VA/DoD Joint Executive Council FY 2005 Annual Report

January 2006

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Deputy Secretary
Department of Veterans Affairs

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

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VA/DoD Joint Executive Council Fiscal Year 2005 Annual Report

SECTION 1 - INTRODUCTION

The Department of Veterans Affairs (VA)/Department of Defense (DoD) Joint Executive Council has completed its third year. This Council is entrusted to enhance coordination and resource sharing between VA and DoD. The Joint Executive Council (JEC) is pleased to submit this Annual Report to the Secretaries of Defense and Veterans Affairs and Congress, as required by law.[1]

Working together during Fiscal Year (FY) 2005, VA and DoD, improved the effectiveness and efficiency of health care services and benefits to veterans, servicemembers, military retirees, and eligible dependents. VA/DoD successes in the areas of financial management, joint facility utilization, capital asset planning, pharmacy, medical-surgical supplies, procurement, patient safety, deployment health, clinical guidelines, contingency planning, medical education, and benefits delivery have strengthened the capability of both Departments to better serve beneficiaries, and established the foundation for future improvements.

The VA/DoD Joint Executive Council is co-chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness. The co-chairs select the membership of the Council, which consists of senior leaders from VA and DoD.

To ensure that appropriate resources and expertise are directed to specific areas of interest, the JEC established sub-councils in the areas of health and benefits: the Health Executive Council (HEC), co-chaired by VA's Under Secretary for Health and DoD's Assistant Secretary for Health Affairs; and the Benefits Executive Council (BEC), co-chaired by VA's Under Secretary for Benefits and DoD's Principal Deputy Under Secretary for Personnel and Readiness. Additionally, the JEC has standing committees for joint construction planning and strategic planning.

[1] This Report is intended to satisfy the reporting requirements for Public Law 97-174 and Public Law 108-136 codified at 38 U.S.C. 320 and 8111(f).

In the *FY 2004 VA/DoD Annual Report*, the JEC submitted a revised Joint Strategic Plan, which has served as the roadmap for the Joint Executive Council and its sub-councils. The *VA/DoD Joint Strategic Plan for FY 2006-2008* is based on three guiding principles:

Collaboration: Achieve shared goals through mutual support of our common and unique mission requirements.

Stewardship: Provide the best value for the beneficiaries and the taxpayer through increased coordination.

Leadership: Establish clear policies and guidlines for enhanced partnerships, resource sharing, decision making, and accountability.

The Joint Strategic Plan is the primary means to advance performance goals, and should be continuously evaluated, updated, and improved. After reviewing and revising the goals, strategies, and performance measures in the FY 2005 Joint Strategic Plan, VA and DoD have developed the *VA/DoD Joint Strategic Plan for FY 2006 – 2008*, which is appended to this Annual Report.

SECTION 2 - VA/DoD COLLABORATION RESULTS

The two Departments made considerable progress towards promoting mutually beneficial coordination, use, and exchange of services and resources in FY 2005.

SECTION 2.1 – SEAMLESS TRANSITION

Seamless transition is an approach to health care and benefits delivery whose goal is to ensure continuity of service through the coordination of benefits, with the intended result of improving the understanding of, and access to, the full continuum of benefits and services available to servicemembers and veterans through each stage of life. In FY 2005, focus was directed at ensuring a smooth transition from active duty to veteran status with an emphasis on those servicemembers returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) suffering from injuries or illnesses related to their service.

The seamless transition initiative has made significant progress in the areas of outreach and communication, tracking workload, data collection, and staff education. To better meet beneficiary expectations, VA and DoD have developed and implemented a number of strategies, policies, and programs to provide timely, appropriate services to returning servicemembers and veterans – especially those transitioning directly from DoD Military Treatment Facilities to VA Medical Centers. Seamless transition efforts have made it possible for servicemembers to enroll in VA health care programs and file for VA benefits prior to separation from active duty.

In January 2005, VA established an Office of Seamless Transition (OST) to improve collaboration and communication between VA and DoD. The OST is staffed with representatives from the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), the United States Marine Corps, and the United States Army. Improving communication between the Departments facilitates outreach to servicemembers and veterans. By improving communication between the two Departments, the OST ensures the consistency of information and services provided, and facilitates outreach to servicemembers and veterans.

In FY 2005, VA and DoD collaborated on regulations to implement Traumatic Injury Protection under Servicemembers' Group Life Insurance (TSGLI). This coverage serves as insurance for servicemembers who lose limbs, sight, or hearing, or incur certain other conditions that are directly caused by a traumatic injury. The program is designed to provide a cash payment to servicemembers recuperating from traumatic injuries. The purpose of the program is to lessen the economic burden on the servicemember and their family during the servicemember's recuperation period. Effective December 1, 2005, all servicemembers enrolled in the Servicemembers' Group Life Insurance (SGLI) program automatically received this added coverage. This benefit is also provided retroactively for servicemembers who suffered a traumatic injury on or after October 7, 2001 through and including November 30, 2005 if the loss resulting from the injury was a direct result of injuries incurred in Operations Enduring Freedom (OEF) or Iraqi Freedom (OIF). TSGLI payments range from $25,000 to a maximum of $100,000. As of late January 2006, VA paid over 900 claims, with an average payment of $70,000 per claim, under this new program.

VA and DoD collaborated with the appropriate Congressional Committees to develop a new educational benefit that recognizes the sacrifice of National Guard and Reserve members who are activated for short, but dangerous missions, such as those in Iraq and Afghanistan. P.L. 108-375 created a new education benefit entitled the "Reserve Educational Assistance Program" (REAP) that is targeted toward members in the Reserves and National Guard who are called up to active duty. While REAP is a DoD program and the military services determine who is eligible, the law requires VA to administer the program in a manner similar to other VA education programs, such as the Montgomery GI Bill. REAP provides a level of benefits that is intermediate between those for persons who serve a full two years of active duty and those who serve in a drilling status in the Selected Reserve, but are not activated. The first REAP payments were processed in December 2005. DoD has not published implementation guidance for the new program. The Services encourage servicemembers to apply for the benefit through their respective schools to the Department of Veterans Affairs in order to receive the benefits.

VA and DoD continued joint development and implementation of the Cooperative Separation Process/Examination at VA/DoD Benefits Delivery at Discharge (BDD) sites. As of January 6, 2006, Memorandum of Understanding (MOU's) were in place at 111 BDD sites. VA representatives assist servicemembers in filing disability claims before they are separated from active duty service. This

program improves the timeliness of claims processing, thereby ensuring that veterans will receive disability benefits at the earliest time after their separation.

DoD implemented a policy entitled "Expediting Veterans Benefits to Members with Serious Injuries and Illness," which provides authority and guidance on the collection of critical data elements for seriously injured and ill returning combat veterans. Under this policy, DoD began transmitting pertinent data to VA in September 2005. Receiving this data directly from DoD eliminates potential delays in developing a claim for VA benefits. This initiative reduces the burden on the servicemember for submitting information and ensures that VA will have the necessary information to award all appropriate benefits and services at the earliest possible time.

In response to the increasing number of servicemembers returning from combat with multiple trauma injuries, VA has committed to the development of specialized care for these patients. VA has created four Polytrauma Centers. These Centers, located at the sites of VA Traumatic Brain Injury Lead Centers, are designed to meet the needs of active duty servicemembers and veterans who have experienced severe injuries resulting in spinal cord injuries, brain injuries, amputations, visual impairment, or Post-Traumatic Stress Disorder. In March 2005, the Army assigned an active duty soldier to each of the Centers to function as a military liaison and to assist servicemembers and their families with transition issues and concerns.

In FY 2005, VA Military Service Coordinators conducted approximately 7,500 Transition Assistance Program (TAP)/Disabled Transition Assistance Programs (DTAP) briefings attended by almost 310,000 active duty personnel and their families residing in the United States. These briefings include 1,984 pre- and post-deployment briefings attended by nearly 119,000 National Guard/ Reserve. In addition, VA also conducted 686 briefings attended by over 17,000 servicemembers based overseas.

VA, DoD, and the Department of Labor (DoL) collaborated on the revision of DD Form 2648 - *Checklist for Active Duty Personnel*. The form now lists more sources to assist separating and retiring servicemembers in obtaining information about the full spectrum of veteran's benefits and services, such as employment and relocation assistance. A new DD Form 2648-1 - *Checklist for Reserve Component Personnel* was also developed to reduce confusion caused by using a single separation counseling form for active duty, National Guard, and Reserve personnel.

In FY 2005, a special VA/DoD Survivors' Benefits Website was launched. Surviving spouses and dependents of military personnel who have died while in active military service and survivors of veterans who died after active service can now use this online resource to better understand the benefits for which they may be eligible (http://www.vba.va.gov/survivors/index.htm).

SECTION 2.2 – HIGH QUALITY HEALTH CARE

The following accomplishments reflect VA and DoD efforts to improve the access, quality, effectiveness, and efficiency of health care for beneficiaries through collaborative activities.

Deployment Health

The Health Executive Council (HEC) established a Deployment Health Workgroup to focus on activities designed to enhance the sharing of deployment health related information between the Departments. The group focuses on the continuity of medical care for servicemembers as they leave active duty and become beneficiaries of the VA system.

VA continually defines the data and information required to meet the health care demands that transitioning veterans will place on VA. DoD provides the medically relevant data and information collected before, during, and after deployments. The following are examples of VA/DoD coordination:

- DoD provides VA the rosters of OEF/OIF veterans who separated from active duty.
- VA and DoD jointly develop post-deployment health assessments and reassessments.
- DoD transmits electronic data from health assessments to VA when veterans separate from active duty.
- DoD provides information on diseases, non-battle injuries in theater, and environmental surveillance data.
- VA and DoD share information on post-deployment health care utilization by OEF/OIF veterans.
- VA and DoD share results from deployment-related research ongoing in each Department.

Patient Safety

VA and DoD are collaborating on ways to enhance overall patient safety practices based on VA's lessons learned and DoD's experience to date. In 1999, a landmark study by the Institute of Medicine of the National Academy of Sciences estimated that almost 100,000 lives were lost annually in the U.S. due to factors related to patient safety. That same year, VA established its National Center for Patient Safety (NCPS) to develop and nurture a culture of safety throughout VA, with a goal of nationwide reduction and prevention of harm to patients as a result of their care. Examples of successes in improving patient safety include:

- DoD established a Patient Safety Center at the Armed Forces Institute of Pathology using the VA's National Center for Patient Safety as a model.
- DoD implemented an internal system for reporting adverse events based on the reporting system currently employed by VA.
- VA and DoD made improvements in the process for sharing technical and clinical information related to issuing patient safety alerts and advisories.
- VA information technology personnel assisted DoD efforts in developing a system for barcoding medications.

- VA provided joint on-site patient safety training to both VA and DoD personnel in Alaska.

To ensure continued success in this area, the HEC established a Patient Safety Workgroup to oversee patient safety activities.

Evidence-Based Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are evidence-based protocols that promote the systematic use of current best practices in making decisions about the care of individual patients or the delivery of health services. Numerous CPGs are in place throughout the VA and DoD health care delivery systems, with a focus on the health care needs of servicemembers and veterans. The VA/DoD Evidence-Based Workgroup and its five sub-workgroups engaged in managing numerous high-volume, high-cost diseases and medical conditions facing the DoD and VA populations. Since 1998, 26 CPGs have been published. In FY 2005, a new CPG was developed – the Screening and Management of Overweight and Obesity. Also in FY 2005, six existing CPG's were reviewed, two of which have been completed and released (Tobacco Use Cessation, and Hypertension).

