VA/DOD JOINT EXECUTIVE COUNCIL
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VA/DOD JOINT EXECUTIVE COUNCIL
Annual Report – Fiscal Year 2004

EXECUTIVE SUMMARY

Public Law 108-136, Section 583, established the Department of Defense-Department of Veterans Affairs Joint Executive Council to recommend to the Secretary of Veterans Affairs and the Secretary of Defense a strategic direction for the joint coordination and sharing of efforts between and within the two Departments. The Department of Veterans Affairs (VA) and the Department of Defense (DoD) established the VA/DoD Joint Executive Council (JEC) in February 2002. The VA/DoD JEC has incorporated the responsibilities of this Executive Council into its charter. The law further requires the JEC submit to the two Secretaries and Congress an annual report. Attached is the first Annual Report.

During Fiscal Year 2004 (FY 2004) the VA/DoD JEC met quarterly to review existing policies, procedures, and practices to improve beneficiary access to quality health care and benefits and to strengthen resource sharing. Opportunities for change and improvement were identified and the Council oversaw implementation of over a dozen VA/DoD cooperative and sharing initiatives. These new cooperative initiatives are discussed in greater detail in the report.

Based on a review of past and current practices in VA/DoD collaboration, Congressional proceedings, GAO reports, and the findings of the President's Task Force to Improve Health Care Delivery for Our Nations Veterans (PTF), the JEC concluded that the most effective way to improve VA/DoD sharing was through the development of a Joint Strategic Plan to guide the Departments' future relationship.

The initial VA/DoD Joint Strategic Plan (JSP) was approved by the JEC on April 15, 2003 (see Appendix A). The first document of its kind, the plan represented a significant step forward in institutionalizing VA and DoD collaboration. The JSP articulated a vision for collaboration; established priorities for partnering; launched processes to implement interagency policy decisions and develop joint operation guidelines; and instituted performance monitoring to track the Departments' progress in meeting the specific goals and objectives defined in the plan. The JSP goals include: Leadership Commitment and Accountability; High Quality Health Care; Seamless Coordination of Benefits; Integrated Information Sharing; Efficiency of Operations; and Joint Medical Contingency/Readiness Capabilities.

In FY 2004 the JEC reviewed and updated the JSP. During the planning process, the JEC clarified roles and responsibilities of the entities under the Executive Council structure, included specific performance metrics, introduced a more

strategic planning horizon, and committed to linking VA/DoD JSP goals and objectives to Departmental strategic plans. The Fiscal Year 2005 (FY 2005) Joint Strategic Plan is located at Appendix B of the Annual Report.

The JEC closely followed the activities of the PTF and reviewed the recommendations on improving VA/DoD sharing contained in their Final Report (May 2003). The majority of the PTF's recommendations have been implemented by the Departments or incorporated in the JSP. The Departments' response to the PTF Final Report is located at Appendix C.

VA/DoD JOINT EXECUTIVE COUNCIL
Annual Report 2004

TABLE OF CONTENTS PAGE

THE DEPARTMENT OF VETERANS AFFAIRS/DEPARTMENT OF DEFENSE
JOINT EXECUTIVE COUNCIL
Annual Report
Fiscal Year 2004

I. BACKGROUND

Public Law 108-136, Section 583, established the Department of Defense-Department of Veterans Affairs Joint Executive Council to recommend to the Secretary of Veterans Affairs and the Secretary of Defense the strategic direction for the joint coordination and sharing efforts between and within the two Departments and to oversee the implementation of those efforts. The law further requires the Council to submit to the Secretaries and to Congress an annual report highlighting major accomplishments and containing recommendations the Council considers appropriate.

II. THE VA/DOD JOINT EXECUTIVE COUNCIL

Established in February 2002, the Department of Veterans Affairs (VA) - Department of Defense (DoD) Joint Executive Council (JEC) is co-chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness. Membership is comprised of senior leaders from both VA and DoD, including VA's Under Secretary for Benefits and Under Secretary for Health and DoD's Principal Deputy Under Secretary of Defense for Personnel and Readiness and Assistant Secretary for Health Affairs. The JEC was established to enhance VA and DOD collaboration; ensure the efficient use of federal services and resources; remove barriers and address challenges that impede collaborative efforts; assert and support mutually beneficial opportunities to improve business practices; facilitate opportunities to improve resource utilization and to enhance sharing arrangements that ensure high quality cost effective services for both VA and DoD beneficiaries; and develop a joint strategic planning process to guide the direction of joint sharing activities.

In November 2003, the National Defense Authorization Act (P.L. 108-136) codified the JEC under USC Title 38, Section 8111. The statute requires the JEC to submit to the Secretary of Veterans Affairs, the Secretary of Defense, and Congress an annual report containing such recommendations as the JEC considers appropriate to enhance VA/DoD sharing and collaboration.

III. THE EXECUTIVE COUNCIL STRUCTURE

VA and DoD have undertaken unprecedented efforts to assert and support mutually beneficial collaboration and sharing opportunities by establishing four additional interagency councils/committees: the VA/DoD Health Executive Council (HEC), co-chaired by the VA Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs; the VA/DoD Benefits Executive Council (BEC), co-

chaired by the VA Under Secretary for Benefits and the Principal Deputy Under Secretary of Defense for Personnel and Readiness; the Joint Strategic Planning Committee (JSPC) co-chaired by the VA Principal Deputy Assistant Secretary for Policy, Planning, and Preparedness and the Principal Deputy Assistant Secretary of Defense for Health Affairs; and the Capital Asset Planning and Coordination Steering Committee (CAPC), co-chaired by the VA Principal Deputy Assistant Secretary for Management and the Deputy Assistant Secretary of Defense for Health Budgets and Financial Policy. The co-chairs of each of these groups are members of the JEC and actively participate in the joint strategic planning process. The JEC's primary responsibility within this structure is to set strategic priorities for the HEC, BEC, JSPC, and CAPC; monitor the development and implementation of the Joint Strategic Plan; and ensure appropriate accountability is incorporated into all joint initiatives.

A. VA/DoD Health Executive Council (HEC)

Comprised of senior leaders from each organization, the Health Executive Council (HEC) works to institutionalize VA and DoD sharing and collaboration to ensure the efficient use of health services and resources. The HEC oversees the cooperative efforts of each agency's health care organizations.

The HEC has charged work groups to focus on specific high-priority areas of national interest. Through these work groups, the Departments have achieved significant success in improving interagency cooperation in key areas such as pharmacy, procurement, deployment health, clinical guidelines, contingency planning, graduate medical education, information management/information technology, financial management, joint facility utilization, and benefits coordination. Local and regional cooperation has increased due to innovative projects that extend resources and increase operational readiness through shared staffing, services, and facilities.

Through the HEC, VA and DoD have worked closely to ensure coordination of health care services to our military and newest veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

B. VA/DoD Benefits Executive Council (BEC)

The Benefits Executive Council (BEC) is charged with examining ways to expand and improve information sharing, refine the process of records retrieval, identify procedures to improve the benefits claims process, improve outreach, and increase service members' awareness of potential benefits. In addition, the BEC provides advice and recommendations to the JEC on issues related to seamless transition from active duty to veteran status through a streamlined benefits delivery process, including the development of a cooperative physical examination process and the pursuit of interoperability and data sharing. The BEC has made significant progress in meeting the objectives set forth in the JSP.

C. VA/DoD Joint Strategic Planning Committee

In October 2002 the JEC established the VA/DoD Joint Strategic Planning Committee (JSPC). The JSPC was charged with developing a joint strategic plan that, through specific initiatives, would improve the quality, efficiency, and effectiveness of the delivery of benefits and services to both VA and DoD beneficiaries through enhanced collaboration and sharing. Based on a review of past and current practices in VA/DoD sharing, Congressional proceedings, GAO reports, and the findings of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF), the JSPC developed the JSP to guide the Departments' future sharing and collaboration.

D. VA/DoD Capital Asset Planning and Coordination Steering Committee

The JSPC chartered the Capital Asset Planning and Coordination Steering Committee in August 2003. The CAPC provides a formalized structure to facilitate cooperation and collaboration in achieving an integrated approach to capital coordination that considers both short-term and long-term strategic capital issues and is mutually beneficial to both Departments. The CAPC provides the oversight necessary to ensure that collaborative opportunities for joint capital asset planning are maximized, and will serve as the final review and approval of all joint capital asset initiatives recommended by any element of the JEC structure.

IV. The VA/DoD Joint Strategic Plan

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In FY 2004 the JEC reviewed and updated the JSP. During the planning process, the JEC clarified roles and responsibilities of the entities under the Executive Council structure, included specific performance metrics, introduced a more strategic planning horizon, and committed to linking VA/DoD JSP goals and objectives to Departmental strategic plans. The Fiscal Year 2005 (FY 2005) Joint Strategic Plan is located at Appendix B of the Annual Report.

A. Summary of Performance on Key Strategic Goals

The VA/DoD Joint Strategic Plan identified six strategic goals essential to meaningful collaboration between the Departments. Each goal has specific objectives and performance measures to assess the progress made toward achievement. The following summary is structured around the six strategic goals.

GOAL 1: Leadership Commitment and Accountability: Promote accountability, commitment, performance measurement, and enhanced internal and external communication through a joint leadership framework.

A formal Executive Council Structure was established under the umbrella of the VA/DoD Joint Executive Council. The VA/DoD Health Executive Council, Benefits Executive Council and a Capital Asset and Coordination Steering Committee were created and charters approved. The Joint Strategic Planning Committee (JSPC) was established by the JEC to develop and maintain a joint strategic plan. The councils serve as a forum for senior leaders of both Departments meet on a regular basis to provide oversight and direction on the joint strategic plan, discuss and plan for future joint initiatives, and assist in resolving organizational impediments to collaborative efforts. Additionally, the Councils ensure joint strategic objectives and accomplishments are communicated to the Departments' internal and external stakeholders and appropriate media outlets.

GOAL 2: High Quality Health Care: Improve the access, quality, effectiveness and efficiency of health care for beneficiaries through collaborative activities.

Patient Safety: VA and DoD are collaborating on internal and external reporting systems for patient safety. DoD has established a "Patient Safety Center" at the Armed Forces Institute of Pathology using the VA National Center for Patient Safety as a model.

Clinical Practice Guidelines: VA and DoD are collaborating in the creation and publication of jointly used clinical practice guidelines for disease management. DoD and the Veterans Health Administration (VHA) are now using the same explicit clinical practice guidelines to improve patient outcomes. Clinical guidelines have provided consistent, high-quality health care delivery in both Departments. Guidelines have been published for the following clinical areas: asthma, chronic kidney disease, chronic obstructive pulmonary disease (COPD), cardiovascular disease, (including hypertension, hyperlipidemia, ischemic heart disease and chronic heart failure), depression, diabetes mellitus, dysuria in women, low back pain, medically unexplained symptoms, (including chronic pain and fatigue), post-operative pain management, post deployment health, substance abuse, uncomplicated pregnancy, stroke rehabilitation and tobacco cessation. The Work Group also completed work on guidelines for use of opioids in the management of chronic pain, post-traumatic stress disorder, and a pocket card related to blast injuries. Other guidelines that are pending or planned for 2005 include updates for

tobacco use cessation, hypertension, dyslipidemia, post-deployment including a module on amputation and psychoses with a module on bipolar disorder and a new guideline pertaining to obesity. The Work Group also conducted joint reviewer training, three satellite broadcasts and four face-to-face meetings to disseminate new and updated guidelines and facilitate implementation. Tools for each guideline were also made available to providers. Patient brochures, CD-ROMs, pocket cards, and other self-study continuing education are available on the web. Guideline products have also been presented at national meetings throughout the year. On September 8, 2004, the revised charter was signed to enhance the continued collaboration and further champion the implementation of evidence-based clinical advances into practice.

Deployment Health: The HEC established the Deployment Health Work Group to enhance health care available to service members returning from an overseas deployment. Focusing on health risks associated with specific deployments, the group developed proactive approaches toward deployment health surveillance, health risk communication, and early identification and treatment of deployment related health problems. Examples of initiatives include: administering pre- and post-deployment health assessments; identifying and tracking health care utilization of individual personnel returning from deployments; providing targeted outreach and education through personal letters, pocket cards, web sites, and targeted briefings; enhancing clinical and staff education to facilitate early identification of potential health risks; and sharing appropriate, relevant medical and service information between VA and the military services.

Pharmacy: The goal of the VA/DoD Federal Pharmacy Executive Steering Committee of the HEC is to improve the management of pharmacy benefits for both VA and DoD beneficiaries. Joint partnerships for contracting for pharmaceuticals have been very successful. The Departments have conducted a pilot test where VA Consolidated Mail Out Pharmacy (CMOP) Leavenworth refills outpatient prescription medications from DoD's Military Treatment Facilities (MTF) at the option of the beneficiary. The original DoD sites were Naval Medical Center San Diego, California; Fort Hood Army Community Hospital, Killeen, Texas; and 377th Medical Group, Kirtland Air Force Base, New Mexico. The Departments have reviewed analysis of the joint VA/DoD CMOP Pilot prepared by Center for Naval Analysis (CNA) and have found the program to be feasible, with high participation by DoD beneficiaries, and high satisfaction among users of the program. The Departments are also aware that DoD has deemed the CNA report inconclusive on whether the CMOP program is cost-effective for DoD. Relative cost data will continue to be assessed by DoD. The United States Government Accountability Office is conducting an in-depth analysis of the pilot program and is expected to issue a report in the near future. DoD continues to be interested in exploring this joint activity with the VA; however, DoD will not centrally fund the effort. For Fiscal Year 2005, continuation of CMOP services to the pilot sites will be at the discretion of each MTF Commander and respective Service. Current status at the pilot sites: Fort Hood discontinued the service effective September 30, 2003; however, the

Army is considering continuation of the program; Naval Medical Center San Diego continues to participate at a rate of approximately 500,000 prescriptions per year; Kirtland Air Force Base continues to participate at a rate of approximately 60,000 prescriptions per year.

Resource Sharing: The Joint Facility Utilization and Resource Sharing Work Group was established by the HEC to examine issues such as removing barriers to resource sharing and streamlining the process for approving sharing agreements. The Work Group was originally tasked with identifying areas for improved resource utilization through local and regional partnerships, assessing the viability and usefulness of interagency clinical agreements, identifying impediments to sharing and identifying best practices for sharing resources. The work group was responsible for providing oversight of the VA/DoD Joint Assessment Study mandated by the FY 2002 National Defense Appropriations Act. A contract was awarded in November 2002, for a study of beneficiary utilization within three federal health care markets: Puget Sound; Hawaii; and along the Gulf Coast between Biloxi, MS, and Panama City, FL. The study was submitted to Congress on September 20, 2004.

