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VA/DoD Joint Executive Council
Fiscal Year 2006
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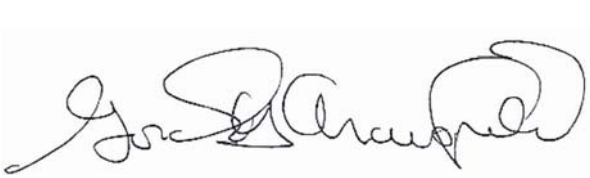

Gordon H. Mansfield
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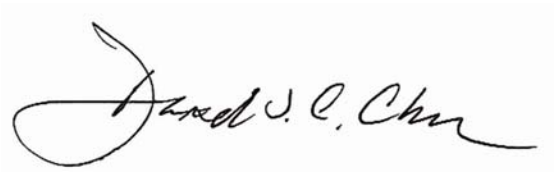

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February 2007

VA/DoD Joint Executive Council Fiscal Year 2006 Annual Report

SECTION 1 – INTRODUCTION

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Joint Executive Council (JEC), has completed its fourth year. This Council, established to provide senior leadership for coordination and resource sharing between VA and DoD, met quarterly in Fiscal Year 2006. The JEC is pleased to submit this Annual Report, for the period October 1, 2005 to September 30, 2006, to Congress and the Secretaries of Defense and Veterans Affairs, as required by law.[1]

The 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 executives from both 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.

In the *VA/DoD 2005 Annual Report*, the Joint Executive Council submitted a revised *Joint Strategic Plan for FY 2006 - 2008*, which served as the roadmap for the JEC and its sub-councils, and 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 guidelines for enhanced partnerships, resource sharing, decision making, and accountability.

[1] This report meets the reporting requirements for Public Law 97-174 and Public Law 108-136 codified at 38 U.S.C. 320 and 8111(f). Neither Secretary used the waiver authority granted by section 722(d)(1) of the Bob Stump National Defense Authorization Act for Fiscal Year 2003 (Public Law 107-314).

The *VA/DoD Joint Strategic Plan* is the primary means to advance performance between VA and DoD, and it will be continuously evaluated, updated, and improved. After reviewing and revising the goals, strategies, and performance measures in the *VA/DoD Joint Strategic Plan for FY 2006-2008,* VA and DoD developed the *VA/DoD Joint Strategic Plan for FY 2007-2009*, which is appended to this Annual Report.

In FY 2006, VA and DoD continued to focus on improving the effectiveness and efficiency of health care services and benefits to veterans, servicemembers, military retirees, and eligible dependents. This report describes and provides details on our collaborative efforts and VA/DoD successes in the areas of financial management, joint facility utilization, pharmacy, medical-surgical supplies, procurement, patient safety, deployment health, clinical guidelines, contingency planning, medical education, and benefits delivery that strengthened the capability of both Departments to better serve our beneficiaries.

The report also discusses the progress made over the past year in the area of sharing, both health and demographic data, and highlights the ongoing activities under the auspices of the Joint Incentive Fund and Demonstration Site Projects authorized in the National Defense Authorization Act for FY 2003. Finally, the report concludes with a synopsis of VA and DoD joint training and education initiatives and activities to promote collaboration and greater sharing of resources.

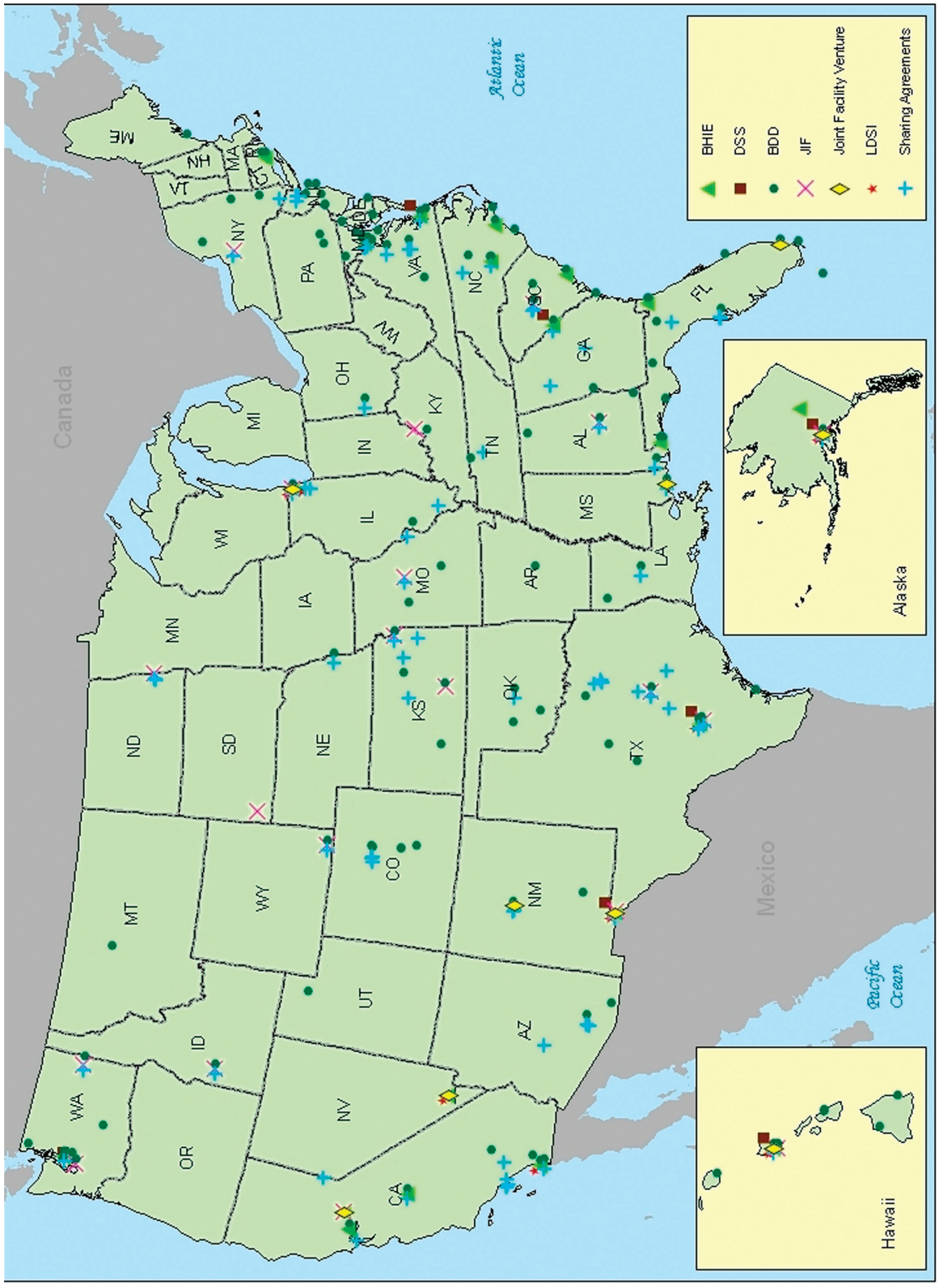
SECTION 2 – VA/DoD COLLABORATION RESULTS

This section details the operational activities and successes associated with the strategic goals: *Seamless Transition of Benefits, High Quality Health Care,* and *Efficiency of Operations.* Together, the two Departments made considerable progress towards promoting mutually beneficial coordination, use, and exchange of services and resources in FY 2006. Figure 1 depicts some of the key geographic locations of VA/DoD collaborations.

SECTION 2.1 – SEAMLESS TRANSITION

The goal of seamless transition is to coordinate medical care and benefits during the transition from active duty to veteran status in order to ensure continuity of services. In FY 2006, the focus was on ensuring a smooth transition for injured servicemembers returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Seamless transition efforts made it possible for servicemembers to enroll in VA health care programs and file for VA benefits prior to separation from active duty status.

Figure 1 VA/DoD Collaboration Sites



VA Office of Policy and Planning

VA and DoD developed and implemented a number of strategies, policies, and programs to provide timely, appropriate services to servicemembers and veterans, especially those transitioning directly from DoD Military Treatment Facilities to VA Medical Centers. Significant progress was made in the areas of outreach and communication, tracking workload, data collection, and staff education. Improving communication between the two Departments led to improvements in the consistency of information and services provided, and facilitated outreach to servicemembers and veterans.

In July 2006, the JEC approved a proposal to establish a VA/DoD Joint Coordinated Transition Working Group. This Working Group specifically focused on achieving an even greater integrated approach to coordinated transition for injured and ill servicemembers, and their families.

Traumatic Injury Protection

Traumatic Injury Protection under the Servicemembers' Group Life Insurance (TSGLI) program was designed to provide financial assistance to traumatically injured servicemembers while they recover became effective December 1, 2005. The first TSGLI payments were released to eligible claimants on December 21, 2005.

Interim regulations including defining qualifying losses and a schedule of payments, were published on an expedited basis on December 22, 2006. The final regulation, expected to be published shortly, will enhance TSGLI by providing the maximum time period between traumatic injury and traumatic loss from one to two years. As of September 30, 2006, 2,607 claimants have been paid a total of $170 million with the average payment being just over $65,000. Of the claimants, 2,186 were paid for traumatic losses incurred in OEF/OIF from October 7, 2001, through November 30, 2005[2], and 421 payments were made for injuries incurred on or after December 1, 2005.

A number of outreach efforts were launched, to include mailings and news releases, and articles for DoD newsletters to educate and inform servicemembers and veterans as well as personnel providing services on the TSGLI benefit. VA Regional Office OIF/OEF Coordinators also began contacting severely injured veterans from OIF and OEF. Finally, VA and DoD partnered to develop procedures and medical standards and conducted training.

On September 7, 2006, the Director, VA Regional Office and Insurance Center testified before the Senate Veterans' Affairs Committee regarding the implementation and management of the TSGLI program. The committee

[2] The law includes a provision to pay benefits to any servicemember who suffered a qualifying loss as a direct result of a traumatic injury incurred in Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) on or after October 7, 2001 and through and including November 30, 2005.

members indicated they were very pleased with the implementation and consider TSGLI a success. They also requested that VA conduct a comprehensive review of the program following the one-year anniversary of its implementation.

The following example demonstrates how TSGLI can positively affect the lives of servicemembers. Army Sergeant John Keith lost his leg due to an explosion in Iraq in November 2004, which also put him in a coma for three weeks. He was admitted to Walter Reed Army Medical Center where he recuperated for three months and then underwent a long period of rehabilitation. His wife and his two small children joined him, living in a one-bedroom apartment for over eight months at the Malone House on Walter Reed's grounds. Because John and his wife were still paying rent and utilities for their home in Texas while also paying living expenses in Washington, DC — a city with a much more expensive cost of living, their debts began to mount. Then, in December 2005, John found out about TSGLI and shortly thereafter became one of the first to receive a payment under the program. To John, this benefit was "the greatest thing since sliced bread". With a look of relief, he tells the story of the day after receiving the $100,000 check, when he called his creditors to pay off all of his debts and then received one notice after another that said, "Paid in Full." John has remained in the U.S. Army. He and his family now have a home in Virginia, near where he is stationed.

Outreach

VA distributed A Summary of VA Benefits (*VA Pamphlet 21-00-1)* to all military service inductees at the Military Processing Stations (MEPS). This arrangement assured that inductees receive basic information on VA benefits and services for which they may become eligible at separation. In June 2006, the distribution of this pamphlet was expanded to the military service academies for graduating seniors.

VA and DoD also collaborated to reach out to servicemembers while they are still on Active Duty. In accordance with a Memorandum of Understanding (MOU) between the two Departments, DoD began providing VA on a monthly basis, the names of individuals who have completed a Medical Evaluation Board process with a referral to the Physical Evaluation Board (PEB) process in November 2005. This notification enabled VA case workers to assist servicemembers with the application process for VA health care prior to discharge from the military. Equipped with this information, VA will be able to contact these individuals regarding VA health care and disability benefits for which they may be eligible.

VA and the National Guard Bureau collaborated to train 54 National Guard Transition Assistance Advisors (TAAs), formerly known as State Benefits Advisors – one for each of the 50 states and 4 territories. The primary functions of the TAAs are to provide advice on VA benefits and services, and to assist in coordinating VA health care, benefits, and TRICARE. A training conference for TAAs was held in February 2006, to enhance the knowledge of TAAs of VA

services and benefits and to define their roles as advocates. Also, the National Guard, VA, and community organizations partnered to form state coalitions to meet the needs of the Guard and Reserves. Formal partnerships were developed and implemented in 25 states during FY 2006.

VA/DoD outreach also focused on increasing awareness and understanding among the employees of both Departments. During FY 2006, presentations on seamless transition initiatives were given at several conferences including: State of the Military Health System 2006 Annual Conference (February 2006); National Association of State Directors of Veterans Affairs Annual Conference (March 2006); Department of Health and Human Services conference, entitled *The Road Home: The National Behavioral Health Conference on Returning Veterans and Their Families: Restoring Hope and Building Resiliency* (March 2006); and TRICARE Beneficiary Counselors Annual Conference (July 2006).

Continuity of Health Care and Benefits

In response to the increasing number of servicemembers returning from combat with traumatic injuries, VA has developed specialized care for these patients. In FY 2005, VA opened four Polytrauma Rehabilitation Centers (Tampa, FL; Richmond, VA; Minneapolis, MN; and Palo Alto, CA). These centers are designed to meet the needs of active duty servicemembers and veterans who have experienced severe injuries resulting in spinal cord injuries, traumatic brain injuries, amputations, or visual impairment. In addition to the four Polytrauma Centers, VA opened 21 new Polytrauma Network Sites in FY 2006 in order to provide continuing care to injured veterans. VA established an OIF/OEF Polytrauma Call Center to assist the most seriously injured veterans. The Call Center began operations on February 27, 2006. It is operational 24 hours a day, seven days a week, to answer and refer clinical, administrative, and benefit inquiries from OIF/OEF Polytrauma patients and their families. In addition, VBA dedicated a phone line in the Office of Seamless Transition (OST) to handle calls regarding benefits.