North Chicago Task Force

The HEC established the North Chicago VA - Great Lakes Naval Training Center Task Force to recommend short-term and long-term actions to improve resource sharing between the North Chicago Veterans Affairs Medical Center (NCVAMC) and the Naval Hospital Great Lakes (NHGL). Current activities include the ongoing construction project to modernize the NCVAMC surgical and emergency/urgent care facilities scheduled for completion in the summer of 2006. In FY 2005, design authority was granted to Naval Facilities Engineering Command for site and space planning for the $100 million Federal Ambulatory Care Center. The task force chartered six national workgroups to develop detailed operational plans for the fully integrated Federal Health Care Facility by 2010.

SECTION 2.3 – EFFICIENCY OF OPERATIONS

VA and DoD worked collaboratively to increase joint management of capital assets, procurement, logistics, financial transactions, and human resources in order to improve cost effectiveness in these areas.

Capital Asset Coordination

The Construction Planning Committee developed a plan that would align initiatives identified in VA's FY 2007 major capital investment process and DoD's future-year defense program. The intent is to minimize duplication of effort and maximize sharing.

The group also created guiding principles to be used for funding future joint capital initiatives. Funding principles take into account intricate issues such as ownership, identified need, and legislation. VA's capital investment plan was evaluated against Base Realignment and Closure Commission (BRAC)-identified surplus to identify potential alternatives for meeting requirements. And finally, the sharing of best practices with regard to capital investment methodologies led DoD to adopt a methodology and process similar to those used by VA.

In response to Hurricane Katrina, VA and DoD made additional refinements to the scope of joint capital collaborations in affected areas.

Joint Acquisition

As of September 2005, VA/DoD acquisition strategies resulted in 84 joint contracts, nine blanket purchase agreements, and two temporary price reductions in purchasing pharmaceuticals.

VA and DoD worked to eliminate duplicate contracting vehicles for medical and surgical equipment purchases. A total of 16 joint contracts replaced single Departmental purchases: nine joint contracts for radiation oncology, five for high-technology medical equipment maintenance, one for vital signs monitors, and one for surgical instruments. VA and DoD also added VA requirements to 25 DoD high-technology medical contracts.

VA and DoD had approximately the same prices for their agency-only contracts in high-tech medical purchases. Combining the contracts will lead to reductions in administrative overhead costs and savings related to the volume of sales. In addition, VA and DoD began exploration of additional joint procurement opportunities that included: (1) leveraging joint buying power; (2) expansion of joint standardization; (3) utilization of supply chain management; and (4) consolidation of high cost/high-technology equipment.

Pharmacy

VA/DoD success was achieved in the awarding of joint and unilateral contracts for pharmaceuticals. VA awarded 18 joint and three unilateral national contracts resulting in a cost avoidance of approximately $380 million in FY 2005.

VA and DoD conducted a pilot test in which the VA Consolidated Mail-Out Pharmacy Program refilled outpatient prescription medications from Military Treatment Facilities. Both Departments reviewed a study conducted by the Center for Naval Analysis, which found the program to be feasible with high DoD beneficiary participation and high satisfaction among program users. DoD is reviewing these findings along with analysis conducted by the Government Accountability Office as part of the process of developing a new mail order pharmacy program. Both the Navy and Air Force have opted to continue the program at their own expense.

SECTION 2.4 – JOINT CONTINGENCY/READINESS CAPABILITIES

The goal of VA/DoD joint contingency and readiness coordination is to ensure the active participation of both Departments in federal and local incident and consequence response through planning, training, and conducting exercises.

In FY 2005, 14 VA and DoD Federal Coordinating Centers were activated. Together they assisted over 2,800 patients on military aero-medical missions in support of the response to Hurricane Katrina. These operations are similar to those that VA would perform for DoD in support of the joint contingency and readiness mission. In addition, numerous joint mass-casualty training exercises occurred between local VA and DoD medical facilities. Each

Department's dedicated staff, equipment, supplies, and logistical support of these exercises, focused on incident and consequence management as well as VA/DoD contingency operations. VA and DoD jointly drafted a Memorandum of Agreement regarding VA providing health care services to members of the armed forces during a war or national emergency.

SECTION 3 - INFORMATION TECHNOLOGY ADVANCEMENTS

The goal of integrated information sharing for VA and DoD is to enable the Departments to share beneficiary data, medical records, and other information through secure and interoperable information systems. Both the HEC and the BEC have subordinate Information Management/Information Technology Workgroups. VA and DoD advancements in FY 2005 are described below.

Joint Electronic Health Records Interoperability Program

The Joint Electronic Health Records Interoperability (JEHRI) Program is a series of initiatives and projects designed to support the implementation of standards, development of shared technical and data architectures, and hardware and software design and development required to achieve interoperability of electronic health information between VA and DoD. JEHRI is the roadmap for how VA and DoD will enhance the continuity of care from active duty status to veteran status by enabling a consolidated view of health data from VA and DoD medical records.

JEHRI initiatives generally fall into one of the following categories:

- Information Exchange
- Collaborative Software Applications
- Standards Work

Information Exchange

Federal Health Information Exchange

The Federal Health Information Exchange (FHIE) supports the monthly transfer of electronic health information from DoD to VA at the time of a servicemember's separation. VHA providers and VBA benefits specialists can easily access this data via VA's Computerized Patient Record System (CPRS) or Compensation and Pension Records Interchange (CAPRI).

By the end of FY 2005, DoD had transmitted electronic health data on over 3.14 million unique patients containing the following types of information:

- Laboratory results
- Radiology results
- Outpatient pharmacy data
- Allergy information
- Discharge summaries
- Admission, disposition, and transfer information

- Consultation reports
- Standard ambulatory data record
- Patient demographic information

Bidirectional Health Information Exchange

Building from FHIE technical and personnel advancements, the Departments completed the development and implementation of the Bidirectional Health Information Exchange (BHIE) in FY 2005. BHIE enables real-time sharing of demographic, outpatient pharmacy, laboratory, radiology, and allergy data for patients treated by both Departments using existing automated systems. BHIE is operational at all VA health care facilities and at the following DoD sites:

- Madigan Army Medical Center
- William Beaumont Army Medical Center
- Eisenhower Army Medical Center
- Naval Hospital Great Lakes
- Naval Medical Center San Diego
- National Capital Region to include Walter Reed, Bethesda, Dewitt and others
- Michael O'Callaghan Federal Hospital

While FHIE provides access to (historical) health care data, BHIE provides secure, real-time, bidirectional access to current electronic health information on shared patients.

Pre- and Post-Deployment Health Assessments

VA and DoD have also leveraged previous investments into developing FHIE capabilities by incorporating the transmission of pre- and post-deployment health assessment information for separated servicemembers from DoD to VA. This information is used to monitor, maintain, and improve the overall health condition of troops that have been deployed, and inform them of any potential health risks.

DoD has successfully added electronic pre- and post-deployment health assessment information on separated servicemembers to the monthly patient information data exchange with VA. Through December 2005, over 475,000 pre- and post-deployment health assessments have been transmitted to VA on over 248,000 individuals who have separated from Active Duty. In addition, DoD has a listing of approximately 250,000 National Guard and Reserve members who have been deployed and are now demobilized. Data on these individuals should be transmitted by early 2006. Subsequent demobilized National Guard and Reserve member data will be added to the monthly data transmissions. VA implemented the capability to retrieve the data electronically in December 2005.

Clinical Data Repository and the VA Health Data Repository

The next step towards achieving system interoperability entails developing and testing of the interface between the Clinical Data Repository (CDR) of DoD and the Health Data Repository (HDR) of VA. In the initial release of this interface, known as the Clinical Health Data Repository (CHDR), VA and DoD will achieve the bidirectional real time exchange of demographic, pharmacy and medication

allergy information by February 2006 for next generation systems (e.g., AHLTA and HealtheVet-VistA). In FY 2005, the Departments established a CHDR Program Office under the direction of an interagency program manager. VA and DoD made substantial progress in the areas of requirements definition, implementation of data standards and data terminology, and definition of test and production environments for CHDR.

Collaborative Software Applications

Laboratory Data Sharing Initiative Project

The Laboratory Data Sharing Initiative (LDSI) supports real-time, bidirectional electronic ordering and results retrieval of chemistry laboratory results between laboratories within the two Departments. LDSI is fully available to provide laboratory order portability between local VA/DoD sites that have a local sharing agreement for laboratory services.

In FY 2005, LDSI work also focused on the implementation and testing of LDSI as part of the FY 2003 National Defense Authorization Act (NDAA) Demonstration Site Provisions and enhancement of LDSI capability for the electronic ordering and results retrieval of anatomic pathology and microbiology tests. The LDSI product is operational at the following sites:

- Tripler Army Medical Center and the VA Pacific Island Health Care System
- Naval Medical Center and VA Medical System, San Diego
- Naval Hospital Great Lakes, Hines VA Medical Center, and North Chicago VA Medical Center
- William Beaumont Army Medical Center and El Paso, Texas VA Health Care System (NDAA site)
- Brooke Army Medical Center, Wilford Hall Medical Center and VA South Texas Health Care System (NDAA site).

Standards Work

Collaboration on Standards and Architecture between VA/DoD

VA and DoD worked closely together to identify shared lines of business and adopt and implement shared data standards to support these lines of business. In FY 2005, VA and DoD formed the Health Architecture Interagency Group (HAIG) to monitor the interagency architecture compliance review process for joint sharing initiatives. In August 2005, the Departments reached an agreement on the compliance review process, and implementation began in November 2005. The enterprise data standards and architecture work is also closely tied to the larger federal Consolidated Health Informatics (CHI) initiative.

Federal Health Architecture/Consolidated Health Informatics

The Federal Health Architecture (FHA) is one of the lines of business identified in the Federal Enterprise Architecture initiative and involves multiple departments and agencies across the federal government. The primary goals of the FHA are to improve coordination and collaboration on national health IT solutions, and to improve efficiency, standardization, reliability, and availability of comprehensive health information solutions. As the leading providers of federal health care, VA and DoD are important stakeholders in the FHA initiative and are at the forefront

of implementing FHA outputs and collaboration. VA and DoD anticipate improved patient safety and higher quality healthcare for VA and DoD beneficiaries due to improved access to health information by providers and benefits specialists.

Consolidated Health Informatics (CHI) is a workgroup that falls under FHA. VA and DoD are lead partners along with the Department of Health and Human Services (HHS) in the CHI initiative. CHI is aimed at establishing federal health information interoperability standards as the basis for electronic health data transfer in federal health activities and projects. HHS serves as managing partner for CHI, and other partners include the Centers for Medicare and Medicaid Services, National Institutes of Health, Centers for Disease Control, Indian Health Service, Social Security Administration, General Services Administration, Health Resources and Services Administration, Administration for Children and Families, Food and Drug Administration, US Agency for International Development, Department of Justice, and Department of State.

VA and DoD led the CHI efforts in successfully documenting a charter and strategy for the ongoing adoption of standards, and integrating the CHI effort into the larger FHA effort. Workgroup experts from each Department also worked to arrange the identified areas for CHI standards adoption into 27 clinical domain areas for assessment purposes. To date, 20 standards have been successfully adopted and endorsed for use across the federal government.

VA and DoD are co-chairing the new standards development effort with particular emphasis on two domain areas, *e-Prescribing* and *allergy* standards. Implementation of CHI standards will involve the use of CHI standards in new systems and those undergoing major upgrades where health information is exchanged. Therefore, implementation will occur over time. Working closely with the CHI workgroups, VA and DoD standards and architecture subject matter experts also have completed a draft Digital Imaging and Communications in Medicine (DICOM) implementation guideline which was submitted to CHI. Final approval is anticipated in January 2006. A second implementation guideline is under development for Health Level 7 Clinical Document Architecture.

