VA/DOD

JOINT EXECUTIVE COUNCIL

FY 2008 ANNUAL REPORT

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Executive memebership list as of September 30, 2008

VA/DoD Joint Executive Council
Annual Report
Fiscal Year 2008

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February 2009

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VA/DoD Joint Executive Council Fiscal Year 2008 Annual Report

SECTION 1 – INTRODUCTION

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Joint Executive Council (JEC) has completed its sixth year and is pleased to submit this Annual Report, for the period October 1, 2007 to September 30, 2008, to Congress and the Secretaries of Defense and Veterans Affairs, as required by law.[1] This Council, which provides senior leadership for coordination and resource sharing between VA and DoD, met quarterly in Fiscal Year (FY) 2008. Neither Secretary used the waiver authority granted by section 722(d)(1) of the Bob Stump National Defense Authorization Act (NDAA) for FY 2003 (Public Law 107-314). This report contains no recommendations for legislation related to health care resource sharing.

The JEC is co-chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness. The co-chairs selected 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.

The VA/DoD Joint Strategic Plan (JSP) for the JEC and its sub-councils 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.

[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).

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

The JSP is the primary means to advance performance between VA and DoD, and is continuously evaluated, updated, and improved. The *VA/DoD Joint Strategic Plan for FY 2009-2011*, which is appended to this Annual Report, contains substantial revisions to the goals, strategies, and performance measures in last year's JSP.

In FY 2008, VA and DoD continued to focus on improving the effectiveness and efficiency of health care services and benefits to better serve veterans, servicemembers, military retirees, and eligible dependents. This report describes and provides details on our collaborative efforts and VA/DoD successes in many critical areas including financial management, joint facility utilization, pharmacy, medical-surgical supplies procurement, patient safety, deployment health, mental health, clinical guidelines, contingency planning, clinical case management, and benefits delivery. Additionally, several advisory committees and review groups, including the *Task Force on Returning Global War on Terror Heroes*; the *Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center*; the *President's Commission on Care for America's Returning Wounded Warriors; the DoD Task Force on Mental Health*; and the *Veterans' Disability Benefits Commission*, made more than 400 recommendations to the Departments. Progress on implementing these recommendations has been closely monitored over the past year by the Wounded, Ill and Injured Senior Oversight Committee (SOC) Lines of Action (LOAs). Accordingly, these ongoing initiatives were incorporated into the current revision of the JSP and resulted in a significantly expanded Seamless Transition section in this year's report.

The report also discusses the progress made over the past year in the vital area of information sharing, both health and demographic data, and highlights the ongoing activities under the auspices of the Joint Incentive Fund (JIF) and demonstration projects authorized in the FY 2003 NDAA. 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 following JSP goals: Seamless Coordination of Benefits, High Quality Health Care, and Efficiency of Operations. Together, the two Departments made considerable progress toward promoting mutually beneficial coordination, use, and exchange of services and resources in FY 2008.

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 to ensure continuity of services. In FY 2008, both the SOC and the JEC provided oversight and guidance to myriad new initiatives to improve inter-Departmental cooperation and reduce bureaucratic barriers impeding a seamless transition. The SOC focused on ensuring a smooth transition for severely injured servicemembers returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Meanwhile, the JEC continued to push the Departments in the direction of increasing the numbers of servicemembers in all Military Departments to enroll in VA health care programs and file for VA benefits prior to separation from active duty status.

Senior Oversight Committee

The SOC was established in May 2007 to ensure proper oversight and interagency coordination of the various commissions and review groups looking at wounded warrior issues mentioned above. Supporting the SOC decision-making process is an Overarching Integrated Product Team (OIPT) which is co-chaired by the Principal Deputy Under Secretary of Defense for Personnel and Readiness and the VA Under Secretary for Benefits, and composed of senior officials from both VA and DoD. The OIPT reports to the SOC and coordinates, integrates, and synchronizes work resulting in recommendations to the SOC regarding resource decisions.

SOC Membership	
DoD	**VA**
Deputy Secretary of Defense – Co-chair	Deputy Secretary of Veterans Affairs – Co-chair
Military Department Secretaries	Under Secretary for Health
Chairman or Vice Chairman, Joint Chiefs of Staff	Under Secretary for Benefits
Military Department Chiefs or Vice Chiefs of Staff	Assistant Secretary for Policy and Planning
Under Secretary of Defense for Personnel & Readiness	Deputy Chief Information Officer
Under Secretary of Defense, Comptroller	
General Counsel	
Assistant Secretary of Defense, Health Affairs	
Director of Administration and Management	
Principal Deputy Under Secretary of Defense, P&R	
Deputy Under Secretary of Defense for Plans	

In FY 2008, the two Departments worked through the SOC and the OIPT to address and implement the more than 400 recommendations proposed by the various commissions and review groups, as well as implementing the Wounded Warrior and Veterans titles of the FY 2008 NDAA, Public Law No. 110-181.

VA/DoD Disability Evaluation System

One of the most significant recommendations proposed by the *President's Commission on Care for America's Returning Wounded Warriors* was for VA and DoD to completely restructure the disability and compensation systems. This core recommendation of the Commission centers on the concept of taking DoD out of the disability rating business so DoD can focus on the fit or unfit determination, streamlining the transition from servicemember to veteran.

In order to update and simplify the disability determination and compensation system, VA and DoD initiated a Disability Evaluation System (DES) Pilot program on November 26, 2007 for disability cases originating at the three major military treatment facilities (MTFs) in the National Capitol Region. The Pilot tests a new VA and DoD disability system designed around the servicemember to eliminate the duplicative, time-consuming, and often confusing elements of the two current disability processes of the Departments. Specifically, the Pilot features one medical examination and a single-sourced disability rating with the goal of reducing by half the time it currently takes to transition a servicemember to veteran status and provide them with their VA benefits and compensation. Between November 26, 2007 and the end of FY 2008, 723 servicemembers participated in the Pilot. Of those, 119 completed the process with an average of 203 days or a 62 percent reduction in the amount of time previously required to complete the current DES and VA claim process.

The Pilot was originally scheduled to run for one year; however, at the conclusion of FY 2008, senior leadership decided to expand the Pilot to 17 additional sites, which include seven Army locations and five each for the Navy/Marines and Air Force. The expansion allows the Departments to test the viability of the new process under a broader number of local conditions.

Continuity of Health Care and Benefits

The President's Commission on Care for America's Returning Wounded Warriors also recommended that the Departments create comprehensive, patient-centered recovery plans for every seriously wounded servicemember, including those wounded early in the OEF/OIF conflicts who might still benefit from a recovery plan. To address this recommendation, the SOC established the Federal Recovery Coordination Program (FRCP). The FRCP is operated as a joint VA/DoD program with VA serving as administrative home. VA also provides staffing for program personnel. The Executive Director of the program reports to the Secretary of VA and the SOC.

The goal of the FRCP is to provide assistance to recovering servicemembers, veterans, and their families through recovery, rehabilitation, and reintegration. Therefore, the FRCP is designed to assist recovering servicemembers, veterans, and their families in accessing care, services, and benefits provided by the various programs in VA and DoD, other Federal agencies, states, and the private sector.

In FY 2008, the Departments worked to develop the first two of three phases to fully implement the FRCP. Phase 1, conducted from November 2007 through April 2008, consisted of hiring, training and placing Federal Recovery Coordinators (FRCs) and developing the first iteration of the Federal Individual Recovery Plan. In Phase 2, scheduled for May 2008 through December 2008, the focus has been on establishing performance standards and benchmarks, along with developing appropriate policies and procedures. Additionally, information technology (IT) tools to support the FRCP were refined and data dictionaries were built to reinforce standardization of collected data. Finally, satisfaction surveys were also developed.

Eight FRCs were hired on January 6, 2008, along with a Director and Nurse Supervisor. These 10 individuals completed orientation and training on January 18, 2008. The FRCs were placed at MTFs where most newly evacuated wounded, ill or injured servicemembers are taken. The program placed FRCs at selected VA facilities to assist with assessing and enrolling those wounded, ill or injured veterans who passed through the system prior to the program's implementation. The following chart shows the distribution of FRCs by location as of September 9, 2008.

Facility Name and Location	Number of FRCs
Walter Reed Army Medical Center, Washington, DC	1
National Naval Medical Center, Bethesda, MD	2
Brooke Army Medical Center, San Antonio, TX	2
Naval Medical Center, San Diego, CA	1
Rhode Island VA Medical Center, Providence, RI	1
Michael E. DeBakey VA Medical Center, Houston, TX	1
Total	**8**

As of September 8, 2008, two additional FRCs were hired and, after training, will be located at Eisenhower Army Medical Center (AMC) in Augusta, Georgia, and Brooke AMC in San Antonio, Texas.

A comprehensive, web-based National Resource Directory was developed in FY 2008 to provide recovering servicemembers, veterans, families, care coordinators, care providers and care partners with a single online reference for the full array of programs and benefits available.