During FY 2006, the DoD Military Severely Injured Center (MSIC), originally established in February 2005 to operate a 24/7, toll-free hotline center for servicemembers and families, continued to provide a wide array of support services to servicemembers and their families. The Center coordinated outreach and referral services with each of the Service-specific programs, such as the *Army Disabled Soldier Support (DS3)* and *Marine4Life*. To date, the staff has handled over 3,000 cases, and as of September 2006, care managers were working approximately 700 active cases. The most frequent requests were for assistance related to financial and employment concerns and family services, such as travel arrangements or family counseling. DoD personnel were augmented by employees detailed from VA and the Transportation Security Administration.

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 September 30, 2006, Memorandums of Understanding (MOUs) were in place at 129 sites. Under this initiative, VA representatives assist servicemembers in filing disability claims before they are separated from active duty service. This program improved the timeliness of claims processing, and ensured that veterans receive disability benefits at the earliest time after their separation.

SECTION 2.2 – HIGH QUALITY HEALTH CARE

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

Deployment Health

The VA/DoD Deployment Health Working Group (DHWG) was established to ensure coordination and collaboration to maintain, protect, and preserve the health of Armed Forces personnel. In order to improve force health protection efforts, the DHWG focused on the health of active duty members, veterans, and their families during and after combat operations and other deployments. There was a particular focus on servicemembers returning from OIF and OEF. VA and DoD shared information and resources in the areas of deployment health surveillance, assessment, follow-up medical care, health risk communication, and research. The following describes completed, ongoing, and new initiatives related to each of these areas in FY 2006.

Deployment Health Surveillance and Assessment

DoD performed health assessments of servicemembers just prior to their deployment, upon their return, and again, three to six months later. The assessments served as a screen to identify any health concerns that might warrant further medical evaluation. Since December 2005, DoD has sent VA on a monthly basis the electronic pre-deployment and post-deployment health assessments of servicemembers who deactivated from active duty back to the Reserve/National Guard or who separated entirely from service. As of September 2006, DoD sent data on more than 604,000 individuals, including more than 1.4 million pre- and post-deployment health assessments.

Mental health professionals in DoD developed the assessment form and procedures for the post-deployment health reassessment (PDHRA), in consultation with VA and the Department of Health and Human Services. The purpose of the PDHRA is to screen for physical health and mental health concerns at 90 to 180 days after return from their deployments, in order to determine if referral for further medical evaluation is warranted. Pilot projects were performed in Army and Marine units from June to December 2005. Implementation accelerated in January 2006. As of September 2006,

101,514 PDHRA had been completed. Overall, 26% of individuals were referred for further medical evaluation and possible treatment. Depending on the health needs and preferences of the individuals, referrals were made to DoD medical treatment facilities, TRICARE network providers, VA, and Vet Centers. VA and DoD also developed a solution to electronically transfer data from the PDHRA.

The DHWG also worked on a number of initiatives during the past year related to medical surveillance for depleted uranium exposure and pandemic flu. These efforts were an extension of the processes in place since 1998, where VA and DoD provided medical surveillance for potential depleted uranium (DU) exposure in servicemembers and veterans. This program was originally targeted to veterans of the 1991 Gulf War, and has been expanded to include servicemembers returning from OIF in 2003. As of September 2006, more than 2,200 OIF veterans participated in this testing program.

During FY 2006, surveillance and other planning activities related to pandemic flu were a priority for VA and DoD, as well as all other Federal agencies. The DHWG hosted an interagency exchange of information on preparedness activities for pandemic flu on several occasions. Additionally, VA and DoD made major contributions to the development and implementation of the National Pandemic Influenza Plan, and both agencies implemented ongoing surveillance networks, established stockpiles of antiviral medications, and developed educational programs for health care providers, servicemembers, and veterans.

Mental Health

The Health Executive Council established a VA/DoD Mental Health Working Group (MHWG) to focus on increasing the collaboration between VA and DoD on the provision of mental health services to both VA and DoD beneficiaries. The group focused on making recommendations concerning appropriate actions and responses to identified needs. The group also focused on addressing barriers to inter-departmental collaboration and identifying opportunities for improving collaboration within both the VA and DoD.

During FY 2006, the VA/DoD MHWG conducted and completed an assessment of opportunities for greater VA/DoD Collaboration on mental health issues in the following three areas: Education, Administration, and Transition to Care.

The following are examples of recommendations for VA/DoD coordination in each of the three areas:

- *Education —* The implementation of a plan to share training programs to increase the use of evidence-based psychotherapy and pharmacotherapy approaches in both departments.

- *Administration* — The identification of obstacles to making information available to appropriate DoD personnel regarding individual veterans with deployment-limiting conditions who are also Reserve and Guard members slated for return to active duty.

- *Transition to Care* — The development of improved methods and strategies to ensure that reserve component members, who are released from active duty with an on-going health care entitlement, maintain continuity of care across the DoD and VA health care systems. Improved strategies will include methods to identify, track and provide access for treatment for behavioral health issues.

Post-Deployment Medical Care

Joint VA/DoD initiatives related to post-deployment medical care included the provision of multiple DoD databases to VA on an ongoing basis. Since September 2003, DoD has provided a roster to VA periodically, which lists OIF and OEF veterans who have either deactivated back to the Reserve/National Guard, or who have separated entirely from the military. VA used this roster to mail a letter to OIF/OEF veterans thanking them for their service and provided information on VA benefits related to their service in a combat theater. More than 580,000 letters have been sent in this outreach effort. VA also used this roster to evaluate the health care utilization in this population of OIF/OEF veterans. This analysis was useful to plan the allocation of health care resources. VA performed its most recent analysis related to 588,923 veterans in August 2006. Thirty-one percent (184,524) of these individuals had sought VA health care at least once. The three most common diagnostic categories were musculoskeletal, mental, and digestive disorders.

Deployment Health Risk Communication

VA and DoD improved their coordination of risk communication and outreach to servicemembers and veterans related to military health issues, including occupational and environmental exposures. In October 2005, the DHWG Health Risk Communications Subcommittee held its first organizational meeting. Its charge was to develop and coordinate risk communication products that are useful for servicemembers, veterans, and their families, as well as health care providers. DoD launched a web site, entitled the *Deployment Health and Family Readiness Library*. VA published several relevant products that are primarily targeted at VA health care providers such as endemic infectious diseases of the Middle East. In the past year, members of the DHWG developed and released joint risk communication products. The next two products will be pocket cards for health care providers that address servicemembers' and veterans' concerns on the possible health effects of depleted uranium exposure and the use of mefloquine to treat malaria.

In late 2005, the Institute of Medicine (IOM) published a mortality study on Gulf War veterans. Veterans whose units might have been exposed to very low levels of chemical warfare agents due to the demolitions at Khamisiyah, Iraq in 1991 were compared with veterans whose units were unlikely to have been exposed. The rates and causes of death for both groups were similar. The mortality rates from all types of cancer were the same, with only a slightly higher death rate due to brain cancer among servicemembers with possible exposure. The DHWG discussed possible VA and DoD follow-up activities to inform veterans. DoD started mailing letters in late 2005 to more than 99,000 Gulf War veterans who had possible exposure. In addition, VA published an *Information Letter* for clinicians, which provided information on the IOM study that clinicians could use if veterans had questions.

During FY 2005-2006, DoD declassified the records of approximately 6,700 soldiers who were involved in testing of chemical agents, placebos, and/or pharmaceuticals during the period of 1955-1975. DoD provided to VA, the names of individuals, the dates of the tests, and the types of exposures. VA and DoD collaborated on writing a letter and fact sheet for veterans explaining the history of the testing program and providing information about the availability of VA health care. VA also developed an *Information Letter* for VA clinicians about this notification, which was reviewed by DoD. VA started mailing notification letters in June 2006.

Section 746 of the FY 2006 National Defense Authorization Act mandated that the Department of the Navy perform outreach to Navy veterans who previously had exposure to non-skid coatings (deck grinding activities). The Naval Health Research Center (NHRC) performed research on the possible health effects of this exposure. In recent years, approximately 1,000 active-duty Navy personnel have been diagnosed with *sarcoidosis*, which is a chronic disease of the lungs and other organs of unknown etiology. The NHRC evaluated a possible association between deck grinding and the development of *sarcoidosis*, but the findings were inconclusive. VA is working with the Navy Bureau of Medicine and Surgery to develop a notification letter for veterans and *an Information Letter* for VA clinicians.

Deployment Health Related Research

The DHWG developed an inventory of VA and DoD medical research related to the health of deployed servicemembers and veterans, which will be updated annually. The Research Subcommittee of the DHWG worked with the centralized research office in VA and the 22 research offices in DoD to establish a reporting system for deployment health projects. This initiative improves upon the successful coordination of VA and DoD research related to illnesses in Gulf War veterans, which has been ongoing since 1994. Research Subcommittee members established a reporting system to collect, organize, and archive data

on medical projects related to the current deployments to Iraq and Afghanistan, and this system could be expanded in the event of future deployments. This reporting system will be institutionalized to collect data on completed, ongoing, and new projects on an annual basis.

The reporting system was being used to develop a comprehensive inventory of current VA and DoD research projects on deployment health. The results of this collaborative effort will be published in a user-friendly format on an existing, research-related web site, DeployMed ResearchLINK. Publication of the inventory on this DoD web site will provide global access to current information on deployment health research to health care providers, researchers, servicemembers, veterans, their families, and the general public. In addition, a bibliography of all medical articles related to the health of servicemembers deployed to OIF and OEF from 2002 to the present is continually updated and placed on the web site.

Patient Safety

In FY 2006, VA and DoD collaborated to improve patient safety practices. Both Departments have highly-respected patient safety programs, and work with other Federal agencies such as the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Disease Control and Prevention to prevent harm to patients as they receive health care. Examples of VA and DoD coordinated efforts to improve patient safety include:

- DoD implemented a system for developing patient safety alerts that was modeled on the system currently employed by VA.
- VA shared relevant patient safety alerts with DoD patient safety personnel. A group of DoD staff participated in a VA training course on curriculum for patient safety improvement used to provide training to new physicians, nurses, and other health care providers.
- VA and DoD reviewed the potential use of software that uses natural language processing to analyze information contained in reports of adverse events and close calls. Staff participated in a joint training session.
- VA and DoD completed a comparison of educational products to use in the DoD Graduate Medical Education curriculum.

Evidence-Based Clinical Practice Guidelines

In FY 2006, VA and DoD worked together to develop, update, and expand the adoption of Evidence-Based Clinical Practice Guidelines (EBCPGs). EBCPGs reduce variation in care, optimize patient outcomes, and improve the overall health of beneficiaries.

During FY 2006, two new EBCPGs were completed (Management of Overweight and Obesity, and Dyslipidemia). There are four additional EBCPGs at different stages of completion. (Amputation Rehabilitation, Acute Stroke, Chronic Obstructive Pulmonary Disease and Bipolar Disorder).

Several tools to support a culture that uses evidence–based clinical practices were also created. These tools include:

- Web-based interactive clinical practice guideline for the Dyslipidemia CPG.
- Dyslipidemia Pocket Cards for providers and patient education materials.
- PDA versions of two CPGs (Post-Traumatic Stress Disorder and Cardiovascular Drugs) for PALM and Pocket PC.
- Video broadcast on Evidence-Based Practice which emphasizes the "what, how, who and when" in support of evidence-based health care.

Additionally, two recommendations from the U.S. Preventive Services Task Force (Abdominal Aortic Aneurysm and Screening for Postmenopausal Osteoporosis) were reviewed, analyzed, and approved.

The EBCPGs were promoted through exhibits at 11 national and local conferences and health fairs. Selected individuals were invited as guest speakers for five presentations. Their topics ranged from advancing Evidence-Based Health Care to the use of Clinical Practice Guidelines to promote population health.

To obtain a baseline evaluation of practitioner's knowledge, attitudes, and behaviors as they relate to the use of clinical practice guidelines within the Departments, the Evidence-Based Practice Working Group conducted evaluation surveys within each Department. These completed surveys are currently being analyzed.

North Chicago Initiative

On October 17, 2005, Deputy Secretary of Veterans Affairs, Gordon Mansfield, and Assistant Secretary of Defense for Health Affairs, Dr. William Winkenwerder, Jr., signed a Memorandum of Agreement that represented an historic merger between the Department of Veterans Affairs and the Department of Defense. The North Chicago VA Medical Center (NCVAMC) and the Naval Hospital Great Lakes are fully sharing all health services in one facility at North Chicago to provide all needed care to each others beneficiaries. Modernization of the NCVAMC surgical and emergency/urgent care facilities was completed and

activated on June 1, 2006. Naval Hospital Great Lakes was re-commissioned as Naval Health Clinic Great Lakes and on June 1, 2006, all emergency, pediatric, surgical, and inpatient care was transferred from DoD to the VA facility.

Ground breaking for a $130 million Federal Ambulatory Care Center is tentatively scheduled for spring 2007. Six VA/DoD Working Groups are developing detailed operational plans for activation of a fully integrated federal health care facility in 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 (CPC) served as the final reviewer for all joint capital asset initiatives submitted by VA/DoD. The CPC is comprised of individuals with comprehensive knowledge of relevant policy issues within the Departments in the areas of capital asset planning, investment, and management. The CPC continued to evaluate VA and DoD capital investment processes and methodologies in an effort to curtail duplication of effort and maximize budgetary resources in meeting the needs of both veterans and military personnel. The CPC is continuing to work on developing a framework and methodology to identify and evaluate the prospect of partnering with DoD to optimize capital asset needs. VA continued its *Funding Principles* effort, where VA will develop options on how to partner with DoD on capital asset initiatives. Examples of *Funding Principles* being evaluated include the appropriations necessary to fund initiatives, the costing methodologies required to develop budget requests, and the authorizations needed. The development of *Funding Principles* will provide a means for VA and DoD to share budget requests ensuring that there is coordination between each entity and no duplication of capital requests.