Enterprise Architecture

During 2005, the BEC focused on consolidating multiple data feeds into a single bidirectional data feed. In January 2005, VA provided data requirements to the DoD Joint Requirements and Integration Office and the Defense Manpower Data Center (DMDC). A data repository was also developed by VA in parallel with the current data sharing scheme to demonstrate VA's ability to consolidate data. This new repository is critical to VA's migration to a service oriented architecture and establishment of an enterprise data model. The Veterans Information Solution (VIS) is used to ensure VA's access to DoD data as an interim measure to provide access to data from the DMDC while the two Departments pursue an enterprise-wide data sharing architecture. In September 2005, the OneVA Registration and Eligibility Governance Board established a project team to develop the VA/DoD Data Sharing Architecture for personnel and benefits data.

VA and DoD continue to evolve their enterprise architectures to support sharing of timely, consistent personnel-related data between the Departments. A O*ne VA/DoD Data Sharing Schema* was established for VA/DoD data exchange. VA and DoD will continue to evolve systems that deliver necessary data through this Data Sharing Schema.

As of first quarter FY 2006, the BEC is conducting business requirements analysis to ensure that current requirements are captured.

Separating/Separated Military Personnel Data

Working collaboratively in FY 2005 to improve the accuracy and timeliness of the transfer of DoD personnel data to VA, the Departments completed the following Compensation and Pension Records Initiative (CAPRI)/FHIE milestones:

- Updating the Outpatient Pharmacy category with Pharmacy Data Transaction Service Information showing pharmacy prescriptions filled at private drug stores.
- Adding three new CAPRI categories.
- Providing summaries of outpatient treatment episodes, allergies, and consults through a standard Ambulatory Data Record.

CAPRI electronic health records, including FHIE categories, are available to VBA employees at 57 Regional Offices. Access to CAPRI electronic health records helped to accelerate the adjudication of compensation and pension benefit claims. It also facilitated determination of entitlement to vocational counseling, planning, and training as well as insurance and waiver of premiums for veterans totally disabled by service-connected disability.

Information from the DMDC provides VA with the capability to validate that an individual is in the service upon accession. Furthermore, an indicator showing whether or not a servicemember received combat pay has been added. This is particularly significant because verification of combat participation has been difficult and time consuming in the past, where personnel records for recently discharged servicemembers were not available electronically. This will prove to be a significant benefit for servicemembers returning from OIF/OEF, as they are eligible for two years of free health care from VA for conditions possibly related to their combat service. VA will use this information to contact returning veterans to inform them of their benefits and entitlements.

Data received from the DMDC can also be made available to VA field personnel through the VIS database, thus reducing claims processing time, particularly those offices that handle claims filed under the Benfits Delivery at Discharge (BDD) program. BDD allows active duty servicemembers to file a claim for disability compensation up to six months prior to separation. VA often decides the servicemember's claim prior to separation; however, it does not award benefits until they are released from active duty and verification of the release date is received. Prior to deployment of VIS, some veterans waited several months for their benefits to begin while VA attempted to locate a copy of their DD Form 214. Now, VA can often award benefits one or two days after separation by relying on the data available through VIS.

VA/DoD Personnel Demographic Data

VBA, VHA, and the National Cemetery Administration worked collaboratively to identify DoD data that each administration required for determining VA benefits eligibility. The VA data requirements were consolidated and presented to DoD in January 2005.

As mentioned earlier, the DMDC began to include a combat pay indicator in its data feed to VA in July 2005. DoD also completed an interface between its Defense Personnel Records Image Retrieval System (DPRIS) and the US Air Force's personnel record image repository. This allowed VA access to digital personnel records for all four military services.

Personnel records belonging to members of the Army National Guard were converted to a format that now makes them available to VA through the Personnel Information Exchange System (PIES)/DPRIS interface.

As a result, VA has gained access to digital copies of personnel records for servicemembers separated from all four branches of the service, and these records can now be retrieved electronically within three days. This is a significant improvement over the response time for obtaining paper copies of personnel records which previously took anywhere from two to six months.

The number of VA requests for personnel records through the PIES/DPRIS interface is exceeding 3,000 per month. DPRIS is also routing an additional 400 requests for verification of in-service stressors and service in Vietnam to the U.S. Army and Joint Services Records Research.

SECTION 4 - HEALTH CARE RESOURCE SHARING

Health care resource sharing is a term that applies to a wide spectrum of collaboration between VA and DoD that includes providing patient care services, education, training, research and health care support, and administrative services. Both Departments provided these services to one another under the auspices of agreements entered into between VA and DoD officials, primarily at the local level involving reimbursements or the exchange of services.

In FY 2005, 152 VA Medical Centers were involved in direct sharing agreements with 207 Military Treatment Facilities and 111 Reserve Units. There were 446 direct sharing agreements covering 2,298 unique services. The following sections describe ways in which VA and DoD share resources to provide better services to Military Health System beneficiaries and veterans.

SECTION 4.1 – INNOVATIVE VA/DOD RESOURCE SHARING AGREEMENTS

VA and DoD coordinated health services through direct sharing agreements, TRICARE contracting, joint contracting for pharmaceuticals and medical/surgical supplies, information technology collaboration, training cooperation, and joint facilities. The following are examples of innovative resource sharing activities:

- *The Veterans Integrated Service Network 7 (VISN 7) and the Southeast Regional Medical Command* (SERMC) joined together to meet rehabilitative needs of returning combat veterans by creating a regional master sharing agreement which included the provision of comprehensive rehabilitative services to active duty servicemembers. Under the master sharing agreement, VISN 7 and SERMC are able to provide the VA and DoD beneficiary population with internal medicine, psychiatry, nursing, social work (case managers), psychiatry, psychology, neuro-psychology, nutrition, occupational therapy, physical therapy, recreation therapy, audiology, and speech pathology services. Personnel were hired and staffing shared to specifically meet the needs of both beneficiary populations. The medical director of the unit, as well as many of the therapists, came from a local rehabilitation hospital and were specifically involved in Traumatic Brain Injury treatment, including transitional living. At least two of the therapists have extensive experience in burn treatment and rehabilitation.

- *The Military Medical Support Office (MMSO), Great Lakes, Illinois, and VA Spinal Cord Injury and Traumatic Brain Injury Centers* activity increased dramatically over the preceding fiscal year. There were 379 patients treated for combat-related active duty injuries in FY 2005 as compared to 278 treated in FY 2004. In addition, MMSO had 73 agreements with VA facilities. VAMCs provided dental services in most of these agreements.

- *The New Jersey Health Care System and the Army's North Atlantic Regional Medical Command* provide clinical and administrative personnel to augment DoD staff in pre-deployment and post-deployment physicals for National Guard and Army troops processing through Fort Dix, New Jersey. This "Soldier Readiness Processing" site serves most of the eastern United States, and has been expanded several times. Sixty-one VA medical and administrative personnel currently support this site; VA will assume additional clinic and case management responsibilities in FY 2006.

- *The Veterans Integrated Service Network 8 (VISN 8) and the Army Community-Based Health Care Organization (CBHCO) Program* are working together to serve many activated Army Reserves and National Guard members who live in the Southeast and process through Fort Stewart, GA on their way home. For those soldiers who suffered injuries or illnesses in the line of duty, discharge may not be the immediate answer. Instead, these soldiers are assigned to one of several CBHCO units in the network while receiving care at a medical facility near their homes. When a Military Treatment Facility is not available, the soldiers may be referred to the nearest VA Medical Center by the CBHCO case manager. These soldiers receive

all care related to their injury or illness until such time as the Army has reviewed their medical records and made a determination whether the soldier can remain on active duty, be released from active duty, or be medically discharged. Most of the care is provided on an outpatient basis. Once discharged from active duty, these soldiers convert to veteran status, and continue receiving care from VA. Approximately 100 active duty medical hold soldiers were processed through the VA Integrated Service Network 8 in FY 2005.

- *The Central Texas Veterans Health Care System (CTVHCS) and Darnall Army Hospital* entered into a sharing agreement for VA to provide 15 staff members to assist with the increasing demand for mental health services amid the high volume, frequency, and intensity of deployments of the units at Fort Hood. This agreement has the potential to expand. In another agreement, CTVHCS established an innovative joint discharge physical program. This program encouraged active duty servicemembers to file for a VA disability rating while receiving a VA or DoD medical examination. In addition, Texas National Guardsmen reported to the VA for their pre-deployment physical. If minor medical issues are discovered during the exam, VA arranges for care.

- *The South Texas Veterans Health Care System (STVHCS) and Wilford Hall Medical Center (WHMC)* approved a joint 30,000 square foot, $14 million primary care clinic in North Central San Antonio under the VA/DoD Joint Incentive Fund. The clinic will offer mental health, laboratory, radiology, optometry, and pharmacy services.

- *The Alaska VA Healthcare System and Regional Office and the 3rd Medical Group at Elmendorf Air Force Base* used the Joint Incentive Fund process to re-direct VA's Magnetic Resonance Imaging (MRI) needs from the community into the joint venture hospital. VA hired radiology technologists and extended operational hours, then scheduled patients during the evening shift and transmitted the images to a VA radiologist located in South Carolina. The process saved approximately $64,000 in fee basis costs in the first month of operation (June 2005), and allowed the radiology image to be part of the CPRS medical record. The Air Force was able to eliminate the need for having a radiology technologist on call to cover emergency room responses during the evening shift.

- *The VA Central Iowa Health Care System and Iowa National Guard* entered into an agreement whereby VA provided services such as laboratory, radiology, and specialty consults for the Army National Guard at Camp Dodge, IA to complete National Guard member physical exams. The agreement included complete physicals for National Guard full-time active hires with the 71st Civil Support Team Weapons of Mass Destruction/ Hazardous Materials Response Team. The Iowa National Guard provided the equipment and VA conducted the audiology portion of the physical.

SECTION 4.2 – VA/DoD HEALTH CARE SHARING INCENTIVE FUND

The National Defense Authorization Act of FY 2003 requires a fund to be established to "carry out a program to identify, provide incentives to, implement, fund, and evaluate creative coordination and sharing initiatives at the facility, interregional, and nationwide levels." Each Department contributed $15 million to the fund in FY 2005.

The VA/DoD Financial Management Workgroup designated a panel to review the proposals. The panel was comprised of members from the VHA Resource Sharing Office, the Office of Patient Care Services, the Office of the Deputy Under Secretary for Health for Operations and Management, Veterans Integrated Service Network 5, Office of Health Informatics and from DoD Services, Health Affairs and TRICARE Management Activity. The workgroup received 56 proposals for evaluation in January 2005. These proposals were initially reviewed to determine how well they met the criteria. Twenty-five applicants were selected to continue to a second-round review and asked to submit more detailed information, including a cost-benefit analysis. Of these 25 projects, the HEC approved the following 17 projects that totaled $30.5 million for FY 2005:

- *VA Central Office/TRICARE Management Activity (CO/TMA) (Medical Enterprise Web Portals)*
  This project will provide military personnel and veterans access to tools that will facilitate their active participation in the management of their health care, while improving the effectiveness and efficiency of both health care systems. The intent is to position two ongoing programs, *TRICARE On-Line* and *My HealtheVet*, to collaborate on defining business requirements, establishing policy and standards, and identifying areas of unique collaboration that will result in shared projects producing economies of scale and cost avoidance to both agencies in the future.

