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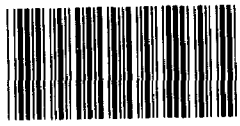

B-253320

June 3, 1993

The Honorable Les Aspin
The Secretary of Defense

Dear Mr. Secretary:

In October 1989 the Department of Defense introduced its Corporate Information Management (CIM) initiative to reengineer its business practices and make better use of information technology. In May 1990, a Medical Functional Group was established within the Office of the Assistant Secretary of Defense for Health Affairs to institutionalize the CIM process within the Military Health Services System. This letter addresses our review of CIM's implementation in military health services--one of the eight functional areas selected for initial CIM implementation. At a time when health care costs are rising dramatically, CIM offers opportunities to reduce not only health care information technology expenses but, more important, the overall costs of providing care.

At this point, the future of CIM is uncertain. However, in view of the ongoing restructuring of military health services and the need for managed change in that process, there are valuable lessons to be learned from examining CIM implementation in military health care and identifying the obstacles encountered in pursuing its goals.

OBSERVATIONS

Defense is faced with the challenge of making major changes in the delivery of health care. This is a complex, daunting undertaking. CIM has offered a framework and approach that would help Defense in this difficult area. However, Health Affairs has yet to fully embrace a process that could make the undertaking easier. While Health Affairs and the military services have initiated a variety of CIM activities, CIM's impact and usefulness have been limited by its organizational placement, underutilized analyses, and the lack of a strategic plan to guide decisionmaking.

Given the size, complexity, and cost of the military health care system, transforming it into a system of managed care will be a massive job. Managing potential changes of this magnitude will require clearly articulating a vision of the future, along with short- and long-term plans for accomplishing the transformation. Because of the key roles of information and information technology, they must feature prominently in these plans. We believe that prospects for success will be significantly enhanced by medical leadership commitment to a comprehensive program of business process improvement, as called for by CIM.

CIM is but one incarnation of an idea that stresses broad, proactive thinking and planning. Regardless of what happens to CIM at the Department of Defense, we believe it is essential to implement a strategic management process consistent with CIM to guide Health Affairs in the coming years as it wrestles with bringing about major change in the delivery of health care--change that will affect millions of Americans.

BACKGROUND

Defense today spends $15 billion a year to provide medical services to over 8 million active and retired military personnel and their dependents. Military health services are provided mainly in two ways. First, each service operates a direct care system providing services through medical facilities--over 700 worldwide. These facilities are government-owned and operated by over 169,000 Defense medical personnel. Second, through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), a military health benefits entitlement program, Defense pays for services from private providers under specified conditions. Claims processing and reimbursement are handled by private-sector intermediaries under contract to the Department.

As in the private sector, the cost of providing health care to the military community has been rising dramatically. As a result, the Congress and Defense have been increasingly interested in reforms aimed at providing high-quality health care more efficiently and effectively. In June 1990 Defense announced a plan to transform military health care into a system of managed care similar to that provided by health maintenance

organizations (HMOs) in the civilian community. As discussed in an earlier report,[1] moving to managed care will necessitate changes in health care delivery techniques, accountability, and financing. Information and computer systems required to support these activities will likewise change.

CIM is a management philosophy that requires senior management attention to the business processes used by the organization to carry out its mission. It provides a set of analytical techniques for examining current business practices for potential areas of improvement or restructuring. CIM has a dual focus--functional and technical--in its objectives, methodologies, and organization. Defense expects significant savings to result from each. However, the largest benefits are anticipated from process improvements in the Department's functional (i.e., business) areas. By reengineering its business processes, Defense expects to eliminate costly and inefficient ways of operating and identify opportunities for using information technology to substantially improve service delivery.

On the technical side, Defense expects to avoid duplicate information system development and operational costs by developing standard systems to support requirements common across all services. CIM's goals are to improve standardization, quality, and consistency of data from Defense's multiple management information systems; eliminate redundant information systems; and develop uniform and consistent information requirements and data formats within each functional area. An important tenet of the CIM approach is that specific technology should not be selected before the goals of business operations are determined and articulated.

CIM's IMPACT ON MILITARY HEALTH SERVICES SYSTEM HAS BEEN MODEST

CIM provides an opportunity for the military to systematically reengineer the way it delivers health care; thus far, however, CIM's impact has been modest. We have identified three key impediments affecting CIM's

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[1] Defense Health Care: Implementing Coordinated Care--A Status Report (GAO/HRD-92-10, Oct. 3, 1992).

implementation. First, Health Affairs has not developed a systemwide strategic plan with measurable goals and objectives--as called for by CIM--to guide restructuring of health care delivery. Second, while Health Affairs has initiated a variety of CIM activities and analyses, these have played a minimal role in its decisions about restructuring military health services. Third, CIM's organizational placement within one of Health Affairs' five organizational units has limited the scope and impact of CIM activities.

Strategic Business Plan Essential--Yet Lacking

According to CIM guidelines, management must implement a business process improvement program that covers the entire functional area. These guidelines lay out a structured approach for identifying, evaluating, and implementing improvements to current business processes. They stress the importance of developing a strategic plan showing how the organization will pursue measurable goals for improving service and increasing productivity. A strategic or business plan articulates management's commitment to a strategic direction, and serves as a philosophical grounding for coordinating diverse planning and management activities.