The Departments evaluated the Base Realignment and Closure Commission (BRAC) report, and determined that few collaborative opportunities exist based on the BRAC results. They made this determination after recognizing that once VA obtained title to the properties, DoD presence and therefore, opportunities for VA/DoD collaboration, were minimal.

Acquisition and Management of Medical Materiel Working Group (AMMMWG)

For medical and surgical equipment, there were a total of 46 shared contracts in FY 2006: 8 joint contracts for radiation oncology, 5 for imaging maintenance, 31 for radiology, 1 for vital sign monitors and 1 for surgical instruments. VA and DoD jointly reviewed 26 proposals for new VA/DoD shared high-technology medical contracts and will equally share the award of subsequent contracts. The Defense

Supply Center in Philadelphia (DSCP) had sales under these shared contracts just over $170 million in FY 2006. Direct delivery sales exceeded $201M for VA in the first three quarters of FY 2006.

Efforts to further expand VA/DoD joint acquisition strategies continue. Six new areas of potential joint savings were evaluated. These include prosthetics, optical supplies, hearing aids, hearing aid batteries, hand-held physiological monitors, operating room surgical instruments, and pharmaceutical returns.[3]

DSCP developed, and is currently using, the DoD DAPA application, web prototype, MECA Catalog, which is a precursor to the joint electronic catalog. The MECA Catalog will be officially called the "VA/DoD Catalog" upon final testing and refinement. The HEC worked with industry to synchronize data on approximately 16,000 items from 17 manufacturers and over 160,000 items from Prime Vendor distributors. Research indicated that many U.S. industries are using the Global Trade Item Number (GTIN) as their uniform identification code (UID) for product identification. Over 5,000 manufacturers submit their GTIN product data to the Global Data Synchronization Network (GDSN). A contract was awarded May 6, 2006, to maintain and build on previous tasks and add a data synchronization pilot study, as an industry proof of concept to determine the potential of GDSN as a Product Data Utility (PDU) solution to sanitize and standardize the data to determine the best purchase of medical items for the health care industry. VA and DoD expect to complete the initial phase of this pilot study by April 2007.

The VA/DoD Joint Incentive Fund (JIF) project worked to synchronize DoD manufacturer, distributor, and pricing data files with the acquisition data files of VA, such as the National Item File (NIF) used by VA and the medical segment of Federal Supply Schedules (FSS) being managed by the Office of Acquisition and Materiel Management. The NIF was compared to the DoD Product Data Bank (PDB), resulting in a 95% match on business names and/or part numbers; packaging data synchronization requires additional work. In FY 2006, VA and DoD began efforts to match the FSS and procurement history file with the DoD PDB, which should be incorporated into the PDB by the first quarter of FY 2007.

Pharmacy

The VA/DoD Federal Pharmacy Executive Steering Committee (FPESC) improved the management of pharmacy benefits for both VA and DoD beneficiaries. Historically, VA/DoD joint contracting for pharmaceuticals has been very successful. VA and DoD continued to experience remarkable

[3] A contract with a reverse distribution vendor to take expired or otherwise unusable pharmaceuticals and return them to the manufacturer for partial credit, which is then returned to VA/DoD less the vendor's cost to provide the service.

success awarding joint contracts and unilateral contracts for pharmaceuticals. For the first three quarters of FY 2006, there were 77 Joint National Contracts, 17 VA unilateral National Contracts[4], and 32 DoD unilateral Blanket Purchase Agreements for pharmaceuticals. The Joint National Contracts for the first three quarters of FY 2006 resulted in $423 million in cost avoidance and $378 million in purchases. In the 4th Quarter of FY 2006 through FY 2007, VA and DoD anticipate the award of 10 VA/DoD contracts for pharmaceuticals.

The Clinical Working Group continued the evaluation of 21 drugs identified as having the potential for a joint National Contract. In FY 2005, VA and DoD joined the U.S. Food and Drug Administration, Shelf Life Extension Program (SLEP) for pharmaceuticals. VA used this program to extend the expiration dates on products in its Emergency Pharmacy Service program. In FY 2006, VA submitted 60 specific lot numbers of pharmaceuticals to be tested for the SLEP. A total of 56 lot numbers were granted shelf life extension for two years and four lot numbers were granted a shelf life extension of one year. All 60 lots were re-labeled with the appropriate new expiration date. The estimated cost savings to VA from the participation in the SLEP for pharmaceuticals was $4 million.

The Departments continued to share a program where the VA Consolidated Mail Outpatient Pharmacy (CMOP) in Leavenworth, KS refills outpatient prescription medications from DoD's Military Treatment Facilities (MTF) at the option of the beneficiary. The original DoD sites were Naval Medical Center, San Diego, CA; Fort Hood Army Community Hospital, Killeen, TX; and 377th Medical Group, Kirtland AFB, NM.

SECTION 2.4 – JOINT CONTINGENCY/READINESS CAPABILITIES

The goal of VA/DoD joint contingency and readiness coordination is to ensure that scenario-based planning, training, and exercise activities support DoD requirements.

In FY 2006, VA and DoD completed a Memorandum of Agreement, regarding VA provision of health care services to members of the armed forces during a war or national emergency. This memorandum called for an integration of VA and DoD medical facility contingency operations in major metropolitan areas of the United States and it replaces the 1982 VA/DoD Contingency Hospital System. In addition, numerous joint mass-casualty training exercises occurred between local VA and DoD medical facilities.

[4] It is noteworthy to show that it is not always practical or possible for VA and DoD to utilize a joint contracting strategy to achieve their formulary management/drug therapy objectives.

SECTION 3 – INFORMATION TECHNOLOGY ADVANCEMENTS

The goal of integrated information sharing for VA and DoD is to enable the Departments to better share the vast array of beneficiary data, medical records, and other health care information through secure and interoperable information systems. The HEC Information Management/Information Technology (IM/IT) Working Group and the BEC Information Sharing/ Information Technology (IS/IT) Working Group strived to achieve these goals. The following reflect VA and DoD information sharing advancements in FY 2006.

Joint Electronic Health Records Interoperability Program

The Joint Electronic Health Records Interoperability (JEHRI) Program is a set of related data sharing 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 provides the roadmap for how VA and DoD will enhance the continuity of care from active duty status to veteran status by enabling a view of health data from VA and DoD medical records. JEHRI initiatives are compliant with federal security and privacy regulations based on existing health care data standards, or where these are lacking, based on mutually-adopted VA/DoD enterprise reference terminologies. JEHRI initiatives generally fall into one of the following categories:

- Information Transfer
- Information Exchange
- Standards Work

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 access this data via VA's Computerized Patient Record System (CPRS) or Compensation and Pension Records Interchange (CAPRI). Since it's inception, through the end of FY 2006, DoD transmitted electronic health data on over 3.6 million patients to the FHIE data repository 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

The amount of data continued to grow as health information on recently separated servicemembers is extracted and transferred to VA monthly. Building on the FHIE capability, DoD also transferred data for VA patients being treated in DoD facilities under local sharing agreements. As of September 2006, DoD completed over 1.8 million data transmissions (e.g., laboratory results, radiology results, pharmacy data, and consult reports) for VA patients treated in DoD facilities.

Pre- and Post-Deployment Health Assessments

DoD extended the FHIE capabilities to incorporate Pre- and Post-Deployment Health Assessment (PPDHA) information for separated servicemembers and demobilized Reserve and National Guard members. PPDHAs were provided to active duty service members and demobilized Reserve and National Guard members as they leave and return from deployment. This information was used to monitor the overall health condition of deployed troops, inform them of potential health risks, as well as maintain and improve the health of servicemembers and veterans.

As of September 2006, over 1.4 million PPDHA's on over 604,000 individuals had been transmitted by DoD to VA. Additionally, DoD completed the historical data extraction and transfer of over 29,000 Post-Deployment Health Reassessment (PDHRA) forms. This historical data will be transferred to VA beginning in the 1st Quarter FY 2007. DoD will also begin a weekly transfer of PDHRA data for individuals directly referred to VA for care (based on provider referral checked on the PDHRA form).

Medical Records Scanning

The Departments pursued a pilot project to scan paper medical record items for severely wounded and injured servicemembers, and to make those records available to VA in a digital format. The TRICARE Management Activity (TMA) and the Telemedicine and Advanced Technology Research Center (TATRC) of the U.S. Army Medical Research and Materiel Command conducted a pilot study in close collaboration with the Walter Reed Army Medical Center (WRAMC) and the Veterans Health Administration (VHA) to develop a method for scanning paper-based medical records of seriously injured inpatients into electronic media that can be efficiently organized and viewed by VA providers.

The primary focus is on the medical records of patients being transferred to VA's Polytrauma Rehabilitation Centers. This one-year project looked at building upon existing relationships between WRAMC and VHA, and is examining business processes and indexing methodologies that can assist in the automation of a current process of sending paper copies of requested medical documentation from the Military Health System (MHS) to VA.

Bidirectional Health Information Exchange

The Bidirectional Health Information Exchange (BHIE) provides a real-time, bidirectional interface between VA and DoD which enabled providers to view patient demographic data, outpatient pharmacy data, laboratory results, radiology text reports, and allergy information for patients treated by both Departments. As of September 2006, BHIE was operational at all VA healthcare facilities and at the following DoD sites:

- Madigan Army Medical Center, WA
- William Beaumont Army Medical Center, TX
- Eisenhower Army Medical Center, GA
- Naval Health Clinic Great Lakes, IL
- Naval Medical Center San Diego, CA
- National Capitol Region to include Walter Reed Army Medical Center, DC; and Malcolm Grow Medical Center, MD
- Michael O'Callaghan Federal Hospital, NV
- Landstuhl Regional Medical Center, Germany
- Tripler Army Medical Center, HI
- Womack Army Medical Center, NC
- David Grant Medical Center, CA
- Brooke Army Medical Center, TX
- Wilford Hall Medical Center, TX
- Bassett Army Community Hospital, AK
- Naval Hospital Jacksonville, FL
- Naval Hospital Charleston, SC
- Naval Hospital Pensacola, FL
- Naval Hospital Camp Lejeune, NC
- Navy Ambulatory Care Center, Groton, CT
- Naval Hospital Lemoore, CA
- Naval Medical Center Portsmouth, VA

Implementation at these sites encompassed 14 medical centers, 19 hospitals, and over 170 outlying clinics. Site prioritization and selection was based on support to returning members of Operation Enduring Freedom and Operation Iraqi Freedom, number of visits for VA beneficiaries treated in DoD facilities, current FHIE usage, number and types of DoD MTFs, local sharing agreements, and the retiree population. To further increase the availability of clinical information on a shared patient population, VA and DoD worked together to leverage the BHIE functionality to enable bidirectional access to inpatient discharge summaries. As a part of the Puget Sound National Defense Authorization Act Demonstration Project, testing of this functionality was successfully completed in 4th Quarter FY 2006 at Madigan Army Medical Center (MAMC) and VA Puget Sound Health Care System (PSHCS) enabling access to inpatient documentation from MAMC's Clinical Information System (CIS) and VA's

Veterans Health Information System and Technology Architecture (VistA) system. Planning is in progress for the further deployment of this functionality to additional DoD sites in FY 2007. In the future, additional inpatient documentation, such as surgical notes and inpatient consultations, will be added to the information made available to both agencies.

Clinical Data Repository and the VA Health Data Repository

The Departments established interoperability between the Clinical Data Repository (CDR) of AHLTA, DoD's electronic health record, and VA's Health Data Repository (HDR) of VistA, VA's electronic health record. The initial release of this interface, known as the Clinical/Health Data Repository (CHDR), supported the first exchange of interoperable and computable health data between the Departments. During the 4th Quarter FY 2006, VA and DoD successfully completed production testing and received government acceptance of CHDR in a patient care environment using standardized pharmacy and medication allergy data. Clinicians from the William Beaumont Army Medical Center and the El Paso VA Healthcare System exchanged pharmacy and medication allergy data on patients who received health care services from both health care systems. Using CHDR, VA clinicians are able to access DoD's outpatient pharmacy data that includes military treatment facility pharmacy, retail pharmacy, and mail order pharmacy information. The exchange of interoperable, computable, and standardized data through the CHDR interface enabled decision support which provided the ability to conduct drug-drug and drug-allergy order checking and alerting using the consolidated pharmacy and allergy data from both agencies. Having completed interagency testing in El Paso, Texas and received government acceptance, DoD is proceeding with enterprise deployment of the CHDR interface. VA continued internal field testing of CHDR in its next-generation Health*e*Vet environment. The Departments will deploy CHDR to an additional two sites in the 1st Quarter of FY 2007, before beginning enterprise-wide implementation of this capability. Following implementation of pharmacy and allergy domains and the supporting infrastructure, the work necessary to exchange laboratory data between the repositories will be completed.