The Work Group also had responsibility for overseeing compliance with Sections 722, and 723 of the FY 2003 National Defense Authorization Act. These activities are discussed under Goal 5 in this report.

The HEC established the North Chicago-Great Lakes Task Force to recommend short and long term actions to improve resource sharing between the North Chicago Veterans Affairs Medical Center (VAMC) and the Naval Hospital Great Lakes. Current activity includes initiation of the construction project to modernize the NCVAMC surgical emergency/urgent care facilities. Discussions are underway on funding for site and space planning for the Navy Ambulatory Care Center on adjacent to the North Chicago VAMC. Discussions are planned on potential governance models for integrating operations of the two facilities.

GOAL 3: Seamless Coordination of Benefits: Promote the coordination of benefits to improve the understanding of, and access to, benefits and services earned by service members and veterans through each stage of life, with a special focus on ensuring a smooth transition from active duty to veteran status.

Transition Assistance: The BEC supports the enhancement of collaborative efforts to educate active duty, Reserve and National Guard personnel on VA and DoD benefits programs, eligibility criteria and application processes. A pilot initiative is underway to ensure wide dissemination of VA benefits information to VA and DoD beneficiaries at the time of accession. VA's brochure: "A Summary of VA Benefits" will be provided to each enlistee beginning in October 2004.

The Department of Labor, the Public Health Service and the Coast Guard participates with VA and DoD in a BEC Work Group established to enhance

collaborative efforts to educate active duty, Reserves and National Guard personnel. DoD promotes pre-separation participation in the Transition Assistance Program (TAP) and the Disabled Transition Assistance Program (DTAP) for all service members. The possibility of posting TAP and DTAP information on a central transition website is being explored. The VA Homepage provides information of specific interest to returning Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans and their families and has hyperlinks to relevant sites including Readjustment Counseling Centers, DoD Family Services, and Guard and Reserve specific policies.

Benefits Delivery at Discharge: The Benefits Delivery at Discharge (BDD) program is designed to facilitate the adjudication process for service members filing claims for disability compensation at the time of their separation/retirement from active duty. At the time of separation service members usually have ready access to their service personnel and medical records which provide the documentation necessary to support a disability claim. Providing a comprehensive physical examination in support of a disability claim at the time of separation eliminates the need for an additional examination post discharge, expediting the adjudication process. VA and DoD have been working together to develop a cooperative physical examination process that meets both the services' separation examination requirements and VA's compensation examination criteria. A test protocol has been piloted at 28 BDD sites located at, or in close proximity to, Army, Navy and Air Force bases across the country. Based on the success of the pilots a national Memorandum of Agreement has been developed, outlining the conditions, stipulations, and responsibilities of each party in support of the Cooperative Physical Examination initiative. The MOA is on schedule to be completed and approved by both Departments by the end of first quarter of FY 2005, and implementation guidelines issued during the second quarter of that same year.

GOAL 4: Integrated Information Sharing: Enable the efficient sharing of beneficiary data, medical records, and other information through secure and interoperable information management systems.

The Information Management/Information Technology (IM/IT) Work Group of the HEC is responsible for developing and implementing joint policy for improving exchange of health data between the Department of Defense and the Department of Veterans Affairs. Highlights of key HEC IM/IT initiatives for FY 2004 include:

Joint Electronic Health Records Interoperability (JEHRI) Initiative: VA and DoD strongly support the need for appropriate sharing of electronic health information. To strengthen VA/DoD electronic medical information exchange while leveraging Departmental systems investments, VA and DoD are working to ensure the interoperability of the Departments' electronic health records systems by the end of FY 2005. JEHRI includes implementation of standards, technical and data architectures, hardware, and software design and development required to achieve the ability to securely exchange electronic health information.

The Under Secretary of Defense for Personnel and Readiness and the Deputy Secretary for Veterans Affairs signed the Executive Decision Memorandum defining the goals of the VA/DoD Joint Electronic Health Records Interoperability Initiative at the September 2002 JEC meeting. This initiative, which has been approved by the Office of Management and Budget, addresses the Departments' long-range plan to improve sharing of health information; adopt common standards for architecture, data, communications, security, technology and software; seek joint procurement and/or building of applications, where appropriate; seek opportunities for sharing existing systems and technology, and explore convergence of VA and DoD health information applications consistent with mission requirements. JEHRI also responds to the recommendations of the PTF.

VA and DoD are committed to exchanging appropriate health information in the most efficient and effective means possible while continuing to meet unique agency needs. VA and DoD are in the process of finalizing the JEHRI Program Management Plan (PMP). The JEHRI PMP guides the management oversight, progress reporting, and continued development of JEHRI projects. JEHRI projects are laying the ground work for the clinical information exchange that will enable a consolidated view of health data from VA and DoD medical records.

Health Information Technology Standards: VA and DoD play key roles as lead partners in the Consolidated Health Informatics (CHI) initiative. The goal of the CHI initiative is to establish Federal health information interoperability standards as the basis for electronic health data transfer in all activities and projects among all agencies and departments.

In March 2003, the Departments of Health and Human Services (HHS), Defense, and Veterans Affairs announced the first set of uniform standards to be adopted from the CHI effort. They included standards in clinical laboratory results, health messaging, prescription drug codes, digital imaging, and connectivity of medical devices to computers. The standards adopted will be used in new acquisitions and systems development initiatives.

On May 6, 2004, HHS, VA, and DoD announced the adoption of 15 additional standards recommended by CHI including:

- Health Level 7 (HL7) vocabulary standards for demographic information, units of measure, immunizations, and clinical encounters and HL7s Clinical Document Architecture standard for text based reports;

- College of American Pathologists (CAP) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) for laboratory result contents, non-laboratory interventions and procedures, anatomy, diagnosis and problems, and nursing;

- Logical Observation Identifier Name Codes (LOINC®) for electronic exchange of laboratory test orders;

- Health Insurance Portability and Accountability Act (HIPAA) transactions and code sets for electronic exchange of health related information to perform billing or administrative functions;

- Food and Drug Administration's (FDA) names and codes for ingredients, manufactured dosage forms, drug products and medication packages; National Library of Medicine's RxNORM for describing clinical drugs; and VA's National Drug File Reference Terminology (NDF-RT) for specific drug classifications;

- Human Gene Nomenclature (HUGN) for the role of genes in biomedical research;

- Environmental Protection Agency's Substance Registry System (SRS) for non-medicinal chemicals of importance to health care.

Both VA and DoD are engaged in discussions regarding CHI Phase II and the necessity for an updated CHI Phase II Memorandum of Understanding in light of CHI now being a workgroup under the Federal Health Architecture initiative.

For CHI Phase II there are three key activities:

1) Implementation of adopted standards,

2) Maintenance and enhancement of adopted standards, and

3) Continuation of new standards adoption needed to support business priorities.

VA and DoD are co-chairing the CHI Phase II new standards development effort with particular emphasis on e-Prescribing and allergy standardization.

VA and DoD are also leading partners in many national standards development efforts. Both Departments participate in multiple standards boards to collaborate and share expertise. The VA/DoD Standards Convergence Group continues to work towards leveraging synergies and avoiding duplication and inconsistencies with their respective Enterprise Architecture (EA) development. EA links the business mission, strategy, and processes of an organization to its Health Technology strategy.

The Federal Health Information Exchange (FHIE): The FHIE is the initial VA/DoD effort at sharing appropriate clinical health data electronically. The transfer of data

on service members at the point of separation is a one time (per beneficiary) transfer, in keeping with applicable privacy laws and regulations, from DoD's Composite Health Care System (CHCS) to VA's Veterans Health Information System and Technology Architecture (VistA) for use by VA providers and benefits claims specialists.

DoD has transmitted over 95 million messages on 2.3 million unique patients containing information on laboratory results (clinical chemistry, blood bank information, microbiology, surgical pathology, and cytology); radiology results; outpatient pharmacy data from military treatment facilities, retail network pharmacies, and DoD mail order pharmacies; allergy information; discharge summaries (inpatient history, diagnosis, and procedures); admission, disposition, and transfer information (admission and discharge dates); consult reports (referring physician and physical findings); standard ambulatory data record (diagnosis and procedure codes, treatment provided, encounter date and time, and clinical services); and patient demographic information (name, social security number, date of birth, sex, race, religion, patient category, marital status, primary language, and address). This number continues to grow as health information on recently separated Service members is extracted and transferred to VA monthly.

VA providers at all VA Medical Centers and clinics nationwide have access to data on separated Service members. The FHIE data repository contains historical clinical health data from 1989 to the present that significantly contributes to the delivery and continuity of care and adjudication of disability claims of separated Service members as they transition to veterans.

Bidirectional Health Information Exchange (BHIE) (formerly known as CHCS/VistA Data Sharing Interface (DSI)): Building on FHIE and reusing a significant number of its products is the BHIE. The focus of this interface is exchanging data on shared VA/DoD patients such as at joint venture sites and to support other local sharing agreements. While FHIE provides joint health care facilities access to pre-separation DoD health care data on separated service members, BHIE will provide secure, near real-time, bidirectional access to electronic health information on shared patients. This project is an incremental step in the accomplishment of the goal to create a bidirectional interface between DoD's and VA's health information systems.

The initial data shared, in the first Quarter of FY 2005, will be patient demographic data (name, patient category, social security number, gender, and date of birth), DoD and VA outpatient pharmacy data (Military Treatment Facility data for all shared beneficiaries, DoD mail order pharmacy and retail pharmacy network for separated service members, and VA pharmacy data), and allergy information. Additional data elements that will be added are: DoD mail order pharmacy and retail pharmacy network data for other shared beneficiaries, laboratory results (surgical pathology reports, cytology, microbiology, chemistry, hematology, and lab orders data), and radiology results.

DoD Clinical Data Repository (CDR) and the VA Health Data Repository (HDR) – (CHDR): To provide a more robust bidirectional real-time exchange of clinical health care data in the future, VA and DoD are working on interoperability between the DoD CDR and the VA HDR – (CHDR) utilizing the Departments' next generation of systems, DoD CHCS II and VA HealtheVet VistA.

Phase I of this effort is a pharmacy prototype. The Departments' technical and functional teams successfully completed a demonstration of the bidirectional pharmacy prototype in a lab environment on September 1, 2004. The data exchanged through the pharmacy prototype includes patient demographic data (sufficient to correlate patients), provider demographic data (sufficient to identify the ordering provider), medication lists, and allergy lists from one agency repository to the other. In addition, the prototype provides the capability for agency drug to drug interaction screening (based on the integrated VA/DoD medication list) and local (intra-agency) database drug to drug allergy interaction screening (based on the integrated VA/DoD allergy list).

Phase II will include the exchange of patient demographics, outpatient pharmacy (Military Treatment Facility, DoD mail order, and retail pharmacy network data), laboratory, and allergy information which will occur by October 2005.

FHIE, BHIE, and CHDR projects share clinical health care data and are complimented by the following projects which share supporting types of data:

Laboratory Data Sharing Interface (LDSI): LDSI focuses on sharing real-time laboratory order entry and laboratory results retrieval between DoD, VA, and commercial reference laboratories. Employing LDSI, a VA provider using VistA writes an order for lab work. That order is electronically transferred to DoD, which is acting as a reference lab to VA for fulfillment. The results are electronically transferred from DoD to VA and included in the patients' record in VistA. LDSI provides laboratory order portability between local VA/DoD sites that have a sharing agreement regarding laboratory services. Testing is underway on similar electronic order entry and results retrieval to support VA functioning as a reference lab for DoD. As part of the National Defense Authorization Act (NDAA) Demonstration Site initiative, the Departments will implement LDSI in San Antonio, Texas, for use by Wilford Hall Medical Center, Brooke Army Medical Center, and the South Texas Veterans Healthcare System, and in El Paso, Texas, for use by William Beaumont Army Medical Center and the El Paso Veterans Affairs Health Care System.

VHA's VetPro Credentialing System (VetPro) and DoD's Central Credentials Quality Assurance System (CCQAS): To improve the process of initial provider credentialing, the VetPro/CCQAS project enables the electronic sharing of provider credentialing data elements between VA and DoD. This allows both Departments to expend fewer resources to initially credential a provider that has already been credentialed in the other Department. The interface supports the exchange of

approximately 50 credentials data elements between the Departments. The interface meets the content of the Joint Commission for the Accreditation of Health Care Organization guidance regarding the acceptance of credentials data verified by another source.

Pilot testing of the interface between the VA and DoD credentialing systems took place at the following sites: Naval Hospital Great Lakes/North Chicago Veterans Health Care System/Hines VA Hospital, Illinois; Ireland Army Community Hospital/Louisville VAMC, Kentucky; and Mike O'Callaghan Federal Hospital in Las Vegas, Nevada. The pilot test was completed in the third quarter, FY 2004. Participants in the pilot test agreed that the integration reduced duplication and resulted in time savings. The Departments are now implementing VetPro/CCQAS credentials interface into the San Antonio area for use by Wilford Hall Medical Center, Brooke Army Medical Center, and the South Texas Veterans Healthcare System, as part of the NDAA Demonstration Site initiatives. This will provide a longer period of use and a more in-depth evaluation of the merits of the interface.

In the Benefits arena, VA and DoD made progress during FY 2004 in improving data exchange to enhance coordination of benefits for service members and veterans:

Expedited Information Exchange for Claims Processing: Efforts are underway to provide VA access to claimants' personnel information from the Defense Integrated Military Human Resources System (DIMHRS) through the DoD/Defense Manpower Data Center (DMDC) interface when it is fielded in late 2005. VA is also interfaced with the imaged Official Military Personnel Files for the Army, Navy and Marine Corps via the VA Personnel Information Exchange System (PIES) and the Defense Personnel Records Image Retrieval System (DPRIS). Within the last quarter of FY 2004, VA made access to Defense Enrollment and Eligibility Reporting System (DEERS) data, from within the Veterans Information System (VIS)*, available to VA Regional Offices and Medical Facilities for the purpose of early identification of recently discharged DoD service members. Through this process, recently discharged service members are routinely verified as being honorably discharged within two days of the discharge event; without the DEERS/VIS Interface notification can take up to 90 days. VA and DoD are also expanding the scope of data VA receives from DMDC/DEERS so combat history and hazardous duty information on returning OIF/OEF service members will be available during the first quarter of FY 2005. VBA's original list of 100 data elements necessary to determine an individual service members' eligibility for benefits sent to the Joint Requirements and Integration Office (JR&IO) in June of 1998, has recently been updated and validated by VA and an interagency team of functional subject matter experts from the DIMHRS requirements and reengineering team and VBA.