The directory was activated in November 2008 and contains checklists for common processes and a section for frequently asked questions. It also provides information on services and catalogues resources available through national, state and local governmental agencies, veterans' benefit/service/advocacy organizations, professional provider associations, community/faith-based/non-profit organizations, academic institutions, employers, and business and industry's philanthropic activities. It provides information designed to help meet the medical or non-medical needs and personal goals of recovering servicemembers and veterans regardless of location. Users are able to search for information by user type, geographic location, military affiliation, and specific service or resource. The directory is a joint development project by DoD, VA and the Department of Labor with content information provided by partners across the nation.

The Polytrauma Liaison Officer/Noncommissioned Officer Program

In addition to the FRCP, the Departments have instituted the Polytrauma Liaison Officer/Noncommissioned Officer Program. DoD conducted an assessment of

the program this year in accordance with Section 1665 of the FY 2008 NDAA. This program was originally established in March 2005 as the Army Liaison/VA Polytrauma Rehabilitation Center Collaboration, a "boots on the ground" program specifically focused on providing non-clinical transition assistance for the most severely injured and ill servicemembers being transferred directly from a MTF to one of the four VA Polytrauma Rehabilitation Centers (PRCs) in Richmond, VA; Minneapolis, MN; Tampa, FL; and Palo Alto, CA. However, in FY 2008, the program was expanded and now includes an Army and Marine Corps liaison at each PRC and a Navy liaison at the Palo Alto and Tampa locations.

Each of the Military Departments has a formal chain-of-command in place to provide guidance and resolve issues for the program. The Army program operates under the auspices of the Army Office of the Surgeon General through the Regional Medical Commands down to the Warrior Transition Units. The Navy and Marine Corps programs are overseen by the personnel community; the Navy Safe Harbor Command and the Wounded Warrior Regiment, respectively. Each Military Department has a dedicated program manager to oversee the liaison program and interface with the Veterans Health Administration (VHA) program manager to address issues related to the program. A Memorandum of Understanding (MOU) between the Marine Corps and VHA was signed on February 28, 2008. As of November 2008, the Army and the Navy were developing MOUs with VHA.

The Department reported that the primary objective of this program is to provide a uniformed advocate to support and assist injured servicemembers and their families, particularly with resolving non-clinical, military related issues. Using this objective as a benchmark for effectiveness, it is the nearly unanimous consensus of everyone interviewed that the military liaisons provide great value to the comfort of the servicemembers and their families. In executing their duties, the military liaisons unanimously cited that they do "whatever it takes." It is also widely noted that their advocacy in solving problems, providing a uniformed presence and perpetuation of military culture while being cared for in an unfamiliar VA environment enables these servicemembers to focus completely on recovery and rehabilitation. All levels of VA leadership within the PRCs expressed support for making the program permanent and a desire to be involved in the selection process for future military liaisons.

As VA and the Military Departments continue to learn more about the needs of these servicemembers and their families, as well as what is working well and what is not, there continues to be some fine tuning of the program. Thus, the program will continue to evolve in the coming years.

The Benefits Executive Council

In FY 2008, the BEC supported the SOC's efforts and, at the same time, continued its work on meeting the objectives contained in the JSP under Goals 3 and 4. The BEC work groups focused on developing and implementing a

number of strategies, policies, and programs to provide timely and appropriate services to all servicemembers and veterans, including those transitioning directly from MTFs to VA Medical Centers (VAMCs). Significant progress was made in the areas of outreach and communication, workload tracking, data collection, and staff education. Clear and consistent communication between the two Departments led to improvements in all facets of information sharing, coordination of services, and expanded outreach to all servicemembers and veterans. Finally, the BEC also chartered the Medical Records Work Group (MRWG) to examine and develop recommendations to improve the life-cycle management of the DoD outpatient paper health record and its availability to the Veterans Benefits Administration (VBA) for claims processing and benefits determination.

Communicating VA/DoD Benefits and Services Work Group

This work group under the BEC is focused on expanding outreach to all servicemembers and veterans. In FY 2008, the work group continued to identify different avenues to allow VBA to provide information on VA benefits. The work group has also worked with the Personnel, Pay and Financial Support LOA under the SOC to develop and publish a comprehensive reference guide, *The Compensation and Benefits Handbook*, for seriously ill and injured servicemembers.

The work group also began exploring the use of e-mails to allow VA to stay in contact with servicemembers on active duty and as they transition to civilian life. VA and DoD are developing displays of benefit information to be placed at MTFs and are exploring the possibility of placing information about VA benefits on servicemembers' leave and earnings statements.

Lastly, the work group began the process of developing a survey methodology that will enable the Departments to measure and track increases in servicemembers' level of awareness. The work group is especially interested in evaluating the effectiveness of each outreach effort, and makes any necessary revisions to improve their outreach strategies based on servicemember feedback.

VBA is briefing significant numbers of National Guard and Reserve members as they demobilize. However, VBA has not captured these numbers as demobilization briefings because of the design of its data collection program. VA and DoD have been working to put into place mechanisms to collect metrics on pre-and post-deployment briefings to evaluate how many National Guard and Reserve members are actually receiving information on VA benefits as they leave active duty.

Benefits Delivery At Discharge Work Group

Benefits Delivery at Discharge (BDD) is a pre-discharge claims processing program targeted at servicemembers between 60 and 180 days prior to separation. VA and DoD developed a formula to calculate the participation rate of servicemembers who filed a claim through the BDD program at 130 intake

sites with a MOU. Toward the end of FY 2008, the definition of an intake site was expanded to include all places where VA claims are accepted. Intake sites are defined as any location where VA accepts claims. This includes all regional offices; demobilization sites; military installations, and VA health care facilities.

To further promote awareness of the BDD program, VA and DoD collectively developed a pamphlet for all intake sites and military installations. This joint pamphlet identifies the advantage of filing a BDD claim prior to separation, the process of filing a BDD claim, and web site addresses for VA/DoD information. Additionally, the information has been posted on VA's web site and will be further disseminated via multiple delivery methods throughout DoD.

As it was recognized that not all separating servicemembers could meet the time guidelines of the BDD program, the VA introduced the Quick Start program on July 2, 2008, to serve this population. The Quick Start program is also a pre-separation claims processing program; however, Quick Start reaches out to all servicemembers who have less than 60 days prior to their separation up until the day of discharge. While Quick Start is available for active duty servicemembers who are unable to meet BDD program criteria, this program is particularly beneficial to National Guard and Reserve members who many times also cannot meet BDD program criteria due to demobilization constraints.

Medical Records Work Group

DoD has been rolling out its electronic health record (EHR), AHLTA, and while utilization continues to increase within the Military Health System (MHS), the Departments' reliance on paper records to capture and document treatment will also continue. This finding and several other significant findings were reported to the BEC in early 2007 by a specially chartered Interagency Task Force on Medical Records. The Task Force also found that a common term and standard definition were essential to decreasing if not eliminating the confusion that existed at the time with regard to what constitutes the medical record used by the VBA to make benefits determinations.

Thus, the MRWG was chartered under the BEC in FY 2008 for the purpose of addressing emerging issues associated with the hybrid records system currently in place during this period of evolution toward a fully electronic and interoperable record. During FY 2008, the MRWG presented for approval an Executive Decision Memorandum (EDM), which was signed by the VA Under Secretary for Benefits and the Principal Deputy Under Secretary of Defense for Personnel and Readiness. This joint decision memorandum clearly defined the Service Treatment Record (STR) as the "chronological documentation of medical and dental care received by a military member during the course of his/her military service." The MRWG also drafted a DoD Directive that was in coordination at the close of FY 2008.

With expansions of the DES Pilot program and VA's BDD and Quick Start programs, as well as the issues regarding the Guard and Reservists, the MRWG's strategic goal was refocused this year to emphasize the simultaneous need for information contained in the STR by numerous offices within the Departments. The Departments collaborated in a Lean Six Sigma exercise whose overarching objective is to develop a media-neutral, 21st century solution for managing the STR life cycle. This solution will serve as a bridge between maintaining and transferring a completely paper based record and managing the record in its current hybrid state containing both paper based and electronic information until the Departments implement a complete EHR.

SECTION 2.2 – HIGH QUALITY HEALTH CARE

The HEC concentrates on joint VA and DoD efforts to improve access, quality, and effectiveness of health care for beneficiaries through collaborative activities. The following section describes our work over the past FY in the areas of fostering a greater understanding of issues directly related to forward deployment as it relates to decreasing injury and illness, improving patient safety in both health care systems, and instituting evidenced-based clinical practice guidelines.

Over the past year hundreds of mandates and recommendations to improve the psychological health of servicemembers and veterans, as well as substantive Congressional funding to assure adequate numbers and training of mental health providers, have resulted in newly established structures to meet current wartime challenges. The DoD Center of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) was stood up in November 2007 to help meet these challenges, and includes an embedded VA mental health leader. Aligning DoD representation through the DCoE on the HEC Mental Health Work Group is currently under way as the DCoE is staffed.