Clinical Health Data Repository-Bidirectional Health Information Exchange Interface

With an eye toward the future, the VA/DoD health information technology sharing team began working on the Clinical Health Data Repository-Bidirectional Health Information Exchange (CHDR-BHIE) Interface in order to accelerate the progress in sharing appropriate health information between the two Departments. The CHDR-BHIE Interface will make the same data elements that are currently available in BHIE available to the VA from DoD's CDR. This will result in the ability of all VA and DoD sites worldwide to view data from the other Department for shared patients. This will be made possible by DoD making data from the CDR of

AHLTA viewable by VA. As of September 2006, AHLTA was implemented at 137 of 138 MTFs worldwide. All DoD sites are expected to have AHLTA by the end of calendar year 2006. Using the CHDR-BHIE Interface, DoD plans to make allergy information, outpatient pharmacy data, radiology reports, and laboratory results (chemistry and hematology) viewable to VA from AHLTA sites by the 3rd Quarter FY 2007. Making additional data from AHLTA available to VA, such as provider notes, procedures, and problem lists, is also planned for delivery in FY 2007.

Laboratory Data Sharing Initiative Project

The Laboratory Data Sharing Initiative (LDSI) facilitates the electronic sharing of laboratory order entry and results retrieval between VA, DoD, and commercial reference laboratories. LDSI for laboratory chemistry tests is available for use throughout DoD, and is actively being used on a daily basis between VA and DoD at several sites where one Department uses the other as a reference lab. Either Department may function as the reference lab for the other depending on the local business case. This software markedly improves the safety of the Departments' shared patient population because it eliminates the manual re-keying of patient information and other human interventions that may cause medical errors and delays in patient care. LDSI is operational at the following sites:

- Tripler Army Medical Center VA Pacific Island Health Care System, HI
- Naval Medical Center San Diego/ San Diego VA Medical System, CA
- Naval Health Clinic Great Lakes/ Hines VA Hospital/North Chicago VA Medical Center, IL
- William Beaumont Army Medical Center/El Paso VA Health Care System, TX
- Brooke Army Medical Center/Wilford Hall Medical Center/VA South Texas Health Care System, TX
- Bassett Army Community Hospital/ VA Alaska Health Care System, AK
- Mike O'Callaghan Federal Hospital and VA Southern Nevada Health Care System, NV

As part of the South Texas National Defense Authorization Act Demonstration Project, VA and DoD began developing the next phase of LDSI which will support the electronic order entry and results retrieval of anatomical pathology and microbiology tests, in addition to chemistry tests. The Departments will use the Consolidated Health Informatics (CHI) approved Logical Observation Identifier Name Codes (LOINC) and Systematized Nomenclature of Medicine Clinical Terminology (SNOMED CT) standards for the anatomic pathology and microbiology domains. Site testing is anticipated to begin in the 1st Quarter FY 2007.

Collaboration on Standards and Architecture between VA/DoD

VA and DoD worked closely 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 foster collaboration on enterprise architecture sharing initiatives between VA and DoD. In the 1st Quarter of FY 2006, the HAIG was chartered through June 2007.

During FY 2006, the Departments completed an initial review of the six joint initiatives using the 2006 Target VA/DoD Health Standards Profile and developed an FY 2007 review schedule. VA and DoD completed two Digital Imaging and Communications in Medicine (DICOM) implementation guidelines for general radiology and dental imaging exchange and storage between the two agencies. The documents were posted to the Federal Health Architecture (FHA) e-Community and used to create a Consolidated Health Informatics (CHI) Standards Implementation Guideline template.

The enterprise data standards and architecture work have been closely tied to the larger Federal CHI initiative. However, the CHI Working Group function and activities are being realigned with the Health Information Technology Standards Panel (HITSP) under the auspices of the Office of the National Coordinator's (ONC), American Health Information Community (AHIC/"The Community") governance structure and future direction is being determined.

Enterprise Architecture

In FY 2006, the HEC continued its efforts to improve the alignment between VA and DoD enterprise architectures; however, the VA/DoD charge to build an interagency architecture and to develop a joint VA/DoD data strategy for health data that is compliant with the Federal Health Architecture (FHA) has been suspended until the FHA's transition to align with the American Health Information Community (AHIC) agenda is completed. VA and DoD will continue to monitor the re-alignment of FHA with AHIC to determine the future direction of VA/DoD interagency work in this area.

In the 3rd Quarter of FY 2006, VA/DoD assembled a joint enterprise architecture team to work on the Federal Nationwide Health Information Organization (NHIO) Gateway AHIC initiative. VA and DoD partnered with private sector entities to create a Regional Health Information Organization (RHIO) that intends to demonstrate secure health information exchange between Federal agencies and non-government entities via the NHIO Gateway. Anticipated data exchanges include problem summary lists, demographics, medication histories, allergies, and consult reports. The exchanges between major health organizations will be based on use cases and use Health Information Technology Standards Panel (HITSP)-approved standards. The initiative is currently in the Concept

Exploration and Engineering Examination Phase. A storyboard and a Concept of Operations are under development, terminology and architecture teams have accomplished their kick-off sessions, and presentation to VA/DoD leadership for approval to enter the next phase is planned for FY 2007.

VA also established an Integrated Process Team (IPT) to address Identity Management issues. The IPT developed an Identity Management Strategy that describes the activities associated with enterprise Identity Management within VA, and between VA and DoD. High-level business requirements were developed setting the stage for implementation to begin. The IPT focused on the requirements surrounding uniquely identifying veterans and other beneficiaries, as well as other persons, such as VA employees and contractors. This facilitated the accurate sharing of information for each person being treated in VA. The establishment and availability of a unique person identity within VA is the foundation on which several "downstream" processes, such as Enterprise registration, enhanced veteran self-service, and Enterprise Contact Management, initiatives are based.

VA/DoD Military Personnel Data Sharing

During FY 2006, VA and DoD continued developing and implementing the VA/DoD Military Personnel Data Sharing initiatives as outlined in Objective 4.1 of the Joint Strategic Plan. VA and DoD moved forward with a number of accomplishments to support streamlined benefits processing and reductions in operating costs. Organizational benefits of the initiative included cost reductions as individual data exchanges are reduced, with the ideal goal of a single bidirectional data exchange, if feasible. In addition, data quality was improved as multiple sources of data are consolidated into a single consolidated source and claims processing is streamlined as more data is available more quickly to claims processors. Accomplishments over the past year are classified into two broad areas:

(1) overall VA/DoD personnel data sharing plans and processes, and
(2) delivery of specific data sets and improved access to data.

Overall VA/DoD Personnel Data Sharing Plans & Processes

In April 2006, the BEC approved the detailed, integrated project and sequencing plan for VA/DoD Personnel Data Sharing. This document identified data requirements across VA and DoD offices, established the sequencing plan for incorporation of VA and DoD data elements into the VA/DoD Data Sharing Schema, and displayed the timeline for subsequent reduction of legacy data feeds. In addition, VA and DoD identified the need for comprehensive joint plans and strategies for managing person identity data across both agencies. In response to that need, VA and DoD developed the VA/DoD Identity Management plan and strategy document. The initial plan and strategy was developed in March 2006, and it continues to evolve to meet the complex needs of managing person identity data across a myriad of VA and DoD systems. Furthermore, VA

and DoD began establishing a Joint Configuration Management Process, which highlights the institutionalization of VA/DoD data sharing across both agencies.

Delivery of Specific Data Sets and Improved Access to Data

Movement toward a single bidirectional data feed between VA and DoD is achieved by incorporating necessary data sets into a Data Sharing Schema and then eliminating legacy feeds. Specific data sets incorporated into the VA/DoD Data Sharing Schema in FY 2006 include the Activation and Mobilization and Education Eligibility data enhancements (Montgomery GI Bill and Montgomery GI Bill Selected Reserve).

Each reduction in legacy data feeds implies a reduction in maintenance costs, and often a reduction in duplicative data sets. Since the inception of the initiative in 2005, distinct VA/DoD personnel data feeds have been reduced as follows:

Fiscal Years	Number of Distinct Data Exchanges	
	From DoD to VA	From VA to DoD
2005	31	11
2006	20	8

In addition to providing VA with computable data via the VA/DoD Data Sharing Schema, DoD also provided VA with online access to the Defense Personnel Records Imaging Retrieval Records System (DPRIS). This imaging system provides enhanced access for VA employees to the Official Military Personnel File (OMPF).

Separating/Separated Military Personnel Data

In FY 2006, the Departments worked collaboratively to improve the accuracy and timeliness of transferring DoD personnel data to the VA Compensation and Pension Records Interchange (CAPRI)/FHIE by adding electronic pre- and post-deployment health assessment information on separated servicemembers.

In an effort to develop a common set of VA/DoD definitions for military operations, joint VA/DoD “Theater of Operations” and “Reserve Forces Ordered to Active Duty” definitions were approved by the BEC. An annual schedule was developed and approved which will allow both Departments to formally review definitions and the supporting documentation. This initiative supported information technology advancement goals through:

- Accurate determination of eligibility for VA health care and disability benefits among veterans who were deployed.
- Assistance in the preparation of VA reports for VA health care and benefit activity among deployed veterans.
- Identification of deployed populations for scientific research.

SECTION 4 – HEALTH CARE RESOURCE SHARING

Health Care Resource Sharing is a term used to describe a wide spectrum of collaboration between VA and DoD. Resource sharing may include the following types of services: general and specialized patient care, education and training, research health care support, and health care administration. Both Departments provide these services to the other under the auspices of direct sharing agreements between VA and DoD officials, primarily at the local level involving reimbursements or the exchange of services.

In FY 2006, 157 VA Medical Centers were involved in direct sharing agreements with most Military Treatment Facilities (MTFs) and 125 Reserve Units for a total of 504 direct sharing agreements that covered 2,090 unique services. In addition, most VA Medical Centers were authorized to participate in TRICARE managed care networks. Ninety-eight (98) VA Medical Centers reported TRICARE reimbursable earnings. Funds generated from both VA/DoD agreements and TRICARE contracts provided revenues that can be used by VA to provide care to VA beneficiaries. The benefits to VA, MTF, and TRICARE patients included additional services and extended hours of care. The following sections provide examples of VA and DoD sharing initiatives implemented to improve the delivery of health care services to Military Health System beneficiaries and veterans.

SECTION 4.1 – INNOVATIVE VA/DoD RESOURCE SHARING AGREEMENTS

VA and DoD coordinated health services through several venues: direct sharing agreements, TRICARE contracting, joint contracting for pharmaceuticals and medical/surgical supplies, information technology collaboration, training cooperation, and joint facilities. The following resource sharing activities represent innovations in joint health care delivery.

- *Women's Health Center*
  (NAVHOSP Great Lakes/ North Chicago VAMC, IL)
  This agreement established a comprehensive women's health center to serve both female veterans and DoD beneficiaries. VA hired gynecology staff (replaced lost military physician billet), purchased ultrasound equipment for a breast care clinic, and hired two wellness education/case management nurses. A partial cost savings of $70,000 resulted from the initiation of coordinated services during the fiscal year.

- *Telepsychiatry Initiative*
  (Fort Drum/Syracuse VAMC, NY)
  The Syracuse VAMC provided psychiatric coverage for Fort Drum using telemental health technology. Fort Drum previously used this technology

with Walter Reed Army Medical Center but was given only a few hours a week of provider time, not enough to meet the demand. A full-time provider is located at the VAMC Syracuse who devotes 80% of their time to DoD patients and 20% to VA patients. The equipment is in place with staffing now provided.

- *Expanding Radiology Services*
  (VAMC Louisville/Ireland Army Hospital, Fort Knox, KY)
  This new agreement provides a continuum of in-house radiology services for VA and DoD active duty patients. The Army plans to recapture 9,600 procedures and the VA plans to recapture 2,400 procedures as a direct result of this agreement.

- *Adding Oncology Services*
  (VAMC North Chicago/NH Great Lakes, IL)
  A hematology-oncology program was added to include consultations, inpatient support, outpatient care, and chemotherapy services to VA and DoD beneficiaries. Neither the VA nor DoD previously provided these services, and all patients were referred to the local community for care. By combining services, access was improved and patients no longer needed to travel long distances to receive their care. An additional benefit was realized in that continuing education opportunities and breadth of practice experiences for staff were increased.

- *Improved Services, Servicemembers Pending Discharge*
  (South Texas Veterans Health Care System/Brooke Army Medical Center, TX)
  South Texas Veterans Health Care System (STVHCS) and Brooke Army Medical Center (BAMC) entered into a sharing agreement to provide specialized, custom-fitted wheelchairs for active duty members who sustained amputations resulting from their service in Afghanistan and Iraq. The cost to DoD was less than the cost for TRICARE or the commercial market to provide the customized wheelchairs. STVHCS also provided driving simulation training to active duty members under a sharing agreement with BAMC. STVHCS has developed a local steering committee to partner with BAMC personnel on the activation of the Center for the Intrepid, a highly specialized outpatient rehabilitation facility, which will be donated to the Army in January 2007.

- *Mental Health Staffing*
  (Central Texas Veterans Health Care System (CTVHCS)/Darnall Army Hospital, TX)
  CTVHCS and Darnell entered into a sharing agreement for VA to provide up to 15 staff members to assist with the increasing demand for mental health services related to the high volume, frequency, and intensity of deployments of the units at Fort Hood. CTVHCS operated 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.

- *Comprehensive Clinical Agreement*
  (El Paso VA Health Care System/William Beaumont Army Medical Center, TX)
  VA purchased emergency room services, specialty consultations, and inpatient care through an extensive sharing agreement. VA operates a four-story 250,000 square foot health outpatient/ambulatory care center adjacent to William Beaumont Army Medical Center (WBAMC). The VA center's 453 staff provide primary medical care, specialty services, ambulatory surgery, and dental services to over 23,000 enrolled veterans. Both VA and Army surgeons use the Center's eight operating rooms and 16-bed recovery area. Affiliation agreements for residency programs in internal medicine are administered with Texas Tech University and WBAMC. This joint venture has led to agreements that have decreased costs while at the same time increasing veteran access to orthopedics, general, and vascular surgery services. Selected laboratory functions have been integrated in a seamless IT environment resulting in improved services and reduced costs. Information systems are now linked so that patient medical record information is accessible to both the VA and Army patient care providers at computer terminals.

