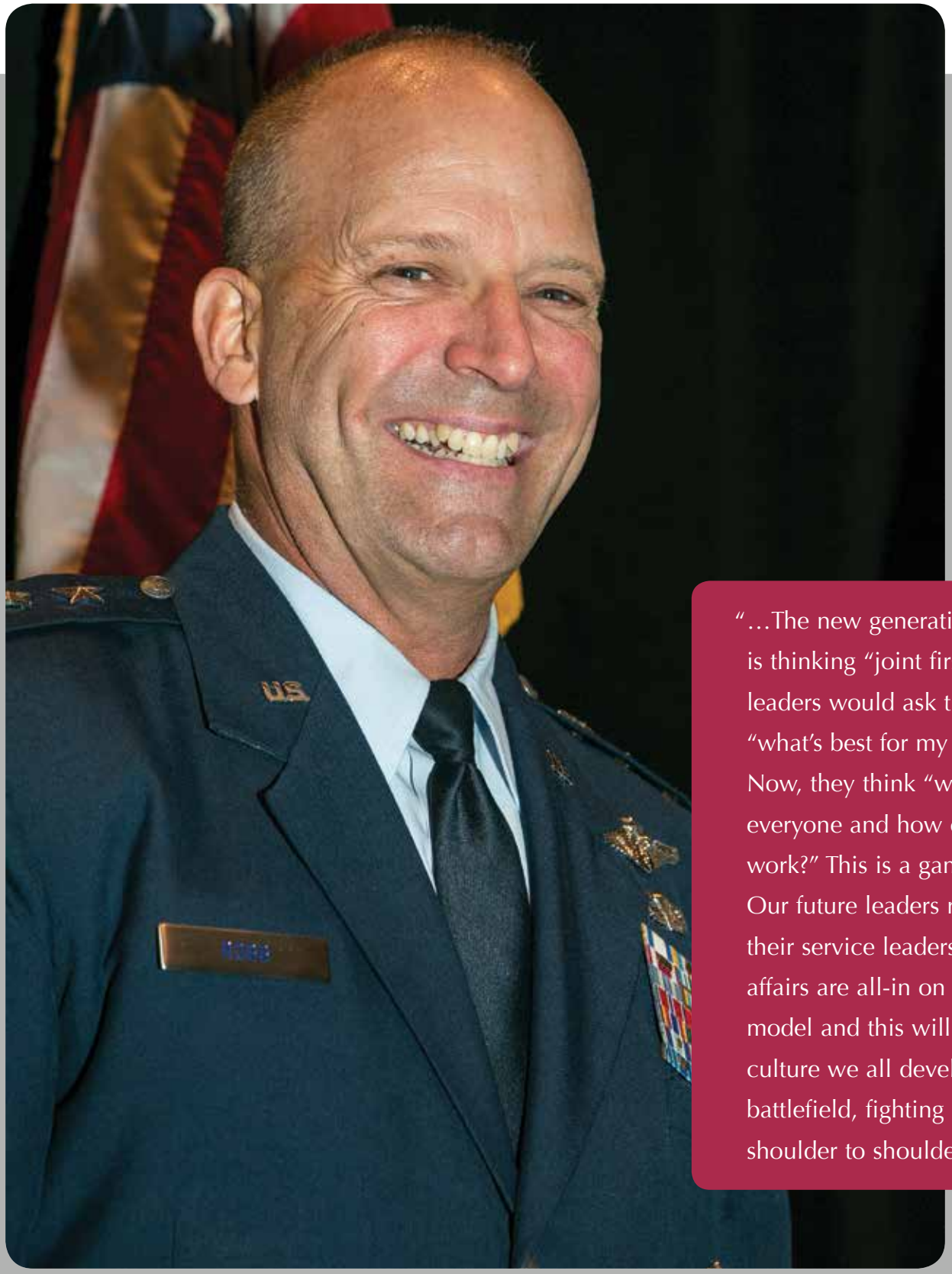
The three separate but related electronic health record (EHR) modernization events or phases are:

- The procurement of an EHR solution.
- The installation of the EHR software across all venues of health care in DoD.
- The retirement of legacy EHR systems.