Deployment Health

The VA/DoD Deployment Health Work Group (DHWG) was established to ensure coordination between the two Departments in order to effectively maintain, protect, and preserve the health of Armed Forces personnel, veterans, and their families during and after combat operations and other deployments. In FY 2008, the DHWG focused predominantly on servicemembers returning from OEF and OIF, while continuing to coordinate initiatives related to veterans of all eras, going back to the 1940s. Through the DHWG, VA and DoD share information and resources in the areas of deployment health surveillance, assessment, follow-up medical care, health risk communication, and research. This progress report describes new, ongoing, and completed initiatives related to each of these areas in FY 2008.

Deployment Health Surveillance and Assessment

In 2008, the DHWG worked on two medical surveillance initiatives, one on a new National Veterans' Registry, and the other on exposure to depleted uranium (DU). VA and DoD are working to develop a national listing of all living veterans,

which will be called the VA National Veterans' Registry. Such a database does not currently exist, but the number of 25 million living veterans is often quoted. Staff from several VA and DoD offices have started planning the registry. The VA Beneficiary Identification and Records Location Subsystem will form the foundation of the registry, and it will be supplemented with several other VA and DoD databases. Veterans do not need to be enrolled in VA health care to be included in the registry. This database will be useful for policy development and planning, as well as for outreach and research.

In 1993, VA and DoD began medical surveillance for DU in the most highly exposed group of veterans of the 1991 Gulf War, which has since expanded to include all Gulf War and OIF veterans. More than 2,500 OIF veterans have participated in the program. VA and DoD recently developed programs to respond to new requirements related to heavy metals. In December 2007, DoD implemented a policy for collection and chemical analysis of all metal fragments that are surgically removed from injured servicemembers. DoD is establishing the DoD Embedded Metal Fragment Registry, in order to identify and track servicemembers who have retained fragments, the total number of which is unknown. Potential cases will be identified using two DoD databases, the Theater Medical Data Store and the Joint Theater Trauma Registry. Once DoD identifies cases, their names will be shared with VA.

In 2008, VA established the VA Toxic Embedded Fragment Center, which will provide care and active medical surveillance for veterans with retained fragments. The Center will develop laboratory collaborations that can provide determination of fragment composition; develop medical and surgical management guidelines for veterans with fragments; provide biomonitoring services to assist in medical management; and offer inpatient referrals to the Baltimore VAMC for complex cases. VA and DoD have reached consensus on a list of chemicals for biomonitoring, including lead, uranium, tungsten, and others.

VA and DoD jointly funded an Institute of Medicine (IOM) study of potential long-term health effects of DU, which resulted in the publication of two reports in July 2008. IOM concluded there was "inadequate/ insufficient evidence to determine whether an association exists between exposure to uranium and all the health outcomes examined." Regarding these 20 health outcomes, IOM also stated: "Exposure to uranium is not associated with a large or frequent effect. The committee's evaluation of the literature supports the conclusion that a large or frequent effect is unlikely, but it is not possible to state conclusively that a particular health outcome can not occur." VA scientists will evaluate this report and make a recommendation to the Secretary of VA regarding whether there are diseases which are related to DU exposure, for which a presumption of Service connection is warranted.

DoD requested an IOM study to assist in responding to Section 716 of the FY 2007 NDAA, which required DoD to conduct a comprehensive study of the health of

soldiers with potential exposure to DU, in consultation with VA and the Department of Health and Human Services. In evaluating the feasibility and validity of the type of study mandated in Section 716, IOM concluded: "it would be difficult to design a study to assess health outcomes of DU exposure in military and veteran populations comprehensively. Detecting a small increased risk for a given health outcome of DU exposure in military and veteran populations is not feasible in an epidemiological study." DoD will send a report to Congress that summarizes the IOM report, and describes DoD's plan to continue the biomonitoring program for servicemembers in OIF and to coordinate the appropriate long-term care with VA.

Post-Deployment Medical Care

In 2008, the DHWG was involved in two efforts related to post-deployment care: a medical conference and initiatives related to traumatic brain injuries (TBI). VA and DoD organized a day long conference at the VA Central Office on February 19, 2008, entitled Update on Health Care: Responding to the Needs of VA's Newest Generation of Combat Veterans. The goal was to describe VA and DoD medical care and benefits for servicemembers who have returned from OEF/OIF, and focused on the SOC LOAs. The conference highlighted the considerable progress that has been made since 2006 in establishing programs for returning OEF/OIF veterans. Approximately 200 senior leaders in VA and DoD participated.

The DHWG is monitoring VA and DoD initiatives on the assessment, diagnosis, and treatment of TBI on an ongoing basis, in response to the recognition of TBI as an emerging problem in OEF/OIF. During the past year, VA and DoD have launched or expanded the following efforts related to TBI:

- In October 2007, DoD mandated the three Military Departments to identify, document, and report TBI cases into a central database, established by the Defense and Veterans Brain Injury Center (DVBIC), on an ongoing basis. In the past, only TBI patients diagnosed at DVBIC-designated MTFs could be counted consistently. The new system requires reporting from all DoD medical centers nationwide.

- In May 2008, DoD mandated a program to collect baseline neurocognitive data on all servicemembers before they deploy. The testing takes 15-20 minutes to complete, and includes domains sensitive to the effects of mild TBI. The Army started testing in August 2007; by January 2008, more than 48,000 soldiers had been tested.

- VA and DoD began collaborating with the Centers for Disease Control and Prevention (CDC) to "conduct a longitudinal study on the effects of TBI incurred by members of the Armed Forces serving in OIF or OEF and their families" in accordance with Section 721 of the FY 2007 NDAA. DoD will evaluate the long-term physical and mental health effects of TBI and related health care needs over a 15 year period via annual

telephone interviews. A total of 1,200 servicemembers diagnosed with TBI will be recruited into the study starting in 2009.

- In FY 2008, VA continued to screen OEF/OIF veterans who receive VA medical care for possible TBI. A clinical reminder about the mandatory screening is incorporated into the EHR. A veteran must report current symptoms to screen positive, and is then referred for a comprehensive evaluation and treatment by clinicians with expertise in TBI. A positive screen is not a confirmed diagnosis of TBI; rather, it is a confirmation that the veteran should be medically evaluated. VA has screened more than 214,000 veterans for TBI since April 2007, approximately 19 percent of which have screened positive and subsequently referred for medical evaluation. Less than 10 percent of veterans who have been screened to date have been diagnosed with a confirmed TBI.

Deployment Health Risk Communication

The DHWG continued its efforts to improve their coordination of risk communication and outreach to servicemembers, veterans, and health care providers for deployment related exposures and substantial emerging health concerns. A subcommittee to the work group was established to develop, coordinate, and disseminate risk communication products. In 2008, the subcommittee developed two pocket cards for both VA and DoD clinicians; one on malaria and one on mefloquine, a drug used to prevent malaria infection. Additionally, the DHWG was instrumental in two communication efforts related to the notification of veterans who were involved in chemical and biological testing programs and related to potential environmental exposures in OIF.

The DHWG provides ongoing coordination of notification efforts on chemical and biological agent testing programs that took place from 1942 to 1975. DoD has compiled three databases: mustard/lewisite, Project SHAD (Shipboard Hazard and Defense), and Chemical/Biological Follow-on Database. The mustard/lewisite database includes a list of servicemembers involved in testing of mustard agent and lewisite, another blister agent, from 1943-1946. VA used the findings of a 1993 IOM report to develop a list of medical conditions for which there is a presumption of Service connection for veterans who had full-body exposure to these agents. The Project SHAD database includes a list of participants involved in testing U.S. warship vulnerability to biological warfare (BW) and chemical warfare (CW) agents during 1962-1973. VBA identified current addresses for 4,438 of these veterans, and sent them notification letters about their participation in Project SHAD and the availability of VA medical care and benefits. The Chemical/Biological Follow-on Database includes names of approximately 10,000 veterans involved in several tests of CW and BW agents from 1942-1975 in Edgewood, MD; Fort Detrick, MD Dugway Proving Grounds; and several other locations, which included more than 400 chemicals. Of the 6,700 participants identified by DoD in Edgewood, MD, the largest of the cohorts, VBA identified 2,987 current addresses for these veterans

and sent them notification letters. DoD is investigating other possible test locations, and continues to update the database and forward names of veterans to VA.

The DHWG recently facilitated VA and DoD outreach efforts related to two potential exposure incidents that occurred in Al Tuwaitha and Qarmat Ali, Iraq. In 2003, there was concern about potential radiation exposure at a damaged nuclear research center in Al Tuwaitha. An Army health physics team has since estimated soldier doses to be less than the safety standards set by the U.S. Nuclear Regulatory Commission. However, the news media raised concerns in November 2007 about servicemembers who visited Al Tuwaitha. In response, an Army health physicist held three town hall meetings at Fort Campbell, Kentucky to hear first hand from the soldiers and allay their concerns. In 2008, VA sent an announcement to VA health care providers on potential exposures to servicemembers at Al Tuwaitha.