- *Behavioral Health Counseling*
  (General Leonard Wood Army Community Hospital, Whiteman Air Force Base/Harry S. Truman Memorial Veterans Hospital, MO)
  Behavioral health counseling services were expanded for veterans by initiating a telemental health program to meet the needs of active duty servicemembers and other DoD beneficiaries. The program focuses on providing intensive outpatient mental health treatment with particular emphasis on adjustment issues experienced by OIF/OEF returnees.

- *Expanded Veterans Access to Outpatient Services*
  (Washington VA Medical Center (DC)/DeWitt Army Hospital, Fort Belvoir, VA)
  This sharing agreement enabled veterans who use the VA Community Based Outpatient Clinic in Alexandria, Virginia, to receive radiology, laboratory, pharmacy, and emergency room services from DeWitt Army Hospital. In many instances, DeWitt is closer to these veterans' homes, thus saving transportation expenses and improving access.

- *Shared Cardiothoracic Surgeon Services*
  (Richmond VA Medical Center/81st Medical Group Keesler AFB, MS)
  This no-cost sharing agreement provides for an Air Force cardiothoracic surgeon, previously displaced by Hurricane Katrina, to work at Richmond

VA Medical Center (VAMC). The result is a platform for the Air Force surgeon to work where he can maintain the necessary surgical skills for readiness deployment. At the same time, the VAMC improves access to cardiothoracic services due to the addition of another staff physician and reduces the amount of cardiothoracic purchased care services.

SECTION 4.2 – VA/DOD HEALTH CARE SHARING INCENTIVE FUND

The National Defense Authorization Act of FY 2007 extends the VA/DoD Health Care Sharing Joint Incentive Fund (JIF) until September 30, 2010. The fund was 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." The original authorization had a sunset date of September 30, 2007, with each Department contributing $15 million to the fund per year.

The VA/DoD Financial Management Working Group has implementation responsibility for the Joint Incentive Fund. A designated panel reviewed and scored JIF submissions. The panel is comprised of representatives 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 Service Branches, DoD Health Affairs and TRICARE Management Activity. To date, 47 JIF projects have been approved and funded out of over 200 submissions. In the first three years, $90 million was contributed to the fund, and $88.8 million has been allocated to projects. The following are some of the more innovative projects initiated in FY 2006:

- *VA Central Office/TRICARE Management Activity (CO/TMA) (Medical Enterprise Web Portals, VA)*
  This project will provide military personnel and veteran's 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. This project positions 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 Philadelphia (CO/DSCP) (Medical/Surgical Supply Data Synchronization, PA)*
  This project began 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 they have the

data to make medical/surgical product purchases 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.

- *Delta Systems II CAD/CAM for Orthotics and Prosthetics (Tripler Army Medical Center/Hawaii VA, HI)*
  The Delta Systems II is a fabrication technology system that produces molds for prosthetics and orthotics from lightweight foam through use of a laser scanner and mill. This technology eliminates the need for plaster mold (sometimes in excess of 250 lbs) to be manually fitted to the patient and greatly reduces the amount of time needed to fabricate devices. Installing this device at Tripler will allow for greater patient access due to shorter fabrication time and reduced clinic visits for casting, adjustments, and final fittings. Tripler will be able to accommodate many more VA patients for orthotic and prosthetic devices due to increased productivity.

- *North Central San Antonio Clinic (Wilford Hall/San Antonio VAMC, TX)*
  This Community Based Outpatient Clinic (CBOC) is located in the northern area of San Antonio and is scheduled to open in early December 2006. The clinic will serve both VA and DoD patients, relieving the space constraints at Wilford Hall Medical Center, Kelly Air Force Clinic, and the San Antonio VAMC. Wilford Hall has a large enrolled population living in this fast growing community and staffing from Wilford Hall would be transferred to this location to augment VA staff. This project includes leasing of space, operating expenses, and equipment. VA anticipates funding through the VERA allocation process for new enrollees, and DoD anticipates recapture of purchased care in this location.

- *Cardiac Surgery (Madigan Army Medical Center/Puget Sound Health Care System, WA)*
  The cardiac surgery project consolidates 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 are evaluated at MAMC by DoD 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.

- *Enhanced Outpatient Diagnostic Services (Elmendorf, AFB/VA Alaska, AK))*
  VA spends over $2 million per year on diagnostic imaging in Anchorage, AK. This project increases staffing to fully utilize the imaging equipment at the 3rd MDG Hospital to support VA outpatient care (they are already serving inpatients) during non-peak times and after hours. It includes hiring additional technicians and contracting for radiology interpretation.

- *Mobile MRI (Cheyenne VA Medical Center/F.E. Warren Air Force Base, WY)*
  This project provides on-site MRI availability in a Military Treatment Facility and two VA Medical Centers in northern Colorado and Wyoming. It provides 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 the northern Colorado and Wyoming catchment area.

- *VA/DoD Pharmacy Technician Training*
  This initiative provides enhanced Web-based training for pharmacy technicians while reducing the cost of training. This training is intended to provide initial and on-going learning opportunities for pharmacy technicians to maximize the performance of these personnel. This project provides design, development, and implementation of a 150-hour core didactic Web-based Pharmacy Technician training curriculum.

- *VA/DoD Health Care Planning Data Mart*
  This project develops a standard data repository integrating key data from VA and Air Force sources and will 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 builds 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.

- *Joint Dialysis Unit (Travis AFB / Northern California VA HCS, CA)*
  This project supports expanding nursing staff and equipment for the dialysis unit at David Grant Medical Center, Travis AFB to accommodate VA patients that were receiving dialysis treatments from the private sector. The project required a small renovation to existing space and a Capital Asset Planning Committee review. The dialysis center has expanded from four chairs

to eight chairs with one back-up chair, and operates six days per week instead of three. The Business Case Analysis projects a positive return-on-investment from savings in private sector care and increased collections.

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 1st Quarter of FY 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.

In FY 2006, each Department made available $9 million. 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 and execute the findings from 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 2006 the findings and recommendations for all studies were accepted, and the site began implementing the recommended process improvements.

- *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 to allow both agencies to collaborate on staffing requirements while sharing the cost and risk; and

  (3) utilize the existing VA fee program to capture workload and patient-specific health information across agency lines.

  This year the project completed the implementation of itemized billing for all health care received for VA beneficiaries at the 3rd MDG, developed and

implemented the process for capturing VA workload in the VA fee program, and identified additional areas for integration of services, including a joint central sterile supply.

Coordinated Staffing and Assignment

- *Augusta VA HCS and Eisenhower AMC*

  This project is intended to integrate human resources processes and systems for joint recruitment and training. The goals of this project are to:

  (1) employ the Augusta VA's successful recruitment initiative 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.

  In 2006, two neurosurgeons were hired under VA authority to serve both VA and DoD beneficiaries, and the associated reimbursement procedure was developed and implemented. In addition, the critical care nursing intern recruitment and training program continued to support the needs of both the DoD and VA facilities.

- *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 development of a methodology using a web-based tool and other data sources to select viable shared services. Using this tool and methodology, a shared pathology service was selected and implemented.

Medical Information and Information Technology

- *El Paso VA HCS – William Beaumont AMC*

  This project has three information technology major goals:

  (1) implement Laboratory Data Sharing Initiative (LDSI);

  (2) implement Bidirectional Health Information Exchange (BHIE); and

  (3) participate in the design, development and validation of sharing of radiology images.

  LDSI for chemistry laboratory order entry and results retrieval was successfully implemented in early FY 2005. In FY 2006, the demonstration project team documented lessons learned and collected and reported on utilization metrics.

  BHIE was implemented early in FY 2005. In 2006, in addition to documenting lessons learned and metrics, the project team developed and documented a methodology to resolve patient identification mismatches. This methodology was shared with the Enterprise, and applied to other applications, including CHDR.

  A goal added during 2006 is to develop, demonstrate and validate a bidirectional medical image sharing capability that leverages existing enterprise capabilities in both DoD/VA such as Digital Imaging Network - Picture Archiving and Communications System (DINPACS) and Veterans Health Information System and Technology Architecture (VistA) Imaging.

- *Puget Sound VA HCS – Madigan AMC*

  The Team Puget Sound (TPS) has three goals:

  (1) implement Bidirectional Health Information Exchange (BHIE) and include a capability to exchange inpatient documentation;

  (2) define requirements for the user interface to view BHIE data; and

  (3) development of technical documentation to assist in standardizing information exchange.

  In 2006, the BHIE inpatient documentation capability was successfully implemented and made available for enterprise deployment. In addition, the Clinical Data Architecture (CDA Implementation Guides were approved by the Health Architecture Interagency Group (HAIG).

- *South Texas VA HCS – Wilford Hall AFMC and Brooke AMC*
  This initiative consists of two projects with the following goals:

  (1) implement the Laboratory Data Sharing Initiative (LDSI) that facilitates the electronic sharing of chemistry laboratory order entry and results retrieval; and

  (2) test a credentialing interface between DoD's Centralized Credentials Quality Assurance System (CCQAS) and VA VetPro Credentialing system.

  LDSI was successfully implemented in late FY 2005. In FY 2006, the project team collected and documented lessons learned and metrics, and negotiated a revision to the local sharing agreement to increase the scope of laboratory sharing.

  The CCQAS/VetPro interface effort was completed in FY 2006. The credentialing interface demonstration team is currently documenting lessons learned to support project closeout.

SECTION 4.4 – EDUCATION AND TRAINING

At the end of FY 2006, there were 159 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 Working Group of the Health Executive Council made considerable progress in advancing inter-Departmental collaboration in Graduate Medical Education (GME) in this past year. In FY 2006, the Working Group continued the pilot program for military physician residents placed at VA-affiliated university sites. As part of this program, DoD medical residents rotated through VA facilities and provided care to VA patients under the supervision of VA and university faculty. This program was evaluated in the 4th Quarter of FY 2006, and lessons learned and success factors were categorized. Plans for using lessons learned as a basis for program expansion are underway. Additionally, VA participated in the DoD Quadrennial Defense Review strategy that focused on Graduate Medical Education and collaborated in plans to support GME in the National Capital Region.

Continuing Education and Training

During FY 2006, the Continuing Education and Training Working Group achieved significant progress on collaborative joint continuing education training initiatives. The implementation of a shared training strategic plan — including strategic goals, objectives and processes for designing, developing, and managing projects and programs — facilitated an increased sharing of continuing education and training opportunities between the two Departments.

In FY 2006, the following results were achieved:

- The enhancement of operational elements and procedures necessary to support the shared training venture was implemented.
- The implementation of a plan to share in-service training and continuing education programs on an interim basis while developing distributed learning architectures and refining operational processes.
- Shared training programs continued to generate significant cost avoidance. Using FY 2005 as a baseline, VHA and DoD increased sharing in FY 2006 to 254 programs (an increase of 111%) with an estimated cost avoidance of $5.9 million (an increase of 148%).
- A total of 170 training programs were provided by VHA to DoD with a value of $2.9 million; compared to FY 2005, this was an 84% increase in the number of shared programs and a 45% increase in cost avoidance.
- A total of 84 training programs were provided by DoD to VHA with a value of $3.1 million; compared to FY 2005, this was a 200% increase in the number of shared programs and a 675% increase in cost avoidance.

SECTION 4.5 – VA/DOD PROMOTION OF HEALTH CARE RESOURCES SHARING

DoD's 2006 Military Health System Conference featured a full track on collaboration between VA and DoD. Among the 10 sessions offered were presentations on VA/DoD Collaboration/Leadership, the VA/DoD Joint Incentive Fund, Seamless Transition, and Laboratory Data Sharing. These sessions were co-sponsored by VA and DoD.

VA and DoD staffed an exhibit at the annual Association of Military Surgeons of the United States (AMSUS) meeting in November 2005, in Nashville, TN. Booklets and maps promoting sharing were disseminated. The Navy hosted a VA/DoD Joint Venture Conference on "Anatomy of a Joint Venture - Why, What and How?" in February 2006 at North Chicago, IL. The focus was on how to structure and manage a joint venture.

SECTION 5 – NEXT STEPS

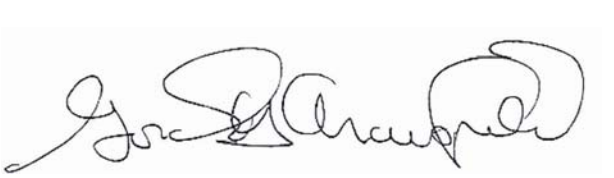
Collaboration between VA and DoD has been gaining substantial momentum over the past few years through the strategic planning and reporting process of the Joint Executive Council. In the upcoming year, the two Departments will continue to focus on all the issues identified in this report. However, the Joint Executive Council will be stepping up its efforts in monitoring the coordinated transition process and joint health care facility operations. The *VA/DoD Joint Strategic Plan for FY 2007-2009* will serve as the primary means to measure performance and results.

The newly established Coordinated Transition Work Group will concentrate on improving the transition process. This group is responsible for ensuring continuity of service and benefits delivery, which is characterized by an improved understanding of and access to the full continuum of health care and benefits available to service members, veterans, and their families at each stage of life.

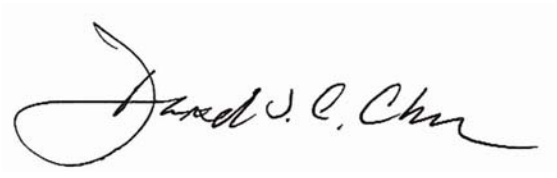
The Joint Executive Council will also be more involved in assisting local initiatives that feature joint operations. The Joint Health Care Facility Operations Steering Group will use lessons learned from our experience with the merger between the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes. The steering group will be responsible for providing support to local leadership, identifying impediments to collaboration, resolving legal issues, and clarifying statutory issues.