The consolidation of all health IT functions within a single HIT shared service, and alignment of efforts with DoD's Office of Acquisition, Technology and Logistics, which is responsible for the procurement of an EHR solution, will play a critical role in supporting our worldwide EHR implementation activities.

Regarding installation, the challenges we face are diverse and involve our people, our processes, and our technology. Ensuring that we optimally involve the clinical community is a key challenge in acquiring and implementing a modernized EHR. Our health IT community must work hand in glove with our clinical community to ensure that necessary business process re-engineering occurs to optimally integrate the EHR system into the clinical workflow across our health care delivery organization and to decrease unnecessary variation from site to site. Preparing our infrastructure to receive the new EHR software across all DoD health care settings is a key challenge. About six months ahead of system rollout to a particular site, critical preparations will be underway to ensure that the health care facilities are technically prepared. This will minimize technical challenges as the software is deployed to each site.

Maintaining operations on our legacy system while we roll out our modernized system is another key challenge. We cannot "flip a switch" and move the entire MHS from system



"…The new generation of leaders is thinking "joint first." In the past, leaders would ask themselves "what's best for my service?" Now, they think "what's best for everyone and how can I make it work?" This is a game changer. Our future leaders recognize that their service leadership and health affairs are all-in on the "joint first" model and this will encourage the culture we all developed on the battlefield, fighting and working shoulder to shoulder."

A to system B. We will have both the new system and the legacy system running at different sites and will be maintaining and supporting both in tandem until the new capability is in place and legacy system capabilities have been migrated or are replaced by the new solution.

Meeting DoD's unique care setting requirements represents a significant challenge. Ultimately, the modernized EHR must support the delivery and documentation of health care in all DoD health care settings, including the forward deployed environment where we deliver care in what we call "disconnected" or low- or no-communications conditions. Our modernized EHR solution must be scalable: it must be able to run on a desktop as well as on handheld devices used by forward deployed medical personnel who document care in a disconnected mode and later upload encounter data upon return to a connected environment.

Retiring the components of the family of systems in our legacy EHR is an ongoing process. System-by-system planning for this transition will continue throughout the acquisition process. We must properly support and maintain the legacy systems until they are replaced and the modernized EHR is fully operational. This long and complex process is critical for ensuring that the MHS continues to meet its mission without disruption throughout the implementation of our modernized EHR and exhibits critical improved performance and reduced cost.

Full deployment (and the turn off of the legacy systems) is years out because the first rule is: don't break anything or compromise continuity of care.

On Fostering a "Joint" Culture

The new generation of leaders is thinking "joint first." In the past, leaders would ask themselves "what's best for my service?" Now, they think "what's best for everyone and how can I make it work?" This is a game changer. Our future leaders recognize that their service's leadership and health affairs are all-in on the "joint first" model and this will encourage the culture we all developed on the battlefield: fighting and working shoulder to shoulder. Today, we don't care about what color uniform someone is wearing; we care about making sure we're all in the fight together. Shaping that culture, to be more integrated without losing each service's unique qualities, is a challenge the DHA looks forward to meeting. ◘

To learn more about the Defense Health Agency, go to www.health.mil/dha.

To hear *The Business of Government Hour's* interview with Lieutenant General Douglas Robb, M.D., go to the Center's website at www.businessofgovernment.org.

To download the show as a podcast on your computer or MP3 player, from the Center's website at www.businessofgovernment.org, right click on an audio segment, select Save Target As, and save the file.

To read the full transcript of *The Business of Government Hour's* interview with Lieutenant General Douglas Robb, M.D., visit the Center's website at www.businessofgovernment.org.