In 2003, military personnel, mostly from the Indiana National Guard, and contractors were potentially exposed to soil contaminated with sodium dichromate while conducting repair work at a water treatment plant in Qarmat Ali, Iraq. The Army performed environmental and medical surveys resulting in a fact sheet that was updated in 2008 to state that it is “unlikely that any current symptoms or health problems could be related to this past exposure or that future problems from this exposure are expected.” The Army National Guard held multiple town hall meetings in Indiana in 2008 and sent letters to Guard members to notify them of the potential exposures at Qarmat Ali. VA participated in the DoD town hall meetings to assist in enrolling veterans in VA health care. VAMCs in Indiana have offered to provide medical evaluations to concerned veterans.

Deployment Health Related Research

During the past year, the DHWG developed its annual research inventory, reviewed the progress of the Millennium Cohort Study (MCS), and participated in planning a research conference on the treatment of Post Traumatic Stress Disorder (PTSD).

The DHWG has developed an inventory of more than 600 VA and DoD research projects related to the health of deployed servicemembers and veterans. Collaborative efforts between the centralized research office in VA and many DoD research offices resulted in the institutionalization of a reporting system and a process to collect, organize, and archive data on relevant projects on an annual basis. The majority of the projects focus on injuries and mental health. Other research areas include infectious diseases, environmental and occupational exposures, vision and hearing, and pain management. The results of this collaborative effort have been published in a user-friendly format on a DoD research web site, DeployMed ResearchLINK,[2] which also includes a continually

[2] http://fhp.osd.mil/deploymed/

updated bibliography of all 2002-2008 medical articles related to the health of servicemembers returning from OEF/OIF. Publication of the projects and articles on this web site provides global access to current information on deployment health research to health care providers, researchers, servicemembers, veterans, their families, Congress, and the general public.

The DHWG monitors the progress of the MCS on an ongoing basis. In February 2008, the DHWG invited the MCS Project Director to provide a detailed update. The Project Director reviewed the objectives of the MCS, which are "to evaluate chronic diagnosed health problems, including hypertension, diabetes, and heart disease, among military members, in relation to exposures of military concerns; and to evaluate long-term subjective health, including chronic multi-symptoms illnesses, among military members, especially in relation to exposures of military concern." The MCS Project Director also briefed that several post-deployment health outcomes are being evaluated in the MCS, including PTSD, depression, alcohol abuse, TBI, smoking, and respiratory health. Approximately 150,000 personnel will be enrolled and followed until 2022, with a health evaluation conducted every three years to determine the course of diseases over time. Several articles related to the MCS were published in 2008, including papers that focused on PTSD and alcohol-related problems before and after combat deployments, as well as several papers on adverse events related to the anthrax and smallpox vaccines.

VA invited scientists from DoD and the National Institutes of Health (NIH) to participate in a two day research symposium on PTSD treatment in January 2008. DHWG members participated in the planning and follow-up of this symposium, the goal of which was to identify state-of-the-art approaches for PTSD research. The meeting addressed an IOM report that was published in October 2007, entitled *Treatment of Posttraumatic Stress Disorder*: *An Assessment of the Evidence*. The IOM concluded that the "evidence was sufficient to conclude the efficacy of exposure therapies in the treatment of PTSD." IOM also concluded the evidence was "inadequate to determine the efficacy" of several other types of psychotherapy and several types of drug therapy. VA published a report on the symposium on the VA Office of Research and Development web site[3]. The report provides guidelines to improve future PTSD research, which will be useful to researchers and VA, DoD, and NIH research administrators.

Patient Safety

In FY 2008, VA and DoD continued to collaborate on improving patient safety practices. Both Departments have nationally recognized patient safety programs and aggressively worked with other Federal agencies such as the Agency for

[3] http://www.research.va.gov/

Health Care Research and Quality (AHRQ), the Food and Drug Administration (FDA), the CDC and the Institute for Healthcare Improvement to prevent harm to patients as they receive health care. Examples of VA and DoD coordinated efforts to improve patient safety include:

- VA and DoD made sharing of relevant patient safety alerts and advisories part of its routine operations.
- VA and DoD developed plans for sharing protected patient safety data to be used following the establishment of a formal VA/DoD data sharing agreement.
- VA and DoD completed the Usability Testing white paper which was subsequently accepted by the JEC. Both systems are independently exploring usability testing while continuing to share lessons learned.
- VA and DoD have continued its joint work with AHRQ on the Patient Safety Work Group and the development of Common Formats in support of the Patient Safety Act of 2005. For this effort, DoD worked collaboratively with VA on the pressure ulcer data collection tool developed by the DoD Patient Safety Center. AHRQ released the Common Formats for public review and use by Patient Safety Organizations in August 2008.

Evidence-Based Clinical Practice Guidelines

In FY 2008, VA and DoD made significant progress in development, updating, and adoption of Evidence-Based Clinical Practice Guidelines (CPGs). A collaborative work group under the auspices of the HEC continued its focus on identifying areas where the Departments could reduce variation in care, optimize patient outcomes, and improve the overall health of our populations.

During FY 2008, the work group completed the Uncomplicated Pregnancy CPG, and nearly completed the CPG for Mild TBI (mTBI) in a record nine months. At the close of FY 2008, the work group was fast-tracking it for public review and comment and final edits. The mTBI CPG will be an essential tool for the systems of care for both Departments to address this vital health concern by facilitating seamless transition from DoD to the VA health care system. The work group also continued its work on the CPGs for Substance Abuse, Stroke Rehabilitation, Major Depressive Disorder, Bipolar Disorder and Asthma. Toolkits to support evidence-based culture and practice completed during FY 2008 were Cardiovascular Disease and Obesity materials. Work continues on the Amputation and Low Back Pain toolkits.

The work group aggressively pursued new opportunities to expand the use of jointly developed CPGs. During this timeframe, lines of communication were

initiated to collaborate with other organizations in CPG development. Current Evidence-Based CPGs were promoted through educational material exhibits at 12 national and local conferences for both military and civilian audiences. Evidence-Based Practice staff served as guest speakers at six national conferences. Conference topics included the advance of Evidence-Based delivery of health care as well as the utilization of CPGs to promote population health and disease management.

Marketing efforts culminated in a 67 percent increase in CPG web views on the Quality Management Office web site[4] from last year. Also noted was a 38 percent increase in the number of toolkit items shipped to DoD sites in support of CPG implementation and utilization from FY 2007. Additionally, strong Evidence-Based recommendations from VA/DoD CPGs have been incorporated into the performance monitoring and performance pay systems within VA and DoD.

SECTION 2.3 – EFFICIENCY OF OPERATIONS

VA and DoD continued to work collaboratively to increase efficiency through joint management of capital assets, procurement, logistics, financial transactions, and human resources. In FY 2008, VA and DoD identified Keesler Air Force Base (AFB) and Biloxi VAMC as a joint sharing site by the JEC and a replacement hospital is under construction at Ft Belvoir, VA, which includes a VA Community Based Outpatient Clinic (CBOC). Additionally, a joint VA/DoD ambulatory surgery and procedure center was awarded at Tripler Army Medical Center (TAMC) in Hawaii.

North Chicago Initiative

The North Chicago VAMC (NCVAMC) and the Naval Health Clinic Great Lakes (NHCGL) will fully integrate and become the Captain James A. Lovell Federal Health Care Center (FHCC) in 2010 to serve both VA and DoD beneficiaries. A Concept of Operations (ConOps) and a draft executive resource sharing agreement have been developed for the FHCC outlining the details of the integration. EDMs were approved for the following issues: Other Health Insurance, Acquisition and Contracting, the Financial Management System, and Credentialing as well as the approval of the VA/DoD Advisory Board Charter which will guide and advise the operations of the FHCC. Seven VA/DoD national work groups are developing detailed operational plans to ensure a smooth transition to the new facility and seamless care for both VA and DoD beneficiaries.

An enterprise level JIF project was approved authorizing $11 million for the continuation of Information Management/Information Technology (IM/IT) requirements gathering and solution development for the FHCC. Contracts were officially awarded to programming/software developers which will begin working

[2] http://quality.disa.mil/index.htm

on site in FY 2009. Construction was completed on the $16 million parking garage and construction contracts were awarded for the $99 million outpatient clinic facility with a scheduled completion of August 2010. The ground breaking ceremony for the Naval Facilities Engineering Command funded ambulatory care facility was held on July 14, 2008 in conjunction with the ribbon cutting ceremony for the new parking structure.

Joint Market Opportunities Work Group

A March 7, 2007 JEC memorandum mandated the HEC to form a joint team to gain an understanding of existing joint venture relationships, identify opportunities for improving the delivery of health care to beneficiaries, and identify those elements of existing joint ventures that are exportable to other market-based partnerships. The Joint Market Opportunities (JMO) Work Group, comprised of members from DoD, VA and contractor technical support, was formed in April 2007.