Both Departments will continue to build from past successes as we move forward in FY 2007, and beyond. The members of the Joint Executive Council, subordinate councils, committees, and working groups remain committed to improving the efficient and effective utilization of VA and DoD resources.

VA/DoD Joint Executive Council Strategic Plan Fiscal Years 2007-2009



Gordon H. Mansfield
Deputy Secretary
Department of Veterans Affairs



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

January 2007

Appendix A
VA/DoD Joint Strategic Plan
Fiscal Year 2007-2009

VA/DoD Joint Executive Council

MISSION

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

VISION STATEMENT

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

GUIDING PRINCIPLES

Collaboration – to achieve shared goals through mutual support of both our common and unique mission requirements.

Stewardship – to provide the best value for our beneficiaries and the taxpayer.

Leadership – to establish clear policies and guidelines for VA/DoD partnership, promote active decision-making, and ensure accountability for results.

STRATEGIC GOALS

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

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

GOAL 3
Seamless Coordination of Benefits
Improve the understanding of, and access to, services and benefits that uniformed 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 that appropriate beneficiary and medical data is visible, accessible, and understandable through secure and interoperable information management systems.

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

GOAL 6
Joint Medical Contingency/Readiness Capabilities
Ensure the active participation of both agencies in Federal and local incident and consequence response through joint contingency planning, training, and conduct of related exercises.

GOAL 1

Leadership, Commitment, and Accountability

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

VA and DoD will 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 Working Groups. 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 INITIATIVES

Strategy 1.1.

The JEC will provide strategic direction for VA/DoD collaboration with the development and publication of a Joint Strategic Plan (JSP).

Strategy 1.1.(a).

The JEC will monitor Joint Strategic Plan progress at quarterly meetings.

Strategy 1.1.(b).

The JEC quarterly meetings will provide a forum for issue resolution between the Departments.

Strategy 1.1.(c).

The JEC will develop appropriate plans to overcome impediments to meeting stated goals and objectives when specific JSP strategies and initiatives are not met.

Performance Measure

PM.1.1: Complete VA/DoD Joint Strategic Plan for FY 2008 – 2010 by September 30, 2007.

OBJECTIVE 1.2

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

The communications efforts in support of the Joint Strategic Plan also reflect the values, mission, and goals of both the Military Health System (MHS) Strategic Plan and the Department of Veterans Affairs Strategic Plan. Both Plans highlight the commitment of the DoD and the VA to manage and deliver world class services. The Joint Strategic Plan is the roadmap for identifying how to provide the best care with combined or shared resources and collaboration. In cases of VA/DoD sharing initiatives, the efforts of the organizations working together promote continuous improvement in order to serve the beneficiaries and fulfill both missions.

Strategies and Initiatives

Strategy 1.2.
The VA/DoD Joint Executive Council will foster and support clear communications by widely reporting collaborative activities and results each year to members of Congress, the Departmental Secretaries, and internal/external stakeholders.

Strategy 1.2.(a).
The JEC will promote internal communication by expanding the use of existing VA and DoD websites, use of e-Room collaboration tools, and use of the integrated calendar of events for councils, committees, and working groups. The integrated calendar will be updated quarterly.

Strategy 1.2.(b).
The JEC will foster and support intra-Department communication of the ongoing collaboration and resulting best practices by utilizing the internet sites and detailing VA/DoD resource sharing initiatives and accomplishments. The sites will be updated regularly.

Strategy 1.2.(c).
The JEC will issue a minimum of three joint press releases and three joint articles or website features quarterly. These releases, articles, or website features will be related to VA/DoD collaboration and address success or progress in shared activities. Joint communications are developed collaboratively and issued or distributed by the appropriate VA and DoD Offices of Public Affairs.

Strategy 1.2.(d).
VA/DoD will jointly present collaboration efforts at three major conferences per year such as the Military Health System Conference, the Joint Venture Conference, and the TRICARE Regional Office Conferences.

Strategy 1.2.(e).
The JEC will develop a plan for a VA/DoD listserv or electronic newsletter by July 2007 for sharing “good news” stories and best practices.

Strategy 1.2.(f).
The JEC will require an update on the number of joint communications pieces released at each quarterly meeting.

Strategy 1.2.(g).
Work towards establishing a regular column in U.S. Medicine Newspaper in FY 2008.

Performance Measure

PM 1.2: Quarterly reports to the JEC.

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 (GME). 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 Initiatives

Strategy 2.1(a).

The Health Executive Council (HEC) Patient Safety Working Group will oversee the design, development, and distribution of joint patient safety initiatives, consistent with legal requirements on uses of quality assurance information.

(1) VA National Center for Patient Safety (NCPS) and the DoD Patient Safety Center (PSC) will share information on patient safety alerts and advisories potentially relevant to both health care systems.

(2) VA NCPS and the DoD PSC will share data, information, and analyses on the patient safety event category: unintentionally retained surgical items (also referred to "foreign bodies left in after a surgery or procedure") by May 2007.

(3) VA NCPS and the DoD PSC will share data, information, and analyses on the patient safety event category: incorrect surgery or invasive procedures (wrong site, wrong side, wrong patient, etc.) by May 2007.

(4) VA NCPS and the DoD PSC will share data, information, and analyses on the patient safety event category: patient falls that cause serious injury, i.e. resulted in fractures, head injuries, etc by July 2007.

(5) The DoD PSC and NCPS will explore the feasibility of establishing a joint work group to provide usability testing and input on medical devices purchased and procured by VA and DoD.

(6) Each agency will add language to their respective policy and/or handbooks to institutionalize the sharing of patient safety alerts and advisories by June 2007.

(7) Examples of each shared alert or advisory will be forwarded in the respective HEC monthly progress report during the month the alert or advisory occurs.

Performance Measures

PM 2.1(a)(2/3): The Patient Safety Working Group monthly progress report for June 2007 and August 2007 will include a consolidated report showing analysis of selected types of events, root causes, and contributing factors

that lead to adverse events in health care systems with examples of interventions implemented in both systems (June 2007 and August 2007).

PM 2.1(a)(5): A Patient Safety Working Group written analysis of the feasibility of establishing a VA/DoD Joint Working Group to provide usability testing input on joint medical devices purchased and procured by VA and DoD to the HEC, with a recommendation (July 2007).

Strategy 2.1(b).

The HEC Evidence Based Practice Working Group will use clinically diverse and collaborative groups to develop, update, adapt, adopt and /or revise four evidenced based clinical practice guidelines (EBCPGs) annually.

(1) For each issued EBCPG, include recommendations for at least one performance measure when that EBCPG was based on a Level I or Level II-1 level of evidence. (Level I includes at least one properly conducted randomized controlled trial and Level II-1 is a well-designed controlled trial without randomization.)

(2) For each EBCPG, develop implementation tools (both a DoD-produced tool kit with patient related tools and a VA-produced tool kit for providers) no later than twelve months after the EBCPG is issued.

(3) The Evidence Based Practice Working Group will formally introduce via podium presentations, abstracts, or exhibits, two EBCPGs at professional conferences, within six months of their completion date by September 2007.

(4) Complete EBCPGs for: Chronic Kidney Disease, Bipolar Disorder, Acute ST-Segment Elevation Myocardial Infarction, and Chronic Heart Failure by September 2007.

Performance Measures

PM 2.1: Achieve National Guidelines Clearinghouse (NGC) approval and recognition on all issued EBCPGs within one year after submission.

PM 2.1(b)(2): One hundred percent (100%) of EBCPGs will have implementation tools developed within 12 months of issue.

PM 2.1(b)(4): The four approved EBCPG for FY 2007 will be introduced on the website within six months of their completion date.

Strategy 2.1(c).
The Evidence Based Practice Working Group will collect and analyze baseline data collected on practitioners' knowledge, attitude, and behavior as it relates to the use of EBCPGs.

(1) Complete the collection of the baseline data by December 2006.

(2) Analyze the data and report findings to the HEC by July 2007.

Strategy 2.1(d).
The HEC Mental Health Working Group will plan and implement shared training programs to increase the use of evidence-based psychotherapy and pharmacotherapy approaches in both Departments.

(1) Training in Cognitive Processing Therapy (CPT) for Post-Traumatic Stress Disorder (PTSD) will be implemented in both VA and DoD by the end of the Fourth Quarter FY 2007.

(2) CPT training will be implemented using a train-the-trainer approach by the close of FY 2007.

(3) Training in Prolonged Exposure Therapy for PTSD in both VA and DoD will be developed and fully planned for implementation in the Third Quarter FY 2008.

(4) Training for primary care providers in both VA and DoD on appropriate pharmacotherapy as first-line treatment for individuals newly presenting with PTSD will be developed and fully planned for implementation in the Third Quarter FY 2008.

(5) Training plans will specify targets to receive training in both VA and DoD, processes for providing training, and target levels to be accomplished by the Fourth Quarter FY 2008.

Performance Measures

PM 2.1(d)(1): One hundred percent (100%) of VA and DoD representatives identified by Veterans Integrated Service Network (VISN)/service site will be trained to provide CPT and train others by the end of Fourth Quarter, FY 2007 for a total of 36:
- VA: 21 (one for each VISN)
- DoD: 15
  - USA: 6 (one at each regional medical command)
  - USMC:3 (one each at Pendleton, Lejeune, and Okinawa)
  - USN: 3 (one each at Pendleton, Lejeune, and Okinawa)
  - USAF: 3 (one each at Lackland, Andrews, and Wright-Patterson)

PM 2.1(d)(2): Trainers will provide care to at least 30 individuals per year, in addition to providing training to other staff at the target goal level. (CPT is a 12-13 session approach – i.e., three months; ten patients at a time for four cohorts = 40) by the end of Fourth Quarter FY 2008.

Strategy 2.1(e).

The HEC Mental Health Working Group will develop improved methods and strategies to ensure appropriate care for reserve component members who are released from active duty with an on-going health care requirement or need to maintain continuity of care across the VA and DoD health care systems. Community care resources will be engaged to ensure a comprehensive safety net for behavioral healthcare.

(1) The VA will actively collaborate with existing Guard and Reserve, State and Regional Coalitions to address the mental health and readjustment needs of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans.

Performance Measure

PM 2.1(e)(1): Ninety percent (90%) or more of existing Guard and Reserve, State or Regional Coalitions will include both VHA mental health and Vet Center staff as members by September 30, 2007.

Strategy 2.1(f).

The DoD Sexual Assault Prevention and Response Office and the Center on Women Veterans will provide a joint semi-annual report to the HEC 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).

OBJECTIVE 2.2

Actively engage in collaborative GME, joint in-service training, and continuing education activities, which will enhance quality, effectiveness and efficiency of health care.

Strategies and Initiatives

Strategy 2.2(a).

The HEC Graduate Medical Education Working Group will examine opportunities for greater VA/DoD GME collaboration and present findings and recommendations to the HEC.

(1) Define GME timeline for VA and DoD programmatic needs throughout the academic cycle.

(2) Submit an Executive Decision Memorandum (EDM) to the HEC requesting a waiver of VA security screening requirements for military health care providers and trainees who have completed DoD security screening by June 2007.

(3) Submit an EDM to the HEC requesting that the armed services agree on a standardized template for affiliation agreements and memoranda of understanding with VA when placing military residents into university-affiliated residency programs, which will be acceptable to the Department of Justice.

(4) The Graduate Medical Education Working Group will address key issues of the impact analysis and lessons-learned study of the pilot project (military residents placement into VA affiliated residency programs) in order to try to expand current participation.

Performance Measure

PM 2.2(a): Fifty percent (50%) increase in the number of military trainees applying for positions in VA-affiliated university-sponsored residency programs within two years.

Strategy 2.2(b).

The HEC Graduate Medical Education Working Group will conduct a needs assessment of GME programs adversely impacted by the Base Realignment and Closure Commission (BRAC) and present a preliminary assessment with recommended VA/DoD actions.

(1) Complete a needs assessment of GME programs in the National Capitol Area and San Antonio that are adversely impacted by BRAC and report findings to the HEC no earlier than September 2008.

(2) Conduct assessment of impact on GME and report findings to the HEC by September 2007.

Strategy 2.2(c).

The HEC Graduate Medical Education Working Group will pilot a Seamless Transition for Trainees Program at one site based on approval of the HEC.

(1) Identify site selection criteria by February 2007.

(2) Design pilot proposal for definitions of “seamless transition for trainees” by June 2007.

(3) Obtain HEC approval (via EDM) of site by September 2007.

(4) Agree on implementation procedures at the pilot site by May 2008.

(5) Begin the pilot by July 2008.

(6) Evaluate the pilot and report results/recommendations to HEC by June 009.

Strategy 2.2(d).

The HEC Continuing Education and Training Working Group will develop a shared training partnership between VA and DoD to provide more and better shared training by optimizing the distributed learning architecture (see note below for definition) which supports the sharing of continuing education and in-service training programs for health care professionals in VA and DoD.

(1) Complete the assessment of the distributed learning architecture in VA and DoD.

(2) Develop a written plan for refining and aligning the distributed learning architectures within VA and DoD to support increased shared training between the partner agencies utilizing distance learning modalities (Web based and satellite training).

(3) Implement the approved plan for maximizing shared training through the efficient use of distributed learning architectures.

(4) Develop standard procedures for managing the shared training venture at the national level. These are to include: vetting of programs to be shared; marketing of shared programs, and collecting data to be used to measure the success of the shared training venture.

Performance Measure

PM 2.2(d): Increase by 150% the number of VA and DoD shared programs pertaining to distributed Learning Architecture and Continuing Education and Training Working Group initiatives in FY 2007 and generate a cost avoidance of $6,500,000 over the baseline established in FY 2005.

