DEFENSE HEALTH BOARD
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AUG 28 2009

DHB

MEMORANDUM FOR: ELLEN P. EMBREY, DEPUTY ASSISTANT SECRETARY OF DEFENSE (FHP&R), PERFORMING THE DUTIES OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

SUBJECT: Preliminary Findings Pertaining to the Establishment of the Department of Defense/Department of Veterans Affairs Centers of Excellence

1. References:

   a. Presentation: Department of Defense/Department of Veterans Affairs Centers of Excellence, by Dr. Jack W. Smith, Acting Deputy Assistant Secretary of Defense, Clinical and Program Policy, and Dr. Gary Matteson, Acting Director, Clinical and Program Policy Integration, to the Defense Health Board Health Care Delivery Subcommittee, 15 July 2009.

   b. P.L. 110-417 110th Congress, Duncan Hunter National Defense Authorization Act for Fiscal Year 2009, § 721-723, 14 October 2008.

   c. P.L. 110-181 110th Congress, Duncan Hunter National Defense Authorization Act for Fiscal Year 2008, § 1621-1623, 28 January 2008.

   d. Congress of the United States, Senate and House Committees on Appropriations, Subcommittee on Defense, Letter to the Acting Comptroller General, Government Accountability Office, 2 April 2009.

2. The DHB Health Care Delivery Subcommittee met on 15 July 2009, during which a briefing was received from Dr. Jack Smith, Acting Deputy Assistant Secretary of Defense, Clinical and Program Policy [DASD(C&PP)] and Dr. Gary Matteson, Acting Director for C&PP Integration, on the establishment of the Department of Defense (DoD)/Department of Veterans Affairs (VA) Centers of Excellence (CoEs). During this session, the Subcommittee reviewed and discussed issues pertaining, but not limited to proposed CoE terms of reference, operational support, and governance options. The Subcommittee held a subsequent teleconference on 13 August 2009, during which specific recommendations were proposed and discussed by the members.

BACKGROUND

3. Sections 721 and 723 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (NDAA FY09) direct the DoD to establish a CoE within the Department for the prevention, diagnosis, mitigation, treatment, and rehabilitation of members of the Armed Forces with hearing loss and auditory system injuries, and a CoE for the mitigation,

treatment, and rehabilitation of Service members with traumatic extremity injuries and amputations.

4. Sections 1621-1623 of the NDAA FY08 stipulate the DoD establish CoEs within the Department for the prevention, diagnosis, mitigation, treatment, and rehabilitation of members of the Armed Forces with traumatic brain injury, post-traumatic stress disorder, and other mental health conditions, as well as for military eye injuries.

5. The Secretary of Defense is directed by Congress to ensure that maximum collaboration is pursued between the VA and the CoEs for hearing loss and auditory system injury, as well as military eye injuries, as well as with other private and public entities well suited to fulfill the responsibilities of the CoEs delineated in the law.

6. Although the CoE for military eye injuries did receive funding in FY08 and FY09, neither the CoE for hearing loss and auditory system injuries nor the CoE for the traumatic extremity injuries and amputations received appropriation or funding during FY08 or FY09.

7. While the law requires the Secretary of Defense to establish CoEs pertaining to hearing loss and auditory system injury, as well as military eye injuries within the DoD, it stipulates the DoD and VA jointly establish a CoE to address issues concerning traumatic extremity injuries and amputations. The DoD and VA are also directed to ensure the development of partnerships between appropriate private and public entities that will assist in performing the required functions of the Center.

8. Among the responsibilities included in the NDAA FY09 for the CoE for traumatic extremity injuries and amputations is a research component focused on military medical requirements. The requirement integrates basic, translational, and clinical research with the objective to advance capabilities for the preservation and restoration of injured extremities.

9. Particular emphasis is placed on the implementation of comprehensive patient tracking registries by the CoEs to include every case of hearing loss and auditory system injury, as well as every reported case of significant eye injury incurred by Service members during active duty. The registries are obligated to include data that span the health care delivery continuum from the point of diagnosis to patient outcome following receipt of treatment or procedure.

10. The CoEs are required by law to ensure the VA's access to and exchange of information contained in the registries, while the responsibility to ensure registry data is available to appropriate DoD and VA care providers and specialists is defined as a joint endeavor of both Departments. Such access is intended to promote and assist in research efforts, the identification of best practices, and the dissemination of clinical knowledge.

11. An additional CoE obligation delineated in the law is the coordination of ongoing care and rehabilitation benefits and services for separated and retired military personnel, through the

provision of notifications to appropriate entities within both the VA and the Veterans Health Administration.

FINDINGS

12. The CoEs have the potential to improve quality of services provided, facilitate the advancement of medical and scientific knowledge, and to expedite the process by which changes resulting from this information inform and are implemented in health care practice. Notwithstanding, the missions and responsibilities of the Centers remain unclear.

13. It is critical the Centers continue to demonstrate military-relevance in their efforts to optimize the quality, coordination, and access to care by Service members. To the fullest extent possible, the terms of reference for the CoEs should be defined with a consideration of various potential risks, including "mission creep" that would impede the successful operation of the Centers.

14. The creation and construction of multiple and discrete "brick and mortar" entities in the endeavors to establish the CoEs may not reflect the original intent for the founding of these Centers as reflected in the Congressional language. If this organizational model is assumed, the potential arises of "stovepiping" medical conditions and the delivery of care. Although the Centers appear to be formed as a solution for the improvement of care coordination, new issues may inadvertently arise. In particular, potential challenges associated with the coordination of care for complex injuries and for patients with multiple care needs pose considerable concerns.

15. Staffing challenges are a possible consequence to the length of military assignments and frequent reassignments. If manifested, this could contribute to a disruption in the transfer of knowledge between the Centers and the provision of appropriate continuity of care.

RECOMMENDATIONS

16. Based on these preliminary findings, the Subcommittee provides the following recommendations to the Department regarding the establishment of the CoEs:

a. Develop strategic plans that clearly define the mission of each Center and that translate the mission into consistent and actionable goals and objectives. These should be mindful of DoD's ultimate need to focus on force health protection and readiness, as well as unique military-relevant research.

b. Coordinate the development of the CoEs' strategic plans, priorities, and objectives not only with preexisting DoD, VA, and other government agencies, but also across the CoEs in order to avoid redundancies and a duplication of efforts.

c. Ensure adequate funding to accomplish the mission objectives of the CoEs.

d. Explore the use of pre-existing infrastructure and sharing of resources such as staff, equipment, and facilities, and encourage collaboration between CoEs where appropriate.

e. Create a financial management structure that tracks expenditures to the goals of the organization.

f. Identify metrics for the CoEs that measure their success, the value of the return on investments, the need for the continuation of their activities, and that reflect back to their strategic plans.

g. Develop strategies to maintain critical capabilities of the CoEs over time, either separate from or within the CoE framework.

CONCLUSION

17. The findings included in this report are preliminary in nature, in order to meet the short-term request by Dr. Smith for comment and recommendations pertaining to issues regarding the establishment of the Centers of Excellence. A follow-on report, to be delivered within a short term from the date of this report, will address issues pertaining to governance as well as the further consideration of the topics addressed in this initial report.

18. The Subcommittee emphasizes the importance of appropriate access to and exchange of information between not only the Departments, but also the Centers as well. Such partnerships are fundamental in augmenting the potentiality for quality and coordination of care improvement necessary for the optimal prevention, recovery, rehabilitation, and reintegration of Wounded Warriors.

19. The above recommendations were unanimously approved.

FOR THE DEFENSE HEALTH BOARD:

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