Phase I

The work group's first task was to determine if joint ventures can maintain or increase access to care, reduce infrastructure, improve efficiency, strengthen provider practices and quality, and mitigate the impact of deployment. Data and information was collected by site visits to the eight current joint venture sites: Albuquerque, NM; Anchorage, AK; El Paso, TX; Fairfield, CA; Honolulu, HI; Key West, FL; Las Vegas, NV; and North Chicago, IL.

While the work group observed varying degrees of sharing during the site visits, all sites reported positive benefits from their shared initiatives. The North Chicago FHCC is unique in its targeted degree of integration; as such, it was observed as a separate model to determine what components might be exportable to other sites.

While the medical facilities of each Department have a goal of providing health care to each other's beneficiaries, they also indicated that differing VA and DoD missions make it difficult, but not impossible, to optimize their joint potential. For example, DoD's support of the Global War on Terrorism (GWOT) and the subsequent deployment of medical personnel may affect the ability to provide health care to veterans at joint venture sites due to the absence of DoD providers.

Close oversight of the joint venture is clearly critical to the success of the partnership. In successful joint ventures, a shared vision and commitment to the venture by leadership was evidenced by all staff throughout the facility. Sites exhibiting a strong commitment to maintaining their shared relationships tended to have stronger ties with their partners, focused on the patients, and recognized the benefits of the relationship. This commitment is enhanced by local level joint policy documentation that ensures continued joint operations when there are changes in leadership. Significant barriers were cited in the areas of IT sharing, claims billing, payment issues, and human resources and staffing.

An unanticipated outcome of these site visits was renewed interest in exploring additional collaborative efforts at virtually all of the joint venture sites.

Phase Ib

The Under Secretary of Defense for Personnel and Readiness and the Deputy Secretary of Veterans Affairs met on March 26, 2008 to discuss an intensified effort on developing model programs for joint ventures. It was their view that, in the face of escalating facility construction and operating costs, the Captain James A. Lovell FHCC, scheduled to become operational in 2010, should be viewed as the premier model for joint partnerships in health care delivery to our combined population in markets where advantageous. In assessing different markets, they selected four locations to further focus integration advancement: Biloxi, MS; Las Vegas, NV; Denver, CO; and Honolulu, HI. The four sites were tasked with assessing current collaborations and developing a ConOps describing how further integration could be achieved between their local VA and DoD sites. Evaluations were conducted at the local level with DoD, VA, and other interested groups as appropriate. The majority of the sites' successes were attributed to the establishment of an overarching body that provides oversight of joint venture initiatives, which is further enhanced by an active spirit of collegiality amongst the partners. Common barriers were reported similar to the barriers cited by the Phase I sites, including lack of IM/IT interoperability and human resources.

On July 23, 2008, the JEC approved the four Phase Ib sites' ConOps. Going forward, the JMO work group will conduct quarterly meetings with the four sites and conduct site visits once a year, to include an In-Process Review from the site on accomplishments. To further assist these sites in accomplishing their stated goals, the JEC directed the establishment of a separate pool of JIF dollars available currently to only the four identified sites.

Phase II

The JMO work group continues their activities in response to the initial JEC tasking by focusing on VA and DoD sites with funded construction projects and/or market areas with increased political interest in Federal resource sharing.

In addition to preliminary data collected from initial FY 2008 site visits, Phase II uses lessons learned from Phases I and Ib to identify market areas with potential for beginning or increasing VA/DoD sharing. The goal for the JMO work group at the multi-market sites is to improve collaboration between VA and DoD facilities where demand and economies of scale can be optimized to achieve the overarching objectives of maintaining or increasing access to care, reducing infrastructure, improving efficiency and/or streamlining governance, strengthening provider practices and quality, and mitigating the impact of deployment.

The markets and individual sites identified for Phase II include: Gulf Coast; Denver, CO; Colorado Springs, CO; Temple, TX; El Paso, TX; Charleston, SC; Columbus, GA; Central Florida; San Antonio, TX; Corpus Christi, TX; and Tacoma, WA.

During each site visit, based on the needs of each individual market, the work group may recommend possible joint initiatives which include, but are not limited to: pursuing the JIF process to initiate joint programs; exploring joint leadership structures and/or committees, joint local training opportunities, joint staffing opportunities, and joint referral and/or business offices; developing joint web sites and/or marketing programs; and collecting and sharing lessons learned at various venues or in various news articles. The work group is exploring the establishment of a "library" for local lessons learned, building on the demonstration projects' lessons learned report.

Summary

Joint ventures have proven effective in maintaining or increasing access to care. At the sites where reduction of infrastructure was a goal, joint ventures succeeded at sharing wards, clinics and ancillary support spaces. As would be expected, those constructed at the onset to be joint ventures were most successful at infrastructure reductions as well as being highly successful at meeting their stated goals. Efficiency is clearly improved when access to care can be increased, infrastructure is reduced, or staffing is shared. Provider practices and skills as well as Graduate Medical Education (GME) programs are strengthened when clinics and inpatients are shared openly and freely between the partners. Shared staffing, which occurs in varying degrees at most joint ventures, helps mitigate the impact of deployment on access to care.

All successful partnerships are dependent upon high level commitment as well as the willingness of staff to seek out solutions and take on challenges with a determination to succeed. There are major issues still to be resolved, but the benefits which can be and are garnered from joint ventures are sufficient to recommend exporting these arrangements to other sites and multi-market areas.

Acquisition and Medical Materiel Management Work Group (AMMMWG)

For medical and surgical equipment, there were 42 shared contracts in FY 2008: 10 joint contracts for radiation oncology; six joint pharmaceutical returns/reverse distribution contracts; 24 for radiology; one for vital sign monitors; and one for surgical instruments. VA and DoD jointly reviewed 43 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 had sales under these shared contracts just over $165 million through the third quarter of FY 2008. The VA National Acquisition Center had sales of over $400 million through the third quarter of FY 2008.

Efforts to further expand VA/DoD joint acquisition strategies continue. Reverse Distribution contracts ("pharmaceutical returns") have resulted in annual estimated savings in outdated pharmaceuticals of $49 million.

Over the last several years, DoD has developed a Medical Surgical Product Data Base (PDB) and synchronization process now accessible via the Medical Product Data Base (MEDPDB) which over the last two years now includes multiple VA medical surgical product files. Both VA and DoD are currently using and benefiting from the VA/DoD PDB and MEDPDB, which constitutes the precursor to a joint VA/DoD Federal electronic catalog. The PDB and MEDPDB were developed and continue to be enhanced with input from multiple DoD file sources, files from 23 manufacturers, and VA and DoD prime vendors /distributors, creating a powerful data bank with over 1.5 million medical surgical records. Additionally, DoD developed web based product pricing and sourcing tools which are deployed to 80 VA and DoD hospital sites generating over $29 million in product price reduction thus far. DoD is also continuing to work with Health Care Industry standards groups and VA and DoD suppliers on implementing global data standards and data sharing Pilot venues. These efforts are making great progress within the health care industry and will enhance the capability of the joint PDB for VA and DoD to realize best Federal pricing and quality medical surgical products. The joint VA/DoD JIF partnership is providing an active and effective Federal forum to promote industry adoption of global health care data standards and transition to an industry Health Care Product Data Utility network.

FY 2008 Data Synchronization Team Accomplishments/Tasks:

- The VA/DoD program continues to benefit from previously developed data synchronization pricing and site data enhancement applications (eZSAVe) generating $11 million for DoD and over $1 million for VA in product price reductions in FY 2008 and adding an additional 10 eZSAVe sites, to yield a total of 80 VA and DoD sites. Additionally, DoD has transitioned over $11 million in customer buys from less efficient local purchase buys to more beneficial structured contracting venues. The eZSAVe application which was executed and accessed separately outside the MEDPDB system has now been merged into one MEDPDB platform, allowing for a more robust application with single sign on access for both VA and DoD customers.

- Enhanced and expanded DoD customer centric views for theater assets in MEDPDB. This gives DoD warfighter customers greater visibility and access to in-theater assets and will reduce unnecessary new item requests (not on theater master item records).

- Developed and added a new batch of National Stock Number sourcing capabilities which will increase customer operational capabilities to

match to and access commercial items. Additionally, added search functionality to provide VA and DoD customer views similar to Google or Yahoo search engines.

- Developed and added best pricing views in three categories. Pricing views are tailored to the customer based on available regional and national contracting agreements. Commercial benchmarking/pricing availability is based on inclusion of commercial prices provided by ECRI Institute, a nonprofit research organization with price guides based on what commercial hospitals are buying.

- Developed and added a spend analysis capability to look at costs using supply line classifications which can be viewed as aggregated product categories and product lines, to individual items. Also developed a spend analysis aggregation capability by manufacturer. This will greatly assist VA and DoD product category and product line managers and enterprise contracting officials in determining product strategies based on costs and regional needs.