Strategy 2.2(e).

The HEC Continuing Education and Training Working Group will facilitate the development of communities of practice to increase local shared training initiatives between VA Health Care Facilities (HCFs) and DoD Military Treatment Facilities (MTFs).

(1) Plan and establish a forum to increase communications between VA and DoD communities of practice to facilitate increased shared training at the local level by December 2006.[1]

(2) Identify local facility-based educators and commence providing them with in-service training in the area of shared training by December 2006.

(3) Identify the training needed by facility-based educators in order to maximize the volume and quality of shared training at the local level by January 2007.

(4) Develop a toolbox of resources to support the facility-based educator efforts to maximize the volume of shared training at the local level.

(5) Provide in-service training to facility-based educators in VHA HCFs and DoD MTFs to enhance their ability to develop shared training at the local level by June 2007.

(6) Develop methods and procedures for collecting shared training data at the local level in VA and DoD by July 2007.

(7) Establish a shared training baseline data set by collecting and analyzing shared training data at the local level in VA and DoD by September 2008.

[1] For the purpose of this report, Distributed Learning Architecture – the hardware and software necessary to convey training between the partners; the operational methods and procedures to manage the shared training venture and to assure the timely and effective sharing of training; and the commitment of leaders responsible for training in both agencies to the success of the venture. Community of practice will be defined by being composed of facility-based educators in VHA and DoD possessing similar professional needs and interests who also share a common mission and who work in similar ways to accomplish that mission.

OBJECTIVE 2.3

The HEC Deployment Health Working Group shall identify and foster opportunities for sharing information and resources between VA and DoD in the areas of deployment health surveillance, assessment, follow-up care, health risk communication, and research and development.

Strategies and Initiatives

Strategy 2.3(a).

The HEC Deployment Health Working Group will compare and foster research initiatives on military and veteran-related health research to include deployment health issues:

(1) Conduct an annual inventory and catalog current research on deployment health issues in each Department by September of each year.

(2) Establish a VA/DoD forum to share findings of deployment health-related research by June 2007.

(3) Develop an analysis of the ongoing deployment health-related research on an annual basis and provide a summary to the HEC.

Performance Measure

PM 2.3(a)(1): Inventory of all VA/DoD collaborative research projects on deployment health-related issues.

Strategy 2.3(b).

The HEC Deployment Health Working Group, through its Health Risk Subcommittee, will develop joint health risk communication products related to deployment health (fact sheets, information papers, pocket cards, and web site documents).

(1) On a quarterly basis, identify emerging health-related concerns, and develop joint health risk communication strategies, messages, processes, and products related to deployment and other aspects of military service.

(2) On a quarterly basis, coordinate health-related risk communication products to ensure consistency among DoD, VA, the Department of Health and Human Services, and other agencies, as appropriate.

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 service members and veterans, including activated members of the National Guard and Reserve.

Strategies and Initiatives

Strategy 2.4(a).

The JEC Coordinated Transition Working Group, in conjunction with the HEC and BEC, will further strengthen the partnership between Military Treatment Facilities (MTFs) and VA Medical Centers (VAMCs) to facilitate the seamless transition of care and benefits for service members 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 MTFs receiving wounded from OIF and OEF.

(2) Increase additional sites where VA staff members are stationed at MTFs and where DoD staff are stationed at VAMCs, depending on workload of service members transitioning from DoD to VA by September 2007.

Performance Measures

PM 2.4(a)(1): Approved and signed MOU between VA and DoD to institutionalize the placement of VA benefits counselors and social workers at MTFs receiving wounded from OIF and OEF by May 2007.

PM 2.4(a)(2): Increase in the number of sites where VA staff members are stationed at MTFs and where DoD staff are stationed at VAMCs, depending on workload of service members transitioning from DoD to VA.

Strategy 2.4(b).

The JEC Coordinated Transition Working Group, in conjunction with the HEC and BEC, will increase VA's ability to identify and provide services to those servicemembers who are severely injured and/or ill by continuing to work with DoD on the process to notify VA of all servicemembers entering the Physical Evaluation Board (PEB) process.

(1) VA will provide quarterly feedback to DoD regarding the number of servicemembers on the PEB list who are contacted regarding VA benefits and health care services. Start date is March 2007.

Strategy 2.4(c).

The JEC Coordinated Transition Working Group, in conjunction with the HEC and BEC, will further develop and institutionalize processes to ensure appropriate access to VA health care services and benefits for National Guard and Reserve members released from active duty.

(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.

(2) Explore the potential for partnership opportunities for closer collaboration and access to VA services and benefits between the VA and the Reserve Components of all services.

Performance Measures

PM 2.4(c)(1): Formal partnerships developed and implemented with State Directors of Veterans Affairs in 90% of states (for a total of 45 states) by September 2007.

PM 2.4(c)(2): All VA and Reserve Component partnership opportunities accepted by the HEC will be formalized with a MOU by the end of FY 2008.

Strategy 2.4(d).

The JEC Coordinated Transition Working Group, in conjunction with the HEC and BEC, will strengthen the partnership between DoD and VA for the Post Deployment Health Reassessment (PDHRA) program by ensuring that VA staff are present at on-site National Guard and Reserve PDHRA events.

Performance Measure

PM 2.4(d): VAMC and Veteran Readjustment Center staff will be present at 85% of all on-site National Guard and Reserve PDHRA events, when VA is given a 10-day notification.

GOAL 3

Seamless Coordination of Benefits

Improve the understanding of, and access to, services and benefits that uniformed service members 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 benefits 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, and increase the participation in cooperative separation process/examination at Benefits Delivery at Discharge (BDD) sites. This goal encompasses benefits available to VA and DoD beneficiaries, to include health care, educational assistance, home loans, vocational rehabilitation and employment, disability compensation, pension, insurance, burial, and memorial services.

OBJECTIVE 3.1

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

Strategies and Initiatives

Strategy 3.1(a).

The Benefits Executive Council (BEC) will further expand on efforts to disseminate information on benefits and services available to uniformed servicemembers and VA and DoD beneficiaries throughout the military personnel lifecycle.

(1) By March 2007, begin outreach to uniformed servicemembers who are referred to the Physical Exam Board (PEB) to inform this population of VA benefits and services.

(2) By February 2007, disseminate *A Summary of VA Benefits* pamphlets to new recruits at Military Entrance Processing Stations (MEPS).

(3) By April 2007, review and develop a course of action for distribution of *A Summary of VA Benefits* pamphlets to additional key accession and service transition points.

(4) By May 2007, disseminate *VA Health Care and Benefits Information for Veterans* wallet cards and *A Summary of VA Benefits* pamphlets to graduating cadets at military academies (including Coast Guard).

(5) By July 2007, VA and DoD will develop a work plan and resource outline for an awareness survey of VA benefits for servicemembers.

Performance Measure

PM 3.1(a): Expand the distribution of the information about VA benefits through the addition of key accession and training service points by at least 10% each year through FY 2009.

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 Initiatives

Strategy 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.

(1) Increase the number of DoD BDD sites using a cooperative separation process/examination.

(2) Increase the percentage 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.

Performance Measures

PM 3.2(a)(1): Increase the number of DoD BDD sites using a cooperative separation process/examination to 130 sites by the end of FY 2007.

PM 3.2(a)(2): Percent of original claims filed within the first year of release from active duty that are filed at a BDD site prior to a servicemembers discharge (FY 2007 Goal 57%; FY 2008 Goal 61%; and FY 2009 Goal 66%).

OBJECTIVE 3.3

Approved definitions will be included in benefits and health care eligibility criteria for both the Department of Veterans Affairs and the Department of Defense.

Strategy 3.3(a).

Review the set of definitions for current military operations:

(1) March 2007 - Initial six month review

(2) September 2007 - Initial annual review

(3) September 2008 - Annual review

(4) September 2009 - Annual review

Strategy 3.3(b).

Incorporate formal definitions for current military operations into VA health care eligibility determinations and benefits adjudication procedures by January 2007.

Performance Measure

PM 3.3. All approved definitions will be included in benefits and health care eligibility criteria for both the VA and DoD.

GOAL 4

Integrated Information Sharing

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

VA and DoD will utilize 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, faster, and more secure.

OBJECTIVE 4.1

VA and DoD will utilize their enterprise architectures to foster an environment to support secure sharing of timely, consistent, personnel-related data to enhance service delivery in both organizations.

Strategies and Initiatives

Strategy 4.1(a).

The BEC will collaborate in developing Net-Centric solutions for the enhancement of services and benefits delivery.

(1) Identify and implement VA's functional and data requirements for the DoD information necessary to determine a person's identity, benefit eligibility, and health.

(a) Implement compensation data enhancement to the VA/DoD Data Sharing Schema by March 2007.

(b) Implement insurance data enhancement to the VA/DoD Data Sharing Schema by September 2007.

(2) Implement servicemembers / veteran's family member's data enhancement to the VA/DoD Data Sharing Schema by June 2008.

(3) Complete the Identity Management Common Military Population Strategy and Work Plan to allow servicemembers and veterans quick, secure access to their personal information. This will articulate the vision of shared person-information for the purposes of supporting improved services and benefits delivery by March 2007.

(4) Develop shared servicemembers/veteran-centric strategies for DoD and VA Web Portals leveraging Defense Knowledge Online (DKO) and Army Knowledge Online (AKO) solutions, and develop service-oriented architectures for enhancing services and benefits in both organizations.

Performance Measure

PM 4.1: Reduction in the number of distinct personnel data exchanges between VA and DoD (15 from DMDC, 8 to DMDC / FY 2006); (8 from DMDC, 1 to DMDC / FY 2007); (1 from DMDC and 1 to DMDC/ FY 2008).

OBJECTIVE 4.2

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

Strategies and Initiatives

Strategy 4.2(a).

The DoD/VA Health Architecture Interagency Group (HAIG) will continue to improve the availability of shared health information in support of consumer-driven healthcare.

(1) Identify activities in the VA and DoD health architectures relating to empowering the consumer and driving towards patient-centric delivery of health care by the Second Quarter FY 2007.

(2) The HAIG will analyze and report to the HEC IM/IT Working Group, by May 2007, on current processes and opportunities to promote health care quality and efficiency through information sharing to empower our beneficiaries.

(3) Initiate a concept of operations with a project plan promoting VA and DoD beneficiaries access to their personal health information by the Fourth Quarter FY 2007.

Strategy 4.2(b).

The DoD/VA Health Architecture Interagency Group (HAIG) will examine the activities in the VA and DoD health architectures that further evolve the areas of provision of health care delivery.

(1) In support of the Federal Health Information Technology (HIT) community, provide the VA/DoD component for the development of an Emergency Responder Use Case to identify unified requirements, processes, and opportunities to exchange critical health information during emergencies by the Second Quarter FY 2007.

(2) Recommend to the Federal HIT community candidate, polices, practices, and standards related to the management and control of access to electronic health information (e-authentication) by the Fourth Quarter FY 2007.

OBJECTIVE 4.3

Facilitate the adoption of HIT standards for greater interoperability between health systems.

Strategies and Initiatives

Strategy 4.3(a).

VA and DoD will exercise leadership in health IT standards through interoperable products that meet Health Information Technology Standards Panel (HITSP) requirements.

(1) VA and DoD will coordinate on the Federal HIT standards adoption implementation plans due to the Secretary of Health and Human Services by Second Quarter FY 2007.

(2) Align the VA and DoD targeted shared technology profile(s) with HITSP adopted standards by Third Quarter FY 2007.

OBJECTIVE 4.4

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.

Strategy 4.4(a).

The HEC IM/IT Working Group 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 in real-time for shared patients between VA and DoD.

(1) Maintain operating capability to view outpatient pharmacy data, allergy information, and radiology and laboratory results at current sites with bidirectional data sharing.

(2) Bidirectional computable outpatient pharmacy and medication allergy data will begin production testing at the next two sites by First Quarter FY 2007.

(3) DoD will complete the work necessary to support the bidirectional ability to view laboratory results, radiology results, pharmacy data, and allergy information in real-time for shared patients between all sites by Third Quarter FY 2007.

(4) Better define the population of VA/DoD shared patients by determining the number of patients flagged as "active dual consumers" for VA/DoD

electronic health record data exchange. (Update this number quarterly through FY 2007 to the VA/DoD HEC IM/IT Working Group.)

(5) Begin sharing discharge summaries from one DoD site by First Quarter FY 2007.

(6) DoD will begin working with Defense Manpower Data Center (DMDC), Defense Enrollment Eligibility Reporting System (DEERS) to ensure VA patients treated in DoD facilities have DoD Electronic Data Interchange Person Numbers (EDI_PN_IDs) to facilitate matching patients and sharing electronic health information on shared patients by First Quarter FY 2007.

(7) VA and DoD will be able to share viewable encounters/clinical notes, procedures, and problems in real-time and bidirectional for shared patients among all sites by First Quarter FY 2008 – pending funding for VA to begin work.

(8) Begin sharing discharge summaries from two additional DoD sites by Second Quarter FY 2007.

(9) VA and DoD will be able to share viewable vital signs data and scanned/imported documents/images in real-time and bidirectional for shared patients between all sites by Third Quarter FY 2008 – pending funding for VA to begin work.

(10) Begin sharing discharge summaries from two additional DoD sites by Third Quarter FY 2007.

(11) VA and DoD will be able to share viewable family history/social history/other history, questionnaires and forms in real-time and bidirectional for shared patients between all sites by Fourth Quarter FY 2008 – pending funding for both VA and DoD to begin work.

(12) Begin sharing discharge summaries from two additional DoD sites by Fourth Quarter FY 2007.

(13) Complete usability enhancement for DoD providers to access VA data on shared patients from AHLTA, the DoD electronic health record system, by Third Quarter FY 2007.