- *VA Central Office/Defense Supply Center Philadephia (CO/DSCP) (Medical/ Surgical Supply Data Synchronization)*
  This proposal is focused on synchronizing the medical/surgical catalog data and pricing among four VA/DoD components: Distribution and Pricing Agreements, Federal Supply Schedules, the DoD Master Data Synchronization database, and the National Item File. A synchronized catalog data will be made available to end-users to ensure medical/surgical product purchases are made at the lowest VA/DoD-authorized price. This two-year endeavor to expand and link current VA and DoD synchronization efforts will ultimately allow VA and DoD to jointly identify common medical/ surgical products and maximize joint buying power for these products through negotiated volume purchasing contracts.

- *Radiology (VA Medical Center, Louisville and Ireland Army/IACH Ft. Knox)*
  This proposal provides a cost effective means for responding to a clinical deficiency due to the absence of VA or DoD treatment options for VA and active duty DoD patients, who require radiology services. It will establish radiology services to both VA and DoD beneficiary groups by connecting existing sharing relationships in the area of radiologist services.

- *Sleep Lab Expansion (VAMC Harry S. Truman/Whiteman AFB)*
  This project proposes to expand and renovate the Sleep Diagnostic and Treatment Lab at the Harry S. Truman Memorial Veterans Hospital (HSTMVH) in Columbia, MO. The plan calls for the expansion of the two-bed unit located at HSTMVH to four beds, with one new bed being dedicated to DoD workload (509th Medical Group, Whiteman Air Force Base - AF), while the other new bed will assist the HSTMVH in reducing its backlog. A positive return on investment within the first year of operation is anticipated on this project.

- *Cardiac Surgery (Madigan Army Medical Center/Puget Sound Health Care System)*
  The cardiac surgery project will consolidate the Madigan Army Medical Center (MAMC) and VA Puget Sound Health Care System (VAPSHCS) Cardiac Surgery programs into a coordinated program, with surgery being performed at the Seattle Division of VAPSHCS. DoD beneficiaries would be evaluated at MAMC by MAMC staff and referred to VAPSHCS for surgery. By consolidating one moderate-sized and one small cardiac surgery program into a single, larger cardiac surgery program that is team-based at a university-affiliated VA facility, quality of care for patients will be maintained and improved, along with enhanced efficiencies and economies of scale. The consolidated program will be located at the Seattle Division of VA Puget Sound Health Care System.

- *Neurosurgery Program (Madigan AMC/Puget Sound HCS)*
  This project will improve the provision of neurosurgical care to VA and DoD beneficiaries by jointly recruiting neurosurgeons and collaborating to provide coverage for both Madigan Army Medical Center (MAMC) and VA Puget Sound Health Care System (VAPSHCS) (including VISN 20 referrals), resulting in a projected annual volume of 505 cases. On a longer-term basis, it will also allow for both facilities to jointly take advantage of economies of scale in staffing, recruitment, and training of scarce medical specialties, e.g., neurosurgeons and perioperative, critical care, and inpatient medical-surgical Registered Nurses.

- *Dialysis (Tripler AMC/Pacific Island VAHCS (VAPIHCS))*
  This project proposes to expand dialysis services by providing the staff necessary to optimize the use of existing TAMC dialysis center. Hiring additional staff will allow TAMC to provide acute dialysis for its patients who need to be initiated or maintained on dialysis while they are inpatients. Additionally, by combining human resources to improve access to dialysis care, this project will support the VAPIHCS outpatient chronic dialysis mission by saving approximately $40,000 per patient each year in purchased care costs.

- *Pain Management Improvement (Tripler AMC/Pacific Island VAHCS)*
  The Tripler Army Medical Center's Pain Rehabilitation Program proposes to recapture pain management workload currently being outsourced by hiring a full-time board-certified anesthesiologist with a subspecialty in pain

management. Currently, the anesthesiologist for pain rehabilitation position has been staffed part-time through the surgery department. Due to the volume of referrals and unpredictability of the anesthesiologist's schedule, the clinic has had non-availability status for all new non-active duty referrals for the past six months.

- *Joint MRI (VAMC North Chicago/NH Great Lakes)*
  The proposal calls for a state-of-the-art open-field MRI that will be permanently housed in a modern MRI suite. A full-time fixed-site would greatly reduce patient wait time and expensive referrals for contract care. It would reduce delays in treatment and ultimately reduce the length of stay for acutely ill inpatients. This project would also include funding for a radiologist to perform interpretation of MRIs and provider needed consultation.

- *Clinical Fiber-Optics (VAMC North Chicago/NH Great Lakes)*
  The project proposes to provide high speed clinical connectivity between both facilities. This project will provide the necessary bandwidth to transmit clinical images for the VA's Picture Archive Computer System, VistA Imaging, and CPRS for a cost of only $181,000.

- *Oncology (VA Medical Center, North Chicago and Naval Hospital, Great Lakes)*
  This proposal creates a Hematology-Oncology program that provides a range of services to VA/DoD beneficiaries including consultation, inpatient support, outpatient care, and chemotherapy. At the present time, neither organization has Hematology-Oncology services, and all patients are referred to the local community. In addition, combining services will improve access to timely services without necessity for extensive travel. Bringing Hematology-Oncology services to North Chicago will increase the educational value of residency training programs and continuing education/breadth of practice for staff.

- *Digital Imaging (South Texas VAHCS/Wilford Hall Medical Center (WHMC))*
  This project involves image data sharing and establishes a pilot data exchange program in the San Antonio area for both VA and DoD. It will explore developing links to each enterprise's electronic medical record capability. Further, it will allow for the seamless sharing of digital images, texts and patient demographic information between clinical VA and DoD systems; i.e., WHMC, Audie Murphy VAMC, North Central VA/DoD Outpatient Clinic and other locally planned joint outpatient clinics, for a cost of $3,450,000.

- *Hyperbaric Medicine (South Texas VAHCS/Wilford Hall)*
  The United States Air Force School of Aerospace Medicine purchased a state-of-the-art, multi-place hyperbaric chamber and proposes to install it at WHMC where it can be utilized for hyperbaric oxygen therapy. Since the chamber has been funded and purchased, only the facility modifications are needed for installation.

- *Mobile MRI (Cheyenne VA Medical Center/F.E. Warren Air Force Base)*
  Currently, there is no in-house MRI availability in a Military Treatment Facility or VA Medical Center in northern Colorado or Wyoming. This project is designed to provide a mobile MRI device that can be moved between the VAMCs in Cheyenne and Sheridan for services to eligible veterans, active duty personnel from F.E. Warren AFB, and TRICARE beneficiaries in northern Colorado and Wyoming.

- *Mobile MRI (VA Medical Center Boise and Mountain Home Air Force Base)*
  This project proposes to purchase a mobile MRI unit, digital printer, and site preparation that would enable the Boise VAMC and the 366th Medical Group, Mt. Home AFB, to recapture MRI exams currently purchased in the central Idaho community. No federal facility in central Idaho has MRI capability. The mobile MRI will provide a state-of-the-art diagnostic capability, with much improved access at significantly reduced costs, thereby enhancing the quality of care provided to veterans, active duty personnel assigned to Mt. Home AFB, and TRICARE beneficiaries in central Idaho.

- *Health Care Planning Data Mart*
  This project is designed to develop a standard data repository integrating key data from VA and Air Force sources and produce a core set of reports and analytical reporting tools that will provide key management information for local VA/Air Force health care planning and operational activities. The project will build on the lessons learned and databases developed during the VA/DoD Joint Assessment Study. In addition, the project will build on the success experienced by VA and Air Force in extracting, linking, and sharing data on health care services purchased in the community.

- *Mobile MRI (Black Hills VAHCS/Ellsworth AFB South Dakota)*
  This project proposes purchasing a mobile MRI unit that would enable the VA Black Hills Health Care System and Ellsworth AFB to recapture MRI exams currently being purchased in the Rapid City community. Mobile MRI services could then be provided at VA Black Hills Health Care System, Ft. Meade, Hot Springs, and Ellsworth AFB, SD at a cost of $2 million.

SECTION 4.3 - HEALTH CARE RESOURCES SHARING AND COORDINATION

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 implemented in 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.

From FY 2005 through FY 2007, each Department will make available $9 million for each year. The Joint Facility Utilization and Resource Sharing Workgroup is in the process of collecting lessons learned from the demonstration sites for dissemination to other sharing sites where applicable. The seven demonstration sites approved by the HEC are as follows.

Budget and Financial Management

VA Pacific Islands HCS –Tripler AMC

The goal of this demonstration project is to conduct studies of four key areas of the joint venture operations revenue cycle: 1) Health Care Forecasting, Demand Management, and Resource Tracking; 2) Referral Management and Fee Authorization; 3) Joint Charge Master Based Billing; and 4) Document Management. In 2005, the site focused on Joint Charge Master Based Billing and Health Care Forecasting. Studies were conducted and staff are evaluating and prioritizing recommendations from the study for possible implementation.

Alaska VA HCS – Elmendorf AFB, 3rd Med Group

This project is designed to achieve the following goals: 1) evaluate areas of business collaboration as VA moves its operations to the existing joint venture hospital; 2) generate itemized bills and utilize the existing VA fee program to capture workload and patient specific health information across agency lines; and 3) create a coordinated calculation of cost-based expenses to assist in market area procurement decisions. This year, the project successfully completed the implementation of itemized bills for emergency room encounters and inpatient stays, and began work on expanding capability to include outpatient care.

Coordinated Staffing and Assignment

Augusta VA HCS – Eisenhower AMC

This project is intended to integrate human resources processes and systems for joint recruitment and training. The goals of the project are to: 1) employ the Augusta VA's successful recruitment initiatives to aid DoD in hiring staff for direct patient care positions they have had difficulty filling; 2) coordinate training initiatives so that direct patient care staff may take advantage of training opportunities at either facility; and 3) hire and train a select group of staff that could serve either facility when a critical staffing shortage occurs. Over the course of the year, the project facilitated the hiring or placement of 26 employees and interns. By developing a coordinated approach towards staffing, both facilities benefited from savings in cost, time, and training resources.

Hampton VA Medical Center – Langley AFB, 1st Med Group

The goals of this project are to: 1) develop a process to identify agency-specific needs to address staffing shortfalls for integrated services; 2) create a method to compare, reconcile, and integrate clinical services requirements between facilities; 3) determine a payment methodology to support the procurement process; 4) establish a joint referral and appointment process, to include allocation of capacity and prioritization of workload; and 5) maintain an ongoing assessment of issues and problem resolution. Accomplishments this year include the use of a web-based technology to extract, manipulate and report integrated patient and clinical data. The sites received facility specific data in September 2005.

Medical Information and Information Technology

Puget Sound VA HCS – Madigan AMC

The goal of this project is to transmit a limited subset of currently available outpatient clinical data between VA and DoD using the Bidirectional Health

Information Exchange (BHIE). Having successfully exchanged patient information including demographic, outpatient pharmacy, radiology and allergy data in 2005, this demonstration project is scheduled to be replicated at additional VA and DoD sites during FY 2006. This project will also use DoD/VA adopted standards to extract and transmit discharge summaries to be viewable by VA for shared patients.

El Paso VA HCS – William Beaumont AMC

The goal of this project is to implement the Laboratory Data Sharing Initiative (LDSI) that facilitates the electronic sharing of chemistry laboratory order entry and results retrieval. LDSI eliminates the need for manual entry of results. This effort should decrease errors caused from transcription and increase the speed at which lab results are available to VA providers from DoD or to DoD providers from VA. The sites are currently testing a technical solution that will provide laboratory order portability between the two facilities. Another goal of this site is to implement BHIE in an AHLTA environment. BHIE was implemented in FY 2005 and is being successfully utilized by DoD and VA providers. At the end of FY 2005, 40 individual laboratory tests had been mapped and 25 are currently being shared.