- Expanded the GS1 Global Data Synchronization Network (GDSN) Pilot initiated by the team in 2007 to include over thirty participants, consisting of manufacturers, prime vendors, major Group Purchasing Organizations (GPOs) and hospitals. The DoD test Pilot has successfully loaded over 2,600 items into the GDSN test bed. Additionally, the major health care professional organizations such as the Association for Healthcare Resource and Materials Managers and the Healthcare Supply Chain Standards Coalition have endorsed GS1 global data standards. Major health care GPOs, such as Premier and Amerinet, are mandating use of GS1 data standards within the next few years. The GS1 global health care group has built upon the DoD GDSN Pilot successfully conducting its own GDSN Pilot. The VA/DoD PDB partnership continues to be the proving ground for moving the health care industry to adopt global data standards.

Pharmacy

The VA/DoD Federal Pharmacy Executive Steering Committee improved the management of pharmacy benefits for both VA and DoD beneficiaries. VA and DoD continued to experience remarkable success awarding joint contracts and unilateral contracts for pharmaceuticals. For the first three quarters of FY 2008, there were 59 Joint National Contracts, 16 VA unilateral National Contracts[5], and 51 DoD unilateral Blanket Purchase Agreements for pharmaceuticals. The Joint National Contracts resulted in $115 million in cost avoidance and $168 million

[5] 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.

in purchases for the first three quarters of FY 2008. In the first three quarters of FY 2008, VA and DoD awarded 11 VA/DoD joint contracts for pharmaceuticals. The Clinical and Joint Contracting Subcommittee work groups continued the evaluation of 27 drugs identified as having the potential for a Joint National Contract.

The Shelf Life Extension Program (SLEP) for pharmaceuticals is a DoD/FDA program that VA used to extend the expiration dates on products in its Emergency Pharmacy Service program. In FY 2008, VA submitted three different testing cycles consisting of 47 specific lot numbers to the DoD/FDA program for testing. Shelf life extensions were granted with an average extension of 22 months and a range of nine to 30 months. All medications were re-labeled with the appropriate new expiration date. The estimated cost avoidance to VA from SLEP participation in FY 2008 pharmaceuticals was $2,030,955.41.

Subsequent to a successful Pilot, the Departments continued to share a program in FY 2008 where the VA Consolidated Mail Outpatient Pharmacy in Leavenworth, Kansas refills outpatient prescription medications for DoD's Naval Medical Center, San Diego, CA at the option of the beneficiary. At the August 2008 HEC meeting, a request was made to finalize a MOU authorizing this sharing agreement.

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 2008, VA and DoD made considerable progress in collaborative planning for contingency operations using the framework established by the November 16, 2006 VA/DoD Memorandum of Agreement. The Departments consolidated their wartime Patient Receiving Center operations with those supporting the National Disaster Medical System which eliminated duplication and increased efficiency. The Departments embarked on two initiatives to promote joint training for the long-term. The first initiative, in collaboration with U.S. Transportation Command and Air Mobility Command, is a plan to use JIF funds to provide hands-on training at VA and DoD Patient Receiving Centers. The second initiative was the development of a three day Patient Receiving Center course held at Scott AFB, Illinois. Three classes, totaling nearly 100 students, were held in FY 2008 with two more scheduled for FY 2009 and one class annually thereafter.

SECTION 3 - INFORMATION TECHNOLOGY ADVANCEMENTS

The goal of integrated information sharing for VA and DoD is to ensure that appropriate beneficiary and medical information is visible, accessible, and understandable through secure and interoperable information systems. The HEC IM/IT Work Group and the BEC Information Sharing/ Information Technology (IS/IT) Work Group strived to achieve these goals.

The following reflect VA and DoD health information sharing advancements in FY 2008.

SECTION 3.1 – ONGOING VA/DoD INTERAGENCY HEALTH INFORMATICS INITIATIVES AND ACCOMPLISHMENTS

VA and DoD continue their strong partnership in interagency health data sharing activities which serve to deliver IT solutions that significantly improve the secure sharing of appropriate electronic health information. In the last decade, health data sharing and interoperability activities between the Departments have greatly increased, with the primary benefit being more complete, accurate, and secure health information sharing for servicemembers and veterans. VA and DoD continue to support ongoing data exchanges that form the foundation for enhanced interoperability in FY 2009 and beyond. The following are examples of these joint efforts.

Ongoing Care for Separated Servicemembers

Since 2001, DoD has supported the monthly transfer of electronic health information for separated servicemembers to a secure jointly developed data repository known as the Federal Health Information Exchange (FHIE). VA and DoD continue to maintain this repository of data that is accessed by both VHA clinicians treating veterans and VBA claims staff adjudicating benefits. This information is available to VA through VA systems, the Veterans Information Systems and Technology Architecture (VistA)/Computerized Patient Record System (CPRS) and the Compensation and Pension Record Interchange (CAPRI). It also facilitates determination of entitlement to vocational counseling, planning, and training as well as insurance and waiver of premiums for veterans with a 100 percent Service-connected disability rating. The data transferred includes: inpatient and outpatient laboratory and radiology results; outpatient pharmacy data from MTFs, DoD retail network pharmacies, and DoD mail-order pharmacy; allergy information; discharge summaries; admission, disposition, and transfer information; consultation reports; patient demographic information; and Pre-and Post-Deployment Health Assessments and Post-Deployment Health Reassessment (PDHRA) data.

As of September 2008, DoD has transferred electronic health data on over 4.5 million individuals to the FHIE repository. Of these 4.5 million patients

approximately 3.1 million have presented to VA for care, treatment, or claims determination. The amount of information transferred by DoD continues to grow as health information on recently separated servicemembers is extracted and transferred to VA monthly. DoD transfers data to VA in a manner that is compliant with Health Insurance Portability and Accountability Act privacy regulations.

Building on this capability, DoD is also transferring data for VA patients being treated in DoD facilities under local sharing agreements. As of September 2008, more than 2.8 million patient messages (i.e., laboratory results, radiology reports, pharmacy data, and consults) have been transmitted on VA patients treated in DoD facilities.

Deployment health assessments are completed by servicemembers and demobilized Reserve and National Guard members as they leave for and return from duty outside the U.S. This information is 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. Deployment health assessments on Reserve and National Guard members who have been deployed and are now demobilized are included in the monthly data transmissions. In addition, DoD sends deployment health assessments to VA weekly for individuals referred for VA care or evaluation. As of September 2008, over 2.4 million Pre-and Post-Deployment Health Assessments and PDHRA forms on more than 971,000 individuals have been sent from DoD to VA.

Ongoing Care for Shared Patients

For shared patients being treated by both VA and DoD, the Departments continue to maintain the jointly developed Bidirectional Health Information Exchange (BHIE). Using BHIE, VA and DoD clinicians are able to access health data bidirectionally and in real-time, including the following types of information: allergy, outpatient pharmacy, inpatient and outpatient laboratory, and radiology reports, demographic data, ambulatory clinical notes, patient problem lists, diagnoses, vital signs, family history, social history, other history and questionnaires. As of August 2008, there are over 3.1 million unique correlated patients, including over 90,200 theater patients, in BHIE for patients receiving care from both Departments. The data added by the agencies in 2008 were vital signs, patient histories, (including family, social, and other history) and theater data (including inpatient notes, outpatient encounters, and ancillary clinical data such as pharmacy data, allergies, laboratory results and radiology reports). Additionally, DoD sends deployment health assessments to VA for all separated servicemembers.

To increase the availability of clinical information on a shared patient population, VA and DoD have collaborated to further leverage BHIE functionality to allow bidirectional access to inpatient discharge summaries from DoD's Essentris System. This capability is now operational at some DoD inpatient facilities

representing approximately 47 percent of inpatient beds. In 2008, the following additional DoD inpatient note types became available to all DoD providers and VA providers in the Puget Sound area: inpatient consultations, operative reports, history and physical reports, transfer summary notes, initial evaluation notes, procedure notes, evaluation and management notes, pre-operative evaluation notes, and post-operative evaluation and management notes. It is anticipated that VA will expand access to these DoD inpatient note types to additional VA sites in FY 2009.

In addition to sharing viewable text data, VA and DoD are leveraging BHIE to support the increased sharing of digital radiology images. The Departments are currently expanding the BHIE Image Pilot to support the bidirectional exchange of images at select key locations. Images are now being exchanged at Evans Army Community Hospital (ACH) and NHCGL. The technical accomplishments and lessons learned from the BHIE Image Pilot will be used in broader image sharing planning activities.

The Departments continued to support a medical record scanning and image transfer capability for the most seriously injured and wounded servicemembers and veterans. As part of this initiative, the Departments continue to scan paper medical record items from three major DoD trauma centers at Walter Reed AMC; Brooke AMC and Bethesda National Naval Medical Center, and send the scanned files to the four VA PRCs. In 2008, the Departments refined the business process to ensure that VA clinicians received scanned inpatient records on every patient transferred from these MTFs to the PRCs. VA clinicians also received electronic radiology images for these same transferred patients. As of September 2008, scanned medical records for over 190 patients and digital images for over 130 patients had been sent.