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* VIS is an online reference system of veteran service history data derived from DoD/DMDC, which is available from the VA intranet.

GOAL 5: Efficiency of Operations: Improve management of capital assets, procurement, logistics, financial transactions, and human resources.

Capital Asset Coordination: The initial Joint Strategic Plan required VA and DoD to establish a capital coordination process to ensure an integrated approach to capital coordination between the two departments. As a result, the Capital Asset Planning and Coordination (CAPC) Steering Committee was created via charter on August 13, 2003.

The CAPC formed the Capital Budgeting Work Group to identify linkages between VA and DoD capital processes for upcoming budget cycles, identify joint requirements for analysis and planning, and establish funding principles for collaborative projects. The Work Group is finalizing its report, which contains both short and long-term recommendations for major capital collaborations. One of the more notable recommendations is the formation of a "core group," which will facilitate stability and consistency by protecting joint projects from vulnerabilities associated with changing leadership at local and regional levels. The core group will consist of permanent members from corporate headquarters in VA and DoD and variable members who will rotate through the core group based on the specific project or planning needs. This core group is targeted to be piloted in FY 2005.

The CAPC also worked cooperatively with the Health Executive Council in the creation of the Joint Incentive Fund (JIF) Memorandum of Agreement (MOA) to ensure that the MOA had sufficient flexibility to allow monies from the fund to be expended on requirements analysis and planning in relation to construction projects and to outline the CAPC role in evaluating JIF proposals with a significant capital component.

The HEC has established Work Groups to focus on coordination in specific areas to improve efficiency. Highlights of HEC activities and accomplishments for FY 2004 include:

Joint Acquisition: VA and DoD established an agreement to eliminate duplication in specific contracting efforts, to leverage buying power, and obtain best value contract solutions. Appendices have been developed to cover acquisitions in medical-surgical, pharmaceuticals, and high tech medical equipment. Through these agreements, both VA and DoD save substantial taxpayer dollars through cost avoidance and lower prices. Collaboration in pharmaceuticals contracting has been notably successful.

There are currently 81 joint contracts, 13 blanket purchasing agreements, 12 pending joint contracts, and 17 proposed joint contracts. In FY 2002, cost avoidance through joint pharmaceutical procurement contracts totaled over $139 million; in FY 2003 cost avoidance was $148 million; and in FY 2004 cost avoidance was $185 million.

VA and DoD began the migration to a single Federal pricing instrument, the Federal Supply schedule, for medical surgical products in January 2002. The Materiel Management Work Group is continuing to define requirements for a joint on-line single Federal pricing catalog, which will provide "real time" visibility of contract items.

Financial Management: The Departments established a standardized reimbursement methodology between VA and DoD medical facilities through a Memorandum of Agreement implementing standardized outpatient billing rates based on discounted CHAMPUS Maximum Allowable Charges schedule. Guidelines and procedures were also developed for waiver request applications.

Joint Incentive Fund: As mandated by Section 721 of the FY 2003 National Defense Authorization Act, the HEC established a Joint Incentive Fund to provide incentives for creating innovative sharing initiatives at the facility, regional and national levels. Each Department contributed $15 million to the fund in FY 2004. A similar amount will be deposited to the fund at the beginning of each fiscal year. A charter was approved and implementation guidelines developed for administration of the JIF in July 2004. The VA/DoD Financial Management Work Group (FMWG) received 58 proposals in response to the initial call for proposals. The Work Group approved 29 of these proposals to proceed to the second round. In the second round, 19 projects were scored and 12 recommended for funding at a total cost of $29.9 million. Funding will be allocated to the selected projects upon certification that they are self sustaining. Proposals recommended for funding involve a wide range of services including various tele-health projects, women's health services, a joint cardiac catheterization lab, a joint dialysis unit and the opening of a joint clinic.

Demonstration Projects: Section 722 of the FY 2003 National Defense Authorization Act mandates the establishment of health care coordination projects between VA and DoD. Seven demonstration projects were selected in FY 2004 and implementation is scheduled for the first quarter of 2005. The program will evaluate the success of demonstration projects designed to improve the coordination of health care resources between VA and DoD for application elsewhere. Each Department made available $6 million in FY 2004. From FY 2005 through FY 2007 each Department will make available $9 million for each year. All sites are expected to begin their projects by October 2004. The seven demonstration sites approved by the HEC are:

Budget and financial management systems:

- VA Pacific Islands Health Care System and Tripler Army Medical Center, Hawaii
- Alaska VA Health Care System and the 3rd Medical Group, Elmendorf Air Force Base, Alaska

Coordinated staffing and assignment systems:

- Augusta VA Medical Center and Eisenhower Army Medical Center, Georgia
- Hampton VA Medical Center and the 1st Medical Group, Langley Air Force Base, Virginia

Medical information and information technology management systems:

- Puget Sound VA Health Care System and Madigan Army Medical Center, Washington
- El Paso VA Health Care System and William Beaumont Army Medical Center, Texas
- South Texas VA Health Care System, Wilford Hall Medical Center and Brooke Army Medical Center, Texas

GOAL 6: Joint Contingency/Readiness Capabilities: Ensure the active participation of both agencies in support of the VA/DoD Contingency Plan and National Response Plan.

The VA/DoD HEC established the Contingency Planning Work Group in FY 2004 to enhance collaborative efforts in support of the VA/DoD Contingency Plan and the National Disaster Medical System. Through the Work Group, VA and DoD are jointly updating the MOU regarding VA furnishing health care services to members of the armed forces during a war or national emergency. Additionally, hundreds of joint mass casualty training exercises occur between local VA and DoD medical facilities on an annual basis. Each Department dedicates staff, equipment, supplies and logistical support to these exercises, which focus on incident and consequence management as well as VA/DoD contingency operations. To enhance medical readiness, VA and DoD participate in an alliance with other federal agencies, FEDS-Heal, to ensure that Army reservists are ready for deployment to any global military mission. Through this initiative VA helps the reserve component meet the requirements of retention physicals and prepare for mobilization.

B. Summary of Update of Joint Strategic Plan for FY 2005

In FY 2004 the JEC reviewed and updated the JSP. During the planning process, the JEC clarified roles and responsibilities of the entities under the Executive Council structure, included specific performance metrics, introduced a more strategic planning horizon, and committed to linking VA/DoD JSP goals and objectives to Departmental strategic plans. The FY 2005 Joint Strategic Plan is located at Appendix B of the Annual Report.

V. RECOMMENDATIONS TO PROMOTE SHARING BETWEEN THE DEPARTMENTS

No formal recommendations for legislation are made at this time. Work Groups under the Executive Council Structure developed recommendations to promote sharing between VA and DoD. Highlights of those recommended actions approved through the Executive Council structure and implemented in FY 2004 are outlined above. Ongoing and future initiatives to enhance VA/DoD collaboration are included in the revised JSP.

VI. THE PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS (PTF)

In May 2001, President George W. Bush signed Executive Order 13214 creating the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). The charge to the PTF was to identify ways to improve health care delivery to Department of Veterans Affairs (VA) and Department of Defense (DoD) beneficiaries through better coordination and improved business practices. The PTF published its final report in May 2003. The Final Report contained recommendations organized around the principles of Leadership; Providing a Seamless Transition to Veteran Status; Removing Barriers to Collaboration; and Timely Access to Services and Funding. The JEC incorporated the majority of the Task Force's final recommendations into the VA/DoD Joint Strategic Plan. The formal response to the PTF's recommendations can be found in Appendix C.

APPENDIX A

Department of Veterans Affairs
Department of Defense
Joint Strategic Plan
Approved by VA/DoD Joint Executive Council
April 15, 2003

VA/DoD Joint Strategic Planning Initiative
4/15/03

Mission:
To improve the quality, efficiency and effectiveness of the delivery of benefits and services to veterans, service members, military retirees and their families through an enhanced VA and DoD partnership.

Vision Statement:
A world-class partnership that delivers seamless, cost-effective, quality services for beneficiaries and value to our nation.

Guiding Principles:
- *Collaboration-* to achieve shared goals through mutual support of both our common and unique mission requirements
- *Stewardship* - to provide the best value for our beneficiaries and the taxpayer.
- *Leadership* – to establish clear policies and guidelines for VA/DoD partnership, promote active decision-making, and ensure accountability for results

Strategic Goals:

Goal 1 Leadership Commitment and Accountability - Promote accountability, commitment, performance measurement, and enhanced internal and external communication through a joint leadership framework.

Goal 2 High Quality Health Care - Improve the access, quality, effectiveness and efficiency of health care for beneficiaries through collaborative activities.

Goal 3 Seamless Coordination of Benefits - Promote the coordination of benefits to improve understanding of and access to benefits and services earned by service members and veterans through each stage of life, with a special focus on ensuring a smooth transition from active duty to veteran status.

Goal 4 Integrated Information Sharing - Enable the efficient sharing of beneficiary data, medical records, and other information through secure and interoperable information management systems.

Goal 5 Efficiency of Operations - Improve management of capital assets, procurement, logistics, financial transactions, and human resources.

Goal 6 Joint Contingency/Readiness Capabilities - Ensure the active participation of both agencies in Federal and local incident and consequence response through joint contingency planning, training, and exercising.

Goal 1 Leadership Commitment and Accountability
Promote accountability, commitment, performance measurement, and enhanced internal and external communication through a joint leadership framework.

VA and DoD will establish a leadership framework to provide the necessary support for a successful partnership, help to institutionalize change, protect efforts from a loss of momentum, and sustain collaboration into the future. This framework will consist of the Joint Executive Council (JEC), the Health Executive Council (HEC), the Benefits Executive Council (BEC), and any other necessary sub councils or boards. Council membership will be comprised of senior leaders of both departments. The JEC co-chairs will develop a joint strategic plan to shape, focus, and prioritize the activities of the partnership, and ensure that clear and measurable performance targets are established. The JEC will oversee the implementation of the strategic plan, be responsible and accountable for the development and implementation of a communication plan to increase the exchange of knowledge and information between agencies and to external stakeholders.

1.1 Formalize the VA/DoD Executive Councils governance structure

1.1.1 Develop charter for the Joint Executive Council (JEC).

1.1.1.1 The Joint Strategic Planning Committee shall develop JEC Charter

a. Charter will include descriptions of membership, roles and responsibilities, chairmanship; frequency of meetings, decision-making process and staff support

i. Target Date: Charter approval: April, 2003

1.1.1.2 The JEC will specify charter requirements for HEC and BEC and other councils as determined

a. Charters will include descriptions of membership, roles and responsibilities, relationships with other Councils, chairmanship; frequency of meetings, decision-making process, description of the communications process between committees (including tasking) and staff support.

i. Target Date: HEC/BEC Charter approval: July 2003

1.2 Oversee the Development and Implementation of a Joint Strategic Plan

1.2.1 Develop and assign accountability for goals, objectives, strategies, and performance targets and maintain the strategic plan.

1.2.1.1 The Joint Executive Council shall:

a. Develop a Joint Strategic Plan
   i. Target Date: July 2003
b. Review, revise and approve and communicate subsequent strategic plans annually.
   ii. Target Date: March 2004

c. Perform periodic reviews of progress and achievements.
   iii. Target Date: October 2004 and quarterly thereafter
d. Provide an annual report to the Secretaries of the respective
   iv. Target Date: December 2003

1.2.1.2 The Joint Strategic Planning Council shall:

a. Review strategies and recommend adjustments/updates as necessary
   i. Target Date: January 2004 and semi-annually thereafter
b. Conduct quarterly reviews and make recommendations for corrective actions and improvements and submit recommendations at quarterly JEC meetings
   i. Target Date: September 2003
c. Provide an annual report to the JEC on current status of joint strategic planning
   i. Target Date: October 2003
d. Report on the feasibility of synchronizing the two Departments strategic planning cycles.
   i. Target Date: January 2004

1.3 Enhance internal and external communication regarding VA/DOD collaboration

1.3.1 Develop a joint communications plan to:

a. Promote VA/DoD collaborative initiatives within each Department
b. Educate internal and external stakeholders about joint VA/DoD initiatives
c. Provide periodic updates on accomplishments, new initiatives and other activities arising from VA/DoD collaboration
   i. Target Date: July 2003

Goal 2 High Quality Health Care
Improve the access, quality, effectiveness and efficiency of health care for beneficiaries through collaborative activities.

VA and DoD will expand the use of partnering and sharing arrangements to improve support to all beneficiaries. Collaboration will continue on the development of joint guidelines and policies for the delivery of high quality care and assurance of patient safety. VA and DoD will identify centers of excellence where specialized services can be made available to eligible beneficiaries; engage in joint training in multiple disciplines including ancillary services; and explore opportunities to enhance collaborative activities in Graduate Medical Education. Sharing research and development will be aggressively supported and encouraged. For dual beneficiaries, VA and DoD will seek to ensure that similar services are available and that the two systems are mutually supportive.

2.1 To be recognized as leaders in the development and delivery of innovative clinical processes and programs designed to enhance the quality of care delivered
The Health Executive Council shall develop collaborative processes in:

2.1.1 Reporting, training and other activities related to the promotion of patient safety and improved outcomes; and continue to work with other national agencies to assure patient safety and improved outcomes remain a primary focus for health care delivery systems.
   i. Target Date: Process and implementation plan: October 2003

2.1.2 Upgrading clinical practice guidelines, facilitating their communication to the field and monitoring their integration into the care delivery system on a periodic basis.
   i. Target Date: Process and implementation plan: October 2003.

2.1.3 Establish a VA/DoD Centers of Excellence working group to
   a. Define their nature and use
   b. Develop an inventory of existing Centers within each Department and the criteria used to establish them
   c. Identify their advantages and disadvantages
   d. Identify barriers and obstacles to their establishment and how they may be overcome
      i. Target Date: Report and recommendations completed: October2003.