South Texas VA HCS – Wilford Hall AFMC and Brooke AMC

The goal of the project is to create bidirectional communication between VistA and CHCS to facilitate ordering, sending, and receiving lab tests. Benefits from this demonstration include more efficient use of human resources and improved timeliness and accuracy of results. These benefits should translate into enhanced patient safety and care. These sites are collaborating to test a Lab Data Sharing Interface and a joint credentialing interface between DoD Centralized Credentials Quality Assurance System and VA VetPro System. At the end of the FY 2005, seven original chemistry tests had been mapped and development of anatomic pathology and microbiology functionality was underway.

SECTION 4.4 - EDUCATION AND TRAINING AGREEMENTS

There are 119 VA/DoD agreements involving education and training support, including training for physicians and nurses. These agreements typically involve training opportunities in exchange for staffing assistance. Most agreements are between VA Medical Centers (VAMCs) and Reserve units.

Graduate Medical Education

The VA/DoD Graduate Medical Education Workgroup made considerable progress in advancing inter-Departmental collaboration in Graduate Medical Education. In FY 2005, the Workgroup piloted a new program for military physician residents to be placed at VA-affiliated university sites to receive advanced clinical training. As part of the curriculum, the DoD medical residents rotated through VA patient care areas and provided care to VA patients. In September 2005, the Graduate Medical Education Workgroup distributed 155,000 copies of the newly developed Trainee Military History Card, which educated health professions trainees (including physician residents) about the potential health consequences of military service.

Continuing Education and Training

During FY 2005, the Continuing Education and Training Workgroup provided the forum for enhancing the collaboration on joint training initiatives between the two Departments. Significant progress has been made in this area during FY 2005, including:

- The establishment of a shared training strategic plan, including strategic goals, objectives, and processes for designing, developing, and managing projects and programs intended to facilitate increased sharing of continuing education and training opportunities between the two Departments.

- The development of operational elements and procedures necessary to support the shared training venture.

- The implementation of a plan to commence sharing in-service training and continuing education programs on an interim basis while developing distributed learning architectures and refining operational processes.

- A total of 60 training programs were provided by VHA to DoD with a value of $900,000, and 28 training programs were provided by DoD to VHA with a value of $420,000. This training was a value-added byproduct of the demonstrations and pilots conducted to test various aspects of the shared training architecture and its components which were done as pre-work to the development of the FY 2006 shared training strategic plan.

SECTION 4.5 – VA/DoD PROMOTION OF HEALTH CARE RESOURCES SHARING AND COORDINATION

VA and DoD provide care to certain patients on a reimbursable basis. Funds generated from TRICARE patients provide revenues which can be used by VA to provide care to VA beneficiaries. The benefits to VA and TRICARE patients include additional services and extended hours for care. One hundred and thirty six (out of 157) VA Medical Centers reported reimbursable revenues during the year. This is an increase of 59 percent over the previous year.

The 2005 TRICARE Conference featured a full track on collaboration between VA and DoD. Among the 10 sessions offered were presentations on VA/DoD Collaboration – The Way Ahead, the VA DoD Joint Assessment Study, Seamless Transition, and Interoperability Update. These sessions were co-presented by VA and DoD staff.

VA and DoD staffed an exhibit at the annual Association of Military Surgeons of the United States (AMSUS) meeting in November 2004, in Denver, CO. Booklets and maps promoting sharing were disseminated. The Air Force sponsored a VA/DoD Joint Venture Conference on Bridging the Communications Barriers for Success, February 2005 at Travis AFB, CA. The focus was on reimbursement and Information Management/Information Technology.

SECTION 5 - NEXT STEPS

In FY 2005, VA and DoD made progress towards improving the quality and efficacy of services provided to veterans, servicemembers, military retirees, and their families.

During the next fiscal year, the Joint Executive Council will continue to focus its attention on issues such as financial management, capital asset planning, procurement, patient safety, deployment health, clinical guidelines, contingency planning, medical education, and benefits delivery. The *VA/DoD Joint Strategic Plan for FY 2006-2008* will serve as a primary means to measure performance and results, and progress will be achieved by building upon ongoing efforts and implementing new initiatives.

Both Departments will strive to advance the benefits of collaboration and cooperation that are necessary to achieve improved results in FY 2006, and beyond. The members of the Joint Executive Council, subordinate councils, committees, and workgroups remain committed to improving the efficient and effective utilization of VA and DoD resources.

VA/DoD
Joint Executive Council
Strategic Plan
Fiscal Years 2006-2008

VA/DoD Joint Executive Council
Strategic Plan
Fiscal Years 2006-2008

Gordon H. Mansfield
Deputy Secretary
Department of Veterans Affairs

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

January 2006

Appendix A
VA/DoD Joint Strategic Plan
Fiscal Years 2006-2008

Department of Veterans Affairs/Department of Defense Joint Strategic Plan for Fiscal Years 2006–2008

MISSION

To improve the quality, efficiency, and effectiveness of the delivery of services and benefits to veterans, servicemembers, 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 provides seamless, cost-effective, quality services to beneficiaries and delivers value to the Nation.

GUIDING PRINCIPLES

- **Collaboration** – Achieve shared goals through mutual support of our common and unique mission requirements.
- **Stewardship** – Provide the best value for the beneficiaries and the taxpayer through increased coordination.
- **Leadership** – Establish clear policies and guidelines for enhanced partnerships, resource sharing, decision making, and accountability.

STRATEGIC GOALS

Goal 1 **Leadership, Commitment, and Accountability** – Promote accountability, commitment, communication, and performance 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** – Improve the understanding of, and access to, services and benefits that servicemembers and veterans are eligible for through each stage of their life, with a special focus on ensuring a smooth transition from active duty to veteran status.

Goal 4 **Integrated Information Sharing** – Ensure beneficiary and medical information is visible, accessible, and understandable through secure and interoperable data management systems.

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

Goal 6 **Joint Medical Contingency/Readiness Capabilities** – Ensure the active participation of both Departments in federal and local incident and consequence response through joint contingency planning, training, and exercises.

Goal 1 - Leadership, Commitment, and Accountability

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

VA and DoD will maintain a leadership framework to promote successful partnerships, institutionalize change, and sustain momentum and 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 other necessary sub-councils or workgroups. The JEC will be responsible for developing a plan to increase the exchange of knowledge and information between the Departments, as well as with external stakeholders.

Objective 1.1

Improve the access, quality, cost effectiveness, and efficiency with which benefits and services are provided to beneficiaries of VA and DoD through increased resource sharing and organizational collaboration.

Strategies and Key Milestones

1.1(a) The JEC will provide leadership and strategic direction for VA/DoD collaborative efforts through the development and annual revalidation of a joint strategic plan. The JEC will monitor progress and report annually to the Secretaries of Veterans Affairs and Defense and Congress.

1.1(b) The JEC will provide executive oversight to ensure accountability of VA/DoD collaboration efforts through quarterly report monitoring.

1.1(c) The JEC will provide for the coordination of HEC and BEC initiatives and provide a forum for conflict resolution between the Departments.

Performance Measures

- The JEC will monitor the strategies and key milestones of the HEC and BEC on a quarterly basis.
- The JEC will provide leadership in the development of appropriate plans to overcome impediments to meeting stated goals and objectives when specific strategies and milestones are not met.

Objective 1.2

Improve stakeholder awareness of sharing and collaboration initiatives, and communicate and promote results and *best practices* throughout the two Departments.

Strategies and Key Milestones

1.2(a) The JEC will foster and support clear communication to ensure that optimal conditions exist for collaboration. The JEC will accomplish this by implementing a joint communication plan. The JEC will promote communication by developing and distributing an integrated calendar of events to the councils, committees, and workgroups on a quarterly basis.

1.2(b) The JEC will foster and support intra-Department communications to ensure that field units remain informed about the ongoing collaboration and resulting *best practices* by launching an internet site detailing VA/DoD resource sharing initiatives and accomplishments by March of 2006. The site will be updated quarterly.

1.2(c) The JEC will foster and support communication with internal and external stakeholders, as well as with other organizations and the public, to advance strategies that improve sharing and collaboration. This will be accomplished by issuing a quarterly report to VA and DoD Offices of Public Affairs.

Performance Measures

- Identify and survey key internal and external stakeholders to determine awareness of VA/DoD *best practices* web site.
- Ensure that 100 percent of press releases related to VA/DoD collaboration are developed and released jointly by the appropriate VA and DoD Offices of Public Affairs.

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 services for all beneficiaries. Collaboration will continue on developing joint guidelines and policies for the delivery of high-quality care and the 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 ensure that the two systems are mutually supportive.

Objective 2.1

Be leaders in developing and delivering innovative clinical processes and programs that enhance the quality of health care.

Strategies and Key Milestones

2.1(a) The Health Executive Council (HEC) will oversee the design, development, and distribution of patient safety-related initiatives including:

- **(1)** Assessing the need for a DoD Patient Safety Center (DPSC) patient safety alert and advisory rating system by September 2006.
- **(2)** Conducting a joint assessment of the curriculum activities at the DoD Center for Education and Research in Patient Safety (CERPS) and the VA National Center for Patient Safety to share existing materials and identify potential areas for collaboration by September 2006.
- **(3)** Evaluating medical product design, using DoD's human factors expertise and VA's capabilities by September 2006.
- **(4)** Issuing a report on potential for VA and DoD joint purchasing and procurement of medical devices by September 2006.

2.1(b) The HEC will facilitate the development, adoption, and dissemination of evidence-based decision tools to the field.

- **(1)** The HEC will update, revise, or adopt four Clinical Practice Guidelines (CPGs) annually. In support of these CPGs, the HEC will evaluate and recommend appropriate implementation tools, data collection methods, and evidence-based performance (EBP) measures for each CPG within six months of adoption or modification.

(2) The HEC will collect baseline data on practitioner's knowledge, attitude, and behavior as it related to the use of CPGs by December 2006.

2.1(c) The HEC will conduct an assessment of opportunities for greater VA/DoD collaboration on mental health issues and issue a report with findings and recommendations by September 2006.

2.1(d) The HEC will provide a semi-annual report on progress related to sexual trauma issues (consistent with the DoD Care for Victims of Sexual Assault Summit recommendations of September 2004 and the VA Advisory Committee on Women Veterans 2004 Report).

Performance Measure

- Implementation of four new or revised clinical practice guidelines per year.

Objective 2.2

Actively engage in collaborative Graduate Medical Education (GME), joint in-service training, and continuing education activities that will enhance quality, effectiveness, and efficiency of health care delivery.

Strategies and Key Milestones

2.2(a) The HEC will examine opportunities for greater VA/DoD GME collaboration and present findings and recommendations.

(1) Conduct an impact analysis and lessons-learned study regarding placement of military residents into VA affiliated residency programs by July 2006.
(2) Conduct an inventory of GME programs impacted by the Base Realignment and Closure Commission (BRAC) and present a preliminary assessment with recommended VA/DoD actions by June 2006.
(3) Pilot a *Seamless Transition for Trainees Program* at one site based on approval of HEC by July 2007.
(4) Conduct evaluation of *Seamless Transition for Trainees Program* pilot site based on interviews with VA and DoD officials reporting results and lessons learned by November 2007.