Computable Data for Shared Patients

Since 2006, VA and DoD have been sharing computable pharmacy and allergy data through the interface between the Clinical Data Repository (CDR) of AHLTA, DoD's EHR, and VA's Health Data Repository (HDR), called CHDR. CHDR continues to support automatic decision support to VA and DoD clinicians by enabling drug-drug interaction checking and drug-allergy checking using data from both Departments. This enhances patient safety and quality of care. In 2008, the ability to initiate sharing this data on a patient became available to all DoD facilities. VA continues to test CHDR performance in the new HealtheVet environment and anticipates implementing CHDR enterprise wide by summer 2009. As of early September 2008, the number of patients for whom data is shared through CHDR grew from over 10,000 active dual consumers to more than 19,900. As of August 2008, over 3.6 million cumulative patient medications and over 115,000 cumulative drug allergies have been exchanged. In September 2008, DoD implemented an automated capability which enables DoD to automatically identify and begin exchanging computable pharmacy and allergy

data on these shared VA/DoD patients. This capability is being implemented in a phased approach to enable the Departments to monitor the impact on system performance and perform capacity planning.

Joint Inpatient Feasibility Study

The Departments are now concluding the VA/DoD Joint Inpatient EHR Study. The study documented and assessed VA and DoD inpatient clinical processes, workflows, and requirements. It identified areas of commonalities and areas of uniqueness between the Departments. Additionally, it determined the benefits and the impacts on each Department's timelines and costs for deploying a common inpatient EHR solution.

The study then assessed alternatives for a joint approach. A cost and schedule analysis, and risk and value determination for VA and DoD using analytic modeling based on recognized industry best practices was used to assess the alternatives. The findings and recommendations that resulted were based on analysis and collaborative effort with internationally recognized experts in EHRs, VA and Tri-Service clinical and technical subject matter experts, and commercial inpatient system vendors via a formal Request for Information. The outputs from the study were used as inputs into the subsequent decision by VA/DoD executive leadership on the approach for VA/DoD inpatient EHR interoperability. The study recommended that the Departments jointly adopt a common services strategy as the best approach for a joint inpatient EHR.

The Departments continue to collaborate on a high level road map to clarify the issues surrounding the implementation of a common services strategy. A joint VA/DoD inpatient EHR ConOps is being developed and a common services framework is being established. An action plan to identify the key activities necessary to implement a common services approach to support inpatient EHR interoperability between DoD and VA is also being developed.

Order Portability

In 2008, the Laboratory Data Sharing Interoperability Initiative (LDSI) continues to facilitate the electronic sharing of laboratory orders and results between DoD, VA, and commercial laboratories. LDSI is used to support order entry and results retrieval for chemistry, anatomic pathology, and microbiology tests and is available for use by any VA and DoD location where either facility functions as a reference laboratory for the other. LDSI is operational at the following sites:

- Wilford Hall Medical Center/South Texas VA Health Care System (HCS)
- Brooke AMC/South Texas VA HCS
- Tripler AMC/VA Spark Matsunaga Medical Center
- William Beaumont AMC/El Paso VA HCS

- Naval Medical Center San Diego/San Diego VA HCS
- Great Lakes Naval Hospital/Edward Hines Jr. VA Hospital, North Chicago VAMC
- Bassett ACH/Alaska VA HCS
- Naval Hospital Pensacola/VA Gulf Coast HCS

The Departments will continue to coordinate requests for activation of the LDSI interface from additional sites where a business case exists.

VA/DoD Communications Gateways

Through a joint team, VA and DoD defined functional, infrastructure, and policy interoperability requirements which resulted in a VA/DoD Multiple Gateway ConOps: *A Joint Partnership to Support Electronic Data Sharing Infrastructure Enhancements Plan*. One of the major achievements in this partnership is the development and implementation of a joint enterprise architecture infrastructure solution and the establishment of a series of strategically planned network gateways between the Departments. The gateways provide secure, redundant connectivity between VA and DoD facilities and facilitate the seamless transfer of health data. In 2008, the agencies established two new gateways and are currently migrating data to those gateways. The Departments will continue coordination activities to establish two additional gateways by the end of FY 2009.

VA/DoD Interagency Program Office

In April 2008 the Departments established the VA/DoD Interagency Program Office (IPO) to provide operational oversight and management of EHR interoperability initiatives and ensure compliance with jointly coordinated, prioritized, and approved VA/DoD requirements. Additionally, the VA/DoD Interagency Clinical Informatics Board (ICIB) continued to enable clinicians to have a direct voice in the prioritization of recommendations for VA/DoD interoperability initiatives.[6] The ICIB is a VA/DoD clinician led group with the Deputy Assistant Secretary of Defense for Clinical and Program Policy and the Chief Patient Care Services Officer, VHA as proponents. The ICIB guides clinical priorities for what electronic health information the Departments should share next. To meet the JSP milestone requirement for the Departments to have interoperable EHRs by September 2009, the ICIB submitted and briefed final recommendations to the IPO and HEC IM/IT work group in July 2008. The ICIB recommendations were briefed to and approved by the HEC in August 2008. This group will continue to prioritize additional sharing requirements for future development as well.

[6] Formerly referred to as the Joint Clinical Information Board (JCIB). This transformation was not merely a name change; it recognizes the ICIB's role to include policy formulation and informatic considerations, such as clinician workflow.

VA/DoD Information Interoperability Plan

In September 2008, the Departments submitted the VA/DoD Information Interoperability Plan (IIP) to Congress. The purpose of the IIP is to guide leadership, policy makers, and IM/IT personnel in achieving the shared vision of VA and DoD health, personnel, and benefits information interoperability. The IIP is a living document to be adjusted/updated as VA/DoD interoperability advances continue. The plan identifies potential initiatives to enhance the electronic data sharing currently taking place between the Departments and to provide a "road map" for future initiatives to continuously improve service to veterans and servicemembers. The IIP is not an execution plan, but rather, a roadmap that the two Departments will follow to improve interoperability. It establishes an organizing framework for dialog and strategic direction between the Departments' senior leadership. As such, the initiatives described in the IIP project an overall direction with incremental targets. It provides a mechanism to guide prioritization discussions and enables technologists to propose potential solutions to incrementally enhance interoperability. Some targets will not have fully defined technical approaches, nor will some be funded. However, the document provides the pathway for facilitating the decision making process to fully define the incremental technical solutions; identify the amount and source of funds required to implement those solutions; and in turn codify them in execution project plans. As initiatives solidify and are approved they will be incorporated into the JSP.

VA and DoD are committed to continue to evolve and expand the appropriate sharing of electronic health information to enhance care delivery and continuity of care for shared patients and continuity of care for servicemembers as they transition to veterans.

SECTION 3.2 – COLLABORATION ON STANDARDS AND ARCHITECTURE BETWEEN VA/DoD ENTERPRISE ARCHITECTURE

VA/DoD Military Personnel Data Sharing

During FY 2008, VA and DoD continued implementing the VA/DoD Military Personnel Data Sharing initiatives as outlined in Objective 4.1 of the JSP. 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 were reduced, accomplishing the goal of a single bidirectional data exchange where feasible. In addition, data quality improved when multiple sources of data were consolidated into a single authoritative source and claims processing was streamlined since additional data is now available more quickly to claims processors. Accomplishments over the past year are classified into two broad areas: overall VA/DoD personnel data sharing plans and processes; and delivery of specific data sets and improved access to data.

Overall VA/DoD Personnel Data Sharing Plans & Processes

During FY 2008, VA and DoD started the required work necessary to facilitate the requirements for SOC LOA 1, DES, and LOA 4, eBenefits portal. The Veterans Tracking Application (VTA) was implemented in FY 2007, to support the transfers of care of severely injured servicemembers to the OEF/OIF points of contact and case managers at the VAMC or VA Regional Office assuming care or responsibility of the servicemember or veteran. VTA has now been employed by, and proven to be of particular value to, personnel involved in providing case management and transition services to severely injured OEF/OIF servicemembers. VTA brings health, personnel, and beneficiary data from DoD, VHA and VBA together for centralized access to servicemember/veteran information, which is crucial for effective case management. As a result of these successes, VA and DoD are enhancing VTA in support of the newly instituted DES Pilot by creating a module that will track all servicemembers going through the DES Pilot. The DES Pilot consists of four phases: Medical Evaluation Board; Physical Evaluation Board, to include appellate review; VA rating; and Transition. This initiative focuses on providing information necessary to streamline business processes and automate the tracking of servicemembers through the DES Pilot. The enhancements within VTA will significantly improve management and oversight of servicemembers' movement through the DES process and ultimately reduce the amount of time between separation/retirement from Service and receipt of needed benefits.