2.1.4 Identify and foster opportunities for sharing information and resources between VA and DoD in the areas of deployment health surveillance, assessment, follow-up care, and health risk communication to include
   a. Pre-deployment health assessments

b. Medical environmental and CBRNE surveillance during deployments
c. Individual assignments and unit location during deployments
d. Post-deployment health assessments and clinical practice guideline data
e. Post-deployment briefings on VA benefits and services, particularly for those who served in a combat zone.
    i. Target date: July 2003

2.2 Actively engage in joint training and sharing of research and development

The Health Executive Council shall:

2.2.1 Explore and actively seek out opportunities for shared and/or combined Graduate Medical Education and develop a Pilot Program consistent with the provisions of P.L. 107-314 (National Defense Authorization Act of 2003).
    a. Develop and Implement Pilot Program
    b. Target Date: January '04
    c. Publish and disseminate initial lessons learned from the Pilot
    d. Target Date: July '04.
    e. Utilize the findings of the Pilot for the basis for the development of additional collaborative initiatives in joint GME programs.
        i. Target Date: FY'05 and beyond.

2.2.2 Explore and actively seek out opportunities for shared and collaborative research initiatives by establishing criteria through the Deployment Health Work Group responsible to:
    a. Explore Military and Veteran related health research, to include deployment health issues.
    b. Identify opportunities for collaborative research and avoidance of duplicative efforts.
    c. Increase non-federal research funding in support of VA/DoD mission specific research.
    d. Establish a forum for the sharing of best practices in health research.
    e. Develop a mechanism to ensure the research outcomes are shared throughout the Departments.
        i. Target Date: Report on findings and recommendations- January '04

2.3 Encourage continued development of sharing agreements that make the most efficient use of federal resources
The Health Executive Council shall:

2.3.1 Quantify and qualify where sharing agreements already exist (to include formal and informal partnership arrangements).
    i. Target Date: July 2003

2.3.2 Identify and disseminate [see 1.3 communications plan] best practices in VA/DoD Resource sharing
    i. Target Date: September 2003.

2.3.3 Establish criteria for administration and management of the Joint Incentive Fund to include:
    a. Assessing the legal administrative and fiscal implications of the Joint Incentive Fund as directed by P.L. 107-314
        i. Target Date: July 2003
    b. Based on assessment above, develop criteria for the management of the Joint Incentive Fund to include the process by which funds will be awarded in support of sharing initiatives
        i. Target Date: September 03
    c. Establish targeted goals for increasing VA/DoD health care sharing by identifying additional opportunities for increased DoD/VA sharing activity, establishing targets, and reviewing and updating targeted goals on an annual basis. These goals shall include specific dollar volumes and/or transaction targets obtained through shared workload and bartering activities.
        i. Target Date: Goals determined by September '03 and updated annually
    d. Establish a business case analysis process to assess the impact of VA/DoD sharing agreements on resource utilization, access to care, patient satisfaction and quality.
        i. Target Date: Implementation plan: October 2003.

Goal 3 Seamless Coordination of Benefits
Promote the coordination of benefits to improve understanding of and access to benefits and services earned by service members and veterans through each stage of life, with a special focus on ensuring a smooth transition from active duty to veteran status.

VA and DoD will enhance collaborative efforts to improve access to benefits; streamline application processes, eliminate duplicative requirements and correct other business practices that complicate the transition from active duty to veteran status. This will be accomplished through joint initiatives that: ensure wide dissemination of information on the array of benefits and services available to both VA and DoD beneficiaries; enhance educational programming on eligibility criteria and application requirements, increase sites providing Benefits Delivery at Discharge (BDD), improve the physical examination and claim process; and develop interoperable information management systems necessary for the administration and management of beneficiary claims.

This goal includes all benefits available to VA and DoD beneficiaries, including healthcare, educational assistance, home loans, disability compensation, pension, insurance, burial and memorial services.

3.1 Enhance collaborative efforts to educate active duty, reserve, and National Guard personnel on VA and DoD benefits programs, eligibility criteria and application processes.

The Benefits Executive Council shall develop implementation plans to:

3.1.1 Ensure wide dissemination of information on the array of Federal benefits and services available to both VA and DoD beneficiaries throughout the military personnel lifecycle with emphasis on active duty personnel at accession and separation.

3.1.2 Enhance communication and educational programming for active components on eligibility criteria and application processes necessary to access VA/DoD benefits at accession, periodically during active duty, and at separation.

3.1.3 Enhance communication and educational programming for reserve and National Guard personnel on eligibility criteria and application processes necessary to access VA/DoD benefits.

3.1.4 Promote participation in Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) briefings for all separating service members, and explore development of online TAP/DTAP briefings and training on Federal benefits and entitlements in

order to provide widest possible access to information and contacts for assistance.

3.1.5 Enhance collaboration between VA, DoD, Homeland Security, the Department of Labor and the individual states to ensure a comprehensive packet of information on federal benefits (including eligibility requirements) is provided to all VA and DoD beneficiaries.

i. Target Date: Implementation plan: October 2003 with annual reports thereafter.

3.2 Provide for a seamless transition from active duty to veteran status through a streamlined benefits delivery process.
The Benefits Executive Council shall:

3.2.1 Conduct an evaluation of the various components of the current BDD program, including an economic analysis, to determine effectiveness of, and recommendations for enhancing the program.

i. Target Date: October 2003
Suggested Performance Targets
(i) Incremental increase from 60% (current rate) to 90%
(ii) BDD program to account for 90% of CONUS separations by 2006.

3.2.2 Develop a physical examination protocol that is considered valid and acceptable for all Military Service separation requirements and acceptable for VA's disability compensation requirements.

a. Provide the JEC an evaluation of current practices, the results of pilot studies, and recommendations regarding broader implementation of a "one physical examination" protocol.
i. Target Date: January 2004
b. Assess and report on resource requirements for full implementation.
c. Target Date: March 2004
d. Develop an implementation plan to ensure separating service members undergo a single physical examination that meets service separation requirements and is acceptable for VA's disability compensation requirements.
i. Target Date: June 2004

3.2.3 Develop an online benefits application process that allows service members to submit applications directly to the appropriate federal agency. This tool should be available to members stationed in CONUS and OCONUS.

a. Application tool online
i. Target Date: October 2004
b. Market on-line application and monitor utilization

i. Target Date: FY 2004

c. 100% of online applications will have electronic eligibility verification
    i. Target Date: October 06

3.3 Provide for the seamless transfer of beneficiary data between VA and DoD to expedite all benefit and entitlement processes.

The Benefits Executive Council shall make recommendations to

3.3.1 Ensure the timely transfer of complete and accurate benefit eligibility information regardless of media
    i. Target Date: January 2004

3.3.2 Define data requirements for electronic transfer of standardized and validated VA benefit eligibility information target
    i. Target Date: January 2004

3.3.4 Define requirements for electronic availability of future Service Medical Records
    i. [Placeholder June 2004]

Goal 4 Integrated Information Sharing

Enable the efficient sharing of beneficiary data, medical records, and other information through secure and interoperable information management systems.

VA and DoD will develop an interoperable information technology framework and architecture that will enable the efficient, effective, and secure interchange of records and information to support the delivery of benefits and services. The emphasis will be on working together to reduce redundant applications and procedures and make access to services and benefits easier and faster.

4.1 DoD and VA will improve the interoperability of their enterprise architectures to support sharing of timely, consistent, health, personnel and business data.

The Health Executive Council and Benefits Executive Council shall:

4.1.1 Report on the status of current level of interoperability between VA and DoD information systems that support health, personnel and business operations

- i. Target Date: October2003.

4.1.2 Identify joint information needs and assess current availability of information.

- i. Target Date: October 2003

4.1.3 Develop Implementation plan to attain full interoperability with intermediate milestones, as appropriate

- i. Target Date:
  - a. Health: October 2003
  - b. Personnel: January 2004
  - c. Business: October 2004

4.1.4 Achieve full Interoperability

- i. Target Date:
  - a. Health: September 2005
  - b. Personnel: September 2008
  - c. Business: September 2008

4.2 Adopt common data standards to facilitate greater interoperability

The Health Executive Council shall

4.2.1 Adopt initial set of health data standards

- i. Target Date March 03 (completed)

4.2.2 Adopt additional health data standards and updates as available

- i. Ongoing

The Benefits Executive Council in coordination with the Health Executive Council, shall:

4.2.3 Assess current Military Personnel data standards in support of benefits and entitlement determinations; develop new standards as appropriate; and, implement/use standards.

i. Target Dates
   1. Assessment by October 2003
   2. Establishment of requirements of new standards Jan 2004
   3. Implementation by 2nd qtr 2007

The Health Executive Council and Benefits Executive Council shall:

4.2.4 Assess current Business data standards (financial, personnel, logistics) to facilitate interdepartmental business transactions.

i. Target Date: April 2004

4.3 Increase the effectiveness and efficiency with which separating and separated military member data is transferred from DoD to VA.

The Health Executive Council and Benefits Executive Council shall:

4.3.1 Enhance existing technical capability (Federal Health Information Exchange (FHIE)) to transfer separating military members health data from DoD to VA, while maintaining appropriate security

i. Target Date September 03

4.3.2 Demonstrate new technical capability (Clinical Data Repository (CDR)/Health Data Repository (HDR)) to exchange all appropriate health data between DoD and VA while maintaining appropriate security.

i. Target Date: September 05

4.3.3 Design, develop, and test enhancements to existing systems for exchanging separating military data to include creating an environment whereby individual personnel demographic data is shared between DOD's personnel systems and VA's Registration and Eligibility System.

i. Target Dates: October 05

4.4 Create an environment whereby personnel demographic data is shared between DoD and VA to support the delivery of services of both organizations

The Benefits Executive Council shall:

4.4.1 Create a single shared DoD/VA personnel data repository with a bi-directional electronic feed between VA and DEERS Data repositories

i. Target Date: September: 2004 (Prototype)

ii. Target Date: September, 2005 (full implementation)

4.4.2 Create necessary integration points so VA legacy systems are added and that appropriate technologies are in place to migrate to the DIMHRS integration points.

i. Target Date: System Requirement Definitions March 2004

4.5 Develop Plan to Share Information Needed by VA to Support the Claims Adjudication Process

The Benefits Executive Council shall

4.5.1 Establish an Information Sharing Task Force to develop a plan to automate the collection of supporting documentation process so that the necessary information is received in a timely and accurate manner. The plan shall address

a. What information is needed to process a claim
b. Where the information is located
c. How the information is stored

i. Target Date: Establish Task Force July 2003
ii. Target Date: Plan July 2004

4.5 **Develop and document the information technology infrastructure to support the Objectives listed above, to include telecommunications interconnections and security, which include individual identification for information access, such as Public Key Infrastructure (PKI) solutions.**

The Joint Executive Council shall:

4.5.2 Perform an assessment of VA and DoD technology infrastructures

i. Target Date: Complete assessment September 2003

4.5.3 Develop an implementation plan for VA and DoD to have in place an appropriate technology infrastructure to support the Objectives listed above.

i. Target Date: Implementation Plan complete: January 2004

Goal 5 Efficiency of Operations
Improve management of capital assets, procurement, logistics, financial transactions, and human resources.

VA and DoD will enhance the coordination and management of business processes and practices through improved coordination in the planning and managing capital assets; leveraging the Departments' purchasing power; maximizing the recovery of funds due for the provision of health care services; developing complementary workforce plans; and designing methods to enhance the coordination of other key business functions.

5.1 VA and DoD will improve coordination in planning and managing capital assets in order to enhance long-term partnering and achieve cost savings

5.1.1 The JEC will establish a Capital Coordination Process that will provide joint policy recommendations and monitoring of capital asset planning to ensure an integrated approach to capital coordination between VA and DoD, to include.

- a. Identifying high-priority sites that represent the best opportunities for potential VA/DoD partnerships in facility sharing.
  - i. Target Dates
    1. Process established: September 2003
    2. First Quarterly report to JEC: January 2004

5.2 VA and DoD will improve collaboration in the acquisition of commodities and services related to health care.
The Health Executive Council shall:

5.2.1 Conduct an assessment of VA and DoD processes related to the acquisition of goods and services and make recommendations to achieve joint operational and business efficiencies.

- i. Target Date: October 2003

5.2.2 Continue to enhance and implement acquisition and procurement processes to include converting all DoD Distribution and Pricing Agreements (DAPAs) to VA Federal Supply Schedule contracts (FSS)

- i. Target Date: DAPA Conversion-December 2004

5.2.3 Develop a plan to implement standard purchasing of medical/surgical supplies and high-tech equipment, dental, laboratory, x-ray, and prosthetics to leverage joint purchasing power.

- i. Target Date: January 2004

5.2.4 Establish a common electronic catalog for all items under contract
   i. Target Date: Plan to the JEC-October 2003
   ii. Target Date: Implementation TBD by the JEC

5.2.5 Provide input to the Joint Communications Plan (Goal 1.3.1) to improve communication and education promoting the use of joint acquisition and procurement programs.
   i. Target Date: July 2003

5.2.6 Evaluate the pilot project involving DoD's use of VA's Consolidated Mail Outpatient Pharmacy Program and make recommendations concerning potential expansion
   i. Target Date: July 2003

5.3 VA and DoD will collaborate to improve the efficiency and effectiveness of financial transactions between the two Departments
The Health Executive Council shall

5.3.1 Develop interfaces between the Departments' financial systems, in order to increase standardization and to improve the accuracy and timeliness of payments
   i. Target Date July 2004

5.3.2 Enhance collaboration efforts to share collection information in order to reduce duplicate payments and decrease staff time spent on debt management activities.
   i. Target Date: July 2004

5.4 VA and DoD will develop methods to facilitate recruitment, retention, and potential sharing of personnel in positions critical to the Departments' complementary missions.
The Health Executive Council and the Benefits Executive Council

5.4.1 Identify the mission-critical positions common to both Departments and the number of staff needed in each of these positions during the next 3 to 5 years.
   i. Target Date: Identify positions September 2003

5.4.2 Develop and implement human resource strategies to fill mission-critical positions in both Departments
   i. Target Date: January 2004 (plan)
   ii. Target Date: TBD by JEC (implementation)

Goal 6 Joint Contingency/Readiness Capabilities
Ensure the active participation of both agencies in support of the VA/DoD Contingency Plan and National Response Plan.

VA and DoD will enhance collaborative efforts in support of the VA/DoD Contingency Plan and the National Response Plan, to include the National Disaster Medical System (NDMS). This collaboration includes coordinating individual agency response plans and supporting local, state, regional, and national incident management systems. VA and DoD will also collaborate in the training and education of health care responders; and identify opportunities to provide medical readiness training and platforms for first responders and military medical personnel.