2.2(b) The HEC will explore and develop opportunities for shared or combined continuing education and in-service training programs for health care professionals at VA and DoD facilities. Implement the following elements of the shared VA/DoD training plan:

(1) Commence sharing in-service training and continuing education programs on an interim basis while developing distributed learning architectures and refining operational processes by December 2005.
(2) Assess distributed learning architectures to identify those best suited to support the shared training venture by September 2006.
(3) Select distributed learning architectures to be used to implement shared training ventures by October 2006.
(4) Develop a distributed learning architecture to support the shared training venture by March 2007.

2.2(c) Develop the operational elements and procedures necessary to support the shared training venture including:

(1) Develop procedures for identifying and vetting programs to be shared by October 2005.
(2) Develop processes for granting continuing education credit to selected shared training participants by October 2005.
(3) Develop a process for marketing programs to be shared by March 2006.
(4) Develop a procedure for calculating the return on investment of the shared training venture by September 2006.
(5) Develop a process for distributing programs by March 2007.

2.2(d) Establish *communities of practice* to support local shared training initiatives between VA and DoD field locations.

(1) Identify existing *communities of practice* that support the shared training effort by February 2006.
(2) Develop a pilot to demonstrate the efficacy of *communities of practice* by June 2006.
(3) Develop a toolbox of materials to assist local educators at VA facilities and DoD bases in developing shared training efforts by July 2006.
(4) Provide in-service training to VHA and DoD training staff in joint sessions on how to use the *toolbox* materials and how to work collaboratively to develop local shared training programs by December 2006.

Performance Measure

- Beginning in December 2006, the HEC will report annually on the number of individuals who have participated in joint training and/or *communities of practice*.

Objective 2.3

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.

Strategies and Key Milestones

2.3(a) The HEC will review quarterly the status of initiatives related to deployment health surveillance, assessment, and follow-up.

2.3(b) The HEC will provide annual recommendations for updating and modifying the VA/DoD Deployment Health strategic initiatives.

2.3(c) The HEC will compare and coordinate research initiatives on military and veterans' related health research to include deployment health issues:

(1) Establish a reporting system from each Department to the Research Subcommittee of the Deployment Health Working Group for new research initiatives related to deployment health issues by July 2006.
(2) Conduct an annual inventory and catalog current research on deployment health issues in each Department (first report by September 2006).
(3) Establish a VA/DoD forum for sharing findings of deployment health-related research by June 2007.

Performance Measure

- The Research Subcommittee of the Deployment Health Working Group will provide an inventory of all VA/DoD collaborative research projects on deployment health-related issues annually to the HEC. The first inventory will be completed by September 2006.

Objective 2.4

Develop and implement initiatives to improve joint programs and appropriate follow-up procedures to provide world-class health care to injured or ill servicemembers and veterans, including activated members of the National Guard and Reserve.

Strategies and Key Milestones

2.4(a) The HEC will further strengthen the partnership between Military Treatment Facilities (MTFs) and Veterans Affairs Medical Centers (VAMCs) to facilitate the seamless transition of care for servicemembers who require long-term medical care and rehabilitation.

(1) Formalize a Memorandum of Understanding (MOU) between VA and DoD to institutionalize the placement of VA benefits counselors and social workers at major MTFs receiving wounded from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). A signed MOU will be in place by September 2006.

(2) Increase the number of sites where VA staff are stationed at MTFs and where DoD staff are stationed at VAMCs, depending on workload and increased numbers of those entering the Physical Evaluation Board (PEB) process each year. Implement five new sites by September 30, 2006.

2.4(b) The HEC will develop and implement a plan by March 2006 to increase VA's ability to identify and treat timely those servicemembers who are severely injured and/or ill. The plan will include a process to provide VA with information on 100 percent of those servicemembers identified through the PEB process.

2.4(c) The HEC will further develop and institutionalize processes to ensure appropriate and timely access to VA health care services and benefits for separating National Guard and Reserve members.

(1) Develop regional and local partnerships between VA's leadership, National Guard Adjutant Generals, and State Directors of Veterans Affairs to enhance access and services to veterans and to provide information about VA benefits and services through coalitions that integrate VA services at the state and local levels. Formal partnerships will be developed and implemented by September 2006.

2.4(d) The HEC will develop *best practices*, protocols, or guidelines for VA and DoD health care providers, focusing on seriously injured or ill returning servicemembers. At least, two new *best practices* will be developed and implemented by July 2007.

(1) The *best practice* for amputee care will be developed by December 2006 and implemented by May 2007.
(2) The *best practice* for pre-assessment and transfer of polytrauma servicemembers will be developed by February 2007 and implemented by July 2007.

Performance Measure

- Formal partnerships between VA leadership, Adjutant Generals, and State Directors of Veterans Affairs will be established in at least 25 states by September 2006.

GOAL 3 - SEAMLESS COORDINATION OF BENEFITS

IMPROVE THE UNDERSTANDING OF, AND ACCESS TO, SERVICES AND BENEFITS THAT SERVICEMEMBERS AND VETERANS ARE ELIGIBLE FOR THROUGH EACH STAGE OF THEIR LIFE, WITH A SPECIAL FOCUS ON ENSURING A SMOOTH TRANSITION FROM ACTIVE DUTY TO VETERAN STATUS.

VA and DoD will enhance collaborative efforts to 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 the 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 the participation of cooperative separation process/examination at Benefits Delivery at Discharge (BDD) sites, and develop interoperable information management systems.

This goal encompasses benefits available to VA and DoD beneficiaries, to include health care, educational assistance, home loans, vocational rehabilation and employment, 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.

Strategies and Key Milestones

3.1(a) The BEC will further expand on efforts to disseminate information on benefits and services available to VA and DoD beneficiaries throughout the military personnel lifecycle, with emphasis at accession by June 2006.

- **(1)** Disseminate *VA Health Care and Benefits Information for Veterans* wallet cards and *A Summary of VA Benefits* pamphlets to military academies by April 2006.
- **(2)** Develop a Public Affairs plan to market VA services to military members by March 2006.

3.1(b) The BEC will increase participation in the two VA components of the Transition Assistance Program which are VA Benefits briefings and Disabled Transition Assistance Program (DTAP) briefings (for all separating or deactivating servicemembers qualified by law) on benefits and entitlements to provide the widest possible distribution of information and assistance.

(1) VA personnel will participate in briefings at all overseas locations where DoD provides transition assistance by October 2006.
(2) Launch a one-stop informational web site for transition assistance by July 2006.

Performance Measure

- Increase the percentage of separating, deactivating, and retiring servicemembers who participate in VA benefits and TAP/DTAP briefings prior to separation, deactivation, or retirement to 61 percent by FY 2008.

FY 2006 Goal – 53 percent
FY 2007 Goal – 57 percent
FY 2008 Goal – 61 percent

Objective 3.2

Institutionalize a cooperative separation process/examination that is valid and acceptable for all military service separation requirements and acceptable for VA compensation requirements to streamline claims processing for compensation, vocational rehabilitation, and employment assistance.

Strategies and Key Milestones

3.2(a) The BEC will develop an implementation plan to increase the number of servicemembers receiving a separation examination that meets both the service separation requirements and VA's disability compensation requirements.

Performance Measures

- Increase to 100 percent, the number of DoD BDD sites using a cooperative separation process/examination (from the current 111 sites to 133).
- Percent of original claims filed within the first year of release from active duty that are filed at a BDD site prior to a servicemember's discharge.

FY 2006 Goal – 53 percent
FY 2007 Goal – 57 percent
FY 2008 Goal – 61 percent

Objective 3.3

Develop a single, consistent set of definitions for military operations and for *Reserve Forces Ordered to Active Duty*. Consistent definitions will expedite accurate determinations of eligibility for VA health care and disability benefits among veterans who were deployed; will assist in the preparation of VA reports describing VA health care and benefit activity among veterans who were deployed; and assist in identifying deployed populations for scientific research.

Strategies and Key Milestones

3.3(a) Prepare a draft set of definitions of current military operations by December 2005, consistent with 38 U.S.C. 101(33), for review and approval by VA and DoD.

- *Global War on Terrorism*
- *Operation Enduring Freedom*
- *Operation Iraqi Freedom*
- *Operation Noble Eagle*

(1) Prepare draft definition for *Reserve Forces Ordered to Active Duty* by February 2006.
(2) Present recommendations to BEC/JEC by June 2006.
(3) Incorporate formal definitions into VA benefits adjudication and health care eligibility determinations by September 2006.

GOAL 4 - INTEGRATED INFORMATION SHARING

ENSURE BENEFICIARY AND MEDICAL INFORMATION IS VISIBLE, ACCESSIBLE, AND UNDERSTANDABLE THROUGH SECURE AND INTEROPERABLE DATA MANAGEMENT SYSTEMS.

VA and DoD will develop interoperable enterprise architectures and data management strategies to support timely and accurate delivery of benefits and services. The emphasis will be on working together to store, manage, and share data and streamline applications and procedures to make access to services and benefits easier and faster.

Objective 4.1

VA and DoD will design their enterprise architectures to support sharing of timely, consistent personnel-related data.

Strategies and Key Milestones

4.1(a) The BEC will create an interagency plan to enhance the interoperability of beneficiary data and the delivery of benefits.

- **(1)** Complete a *VA/DoD Data Sharing Strategy and Work Plan* that identifies and defines the high-level project milestones, significant interagency dependencies, general timelines, and key administration legacy application modifications by December 2005.
- **(2)** Implement Activation and Mobilization data enhancement to the *VA/DoD Data Sharing Schema* by March 2006.
- **(3)** Implement Education/Insurance eligibility data enhancement to the *VA/DoD Data Sharing Schema* by September 2006.
- **(4)** Replace and decommission all feasible legacy exchanges from DoD to VA and from VA to DoD in favor of a single bidirectional solution by December 2008.
- **(5)** Develop a plan and strategy to implement Identity Management for VA/DoD data sharing by March 2006. Identity Management will allow secure access for authorized servicemembers and veterans to their own personnel information.

Performance Measure

- Reduce the overall number of distinct data exchanges between VA and DoD, and centralize the management of all VA requirements for DoD data into a single interagency body.

FY 2006 – 15 from DMDC; 5 to DMDC
FY 2007 – 10 from DMDC; 5 to DMDC
FY 2008 – 1 from DMDC; 1 to DMDC

Objective 4.2
Improve the effectiveness and efficiency of data accessible to VA on separating and separated military personnel.

Strategies and Key Milestones
4.2(a) The BEC will enhance Veterans Benefits Administration (VBA) access to separating servicemembers health data through the Federal Health Information Exchange (FHIE), while maintaining appropriate security.

(1) Test enhanced Compensation and Pension Record Interchange (CAPRI) access to new FHIE data, pre- and post-deployment health assessments, by January 2006.
(2) Implement enhanced CAPRI access to FHIE data nationwide by March 2006.

Objective 4.3
Create an environment in which demographic and medical data is shared between VA and DoD to enhance the service delivery in both organizations.

Strategies and Key Milestones
4.3(a) The BEC will enhance and refine interagency collaboration on the exchange of information and data between VA and DoD by allowing VA claims examiners access to digital (scanned) copies of personnel records from all service departments through DoD's Defense Personnel Records Image Retrieval System (DPRIS).

(1) DoD deploys a web-based version of DPRIS, which will allow VA to access DPRIS directly without going through Personnel Information Exchange System (PIES), by April 2006.
(2) DoD will transition from an image/paper-based personnel records management environment to a data-centric environment by 2008.