(14) Develop a timeline and milestones for computable laboratory exchange by Second Quarter FY 2007.

Strategy 4.4(b).

The HEC IM/IT Working Group will support electronic transfer of pre- and post-deployment health assessments and post deployment health reassessments (PDHRA) on separated service members from DoD to VA.

(1) Continue monthly transfer of the electronic pre- and post-deployment health assessments.

(2) Begin monthly transfer of PDHRA forms for separated servicemembers and Reserve and National Guard members who have been deployed and are now deactivated by First Quarter FY 2007.

(3) Begin weekly transfer of PDHRA forms for individuals referred to VA on question 10 of the PDHRA form by First Quarter FY 2007.

Strategy 4.4(c).

The HEC IM/IT Working Group will support bidirectional electronic transfer/ sharing of laboratory order entry and results retrieval between VA, DoD, and commercial reference laboratories.

(1) Continue demonstrating the laboratory electronic order entry and results retrieval system capabilities at the two National Defense Authorization Act (NDAA) Demonstration Sites (El Paso and San Antonio).

(2) Begin testing the anatomic pathology and microbiology enhancements at the El Paso NDAA Demonstration site by First Quarter FY 2007.

(3) Begin testing the anatomic pathology and microbiology functionality at the San Antonio NDAA Demonstration site by Second Quarter FY 2007.

(4) Begin testing the anatomic pathology and microbiology functionality at one additional site by Third Quarter FY 2007.

Strategy 4.4(d).

The HEC IM/IT Working Group will support joint efforts to identify areas of convergence across the DoD/VA eHealth Portals: Veterans Health Affairs My HealtheVet (MHV) and Department of Defense TRICARE Online (TOL).

(1) Begin work to implement health content standardization between MHV and TOL by Fourth Quarter FY 2007.

(2) Complete initial draft of functional requirements that are common to both DoD and VA portals by Fourth Quarter FY 2007.

(3) Complete business and technical requirements for authentication and registration of Role-Based Access Control (RBAC) and Role-Based Account Administration (RBAA) for MHV and TOL by First Quarter FY 2008.

(4) Complete a white paper on health information portability between TOL and MHV: viable information exchange between the two sites by First Quarter FY 2008.

(5) Finalize VA/DoD coordination efforts on the Personal Health Record (PHR) in MHV and TOL in concert with overall direction of the American Health Information Community (AHIC) by First Quarter FY 2008.

(6) Complete implementation of health content standardization in MHV and TOL by Second Quarter FY 2008.

Strategy 4.4 (e).
The HEC IM/IT Working Group will support the electronic sharing of images for shared VA/DoD patients.

(1) DoD will leverage VA's Imaging System Viewer for incorporation into the DoD Military Health System (MHS) Enterprise digital imaging capabilities by Fourth Quarter FY 2007.

(2) VA/DoD will pilot the sharing of radiology images for shared test patients as part of the William Beaumont Army Medical Center (WBAMC) and the El Paso VA Health Care System (VAHCS) NDAA demonstration project by Fourth Quarter FY 2007.

(3) VA/DoD will conduct an interagency assessment of the infrastructure requirements for the sharing of images between agencies as part of the WBAMC/El Paso VAHCS NDAA demonstration project by Fourth Quarter FY 2007.

Performance Measure

PM 4.4: Monitor usage and report progress on expansion of bidirectional health information sharing on quarterly basis to the HEC.

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 management 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 investment opportunities at three sites based upon capital needs and requirements identified by both Departments.

Strategies and Initiatives

Strategy 5.1(a).

VA and DoD will continue to improve coordination and collaborative efforts to improve delivery of health care. Examples of collaboration involving capital include the development of Capital Funding Principles. These principles will establish a straightforward, logical, and consistent approach to funding collaborative capital projects in order to foster more VA/DoD partnerships in the future.

In addition to the Capital Funding Principals, the CPC has initiated the development of a nation-wide survey tool, which will gather data to clearly identify both past and present VA/DoD capital investment collaboration ventures. This tool will more clearly define attempts that were both successful and unsuccessful in addition to uncovering potential future opportunities.

The data collected from this survey will establish a centralized database available to both agencies, expediting the development of capital asset collaboration policy and protocols. This data will capture not only project description, scope, cost, fiscal year appropriations, and planning milestones, but will aid in the standardization of VA/DoD planning elements.

This data will also serve as a catalyst to the collaborative opportunities currently being considered by the CPC, which are Biloxi, MS; Keesler, MS; Goose Creek, SC; Washington, DC; Camp Pendleton, CA; and Beaufort, SC.

Strategy 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 by Third Quarter FY 2007.

OBJECTIVE 5.2

Leverage joint purchasing power in the procurement of prosthetics, medical/surgical supplies, high-cost medical equipment, dental, laboratory, radiology equipment, and pharmaceuticals.

Strategies and Initiatives

Strategy 5.2(a).
The HEC Acquisition and Medical Materiel Management Working Group 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) Review regulatory and policy impediments that prevent further collaborations and report results to the HEC by July 2007 with requests for regulatory changes as needed.

(2) Pursue six (6) items/services for joint purchasing consolidation in calendar year 2007. These items include:

- Hearing Aids
- Hearing Aid Batteries
- Physiological Monitors (hand-held)
- Pharmaceutical returns/reverse distribution service contract
- OR Surgical Instruments
- Optical Fabrication

(3) Pursue VA/DoD Joint Incentive Funding to support contractual services to determine measurement of effectiveness of the joint contracting process. The results of this contract will be used for establishing quantifiable metrics. The contract proposal will be submitted by October 2006; contract award by October 2007; and quantifiable metrics established by January 2008.

(4) Increase collaborative logistics and clinical participation by developing joint standardization projects. Complete the project by October 2007. Interim steps include:

- Analyze respective programs and criteria by January 2007.
- Share spend analysis in specific commodities by March 2007 (spend analysis provides a view of what each Agency has purchased for each of the listed commodities). Involve clinical participation from VA and DoD to work with acquisition and logistic personnel in developing mutual framework.
- Identify commodities for joint standardization by July 2007.

Strategy 5.2(b).

The HEC Acquisition and Medical Materiel Management Working Group will increase the value of joint contracts by $20 million by September 2007, targeting commonly used manufacturers for joint contract initiatives and continuing to seek new opportunities for joint contract initiatives.

(1) The HEC Acquisition and Medical Materiel Management Working Group will track the number and dollar value of joint contracts and estimated savings quarterly in a report to the HEC. Begin quarterly reports in January 2007.

(2) National Acquisition Center (NAC) and Defense Supply Center Philadelphia (DSCP) will work together to award a joint imaging contract in FY 2007.

Performance Measure

PM 5.2(a)(2): Review 100% of identified items by October 2007 and identify items for joint contracts.

PM 5.2(b): Increase in joint acquisition sales realized from the joint procurement of high cost medical equipment by $20 million annually, beyond the 2006 baseline level of $150 million (FY 2007 – $170 million; FY 2008 – $190 million).

PM 5.2(b)(2): Number of joint contracts awarded each fiscal year.

Strategy 5.2(c).
The HEC Pharmacy Working Group will identify pharmaceuticals and commonly used products and manufacturers for potential joint contracting action and continue to seek new joint contracting opportunities.

(1) Evaluate 100% of all brand-to-generic conversions (loss of patent exclusivity) within the top 25 drugs as measured by acquisition dollar volume and report the status of the reviews to the HEC on an annual basis, at the first meeting after the end of the first quarter.

(2) Evaluate 100% new molecular entities used in the ambulatory setting for contracting opportunities and report the status of the reviews to the HEC on an annual basis, at the first meeting after the end of the first quarter.

(3) Evaluate 100% of all expiring joint national contracts and report the number to the HEC on an annual basis.

Performance Measures

PM 5.2(c)(1): Award at least 8 joint contracts each fiscal year.

OBJECTIVE 5.3

Establish a common electronic catalog for all items under contract by both Departments by October 2007.

Strategies and Initiatives

***Strategy 5.3*(a).**
The HEC Acquisition and Medical Materiel Management Working Group 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.

***Strategy 5.3*(b).**
The HEC Acquisition and Medical Materiel Management Working Group will create a single database that includes all VA Federal Supply Schedule (FSS) as well as VA and DoD national contract information by October 2007. A status report to the HEC through the Acquisition and Medical Materiel Management Workgroup will be provided quarterly.

OBJECTIVE 5.4

VA and DoD will collaborate to improve business practices related to financial operations.

Strategies and Initiatives

Strategy 5.4(a).
The HEC Financial Management Working Group will revise outpatient billing guidance by April 2007.

Strategy 5.4(b).
The HEC Financial Management Working Group will explore opportunities to adjust, amend or modify VA and DoD budget management processes and appropriation language 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 2007.

Strategy 5.4(c).
The HEC Financial Management Working Group will continue to solicit and recommend Joint Incentive Fund projects to the HEC, and will monitor and report the progress of approved projects quarterly.

Strategy 5.4(d).
The HEC Joint Facility and Resource Sharing Working Group will oversee VA and DoD efforts to jointly implement the FY03 NDAA Demonstration Projects in budget and financial management, coordinated staffing and assignment, and medical information and information technology management.

(1) Conduct reviews of the demonstration sites and report progress toward meeting goals established in approved business plans annually by March 31 of each year.

(2) Conduct demonstration project site visits and assist with completion of final report, transition plans, and lessons learned.

(3) Disseminate lessons learned to VA and DoD staff. Lessons learned will be presented in a VA/DoD breakout session at the Military Health System Conference in January 2007.

Performance Measures

PM 5.4(d)(2): Conduct site visits/workshops with 100% of sites and complete initial draft of final report by December 2006.

GOAL 6

Joint Medical Contingency/Readiness Capabilities

Ensure the active participation of both Departments in Federal, State, and local incident and consequence response through joint contingency planning, training, and conduct of related 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:

(1) joint planning to ensure VA support of DoD contingency requirements;

(2) collaborative training and exercise activities to enhance joint contingency plans; and

(3) improvement of joint readiness capabilities.

OBJECTIVE 6.1

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

Strategies and Initiatives

Strategy 6.1(a).

The HEC Contingency Planning Work Group will develop Departmental plans to support the revised VA/DoD Memorandum of Agreement and Contingency Plan and ensure that all VA and DoD Primary Receiving Centers (PRCs) complete local plans to support the VA/DoD MOA and Contingency Plan by June 2007.

(1) Complete signature approval on the VA/DoD MOA and Contingency Plan by January 2007.

(2) Craft implementing guidelines at the Department level as appropriate.

(3) Report on a quarterly basis to the HEC the percentage of 87 PRC's that have completed their local plans.

Performance Measure

PM 6.1(a)(1): Approval of Departmental implementation plans. Craft implementation guidance at the Department level as appropriate by September 2007.

PM 6.1(a)(3): Percentage of Primary Receiving Centers that have completed their local plans.

Strategy 6.1(b).

The HEC Contingency Planning Working Group will conduct first annual review of joint contingency/readiness capability activities seeking inclusion of VA capabilities and capacities and report findings to the HEC in March 2007.

OBJECTIVE 6.2

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

Strategies and Initiatives

Strategy 6.2(a).

The HEC Contingency Planning Working Group will review common training requirements and joint training opportunities for personnel involved in joint VA/DoD contingency operations and will facilitate development of MOAs between selected VA and DoD training organizations to ensure funding agreements and space allocation for VA personnel involved in DoD contingency operations.

(1) Compile a list of training opportunities by January 2007.

(2) Initiate coordination with all agencies identified in Item 6.2**(a)(1)** by March 2008.

(3) Provide the HEC an annual report on use of satellite training resources by December 2007.

(4) Report to the HEC on a quarterly basis the percentage of agreements concluded.

(5) Report to the HEC on a quarterly basis the number of VA/DoD personnel trained in joint venues.

Performance Measures

PM 6.2(a)(1 and 4): Number of agency agreements concluded from a list of identified training opportunities.

PM 6.2(a)(5): Number of agency personnel trained in joint venues.

Strategy 6.2(b).
The HEC Contingency Planning Working Group will review the Chairman of the Joint Chiefs of Staff Exercise Program to ensure that joint tasks (e.g. patient movement within the continental United States) are included in at least one National Level Exercise annually.

(1) Report to the HEC on number of exercises identified by January 2007.

(2) Report to the HEC on outcome of the next review of the Joint Staff Exercise Program by September 2007.

(3) Report to the HEC annually on joint exercise participation by January 2008.

Strategy 6.2(c).
The HEC Contingency Planning Working Group will convene a sub-working group to create and coordinate Readiness Indicators for all PRCs. Mechanisms to report readiness to VA and DoD will be included.

(1) Review current indicators and report to HEC by March 2007.

(2) Draft new indicators and report to HEC by January 2008.

Strategy 6.2(d).
The HEC Contingency Planning Working Group will facilitate one tactical joint patient movement/reception or disaster response exercise at each VA and DoD PRC every three years beginning in October 2009.

(1) Identify funding requirements and potential sources by March 2007.

(2) Submit funding requests by January 2008.

(3) Coordinate exercise schedules by March 2009.

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 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 "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) 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 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 by that would effectively serve the combined needs of both agencies. Justification for acquiring or increasing resources may be based on the projected workload form 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 recourses 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 protocol 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 the 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 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 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/_____ _____/s/_____

(Signature) (Signature)

Jul 1-1983

Appendix C
Cost Estimate to Prepare Congressionally Mandated Report

TITLE OF REPORT: *VA/DOD 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 and Printing Cost	$15,000
Total Estimated Cost to Prepare Report	$78,229

Brief explanation of the methodology used to project cost estimate:

The estimated number of total direct labor hours expended 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 the sum of direct labor hour costs and fringe benefits.

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