6.1 The Health Executive Council shall establish a Contingency Response Work Group to:

6.1.1 Oversee the Departments' collaborative efforts with respect to incident and consequence management.
   i. Target Date: July 2003 (establish workgroup)
   ii. Target Date: ongoing (oversight)

6.1.2 Support the development of the National Response Plan through participation in existing national/federal forums to include:
   a. Catalogue DoD/VA linkages in support of federal incident and consequence management planning
      i. Target Date: September 2003
   b. Provide recommendations regarding opportunities for joint actions in support of the National Response Plan
      i. Target Date: January 2004
   c. Collaborate with other Federal partners to enhance all components of the NDMS to reflect current and future requirements
      i. Target Date: Quarterly report October 2003

6.1.3 Review and update the VA/DOD Hospital Contingency Plan to reflect current and future requirements to include:
   a. Review current and future requirements for hospital-based care for casualties returning from a military deployment or for casualties generated as a result of a domestic homeland security incident.
   b. Assess utilization of TRICARE Network, as it would impact on requirement for VA support of DOD and of the NDMS system.
   c. Review current medical regulating processes.
   d. Integrate the Integrated CONUS Medical Operations Plan (ICMOP) into VA/DOD contingency planning, and VA/DOD contingency planning into NDMS planning for support of military casualties.

e. Review comprehensive VA involvement in care of selected DOD casualties that would not return to duty.
f. Review the portion of the NDMS that supports war- time casualties and its relationship with ICMOP, VA/DOD contingency planning and NDMS operations.
    i. Target Date: Initial Report January 2004
    ii. Target Date: Final Report TDB by JEC

6.1.4 Coordinate Departmental directives to implement DoD and VA responsibilities identified in the National Response Plan.
    i. Target Date: October 2003

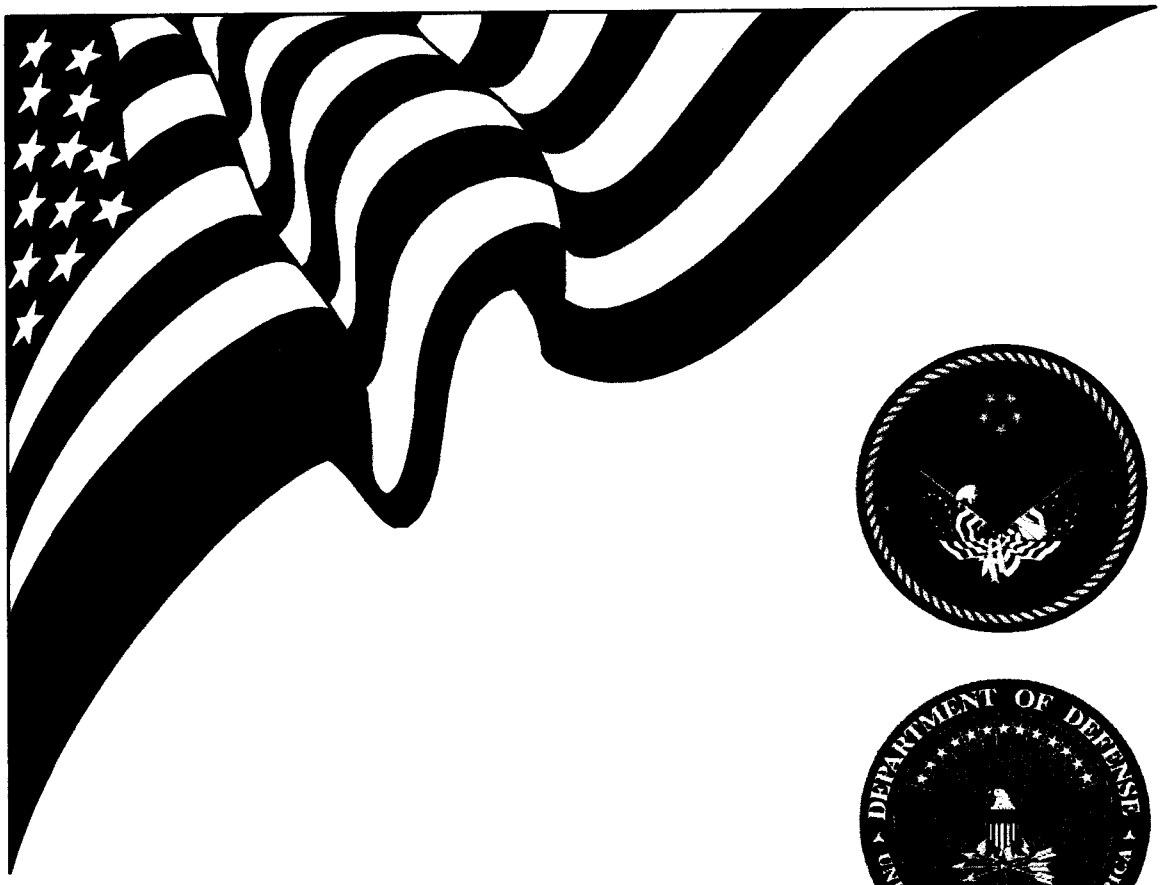
6.1.5 Provide semiannual reports to the Joint Executive Council on the status of joint initiatives in support of the National Response Plan.
    i. Target Date: Initial JEC Report October 2003.

6.2 Collaborate in the training and education for incident and consequence management.
The Health Executive Council shall:

6.2.1 Identify common training requirements and joint training opportunities for medical
personnel participating in incident and consequence management.
    i. Target Date: Status report to HEC October 2003
    ii. Target Date: Implementation Plan to HEC TBD

6.2.2 Develop clinical practice guidelines for incident and consequence management
    i. Target Date: Status Report to HEC October 2003

6.2.3 Develop continuing education programs and other information products (e.g.,
satellite broadcasts, pocket guides) to enhance incident and consequence management training and emergency preparedness for DoD/VA personnel involved in contingency response activities and provide an annual report for the HEC.
    i. Target Date: Report on joint training initiatives: January 2004



Department of Veterans Affairs
Department of Defense
Joint Strategic Plan
December 2004

Gordon H. Mansfield, Deputy Secretary
Department of Veterans Affairs

David S.C. Chu, Under Secretary of Defense (Personnel and Readiness)
Department of Defense

Department of Veterans Affairs/Department of Defense
Joint Strategic Plan Fiscal Year 2005

Mission:

To improve the quality, efficiency, and effectiveness of the delivery of benefits and services to veterans, service members, military retirees and their families through an enhanced Department of Veterans Affairs (VA) and Department of Defense (DoD) partnership.

Vision Statement:

A world-class partnership that delivers seamless, cost-effective, quality services for beneficiaries and value to our nation.

Guiding Principles:

- Collaboration – to achieve shared goals through mutual support of both our common and unique mission requirements
- Stewardship – to provide the best value for our beneficiaries and the taxpayer.
- Leadership – to establish clear policies and guidelines for VA/DoD partnership, promote active decision-making, and ensure accountability for results

Strategic Goals:

Goal 1 ~ Leadership Commitment and Accountability - Promote accountability, commitment, performance measurement, and enhanced internal and external communication through a joint leadership framework.

Goal 2 ~ High Quality Health Care - Improve the access, quality, effectiveness, and efficiency of health care for beneficiaries through collaborative activities.

Goal 3 ~ Seamless Coordination of Benefits - Promote the coordination of benefits to improve understanding of and access to benefits and services earned by service members and veterans through each stage of life, with a special focus on ensuring a smooth transition from active duty to veteran status.

Goal 4 ~ Integrated Information Sharing - Ensure that appropriate beneficiary and medical data is visible, accessible and understandable through secure and interoperable information management systems.

Goal 5 ~ Efficiency of Operations - Improve management of capital assets, procurement, logistics, financial transactions, and human resources.

Goal 6 ~ Joint Medical Contingency/Readiness Capabilities - Ensure the active participation of both agencies in Federal and local incident and consequence response through joint contingency planning, training, and exercising.

Goal 1 ~ Leadership Commitment and Accountability

Promote accountability, commitment, performance measurement, and enhanced internal and external communication through a joint leadership framework.

VA and DoD have established a leadership framework to provide the necessary support for a successful partnership, help to institutionalize change, maintain momentum, and sustain collaboration into the future. This framework consists of the Joint Executive Council (JEC), the Health Executive Council (HEC), the Benefits Executive Council (BEC), Joint Strategic Planning Committee (JSPC), Construction Planning Committee (CPC) and any other necessary sub councils or boards. Council membership is comprised of senior leaders of both departments. The JEC co-chairs oversee the implementation of the joint strategic plan to shape, focus, and prioritize the activities of the partnership, and ensure that clear and measurable performance targets are established. The JEC oversees the implementation of the strategic plan and is responsible and accountable for the development and implementation of a communication plan to increase the exchange of knowledge and information between agencies and to external stakeholders.

Objective 1.1 - Institutionalize the Department of Veterans Affairs /Department of Defense Executive Council governance structure via policy memorandums and the Joint Strategic Plan. The Joint Executive Council shall:

Strategies and Key Milestones:

- The joint councils and committees will produce joint policy memorandums to implement policy decisions made though the council structure and oversee implementation of approved policy initiatives.

- VA and DoD shall ensure dedicated staff is assigned to coordinate the Joint Strategic Plan for the JEC as required by Section 583 of P.L. 108-136.

- The JEC will oversee the implementation and annual update of the Joint Strategic Plan.
  - On an annual basis all councils and committees will review the Joint Strategic Plan and make recommendations for enhancement to the VA/DoD Joint Strategic Planning Committee (JSPC). The JSPC will ensure that specific joint strategic plan initiatives are aligned to (or reflected in) each Department's strategic plan.

- On a quarterly basis, the VA/DoD Health Executive Council, Benefits Executive Council and Construction Planning Committee will review all Joint Strategic Plan initiatives, new policy initiatives, and associated measures and report their status to the Joint Executive Council.

- Council and committee charters will be reviewed and recertified on an annual basis. Accountable Leaders should be specifically identified in the respective charter. Co-chairs of each council will ensure they have appropriate representatives on their charters

ensuring a broad representation from within the Departments (such as the military services).

- Provide an annual report to the VA and DoD Secretaries and to Congress, as required by Section 583 of P.L. 108-136. The annual report will include the specific activities prescribed by the legislation as well as the status of joint strategic plan initiatives and measures.

Performance Measures:

- Joint policy memorandums will be distributed to all appropriate offices within 30 days of approval. The councils will report the status of new and ongoing initiatives to the JEC on a quarterly basis.

- The Joint Strategic Plan will be reviewed and updated by the Joint Strategic Planning Committee (as necessary) and approved by the JEC by September 15th of each year
  - The Joint Executive Council will ensure a copy of this joint strategic plan is provided to 100% of relevant field operating organizations (Department of Veterans Affairs /Department of Defense medical treatment facilities, headquarters, and intermediate commands/offices).

- The Annual Report will be completed in December 2004 and annually thereafter.

Objective 1.2 – Improve internal and external communications to enhance VA/DoD collaboration. The Joint Executive Council shall:

Strategies and Key Milestones:

- Review the current VA/DoD Joint Strategic Planning Initiatives Communication Plan and make recommendations by April 2005.

- Develop a joint communication strategy by April 2005.
  - Promote VA/DoD collaborative initiatives within each Department.
  - Educate internal and external stakeholders about joint VA/DoD initiatives.
  - Provide periodic updates on accomplishments, new initiatives and other activities arising from VA/DoD collaboration.
  - Include a measure to determine effectiveness of communication strategy.

- Develop a joint calendar of significant events and opportunities for joint communication by December 2005. The calendar will include all VA/DoD Joint Council and Committee meetings.

- Establish a VA/DoD web page with hyperlinks on appropriate VA and DoD employee focused intranet sites (to include civilian human resources web pages) by June 2005 to provide easily accessible updates and other approved information on VA/DoD collaboration, including joint policies, procedures, programs, and new initiatives.

- Annually, each Department will include VA/DoD collaboration and sharing track at a minimum of one VA and one DoD national conference.

Performance Measures:

- Web page will be established and populated by June 2005.

- Communication effectiveness measure will be developed as part of the communication strategy by April 2005.

Goal 2 ~ High Quality Health Care

Improve the access, quality, effectiveness, and efficiency of health care for beneficiaries through collaborative activities.

VA and DoD will expand the use of partnering and sharing arrangements to improve support to all beneficiaries. Collaboration will continue on the development of joint guidelines and policies for the delivery of high quality care and assurance of patient safety. VA and DoD will engage in joint training in multiple disciplines including ancillary services and explore opportunities to enhance collaborative activities in Graduate Medical Education. Sharing in deployment related health care information, research and development, and care coordination will be aggressively supported and encouraged. For dual beneficiaries, VA and DoD will seek to ensure that similar services are available and that the two systems are mutually supportive.

Objective 2.1 - To be recognized as leaders in the development and delivery of innovative clinical processes and programs designed to enhance the quality of care delivered. The Health Executive Council shall:

Strategies and Key Milestones:

- Collaborate to promote and enhance patient safety.
  - Share best practices, new procedures, and guidelines relative to patient safety by March 2005.
  - Establish a permanent Joint Patient Safety Council by June 2005.
  - Make recommendations for increased collaboration and establish future objectives by December 2005.

- Facilitate the communication of clinical practice guidelines (CPGs) to the field and monitor their integration into the care delivery system on a periodic basis.
  - Charge and staff work groups through the Evidence-Based Practice Work Group to assure continued collaboration and implementation by April 2005.
  - Develop one new CPG and update/revise four (4) CPGs by November 2005.
  - Develop implementation tools, examine lessons learned and identify best practices by November 2006.
  - Ensure that developed CPGs are nationally recognized by the National Guideline Clearinghouse by November 2007.

Performance Measures:

- When the evidence based practice work group issues a clinical practice guideline, it will include recommendations for at least one performance measure as appropriate.

Objective 2.2 - Actively engage in joint training and education opportunities enhance quality, effectiveness and efficiency of healthcare. The Health Executive Council shall:

Strategies and Key Milestones:

- Explore and develop opportunities for shared and/or combined Graduate Medical Education and develop a pilot program consistent with the provisions of P.L. 107-314.
    - Define "Graduate Medical Education (GME) and training," identify needs, opportunities, and potential barriers to joint training by February 2005.
    - Publish and disseminate interim evaluation of lessons learned from the pilot by September 2005.
    - Evaluate outcomes and benefits of pilot program and other training programs by June 2006.
    - Utilize the findings of the pilot for the basis for the development of additional collaborative initiatives in joint /shared GME programs (FY 2007 and beyond).