Performance Measures
- VA is able to identify all servicemembers who served in support of a named contingency by March 2006.
- VA will have access to servicemember education and insurance benefit eligibility data by September 2006.
- VA has timely (within 48 hours) access to the location of paper benefit eligibility information by December 2008.
- VA has secure and timely (within 48 hours) access to accurate benefit eligibility information available through an electronic medium (data or images) by December 2008.

Objective 4.4
VA and DoD will structure their health enterprise architectures to support sharing of timely, consistent health data.

Strategies and Key Milestones

4.4(a) The HEC will build on the efforts of the government-wide Federal Health Architecture (FHA) initiative to enhance sharing of health information.

(1) Identify joint information needs by July 2006.
(2) Assess and report on current availability of identified information by July 2006.
(3) Build an interagency architecture and joint VA/DoD data strategy for health data that is compliant with the FHA by February 2007.

4.4(b) The HEC will ensure that future health interagency initiatives are in compliance with the VA/DoD targeted architecture.

(1) Continue joint participation in the interagency joint compliance review process.
(2) Apply the interagency compliance review process to joint VA/DoD health information sharing initiatives by November 2005.

Performance Measure

- Percent of VA/DoD projects and initiatives reviewed for compliance with interagency architecture and the joint Target VA/DoD Health Standards Profile:

FY 2006 (1st Quarter) – 33 percent
FY 2006 (2nd Quarter) – 67 percent
FY 2006 (3rd Quarter) – 100 percent

Objective 4.5

Adopt common standards to facilitate greater interoperability between health systems.

Strategies and Key Milestones

4.5(a) The HEC will develop implementation guidelines for appropriate and useful Consolidated Health Informatics (CHI) standards and identify potential standards for additional domains.

(1) Recommend implementation guidelines for one CHI standard by January 2006.
(2) Recommend standard(s) for CHI adoption (for one domain) by February 2006.
(3) Recommend implementation guidelines for one CHI standard by August 2006.
(4) Begin work on an additional implementation guideline for a CHI adopted standard by August 2006.

Performance Measure

- Develop one implementation guideline annually for appropriate and useful CHI standards adopted by VA and DoD.

Objective 4.6

Enhance the effectiveness and efficiency of VA access to the electronic health data on separating and separated military members, and VA and DoD access to electronic health information on shared patients.

Strategies and Key Milestones

4.6(a) The HEC will continue sharing electronic health information at the time of a servicemember's separation, while maintaining appropriate security, and support the electronic bidirectional sharing of health information between VA and DoD.

- **(1)** Provide a timeline and milestones for making outpatient pharmacy data, allergy information, and radiology and laboratory results from DoD's Clinical Data Repository viewable to VA on shared patients by January 2006.
- **(2)** Maintain operating capability to view outpatient pharmacy data, allergy information, and radiology and laboratory results at current sites with bidirectional data sharing.
- **(3)** Provide a timeline and milestones for additional data elements to be viewed bidirectionally and in real time for shared patients by March 2006.
- **(4)** Expand bidirectional, real-time view of outpatient pharmacy data, allergy information, and radiology and laboratory results to two additional sites with a business case by February 2006.
- **(5)** Expand current capability for bidirectional real-time view of outpatient pharmacy data, allergy information, and radiology and laboratory results on shared patients to an additional two sites with a business case by March 2006.
- **(6)** Continue expansion of the bidirectional real-time view of outpatient pharmacy data, allergy information, and radiology and laboratory results on shared patients at additional sites where a business case exists by May 2006.
- **(7)** Continue to make additional data elements viewable as a business case exists and expansion is approved by the HEC.

4.6(b) The HEC will support electronic transfer of pre- and post-deployment health assessments on separated servicemembers from the Defense Medical Surveillance System Office to VA.

- **(1)** Achieve VA capability to view pre- and post-deployment health assessment data by December 2005.
- **(2)** Continue monthly transfer of the electronic pre- and post-deployment health assessments.
- **(3)** Provide a timeline by March 2006 for transferring to VA the electronic post-deployment health reassessments on separated servicemembers.

4.6(c) The HEC will support bidirectional electronic transfer/sharing of laboratory order entry and results retrieval between VA, DoD, and commercial reference laboratories.

- **(1)** Continue demonstrating the system capabilities at the two NDAA Demonstration Sites (El Paso and San Antonio).
- **(2)** Expand the capability at two additional sites for which the business case exists. Complete one by March 2006, and one by September 2006.
- **(3)** Begin testing the expansion of the capability to include anatomic pathology and microbiology by September 2006.

(4) Identify two additional sites for the implementation of the anatomic pathology and microbiology functionality for which the business case exists by December 2006.

(5) Continue to expand and recommend refinements as the business case determines.

Performance Measure

- Monitor usage and report progress on expansion of bidirectional health information sharing on quarterly basis to the HEC IM/IT Work Group.

GOAL 5 - EFFICIENCY OF OPERATIONS

IMPROVE THE MANAGEMENT OF CAPITAL ASSETS, PROCUREMENT, LOGISTICS, FINANCIAL TRANSACTIONS, AND HUMAN RESOURCES.

VA and DoD will enhance the coordination of business processes and practices through improved managing of 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 other key business functions.

Objective 5.1

The VA/DoD Construction Planning Committee (CPC) will implement a pilot core group process to develop collaborative capital opportunities at three sites identified through the Base Realignment and Closure Commission (BRAC) process.

Strategies and Key Milestones

5.1(a) The CPC will identify three locations from the BRAC list that coincide with VA capital requirements as identified in the VA 5-Year Capital Plan and Capital Asset Realignment for Enhanced Services (CARES) program to initiate the core group pilot. Within 30 days of notification by DoD of specific properties that are available for VA, the CPC will provide a status report to the JEC, including a proposed process and timeline for selection of the pilot sites.

5.1(b) The CPC will augment the core group with regional and local members of each Department at the three identified sites. The core group will identify a collaborative opportunity initiative and develop concept plans for specific infrastructure projects in order to designate planning funds in the budget request.

Performance Measure

- Provide status report to the JEC on a quarterly basis.

Objective 5.2

Leverage joint purchasing power in the procurement of prosthetics, standardized medical/surgical supplies, high-cost technical equipment, and dental, laboratory, and x-ray equipment.

Strategies and Key Milestones

5.2(a) The HEC will assess VA and DoD processes related to the acquisition of goods and services and make recommendations to achieve joint operational and business efficiencies.

(1) Conduct a VA/DoD meeting to review acquisition processes by April 2006.
(2) Identify functional areas with potential for joint efficiencies and develop recommendations for increasing joint acquisition by July 2006.

5.2(b) The HEC will work with industry on uniform identification codes for medical surgical products, and strive for consensus between industry and federal partners on a standard format for naming or labeling through the Materiel Management Workgroup.

(1) Track the number of active partners and manufacturers who have adopted actual assignment of uniform identification codes in the medical/surgical arena by reporting at the Materiel Management Workgroup.
(2) Update federal catalogs as standardization occurs and data becomes available. This is an on-going effort supported by cross-sharing of information between the Departments. The appropriate contracting officer takes the lead in updating this information as awards are made.

5.2(c) The HEC will increase the value of joint contracts by $10 million by September 2006, targeting commonly used manufacturers for joint contract initiatives and continuing to seek new opportunities for joint contract initiatives.

(1) Track the number of joint contracts and estimated savings quarterly in a report to the Materiel Management Workgroup.
(2) Assure that awards for joint contracts for high technology medical equipment are alternated between the Departments and provide an annual report to the Materiel Management Workgroup.
(3) NAC and DSCP will work together to issue a joint solicitation for imaging contracts by September 2006 for award in FY 2007.

Performance Measures

- Report semi-annually to the HEC on the status of the Materiel Management Workgroup.

- Increase joint acquisition sales realized from the joint procurement of high cost medical equipment by $10 million annually, beyond the 2006 baseline level of $150 million.

FY 2006 – $150 million
FY 2007 – $160 million
FY 2008 – $170 million

Objective 5.3

Establish a common electronic catalog for all items under contract by both Departments.

Strategies and Key Milestones

5.3(a) The HEC will ensure appropriate personnel are familiar with and utilize the Defense Supply Center Philadelphia (DSCP) Medical Electronic Customer Assistance (MECA). Applications will be developed to allow users to perform

product and pricing comparisons of medical, surgical, and pharmaceutical items by October 2005.

5.3(b) The HEC will establish a joint DSCP/VA Federal Supply Schedule (FSS) medical catalog that will allow both VA and DoD customers to perform product and price comparisons for medical/surgical supplies, pharmaceutical items, and medical equipment by October 2007. The Materiel Management Workgroup will provide a quarterly status report to the HEC.

5.3(c) The HEC will create a single database that includes all VA FSS as well as VA and DoD national contract information. A status report to the HEC through the Materiel Management Workgroup will be provided quarterly.

5.3(d) The HEC will expand access to *E-catalog* and joint purchasing to other federal agencies. Vendor Prototype will be completed by March 1, 2006, with a prototype of *E-catalog* by December 31, 2006. Data mapping is on-going. Test new capability from January to March 2007. Implement new capability by October 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.

Strategies and Key Milestones

5.4(a) The HEC supports joint collaborative efforts in support of the Centers for Medicare and Medicaid Services (CMS) initiatives to establish an insurance data repository. VA and DoD will continue joint collaboration with CMS, and quarterly progress reports will be issued, the first report to be submitted to the HEC by April 2006.

5.4(b) The HEC will develop guidance for VA/DoD standardized inpatient billing rates for direct sharing agreements by March 2006.

5.4(c) The HEC will oversee VA and DoD efforts to jointly implement the NDAA Demonstration Projects in budget and financial management, coordinated staffing and assignment, and medical information and information technology management.

- **(1)** Conduct annual progress reviews to be completed by March 31 of each year.
- **(2)** Continue to collect *lessons learned*.
- **(3)** Disseminate *lessons learned* to VA and DoD staff. *Lessons learned* will be presented in a VA/DoD breakout session at the TRICARE Conference in January 2006.

5.4(d) Explore opportunities to adjust, amend, or modify VA and DoD budget management processes and appropriation rules in order to enhance VA/DoD sharing and support future integrated federal medical care models. A report will be developed for the HEC by June 2006.

Goal 6 - Joint Medical Contingency/ Readiness Capabilities

Ensure the active participation of both Departments in federal and local incident and consequence response through joint contingency planning, training, and exercises.

VA and DoD will collaborate to ensure that plans and readiness capabilities adequately support DoD combatant command contingency requirements and national emergency situations. This collaboration will include the following planning, training, and exercise activities:

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

Objective 6.1

Ensure that joint contingency and scenario-based planning supports DoD requirements.

Strategies and Key Milestones

6.1(a) Develop Departmental plans to support the revised VA/DoD Memorandum of Agreement (MOA) and Contingency Plan.

(1) Complete signature approval on the VA/DoD MOA and Contingency Plan by June 2006.

6.1(b) The HEC will 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.

(1) Include VA capabilities and capacities in DoD contingency plan updates. Process will be completed by June 2006.

(2) Conduct first annual review of joint contingency/readiness capability activities and report findings to the HEC by January 2007.

Objective 6.2

Collaborate on training and exercise activities that support the VA/DoD contingency plan.

Strategies and Key Milestones

6.2(a) Identify common training requirements and joint training opportunities for personnel involved in DoD contingency operations by January 2007.

6.2(b) The HEC will identify VA and DoD common exercise requirements in the Chairman of the Joint Staff Exercise program objectives to ensure that tasks such as patient movement within the continental United States and definitive care requirements are included by January 2007.

6.2(c) The HEC will promote and leverage existing, 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 preparedness operations by June 2006.