CIM work groups have made progress in documenting current business processes and in defining a vision of the future for delivery of military medical services. However, Health Affairs still lacks a strategic business plan. For several years, CIM staff have been drafting an evolving strategic business plan for military health services. However, Health Affairs top management has provided little guidance or support for this effort. Further, the plan lacks performance measures to show progress toward specific goals and objectives. These are crucial if managers are to have a rational basis for choosing from among alternative processes.

Little Use Made of CIM Analyses in Health System Restructuring

Since initiating CIM over 3 years ago, Health Affairs has undertaken many CIM-related activities and analyses. For example, CIM work groups are using computer-aided tools to develop models to document key processes and data

requirements for current processes and for the anticipated future managed care environment. These analyses have been helpful in identifying information requirements for specific program options. However, they have played a minimal role in policy decisions that Defense is making in implementing managed care.

Even before CIM was introduced, Health Affairs was planning major changes in the way it provides health care services. Faced with the need to reduce escalating costs and improve quality and access to care, the Department has conducted many studies, reviews, and demonstration projects, and determined that transforming military health services into a system of managed care was the best way to achieve these goals. It developed the Coordinated Care Program as its version of managed care.

Because of the priority given the Coordinated Care Program within Health Affairs, it became a principal focus for CIM activity in the medical area. In April 1991 a CIM Coordinated Care work group was established that included representatives from the services, local hospitals, and other Health Affairs units. These representatives documented Coordinated Care goals, objectives and strategies, and actions to be pursued. They also used CIM methodologies for modeling the business processes and information requirements to support Coordinated Care implementation.

The work group identified 555 processes that would be required in Coordinated Care implementation, prioritizing 51 as processes so critical that the absence of information systems support for these would jeopardize the entire program's implementation. These requirements were matched against the capabilities of existing baseline systems to determine what modifications would be required. The results of these analyses were detailed in the Coordinated Care Tactical Information Systems Plan completed in October 1991.

The work of this group established the need for developing an integrated planning and management database at three organizational levels: local hospital, service, and Health Affairs. It demonstrated that existing information resources cannot provide all the data that will be required for effective implementation of Coordinated Care. Additionally, it identified interfaces

among existing systems that must be developed in the short term, and a long-range model of standard applications and interfaces to support managed care.

Despite the importance of information support for Coordinate Care implementation, Health Affairs policy and decisions about Coordinated Care were made with limited reference to information support requirements. For example, in January 1992 the Assistant Secretary issued policy guidelines requiring the services to submit plans for full implementation of Coordinated Care within 3 years. Six attached memoranda provided additional guidance on specific related topics. However, Health Affairs directives did not reference the Tactical Information Systems Plan or provide specific guidance on how to address information requirements it identified as critical. As a result, the services experienced difficulties in developing realistic Coordinated Care implementation schedules.

Organizational Placement Has Limited CIM Scope

CIM principles support a top down reexamination of business practices for the entire military health services system. CIM functional process improvement is ultimately intended to cover all functional activities. Managers are expected to identify and implement business process improvements in their functional areas of responsibility before initiating new system development initiatives. However, because of CIM's organizational placement within Health Services Operations--one of Health Affairs' five organizational units--CIM activities have been limited in scope.

CIM functional activities and analyses have been primarily directed to business processes that support the direct care system for which Health Services Operations has responsibility. Health Affairs has been slow to extend CIM to areas such as health insurance claims processing and performance measurement systems--areas that will be critical in restructuring military health services and moving to managed care. Responsibility for these systems currently falls under different organizational units, and CIM staff lack the authority to direct functional improvement activities in other units.

Development of these information systems has been proceeding independent of CIM.

For example, plans for developing a single CHAMPUS national claims processing system were being formulated independently within Health Services Financing prior to a CIM analysis of business processes. Although development of a single national claims processing system is a major new systems development initiative that may cost up to $445 million, Health Affairs has not yet completed a functional analysis of claims processing using the CIM methodology. Thus, in this critical area, decisions about system development continue to precede analysis of the business processes the system is to serve.

The technical side has also suffered from CIM's placement. While CIM has built on the experience of the Defense Medical System Support Center in developing standard systems used in medical facilities in each of the services, extending CIM to systems in other areas has been slow. For example, the first CIM technical management plan describing the military health services systems environment did not include information on CHAMPUS information systems or on systems built by the individual services, although it was in these areas that duplicative and nonstandard systems were most likely to exist. While the second technical management plan published in October 1992 does cover CHAMPUS and service headquarters systems, coordinating activities across organizational boundaries has continued to be difficult.

SCOPE AND METHODOLOGY

To assess CIM's implementation in military medicine, we reviewed evolving CIM policy and analyzed CIM documents, analyses, and actions of the Office of the Assistant Secretary of Defense for Health Affairs beginning in April 1990 when CIM was initiated in the medical area. We interviewed officials in Health Affairs and in each of the services participating in CIM activities; we also attended selected CIM meetings and briefings. A draft of this letter was informally reviewed by officials from Health Affairs, including the Deputy Assistant Secretary of Defense for Health Services Operations, who generally concurred with our observations. Our review was conducted in accordance with generally accepted

government auditing standards, between October 1991 and May 1993.

If you have any questions about this letter, please contact me at (202) 512-6408, or Elizabeth Powell, Evaluator-in-Charge, at (202) 512-6268.

Sincerely yours,

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Director,
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