- Explore and develop opportunities for shared and/or combined Continuing Education and Training programs to include Guard/Reserve health care professionals at VA and DoD facilities. Programs may include clinical practice rotations, web-based joint courses, and joint broadcasts to maintain and update critical skills necessary to providing care to combat causalities and other injuries/illnesses.
    - Establish strategic objectives for designing, developing and managing the operational procedures to facilitate increased sharing of education and training opportunities between agencies by March 2005.
    - Develop a process plan to increase joint training opportunities by June 2005.
    - Implement broadcast capability of continuing education opportunities between VA and DoD by September 2005.
    - Develop plan for clinical training opportunities (e.g., clinical rotations, CME/CEU's, etc.) for Reserve/Guard at VA and DoD facilities and coordination of activities for skill training and continuing education at VA and DoD facilities by December 2006.

Performance Measures:

- Continuing Education and Training Work Group will develop performance measures and targets that demonstrate achievement of outlined objectives by December 2006.

Objective 2.3 - The Health Executive Council shall identify and foster opportunities for sharing information and resources between VA and DoD in the areas of deployment health surveillance, assessment, follow-up care, health risk communication, and research and development. The Health Executive Council shall:

Strategies and Key Milestones:

- Develop and share narrative summaries on progress, describing specific initiatives accomplished and status of initiatives underway by March 2005.

- Provide recommendations for the update, revision, and modification of the VA/DoD Deployment Health strategic initiative, including long range plans, specific milestones, proposed performance measures and achievable timelines by July 2005.

- The updated plan should address at a minimum the following areas.
  - Pre-deployment health assessments (also see Goal 4, Objective 4.6).
  - Medical environmental and Chemical, Biological Radiological Nuclear and Explosives (CBRNE) surveillance during deployments.
  - Individual assignments and unit location during deployments.
  - Post-deployment health assessments (also see Goal 4, Objective 4.6) and clinical practice guideline data.
  - Post-deployment briefings on VA benefits and services, particularly for those who served in a combat zone.

- Explore and expand opportunities for increased collaboration on mental health issues related to military service.
  - Establish a formal VA/DoD work group to discuss mental health issues of mutual interest by February 2005.
  - Sponsor a VA/DoD Mental Health Conference by December 2005.

- Establish an interagency mechanism by June 2005 to address issues related to Military Sexual Trauma (MST) consistent with the Department of Defense (DoD) Care for Victims of Sexual Assault Summit recommendations of September 2004 and the Department of Veterans Affairs (VA) 2004 Advisory Committee on Women Veterans Report Recommendation Number 58.

- Explore and actively seek out opportunities for shared and collaborative research initiatives and establish criteria to explore military and veteran related health research to include deployment health issues.
  - Inventory and catalog current collaborative research by July 2005.
  - Establish a baseline to measure collaborative efforts by December 2005.
  - Identify and report opportunities for collaborative research and avoidance of duplicative efforts by July 2006.
  - Identify potential sources for non-federal research funding in support of military and veteran related health research including deployment health issues and develop plan to increase non-federal funding by January 2007.
  - Establish a VA/DoD forum for sharing best practices in health research by June 2007.

Performance Measures:

- Increase the number of collaborative research projects completed by VA and DoD by December 2007.

Objective 2.4 - Develop and implement a plan to improve joint protocols and follow-up procedures to provide world-class health care to injured or ill service members and veterans, particularly members of the Reserve and National Guard. The Health Executive Council shall:

Strategies and Key Milestones:

- Develop and implement a plan to strengthen the existing bridges between Military Treatment Facilities (MTFs) and Veterans Affairs Medical Centers (VAMCs) to facilitate the transition of care for service members who require long-term medical care and rehabilitation; expand existing partnerships that build upon each other's strengths (for example, Walter Reed Army Medical Center and Washington DC VAMC, Madigan Army Medical Center and Seattle VAMC, and Great Lakes Naval Hospital and North Chicago VAMC) by December 2005.

- Develop and implement a plan to improve health care for members of the Reserve/National Guard who are separating from active-duty; the highest priority would be to identify members who are severely injured and ill and who need seamless continuity of care between VA and DoD by December 2005.

- Facilitate more rapid dissemination of best practices to VA and DoD health care providers related to long-term care and rehabilitation of chronic conditions (for example, best practices based on programs of the VA Centers of Excellence, in PTSD treatment, alcohol rehabilitation, spinal cord injuries, and prosthetics for amputations) by September 2005.

Performance Measures:

- Performance measures and objective milestones will be developed by December 2005.

Goal 3 ~ Seamless Coordination of Benefits

Promote the coordination of benefits to improve understanding of and access to benefits and services earned by service members and veterans through each stage of life, with a special focus on ensuring a smooth transition from active duty to veteran status.

VA and DoD will enhance collaborative efforts to improve access to benefits; streamline application processes eliminate duplicative requirements and correct other business practices that complicate the transition from active duty to veteran status. This will be accomplished through joint initiatives that: ensure wide dissemination of information on the array of benefits and services available to both VA and DoD beneficiaries; enhance educational programming on eligibility criteria and application requirements, increase sites providing Benefits Delivery at Discharge (BDD), improve the physical examination and claim process; and develop interoperable information management systems necessary for the administration and management of beneficiary claims.

This goal includes all benefits available to VA and DoD beneficiaries, including healthcare, educational assistance, home loans, disability compensation, pension, insurance, burial, and memorial services.

Objective 3.1 - Enhance collaborative efforts to educate active duty, Reserve, and National Guard personnel on VA and DoD benefits programs, eligibility criteria and application processes. The Benefits Executive Council shall:

Strategies and Key Milestones:

- Develop and implement a plan to ensure wide dissemination of information on benefits and services available to VA and DoD beneficiaries during the military personnel lifecycle with emphasis at accession.

- Implement accession plan by November 2004.
  - Enhance plan to include wide dissemination of information to military academies by January 2005.
  - Develop a plan to expand marketing of VA services to military members by March 2005.

- Provide comparable communication to reserve/guard components during recruiting process by March 2005.

- Promote participation in Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) briefings [for all separating service members qualified by law,] and develop online TAP/DTAP briefings and training modules on Federal benefits and entitlements in order to provide widest possible access to information and contacts for assistance.
  - Provide VA Benefits Briefings and DTAP to all overseas locations where DoD provides transition assistance by October 2005 (contingent upon funding approval).

- Expand TAP/DTAP participant satisfaction evaluation by August 2005.
- Complete full online TAP/DTAP website by October 2005.
- Seek active collaboration between VA, DOD, Homeland Security, and the Department of Labor to ensure a comprehensive packet of information on federal benefits (including eligibility requirements) is provided to all VA and potential beneficiaries by February 2005.

Performance Measures:

- Increase the percent of separating/retiring veterans who participate in benefits briefing prior to discharge - target 85 percent.

- Increase the number of veterans by 30% who report they understand their VA benefits, as measured through VA's periodic National Survey of Veterans.

Objective 3.2 - Provide for a seamless transition from active duty to veteran status through a streamlined benefits delivery process. The Benefits Executive Council shall:

Strategies and Key Milestones:

- Deploy a cooperative physical examination process that is considered valid and acceptable for all Military Service separation requirements and acceptable for VA's disability compensation and pension requirements.

- Develop an implementation plan to ensure separating service members undergo a cooperative evaluation process that meets service separation requirements and is acceptable for VA's disability compensation requirements by March 2005.

- Develop a strategy to incorporate initiatives on tuition assistance programs, vocational rehabilitation, employment assistance and loan guarantee program for eligible service members and veterans.

Performance Measures:

- BDD implementation guidelines issued by March 2005.

- Number of BDD sites to use a cooperative physical examination process will be increased from 28 to a total of 139.

- Percent of original claims filed within the first year of release from active duty filed at a BDD site prior to a service member's discharge – baseline 51 Percent – target 75 percent by FY 2011.

FY 2005 Goal	FY 2006 Goal	FY 2007 Goal	FY 2008 Goal	FY 2009 Goal	FY 2010 Goal	FY 2011 Goal	Target
	53%	57%	61%	66%	71%	75%	75%

Goal 4 ~ Integrated Information Sharing

Ensure that appropriate beneficiary and medical data is visible, accessible and understandable through secure and interoperable information management systems.

DoD and VA will develop interoperable enterprise architectures and data management strategies that will enable the efficient, effective, and secure interchange of records and information to support the delivery of benefits and services. The emphasis will be on working together to store, administrate, and share data and harmonize applications and procedures to make access to services and benefits easier and faster.

Objective 4.1 – VA and DoD will evolve their enterprise architectures to support sharing of timely, consistent personnel-related data. The Benefits Executive Council shall:

Strategies and Key Milestones:

- Create interagency plan to enhance interoperability of beneficiary data and delivery of benefits.
    - Provide VA data requirements to Defense Manpower Data Center (DMDC) by January 2005.
    - Develop VA interim Defense Integrated Military Human Resource System (DIMHRS) solution (pre-RE/CM) by February 2005.
    - Develop VA permanent DIMHRS solution (w/RE/CM) by February 2005.
    - DMDC provide a schema and stat dictionary to VA by June 2005.
    - Deploy VA interim DIMHRS solution by December 2005.
    - Deploy VA permanent DIMHRS solution by December 2005.
    - Modify VA legacy applications by December 2006.

- Propose recommendations and options for establishment of a consolidated data sharing or exchange architecture strategy where DoD and VA can jointly post and replenish standardized data to a federated warehouse or virtual repository.

Performance Measures:

- Benefits data is visible, accessible, and understandable in accordance with law, policy, and security requirements.

Objective 4.2 – Increase the effectiveness and efficiency with which separating and separated military member personnel related data is accessible to VA. The Benefits Executive Council shall:

Strategies and Key Milestones:

- Enhance Veterans Benefit Administration (VBA) access to the existing technical capability (Federal Health Information Exchange (FHIE)) to transfer separating military member's health data from DoD to VA, while maintaining appropriate security.
    - Test enhanced Compensation and Pension Record Interchange (CAPRI) access to FHIE data by 3rd Quarter 2004.
    - National release of enhanced CAPRI access to FHIE data.

Performance Measures:

- Military personnel data is visible, accessible, and understandable in accordance with law, policy, and security requirements.

Objective 4.3 – Create an environment whereby personnel demographic data is shared between DoD and VA to support the delivery of services of both organizations. The Benefits Executive Council shall:

Strategies and Key Milestones:

- Continue interagency collaboration on the exchange of information and data between VA and DoD.
  - Complete interface between Air Force imaged records repository and Defense Personnel Records Image Retrieval System (DPRIS) by June 2005.
  - Convert future DoD personnel records management systems from paper/image-based to data-centric by 2008.
  - Develop VA corporate database containing personnel and service medical data that is updated by DoD daily by 2008.
  - Develop VA systems that automate eligibility determinations and award processing by 2012.
  - Establish an Information Sharing Task Force to develop a plan to carry out the interagency action items on information exchange and interoperability to facilitate timely transfer of accurate benefit eligibility information.

- Charter for IS/IT Working Group approved and signed and updated annually to meet strategic goals and objectives for information sharing.
  - Obtain imaged personnel records from the Air Force beginning September 2005.
  - Resurrect the Veterans Information System (VIS) and begin using it as a repository for data from Defense Enrollment Eligibility Reporting System (DEERS), Defense Finance and Accounting Service (DFAS), Defense Retired/Annuitant Pay System (DRAS), and DIMHRS.
  - Develop a VA corporate database containing personnel and service medical data that is updated daily by DoD.
  - Develop VA systems that automate eligibility determinations and award processing by pulling data from the corporate database.
  - Develop and propose a common data warehouse/data exchange repository for implementation by architecture stakeholders at VA and DoD.

- Create a strategy for sharing data between VA legacy systems and DIMHRS.
  - Establish method of accessing DIMHRS data by October 2004.
  - Develop interfaces with DIMHRS data by November 2004.
  - DoD/VBA Implementation Plan by March 2005.

- Enable VBA legacy systems to share DIMHRS.

Performance Measures:

- VA Personnel Information Exchange System (PIES) System will be able to request military personnel information from all four of the Military Services via the DPRIS portal.

- DIMHRS will be fully operational and providing VA benefit eligibility information by December 2008

- VA will have secure access to accurate benefit eligibility information regardless of media.

Objective 4.4 – VA and DoD will evolve their health enterprise architectures to support sharing of timely, consistent health data. The Health Executive Council shall:

Strategies and Key Milestones:

- Build on the efforts of the Federal Health Architecture (FHA) initiative to enhance sharing of health information.
  - Identify joint information needs by February 2006.
  - Assess current availability of information by February 2006.
  - Build an interagency architecture and joint DoD/VA data strategy for health data by February 2007.
  - Improve coordination and collaboration on government Health IT solutions and investments by February 2008.

- Ensure that future health interagency initiatives are in compliance with the DoD/VA targeted architecture.
  - Reach agreement on an interagency compliance review process by August 2005.
  - Implementation of an interagency compliance process by September 2005.

Performance Measures:

- Percentage of DoD/VA projects/initiatives reviewed for compliance with interagency architecture and joint DoD/VA Technical Standards Profile.

FY 2006 1st Qtr	FY 2006 2nd Qtr	FY 2006 3rd Qtr	FY 2006 4th Qtr	FY 2007 1st Qtr	FY 2007 2nd Qtr
5%	15%	40%	65%	95%	100%

Objective 4.5 – Adopt common standards to facilitate greater health systems interoperability. The Health Executive Council shall:

Strategies and Key Milestones:

- Build on the Consolidated Health Informatics (CHI) success through development of high level standards implementation guidelines and identification of potential standards for additional domains.
    - Identify two domains for interagency standards work and begin work by December 2004.
    - Begin work on one implementation guideline for a CHI adopted standard (e.g. Health Level Seven (HL7), Systematized Nomenclature of Medicine Clinical Terms (SNOMED), etc.) by December 2004.
    - Identify one additional domain for interagency standards work and begin work (e.g. Dental, Mental Health, etc.) by March 2006.
    - Identify one additional domain for interagency standards work and begin work by June 2005.
    - Begin work on an additional high level implementation guideline for a CHI adopted standard by June 2005.
    - Recommend CHI high level implementation guidelines for two CHI standards by September 2005.
    - Recommend CHI standards for adoption for two domains by September 2005.

Performance Measures:

- Standards to enhance interoperability.
    - Develop implementation guidelines for those appropriate and useful Consolidated Health Informatics Standards adopted by VA and DoD.