Appendix B
VA/DoD Health Care Resources Sharing Guidelines, July 1983

MEMORANDUM OF UNDERSTANDING BETWEEN THE VETERANS ADMINISTRATION AND THE DEPARTMENT OF DEFENSE

VA/DoD HEALTH CARE RESOURCES SHARING GUIDELINES

ARTICLE I

INTRODUCTION

1-101 Purpose. This agreement establishes guidelines to promote greater sharing of health care resources between the Veterans Administration (VA) and the Department of Defense (DoD). Maximization of sharing opportunities is strongly encouraged. Greater sharing of health care resources will result in enhanced health benefits for veterans and members of the armed services and will result in reduced costs to the government by minimizing duplication and underuse of health care resources. Such sharing shall not adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency. In addition, these guidelines are not intended to interfere with existing sharing arrangements.

1-102 Authority. These guidelines are established by the Administrator of Veterans Affairs and the Secretary of Defense pursuant to "The Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," Public Law 97-174, § 3, 96 Stat. 70, 70-73 (1982) (codified at 38 U.S.C. §5011).

ARTICLE II

DEFINITIONS

2-101 "Actual Cost" means the cost incurred in order to provide the heath care resources specified in a sharing agreement.

2-102 "Reimbursement Rate" means the negotiated price cited in the sharing agreement for a specific health care resource. This rate will take into account local conditions and needs and the actual costs to the providing facility or organization for the specific health care resource provided. For example, actual cost includes the cost of communications, utilities, services, supplies, salaries, depreciation, and related expenses connected with providing health care resources. Excluded from the reimbursement rate are building depreciation, interest on net capital investment and overhead expenses incurred at management levels above the medical facility or other organization providing the health care resources (e.g., Pentagon and

Central Office overhead). Equipment depreciation is a component of actual cost to be considered in establishing a reimbursement rate, but facilities are strongly encouraged to exclude it. This rate will be used for billing purpose by the providing medical facility or organization.

2-103 "Beneficiary" means a person who is a primary beneficiary of the VA or DoD.

2-104 "Primary Beneficiary" (1) with respect to the VA, means a person eligible under title 38, United States Code (other than under sections 611(b), 613, or 5011 (d)) or any other provision of law for care or services in VA medical facilities; and (2) with respect to DoD, means a member or former member of the Armed Forces who is eligible for care under section 1074 of title 10.

2-105 "Direct Health Care" means health care provided to a beneficiary in a medical facility operated by the VA or DoD.

2-106 "Head of a Medical Facility" (1) with respect to a VA medical facility, means the director of the facility, and (2) with respect to a medical facility of DoD, means the commanding officer, hospital or clinic commander, officer in charge, or the contract surgeon in charge.

2-107 " Health Care Resource" includes hospital care, medical services, and rehabilitative services, as those terms are defined in title 38 U.S.C. §601 (5), (6), (8); any other health care services, including such health care education, training, and research as the providing agency has authority to conduct; and any health care support or administrative resource or service.

2-108 "Medical Facility" (1) with respect to the VA, means facilities over which the Chief Medical Director has direct jurisdiction; and (2) with respect to DoD, means medical and dental treatment facilities over which DoD, or its organizational elements, or the component Services, have direct jurisdiction.

2-109 "Providing Agency" means (1) the VA, in the case of care or services furnished by a facility, or organizational elements, of the VA; or (2) DoD, in the case of care or services furnished by a facility, or organizational elements of DoD, or its component Military Services.

2-110 "Sharing Agreement" means a cooperative agreement authorized by Public Law 97-174, § 3, 96 Stat. 70, 70-73 (1982) (codified at 38 U.S.C. § 5011 (d)) for the use or exchange of use of one or more health care resources.

ARTICLE III

SHARING AGREEMENTS

3-101 Approval Process. Before a sharing agreement may be executed and implemented, the heads of the medical facilities involved shall submit the proposed agreement to: (1) the Chief Medical Director, through the appropriate Department

of Medicine and Surgery channel, in the case of the VA; (2) the Assistant Secretary of Defense (Health Affairs), or his or her designees, through the appropriate chain of command, in the case of DoD. The agreement shall be effective in accordance with its terms (A) on the 46th calendar day after receipt of the proposed agreement by the designated Department of Medicine and Surgery office on behalf of the Chief Medical Director for the VA, and the next higher organizational element within the chain of command for DoD, unless earlier disapproved by either agency; or (B) if earlier approved by both agencies on the day of such approval. An office that disapproves a sharing agreement shall send a copy of the agreement and a written statement of its reasons for disapproval to the VA/DoD Health Care Resources Sharing Committee.

3-102 Acquiring or Increasing Resources. A head of a medical facility may request permission to acquire or increase health care resources that exceed the needs of the facility's primary beneficiaries but that would effectively serve the combined needs of both agencies. Justification for acquiring or increasing resources may be based on the projected workload from a sharing agreement. Such requests will be considered in the usual planning and budgeting processes. Consideration of such requests will necessarily take into account many factors governing resource allocation. Agreements will not be submitted until permission to increase existing resources or to acquire new resources has been obtained.

3-103 Eligibility. Agreements may permit the delivery of health care resources to primary beneficiaries of one agency at facilities of the other agency. Direct health care to primary beneficiaries of the agency requesting services should be on a referral basis. Delivery of health care resources will not (as determined by the head of the facility of the providing agency) adversely affect the range of services, the quality of care, or the established priorities for care provided to beneficiaries of the providing agency.

3-104 Reimbursement and Rate Setting. Reimbursement for the cost of health care resources provided shall be credited to funds that have been allotted to the facility or organization that provided the care or services. The medical facility or organization providing the resources shall bill the recipient facility or organization directly. Billing frequency shall be established in the agreement. Reimbursement shall be forwarded to the providing medical facility in a timely manner. Heads of medical facilities and other organizations may negotiate a reimbursement rate that is less than actual cost to the providing facility or organization to account for local conditions and needs. (See definitions of "actual costs" and "reimbursement rate" in section 2-101 and 2-102.) The reimbursement rate many not be more than the actual cost to the providing facility or organization of the resources provided.

3-105 Scope of Agreements. The head of a medical facility or organization of either agency may agree to enter into a proposed sharing agreement with the head of a medical facility or organization of the other agency in accordance with these guidelines. Sharing agreements involving more than one medical facility of each agency may be developed. The Chief Medial Director and the Assistant Secretary of Defense for Health Affairs may agree to enter into regional or national sharing

agreements. Sharing agreements shall identify the health-care resources to be shared. Exchange of resources without billing is permitted if costs are specified in the agreement.

3-106 Education, Training, and Research Sharing Agreements.

1. Education and Training – Situation-specific sharing is encouraged at the local, regional, and national levels. Continuing education, formal technical training, and professional education, are areas to be emphasized.

To facilitate educational sharing the Office of Academic Affairs, Department of Medicine and Surgery, VA; and the Office of the Assistant Secretary of Defense for Health Affairs will:

a. Initiate an educational "clearing house" process to exchange information on potential sharing opportunities. This process will encourage the development of timely and effective sharing of educational and training resources.

b. Encourage an ongoing dialogue between those responsible for education and training at all levels – local, regional, and national.

2. Biomedical Research – To encourage more collaboration, an information exchange will be established. The Assistant Secretary of Defense for Health Affairs and the Chief Medical Director will designate representatives to establish such an exchange.

In joint projects or protocols involving human subjects, each agency's procedures for approval of "human studies" protocols will be followed. However, at a minimum, the Department of Health and Human Services Guidelines will be complied with. Sharing agreements involving "human studies" protocols will not be considered without approval of the protocol by both agencies.

3-107 Modification, Termination, Renewal. Each agreement shall include a statement on how the agreement may be modified and terminated. Proposed changes in the quality and quantity of resources delivered, in actual costs, and in the performance in delivering the resources are grounds for modification or termination. Sharing agreements shall provide for modification or termination in the event of war or national emergency. Agreements may exceed one year, provided necessary cost adjustment amendments are included and a statement is included in the agreement to the effect that if the contract period extends beyond the current fiscal year, the sharing agreement is subject to the availability of appropriations for the period after the first September 30 during which the agreement is in effect. Each party to the sharing agreement shall annually review the agreement to make certain that the resources being provided are in accordance with the agreement. Sharing agreements may be renewed in accordance with procedures to be established by each agency.

3-108 Reporting Requirements. The VA/DoD Health Resources Sharing Committee will retain copies of agreements for an annual report to Congress, which is required by the law. A copy of each agreement entered into or renewed will be sent by the

medical facilities or organizations entering into the agreements to the VA/DoD Health Care Resources Sharing Committee. It is the VA/DoD Sharing Committee's responsibility to prepare the annual report to Congress which the Secretary of Defense and the Administrator will submit.

ARTICLE IV

AGENCY PROCEDURES

4-101 Agency Guidance. Each agency will issue implementing and operating guidance to their organizational elements and medical facilities.

4-102 Review. Both agencies agree to refer existing policies, procedures, and practices relating to sharing of health-care resources between the agencies to the VA/DoD Health Care Resources Sharing Committee for its review, which is as required by 38 U.S.C. §5011 (b) (3) A.

4-103 Quality Assurance. Agency medical facilities shall maintain utilization review and quality assurance programs to ensure the necessity, appropriateness, and quality of health care services provided under this agreement. The content and operation of these programs shall, at a minimum, meet the requirements and guidelines set forth in the most recent editions of the Joint Commission on Accreditation of Hospitals accreditation manuals.

ARTICLE V

EFFECTIVE DATE, MODIFICATION, AND TERMINATION OF GUIDELINES

5-101 Duration. This memorandum becomes effective on the date of the last signature. Either party may propose amending these guidelines, but both must agree for amendments to take effect. Either party may terminate these guidelines upon 30 days written notice to the other party.

_____/s/_____
Harry N. Walters
Administrator, Veterans Administration

July 1, 1983

_____/s/_____
Casper W. Weinberger
Secretary
Department of Defense
29 JUL 1983

Appendix C
Cost Estimate to Prepare Congressionally Mandated Report

Title of Report: *VA/DoD JEC FY 2005 Annual Report*
Report Required by: Public Law 108-136, National Defense Authorization Act

In accordance with Title 38, Chapter 1, Section 116, the statement of cost for preparing this report and a brief explanation of the methodology used in preparing the cost statement are shown below.

Direct Labor Cost	$63,229
Contract(s) Cost	0
Production/ Printing Cost	$15,000
Total Estimated Cost to Prepare Report	$78,229

Explanation of the methodology used to project cost estimate:

The estimated number of direct labor hours expended per employee was multiplied by the U.S. Office of Personnel Management's calendar year 2005 hourly rate structure for the metropolitan Washington, DC area.

The calculated net labor costs were multiplied by the fiscal year 2005 fringe benefit amount of 23%. The reported information in the cost statement reflects sum of direct labor hour costs and fringe benefits.

VA/DoD
Joint Executive Council
Fiscal Year 2005
Annual Report

Department of Veterans Affairs
Office of Policy, Planning, and Preparedness
810 Vermont Avenue, NW (008)
Washington, DC 20420

Christopher LaLonde
Telephone: 202.273.7290
Fax: 202.273.5991
Email: christopher.lalonde@mail.va.gov

Department of Defense
DoD/VA Program Coordination Office
TRICARE Management Activity
5111 Leesburg Pike, Suite 306
Falls Church, VA 22041

Robert Hite
Telephone: 703.681.0039
Fax: 703.681.0947
Email: Robert.Hite@tma.osd

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