FY 2005 Goal	FY 2006 Goal	FY 2007 Goal	FY 2008 Goal	FY 2009 Goal	FY 2010 Goal	FY 2011 Goal	Target
1 of 9 Targeted	2 of 9 Targeted	3 of 9 Targeted	4 of 9 Targeted	5 of 9 Targeted	7 of 9 Targeted	8 of 9 Targeted	9 Targeted

Objective 4.6 – Enhance the effectiveness and efficiency with which separating and separated military member electronic health data is accessible to VA. The Health Executive Council shall:

Strategies and Key Milestones:

- Support efforts to continue the accessibility of electronic health information to VA at the point of a Service member's separation, while maintaining appropriate security.
    - Continue to send monthly updates. Ongoing
    - Continue to monitor usage. Ongoing

- Support the sharing of healthcare data from VA's VistA and DoD's CHCS bidirectionally, and in real time.
    - Initial operating capability at test site by November 2004.

- Enhanced operating capability to include bidirectional availability of radiology and laboratory results, admissions and disposition data at test site by 2nd Qtr FY 2005.

- Support bidirectional data sharing (outpatient pharmacy data, laboratory results, allergy information and demographic data) between the Clinical Data Repository (CDR) of DoD's Composite Health Care System II and the Health Data Repository (HDR) of VA's HealtheVet-VistA
  - CHDR Pharmacy Prototype by October 2004.
  - Begin operational use by October 2005.

- Support electronic transfer to VA of pre and post deployment health assessments on separated service members available from the Defense Medical Surveillance System Office.
  - Development of the Technical Capability by March 2005.
  - Begin sharing electronic pre/post deployment health assessments by April 2005.

- Support bidirectional electronic transfer/sharing of laboratory order entry and results retrieval between VA, DoD, and commercial reference laboratories.
  - Begin testing/demonstrating capability at no less than two NDAA Demonstration Sites (El Paso, San Antonio) by December 2004.
  - Expand the capability at no less than three other sites (for which the business case exists) by October 2005.
  - Continue expanding and recommending refinements.

Performance Measures:

- Amount of electronic health data available to the other Department is higher each quarter reported

Goal 5 ~ Efficiency of Operations

Improve management of capital assets, procurement, logistics, financial transactions, and human resources.

VA and DoD will enhance the coordination and management of business processes and practices through improved coordination in planning and managing capital assets; leveraging the Departments' purchasing power; maximizing the recovery of funds due for the provision of health care services; developing complementary workforce plans; and designing methods to enhance the coordination of other key business functions.

Objective 5.1 – The VA/DOD Construction Planning Committee (CPC) will identify areas for collaborative construction and pilot a "core group" process to develop a collaborative opportunity through formulation. The Construction Planning Committee shall:

Strategies and Key Milestones:

- Establish permanent members of a "core group" (CG) to identify opportunities ripe for near-term (FY 2006) and out-year collaboration (FY 2007-2010).
  - List of near-term potential sites identified and necessary adjustments to budget submissions made by December 2004.
  - List of out-year collaborations identified by March 2005.

- The CPC CG will assess and identify collaborative opportunities for joint construction activity on the 2007-2010 timeframe. This list will be identified 3 months after the Base Realignment and Closure (BRAC) is released (expected in Spring 2005) and compared with the VA updated 5-year capital plan and Capital Asset Realignment for Enhanced Services (CARES) initiatives.
  - Identify 2007-2010 collaborative opportunities 3 months after BRAC is released.

- The CPC will identify up to 3 sites from this list of potential collaborations for further development. This effort will incorporate additional team members for each site from the local/regional levels of each organization into the CG.
  - Identify these 3 opportunities and designate teams by September 1, 2005.
  - Present concept plan for these projects by October 15, 2005, in order to designate planning funds in 2007 budget request.

Performance Measures:

- Report status to JEC quarterly

Objective 5.2 – Improve collaboration in the acquisition of commodities and services related to health care. Develop a plan to implement standard purchasing of medical/surgical supplies and high-tech equipment, dental, laboratory, x-ray, and prosthetics to leverage joint purchasing power. The Health Executive Council shall:

Strategies and Key Milestones:

- Conduct an assessment of VA and DoD processes related to the acquisition of goods and services and make recommendations to achieve joint operational and business efficiencies.
  - Review VA and DoD Materiel Management processes on a semi-annual basis by April 2005.
  - Identify specific functional areas with potential for joint efficiencies and develop recommendations for increasing joint acquisition by July 2005.
  - Inventory equipment, vendors and currents costs.

- Work with industry on a uniform identification code for medical surgical products. Report status to the HEC through the Materiel Management Work Group.
  - Strive for consensus between industry and federal partners on standard format for naming/labeling through presentations and attendance at national conferences.
  - Track number of active partners and actual assignment of uniform identification codes by manufacturers to medical/surgical product line.
  - Update federal catalogs as standardization occurs and data becomes available.

- Increase the number of joint contracts. Provide update to HEC on biannual basis by April/October of each FY.
  - Target commonly used manufacturers for joint contract initiatives.
  - Continue to seek new opportunities for joint contracts as current contracts expire.
  - Alternate award of joint contracts between the Departments.
  - Track use of contracts and estimated savings.
  - Issue joint solicitation for imaging contracts.

Performance Measures:

- Joint acquisition sales realized from the joint procurement of high cost medical equipment will increase by $10 Million annually, beyond the 2005 baseline level of $140M.

FY 2005 Goal	FY 2006 Goal	FY 2007 Goal	FY 2008 Goal	FY 2009 Goal	FY 2010 Goal	FY 2011 Goal	Target
$140M	$150M	$160M	$170M	$180M	$190M	$200M	**$200M**

Objective 5.3 – Establish a common electronic catalog for all items under contract by both Departments. The Health Executive Council shall:

Strategies and Key Milestones:

- Ensure appropriate personnel are familiar with and utilize the Defense Supply Center Philadelphia (DSCP) Medical Electronic Customer Assistance (MECA). (Application developed to allow users to perform product and pricing comparisons of Medical/Surgical and Pharmaceutical items) by October 2005.

- Establish a joint DSCP/VA Federal Supply Schedule (FSS) Medical Catalog that will allow both DoD and VA customers to perform product and price comparisons for Medical Surgical, Medical Equipment and Pharmaceutical Items Report status to the HEC through the Materiel Management Work Group.

- Create a single data base that includes all VA FSS as well as VA and DoD national contract information. Report status to the HEC through the Materiel Management Work Group.

- Expand access to catalog (and joint purchasing) to other government agencies (CDC, HHS, and IHS).

Performance Measures:

- Add VA drug pricing and identification data to existing DoD database using standardized format (i.e., National Drug Code (NDC) number, nomenclature, unit of issue, price, manufacturer. etc) by October 2004.
    - Prototype new capability by October 2004.

- Expand the existing database to include all VA FSS Medical/Surgical data items (October 2004 – October 2005).
    - Prototype new capability by October 2005.
    - Test new capability from October to December 2005.
    - Implement new capability by December 2006.
    - Supply line Classification Process by May 2007.
    - Identify and prioritize additional functionality by June 2007 and report status to HEC quarterly.

Objective 5.4 –VA and DoD will collaborate to improve business practices related to financial operations. The Health Executive Council shall:

Strategies and Key Milestones:

- Increase collaboration on core elements of the revenue process such as insurance identification, billing processes (including electronic billing) and coding.
    - Improve Third Party Billing – Increase collaboration on core elements of the revenue process such as insurance identification, billing processes (including electronic billing) and coding.
        - Identify areas of possible collaboration by July 2005.
        - Initiate Joint Incentive Fund project concerning insurance identification. The Federal-Shared Third Party Obligation Program (F-STOP) will enhance the repositories of patient insurance information for both Departments and promote maximum collections for medical care by December 2005.

- Develop guidance for VA-DoD standardized inpatient billing rates for direct sharing agreements.
    - Publish interim guidance on standardized inpatient billing rates by March 2005.

- Publish final guidance on standardized inpatient billing rates by December 2005.

- Refine Business Case Analysis format and process to be used for the Joint Incentive Fund and other future initiatives.
  - Select or develop a Business Case Analysis format acceptable to both Departments for joint initiatives.
  - Publish guidance by March 2005.
  - Implement standard business case analysis process for joint initiatives.

- VA and DoD will jointly implement the FY 2003 NDAA Demonstration Projects in budget and financial management, coordinated staffing and assignment, and medical information and information technology management.
  - Implement demonstration projects by October 2004.
  - Conduct annual progress reviews.
  - Develop lessons learned.
  - Incorporate and apply lessons learned in joint business activities.

Performance Measures:

- Return on Investment for Federal –Shared Third Party Obligation Program (F-STOP).

FY 2005 Goal	FY 2006 Goal	FY 2007 Goal	FY 2008 Goal	FY 2009 Goal	FY 2010 Goal	FY 2011 Goal	Target
none	TBD	TBD	TBD	TBD	TBD	TBD	**TBD**

Goal 6 - Joint Contingency / Readiness Capabilities

Joint Medical Contingency/Readiness Capabilities - Ensure the active participation of both agencies in Federal and local incident and consequence response through joint contingency planning, training, and exercising.

VA and DoD will collaborate to ensure that plans and readiness capabilities adequately support DoD combatant command contingency requirements and National emergency situations.

- Joint planning to ensure VA support of DoD contingency requirements.
- Collaborative programming, training and exercise activities that enhance joint contingency plans and improve joint readiness capabilities.
- Joint VA and DoD planning that considers the impact of domestic contingency plans on VA and DoD capabilities.

Objective 6.1 - Ensure that joint contingency and scenario planning supports DoD requirements. The Health Executive Council shall:

Strategies and Key Milestones:

- In accordance with 38 U.S.C. 8111A, develop departmental plans to support the revised VA - DoD Memorandum of Understanding and Contingency Plan. VA will participate in DoD contingency and scenario planning activities to better understand potential resource requirements.

- Establish and implement a process to ensure that VA capabilities and capacities are considered in DoD contingency operations plans and VA - DoD Contingency Plan updates. Initial process to be established by March 2005. Ensure that the process considers VA capabilities to support DoD as expressed under Goal 2 High Quality Health Care.

Performance Measures:

- Participate in four (4) joint contingency and scenario planning activities per year.

Objective 6.2 - Collaborate in programming, training, and exercise activities that enhance plans and readiness capabilities. The Health Executive Council shall:

Strategies and Key Milestones:

- In accordance with 38 U.S.C., Section 8111A and to address the requirements of the National Response Plan, VA and DoD will collaborate on planning and programming of VA resources to maintain a contingency capacity to support DoD in time of war and/or national emergency situations.

- Identify common training requirements and joint training opportunities for personnel involved in DoD contingency and/or national emergency operations – completed yearly by end of 1st Quarter.

- Identify common exercise requirements and opportunities for VA and DoD personnel involved in DoD contingency and/or national emergency operations – completed annually by end of 1st Quarter.

- Develop continuing education programs and other information products (e.g. satellite broadcasts, pocket guides) to enhance training and emergency preparedness for DoD and VA personnel involved in contingency and/or national emergency operations – meet jointly to review and develop, 2nd Quarter annually.

Performance Measures:

- Participate in two (2) joint contingency operations (actual or exercise) per year.

Objective 6.3 - Consider the impact of domestic contingency plans on joint VA and DoD Military contingency plans, capabilities, and capacities. The Health Executive Council shall:

Strategies and Key Milestones:

- Continuously review those Federal plans and VA/DoD activities that address domestic preparedness issues – meet semi-annually to conduct a joint review.

Performance Measures:

- Meet and report twice per year on the review of those Federal plans and VA/DoD activities that address domestic preparedness issues.

The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans May 2001 – May 2003

Department of Veterans Affairs/Department of Defense Response to the Final Recommendations

Recommendation 1.1: *The interagency leadership committee should, on an annual basis, report to the Secretaries on the status of implementing its collaboration and sharing initiatives and the recommendations in this Final Report, together with any other matters that the committee deems appropriate. Within 60 days of receipt, the Secretaries shall transmit the report, together with any related comments, to the President.*

Response: Goal 1, (Leadership, Commitment and Accountability), Objective 1.2, of the Department of Veterans Affairs (VA) and Department of Defense (DoD) Joint Strategic Plan (JSP) requires the Joint Executive Council (JEC) to provide the Secretaries an annual report on the progress and achievements related to the JSP. P.L. 108-136 requires the JEC provide an annual report to the Secretaries of both Departments and the Congress with recommendations on the strategic direction for the joint coordination and sharing efforts between the two Departments. The JEC has included a separate section addressing the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) recommendations in this appendix of the JEC's first annual report (Appendix C).

Recommendation 2.1: *Congress should amend FY 2003 National Defense Authorization Act to create a broader charter beyond health care for the interagency leadership committee. Additionally, consideration should be given to using civilian experts as consultants to the committee to bring in new perspectives regarding collaboration and sharing.*

Response: The Administration recommended to the 108th Congress a legislative proposal to broaden the scope of the Joint Executive Council beyond health care. This recommendation was incorporated into Section 583 of P. L. 108-136 (National Defense Authorization Act of 2004. The Health Executive Council (HEC), with approval of the JEC, is using civilian consultants to support the demonstrations mandated under Section 722 of the FY 2003 National Defense Authorization Act. Additionally, both Departments use civilian experts as consultants on individual projects and this information is incorporated into JEC briefings as appropriate.

Recommendation 2.2: *The Departments should consistently utilize a joint strategic planning and budgeting process for collaboration and sharing to institutionalize the development of joint objectives, strategies, and best practices, along with accountability for outcomes.*

Response: The JEC approved the first VA/DoD Joint Strategic Plan on April 15, 2003. The plan included specific milestones and target dates for accomplishing enhanced collaboration between the departments. The accomplishments associated with that plan are documented in this report. The plan has been updated for Fiscal Year (FY) 2005. The JSP will be reviewed on an annual basis and updated as necessary to reflect changing practices, needs and mission. A copy of the FY 2005 plan can be found in Appendix B.

Recommendation 2.3: *The Departments should jointly develop metrics (with indicated accountability) that measure health care outcomes related to access, quality, and cost as well as progress toward objectives for collaboration, sharing and desired outcomes. In the annual report prescribed in Recommendation 1.1, the interagency leadership committee should include these results and discuss the coming year's goals.*

Response: The VA/DoD JSP includes metrics, target dates and accountability; the plan also requires the JEC to provide an annual report addressing the status of the plan's objectives, including revisions and additions. This process, combined with the OMB quarterly review of VA/DoD coordination initiatives under the President's Management Agenda, provides suitable venues for addressing the goals for the coming year.

Recommendation 3.1: *VA and DoD should develop and deploy by fiscal year 2005 electronic medical records that are interoperable, bi-directional, and standards-based.*

Response: Goal 4 (Integrated Information Sharing), Objective 4.3, of the JSP set FY 2005 as the target date by which DoD and VA will be able to exchange appropriate health data while maintaining appropriate security . The following is an update on the current status of several of the VA/DoD interoperability projects:

The Federal Health Information Exchange (FHIE): The initial VA/DoD effort at sharing appropriate clinical health data electronically. The transfer of data on Service members at the point of separation is a one time (per beneficiary) transfer from the current DoD Composite Health Care System (CHCS) to the current VA Veterans Health Information System & Technology Architecture (VistA) for use by VA providers and benefits claims specialists. The FHIE data repository contains historical clinical health data from 1989 to the present that significantly contributes to the continuity of care of separated Service members as they transition to veteran status. The FHIE data repository continues to grow as health information on additional Service members who have separated from military service is added each month.

DoD has transmitted over 95 million messages on 2.3 million unique patients containing information on laboratory results (clinical chemistry, blood bank information, microbiology, surgical pathology, and cytology); radiology results; outpatient pharmacy data from military treatment facilities, retail network pharmacies, and DoD mail order pharmacy; allergy information; discharge summaries (inpatient history, diagnosis, and procedures); admission, disposition, and transfer information (admission and discharge dates); consult reports (referring physician and physical findings); standard ambulatory data record (diagnosis and procedure codes, treatment provided, encounter date and

time, and clinical services); and patient demographic information (name, social security number, date of birth, sex, race, religion, patient category, marital status, primary language, and address). This number continues to grow as health information on recently separated Service members is extracted and transferred to VA monthly.

VA providers across the enterprise have access to data on separated Service members. The FHIE data repository contains historical clinical health data from 1989 to the present that significantly contributes to the delivery and continuity of care and adjudication of disability claims of separated Service members as they transition to veteran status.

Bidirectional Health Information Exchange (BHIE) (formerly known as CHCS/VistA Data Sharing Interface (DSI)): BHIE builds on FHIE and reuses a significant number of its products. BHIE sharing is also based on the current VA/DoD systems, CHCS and VistA; however, BHIE will provide for the bidirectional, real-time exchange of clinical health care data between the 2 systems. The focus of this interface is exchanging data on shared VA/DoD patients such as at joint venture sites and to support other local sharing agreements. The initial data shared will be patient demographic data (name, patient category, social security number, gender, and date of birth), VA and DoD outpatient pharmacy data (Military Treatment Facility data for all shared beneficiaries, DoD mail order pharmacy and retail pharmacy network for separated service members, and VA pharmacy data), and allergy information. Additional data elements that will be added are: DoD mail order pharmacy and retail pharmacy network data for other shared beneficiaries, laboratory results (surgical pathology reports, cytology, microbiology, chemistry, hematology, and lab orders data), and radiology results. Data will be shared in a manner that supports information assurance and privacy regulations.

To provide a more robust bidirectional real-time exchange of clinical health care data in the future, VA and DoD are working on interoperability between the DoD Clinical Data Repository (CDR) and the VA Health Data Repository (HDR)–(CHDR) utilizing the Departments' next generation of systems, DoD CHCS II and VA HealtheVet VistA. The initial interface between DoD's CDR and VA's HDR is the pharmacy prototype.

The Departments' technical and functional teams successfully completed a demonstration of the bidirectional pharmacy prototype in a lab environment on September 1, 2004. The data exchanged through the pharmacy prototype includes patient demographic data (sufficient to correlate patients), provider demographic data (sufficient to identify the ordering provider), medication lists, and allergy lists from one agency repository to the other. The prototype also provides the capability for agency drug to drug interaction screening (based on the integrated VA/DoD medication list) and local (intra-agency) database drug to drug allergy interaction screening (based on the integrated VA/DoD allergy list). Future development will include the exchange of patient demographics, outpatient pharmacy (Military Treatment Facility, DoD mail order, and retail pharmacy network data), laboratory, and allergy information by October 2005.

Recommendation 3.2: *The Administration should direct HHS to declare the two Departments to be a single health care system for purposes of implementing HIPAA regulations.*

Response: The Department of Veterans Affairs and Department of Defense believe that the HIPAA legislation has provided sufficient authority and provision for VA and DoD to share protected health information (PHI). The statute permits sharing of PHI when it is required for treatment purposes, allows sharing of PHI when disclosure is required by law, and allows Government agencies to share PHI when serving the same or similar populations as long as both agencies are covered entities under HIPAA. In addition, specific regulatory language in 164.512(k)1 also provides DoD with authority to share protected health information on an individual who is a member of the armed forces upon separation or discharge of the individual from military service for the purpose of a determination by VA of the individual's eligibility for or entitlement to benefits under laws administered by the Secretary of Veterans Affairs.

Recommendation 3.3: *The Departments should implement by fiscal year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process. Upon separation, DoD should transmit an electronic DD214 (includes dates of service, type of discharge, foreign service, medals received, and other personnel data) to VA.*

Response: Implementation of a cooperative physical examination process is addressed in Goal 3 of the FY 2005 VA/DoD Joint Strategic Plan (Objective 3.2). The electronic transmittal of DoD personnel data is addressed in Goal 4 (Objectives 4.1-4.3).

Recommendation 3.4: *VA and DoD should expand the one-stop shopping process to facilitate a more effective seamless transition to veteran status. This process should provide, at a minimum: 1) a standard discharge examination suitable to document conditions that might indicate a compensable condition; 2) full outreach; 3) claimant counseling; and 4) when appropriate, referral for a Compensation and Pension examination and follow-up claims adjudication and rating.*

Response: Goal 3 of the JSP incorporates all elements of this recommendation in its strategic objectives.

Recommendation 3.5: *VA and DOD should expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces; and to conduct epidemiological studies to understand the consequences of such events.*

Response: The VA/DoD Health Executive Council has established a Deployment Health Work Group, which is addressing these issues as reflected in Goal 2 (Objective 2.3), of the FY 2005 JSP. DoD is also establishing an office to be the one point of entry for all VA data requests, including stressor and Chemical, Biological Radiological and Nuclear (CBNR) exposure information. A HEC Work Group focusing on mental health

and deployment will be formed in FY 2005.

Recommendation 3.6: *By fiscal year 2004, VA and DOD should initiate a process for routine sharing of each service member's assignment history, location, occupational exposure, and injuries information.*

Response: Goal 4 of the FY 2005 JSP includes objectives designed to accomplish this recommendation.

Recommendation 3.7: *The Departments should: 1) add an ex officio member from VA to the Armed Forces Epidemiological Board and to the DOD Safety and Occupational Health Committee; 2) implement continuous health surveillance and research programs to identify the long-term health consequences of military service in high-risk occupations, settings, or events; and 3) jointly issue an annual report on Force Health Protection, and make it available to the public.*

Response: A representative from VA serves on the Armed Forces Epidemiological Board. The HEC has chartered numerous joint work groups that have developed and implemented processes addressing the issues listed in this recommendation. These include: Information Management/Information Technology; Financial Management; Joint Facility Utilization and Resource Sharing; Pharmacy; Materiel Management; Contingency Planning; and Deployment Health.

Recommendation 4.1: *The Secretaries of Veterans Affairs and Defense should revise their health care organizational structures in order to provide more effective and coordinated management of their individual health care systems, enhance overall health care outcomes, and improve the structural congruence between the two Departments.*

Response: Recognizing the difficulties in coordinating activities between two structurally different organizations, both the Veterans Health Administration (VHA) and DoD Health Affairs work together to improve coordination activities. Recently, VHA named three VA-DoD liaisons for the new TRICARE Regional Offices (TROs) in Washington, DC; San Antonio, Texas; and San Diego, California. These three individuals have a major role in increasing VA participation in TRICARE networks, and are closely involved in managing the TRICARE regional contracts. In addition, these individuals encourage VA-DoD sharing agreements and other direct relationships with the military services.

Recommendation 4.2: *The Secretaries of Veterans Affairs and Defense, based on the recommendations of the interagency leadership committee, should provide significantly enhanced authority, accountability, and incentives to health care managers at the local and regional levels in order to enhance standardized and collaborative activities that improve health care delivery and control costs.*

Response: This recommendation is similar to a provision in Section 721 of the FY 2003 National Defense Authorization Act requiring the Departments to create a VA/DoD Health Care Sharing Incentive Fund, known as the Joint Incentive Fund (JIF),

to encourage sharing of health care resources. The status of this project is documented in Goal 2 of FY 2005 JSP. Additionally, the Departments worked together to modify the new T-Nex contracts to allow direct sharing between VAMCs and MTFs, and agreed on a single reimbursement rate schedule (CMAC less 10%) to reimburse each other for shared outpatient services.

Recommendation 4.3: *VA and DOD should integrate clinical pharmacy initiatives through the coordinated development of: 1) a national joint core formulary; and 2) a single, common clinical data screening tool by fiscal year 2005 that ensures reliable, electronic access to complete pharmaceutical profiles for VA/DOD dual users across both systems.*

Response: VA and DoD support the continued development of the Interoperable Clinical Screening Tool project which is currently under development and testing. However, VA does not believe there is sufficient justification for VA to adopt DoD's Pharmacy Data Transaction Service (PDTS) without conducting a solicitation and offering to all commercial vendors an opportunity to compete for the combined VA and DoD business.

VA and DoD have taken many actions over the past several years which have rendered the establishment of a VA/DoD National Core Formulary unnecessary. For example, VA and DoD have awarded 81 joint contracts for high cost/high volume pharmaceuticals. Most of these contracts are for drugs which would likely be the top volume drugs under a joint core formulary, therefore VA and DoD have already benefited from contracting actions which would be based on a common drug list.

Additionally, VA Pharmacy Benefits Management Strategic Healthcare Group (PBM) and Medical Advisory Panel (MAP) and DoD Pharmacoeconomic Center (PEC) clinical pharmacist specialists and PBM Medical Advisory Panel (MAP) and PEC physicians have been collaborating closely on common formulary issues for nearly 3 years. VA and DoD physicians and pharmacists each serve on the other Department's formulary committees. This close collaboration has resulted in the 81 joint contracts mentioned above and multiple joint Drug Class reviews and other clinical guidance documents. Therefore VA and DoD do not support the establishment of a joint national core formulary as no additional benefit would likely accrue to either agency.

Recommendation 4.4: *VA and DoD should collaborate on policy and program changes, through local sharing arrangements, which would permit prescriptions written by either VA or MTF providers to be filled for dual users by the other Department's pharmacies.*

Response: This has been assigned to the HEC Pharmacy Work Group for development of a pilot to evaluate the impact of this policy change on the VA and Military Health Care System.

Recommendation 4.5: *VA and DoD should work with industry to establish a uniform methodology for medical supplies and equipment identification and standardization and to facilitate additional joint contracting initiatives. VA and DoD should identify opportunities for joint acquisitions in all areas of products and services.*

Response: VA and DoD have agreements to combine the overall purchasing power of the two Departments and eliminate redundancies in the areas of pharmaceuticals, medical and surgical supplies, and high-tech medical equipment. For example: The HEC has signed a Memorandum of Agreement (MOA) on high-tech medical equipment; DoD is in the process of converting their Defense Medical Surgical Distribution and Pricing Agreements (DAPAs) to the Federal Supply Schedule (FSS) contracts, which will facilitate joint purchasing with VA; VA has developed a National Item File; and the HEC Materiel Management Work Group is working to standardize Universal Product Code (UPC) numbers for medical and surgical supplies and equipment.

Recommendation 4.6: *The interagency leadership committee should identify those functional areas where the Departments have similar information requirements so that they can work together to reengineer business processes and information technology in order to enhance interoperability and efficiency*

Response: VA and DoD are leading the Administration's E-gov initiative in establishing common health information data standards. Goal 4 of the JSP identifies specific objectives designed to ensure that VA and DoD develop an interoperable information technology framework and architecture that will enable the efficient, effective, and secure interchange of records and information to support the delivery of benefits and services.

Recommendation 4.7: *VA and DOD should implement facility lifecycle management practices on an enterprise-wide basis. This should be accomplished by aligning business rules, eliminating statutory barriers, and adopting best practices.*

Response: Goal 5 of the FY 2005 JSP addresses this issue.

Recommendation 4.8: *VA and DOD should declare that joint ventures are integral to the standard operations of both Departments. Through the interagency leadership committee, the Departments should articulate policy requiring that: 1) all major initiatives of each Department be designed and tested for effectiveness and suitability in joint venture sites; 2) lessons learned from successful joint ventures be shared with other joint venture sites and also throughout the health care delivery systems of the two Departments; and 3) all proposed VA and DOD facility construction within a geographic area be evaluated as a potential joint venture.*

Response: This recommendation is addressed in Goals 1 and 5 of the FY 2005 JSP. Goal 1 requires development of a joint communications plan to disseminate best practices and leadership priorities and Goal 5 addresses pilot programs at joint VA/DoD sites.

Recommendation 4.9: *VA and DoD should work together to identify and address staffing shortfalls, develop consistent clinical scopes of practice for non-physician providers, and ensure that provider credentialing systems interface with each other.*

Response: VA and DoD have approved two demonstration projects that directly impact staffing at Augusta Veterans Affairs Medical Center (VAMC)/Eisenhower Army Medical Center, Georgia and Hampton VAMC and 1st Medical Group Langley, Virginia. A credentialing system interface for providers is being tested in the San Antonio area by the South Texas Veterans Healthcare System, Wilford Hall Medical Center and Brooke Army Medical Center, Texas. Additionally, through the HEC Graduate Medical Education Work Group, the VA Office of Academic Affiliations has identified six sites where the VA and its affiliated university have accredited training programs in the medical specialties requested by the Army and have agreed to accept a military resident. Military residents in Urology and Neurological Surgery began July 1, 2004. Additional military residents will begin their residency training on July 1, 2005. Anesthesiology and Radiology residency programs require a first year clinical transitional year and arrangements have been made for the residents to complete this year at an active duty military hospital, hence, the military residents will be entering the VAMC/Affiliated University program on July 1, 2006. The results of these demonstration projects will be evaluated for impact of future collaboration between the two Departments.

Recommendation 5.1, 5.2, and 5.3 of the PTF address appropriation issues and are not addressed by this report.