Efforts in FY 2007 to develop an interconnection between Army Knowledge Online and Veterans Information Portal that allowed for a single sign-on capability and user registration functions between the two systems, led to the capability to streamline application requests and access between the two systems. As a result of this successful accomplishment, it has been determined that this framework will be used to develop and deploy the eBenefits portal. In FY 2008, the initial planning and groundwork were successfully accomplished to support the future deployment of the eBenefits portal. The eBenefits portal will be a secure servicemember/veteran-centric web site portal focused on the health, benefits, and support needs of servicemembers, veterans, and their family members or other delegates. The eBenefits portal will consist of both a public web site and a secure portal. The eBenefits portal will allow for personalization and customized access to content, services, and applications related to benefits. It will enable users to find tailored benefit information and services in one place, rather than scattered across web sites and access channels. Most importantly, its design will allow wounded warriors to find the information and services they need, when they need it. The eBenefits plan has a continual roll out of enhancements into FY 2009 and beyond.

Delivery of Specific Data Sets and Improved Access to Data

One of the largest accomplishments in FY 2008 was successfully incorporating the legacy data feeds into the single bidirectional data feed between VA and DoD. This was achieved and accomplished by incorporating necessary data

sets into a data-sharing schema, which subsequently enabled the elimination of legacy feeds. Specific data sets incorporated into the VA/DoD data-sharing schema in FY 2008 include:

Interface 4: Veteran's Population Model (Reserve)	Interface 29: Gulf War Veterans Information System (GWVIS) Extract
Interface 5: Veteran's Population Model (Active Duty)	Interface 34 Recently Separated Reservists File
Interface 6 MGIB Letters	Interface 36 VGLI/SGLI Dual Coverage Match
Interface 7: Retired & Survivor Pay Extract	Interface 37: Disabled Veterans Outreach File
Interface 8 VA Disability C&P File	Interface 39 MGIB Chapter 1606 & 30 VA Payment File
Interface 10: Reserve Drills & AD Days Match	Interface 41 OEF/OIF
Interface 16 DD 214 Veterans Assistance Discharge System	Interface 43 NCS
Interface 19: DoD-VA Retired/ Survivor Reconciliation	Interface 44 Chapter 1607

Each reduction in legacy data feeds results in a reduction in maintenance costs, reliance on the authoritative data source, and often a reduction in duplicative data sets. Another important aspect is how the established framework enabled VA and DoD data sharing to expeditiously support the data requirements for the OEF/OIF Wounded, Ill and Injured initiatives. Without this established framework and process, additional and often duplicative data feeds would have been created and established. 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
2007	11	6
2008	1	2

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 2008, 113 VAMCs were involved in direct sharing agreements with 137 DoD medical facilities for a total of 323 direct sharing agreements that covered 158 unique services. In addition, most VAMCs were authorized to participate in TRICARE managed care networks and 109 VAMCs reported TRICARE reimbursable earnings. The following sections provide examples of VA and DoD sharing initiatives implemented to improve the delivery of health care services to MHS beneficiaries and veterans.

SECTION 4.1 – INNOVATIVE VA/DoD RESOURCE SHARING

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

Joint Ambulatory Care Center
Naval Hospital Pensacola/VA Gulf Coast Veterans HCS, Biloxi

The Joint Ambulatory Care Center (JACC) opened a 205,000 square foot health care facility on August 25, 2008 for veterans and active duty military personnel. This $55 million project located on 25 acres of U.S. Navy land replaces VA outpatient and mental health clinics and Naval Branch Health Clinic Corry Station. The facility provides joint Navy and VA clinic spaces for dental services, rehabilitative medicine and physical therapy. The JACC additionally offers primary care, laboratory, pharmacy, radiology, optometry, mental health, women's health, medical specialties, and surgical specialties, including minor procedures and endoscopic procedures. This is a VA/DoD sharing project that directly benefits veterans and servicemembers in Pensacola and the surrounding county of Escambia Florida.

VA/DoD Mobile Magnetic Resonance Imaging (MRI)
Naval Health Clinic Charleston/Ralph H. Johnson VAMC

In April 2008, a 1.5 Tesla MRI unit was purchased using JIF to support 26,000 DoD enrollees and over 42,000 VA beneficiaries. In July 2008 the sleek new state-of-the-art mobile MRI began capturing high quality digital images to diagnose medical

issues thanks to a strong and growing partnership between local VA and DoD organizations in the Low Country. The MRI features the latest technology as well as the highest level magnet and coils in the Charleston market area and serves beneficiaries enrolled to Naval Health Clinic Charleston; the Charleston AFB, 437th Medical Group (MDG); and Ralph H. Johnson VAMC. Over the next seven years this project is estimated to save the Federal government over $2 million and greatly improve the quality of diagnostic imaging for VA and DoD beneficiaries.

Master Sharing Agreement Plans for Future Expansion
Eglin AFB/Gulf Coast VA HCS

In September 2008, the 96th MDG at Eglin AFB and the VA Gulf Coast HCS signed a master sharing agreement that opens the door to sharing all available services at the 96th MDG with the newly constructed CBOC located adjacent to the Air Force hospital. The purpose of this sharing agreement is to optimize and maximize the use of VA and DoD medical resources in the Florida Panhandle, especially in Okaloosa County and the surrounding area. The intent is to create an environment in the region wherein providers and beneficiaries of the VA and DoD medical services can deliver and obtain medical services in the most efficient manner possible. The master sharing agreement format is often used at joint ventures and other sites with significant opportunities for sharing clinical services. Joint operational plans are developed and attached to the agreement with the specifics of each service that is shared.

55th MDG, Offutt AFB/VA Western Iowa HCS (VAWIHCS)

The 55th MDG and VANWIHCS have teamed together to establish a VA CBOC within the Air Force MTF. After minor renovation to the space, VA will begin seeing VA patients with the Air Force providing ancillary support as needed. This agreement is the foundation for numerous other initiatives under discussion by these two facilities.

SECTION 4.2 – VA/DoD HEALTH CARE SHARING JOINT INCENTIVE FUND

The JIF was established in FY 2004 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 has been extended until September 30, 2010, with each Department contributing $15 million to the fund per year.

The VA/DoD Financial Management Work Group has implementation responsibility for the JIF. 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, Office of Health Informatics, TMA’s Information Management, Technology and Research office, offices of the Surgeon General of three Military Departments, and DoD Health Affairs. To date, 81 JIF projects have been approved and funded.

Additional contributions were made to the JIF account to fund enterprise level projects to respond to Wounded, Ill and Injured task force/commission recommendations, and for additional projects at JMO sites.

The following are some of the more innovative projects initiated in FY 2008:

Joint Inpatient Mental Health Unit
David Grant Medical Center, Travis AFB/VA Northern California HCS
The proposal will relocate and expand the current inpatient mental health unit from 11 beds to a jointly staffed VA/DoD 20 bed acute care psychiatric bed unit. This allows for an increase in patient acuity and involuntary admissions enabling both Departments to expand and improve care for GWOT veterans and servicemembers. Cost: $5,990,000.

Joint Sleep Lab
3rd MDG, Elmendorf AFB/Alaska VA HCS
This project will establish a five bed sleep lab at the DoD medical facility to provide services to both VA and DoD beneficiaries. Bringing this workload in house will reduce costs and provide more control over the quality of care. Cost: $675,000.

Emergency Department Renovation
377th MDG, Kirtland AFB/New Mexico VA HCS
This project funds renovations of the existing emergency department that services both VA and DoD patients. The new design and two additional staff will facilitate better patient flow and more rapid triage, allowing more patients to be treated. Cost: $999,000.

Standardization of Annual Training Requirements
VA/DoD National
This initiative will provide funds to procure a common set of health care courseware to meet the annual training requirements from various agencies, including the Joint Commission on Accreditation of Hospitals, Office of Safety and Health Administration, and CDC, among others. The courses will be delivered on existing learning management systems. Cost: $3,900,000.

Health Risk Assessment Tool
VA/DoD National
This project expands previous collaboration efforts between VA and DoD regarding personal health records web portals by implementing a Health Risk Assessment Tool to be available for registered users of both eHealth web portals and their respective health care providers. The tool would use extensive branching logic and automated algorithms to determine health care needs and calculate risk, identify health promotion needs and chronic illness care needs, and assess readiness-to-change and chronic condition management issues. Cost: $2 million.

SECTION 4.3 - HEALTH CARE RESOURCES SHARING AND COORDINATION

Section 722 of the FY 2003 NDAA mandated the establishment of health care coordination projects between VA and DoD. Seven demonstration sites were implemented in the first quarter of FY 2005. The program evaluated the success of demonstration projects designed to improve the coordination of health care resources between VA and DoD for application elsewhere.

Funding for the NDAA demonstration projects ended in FY 2007, and each site submitted their draft final reports late in FY 2007. The El Paso and Puget Sound IM/IT projects and the Hawaii Budget and Financial Management project concluded in FY 2008. However, none of these projects required funding beyond what was allocated in FY 2007. The Joint Facility Utilization and Resource Sharing Work Group members reviewed, edited, and coordinated the final site reports throughout FY 2008, while the work group co-chairs completed all close-out site visits during the first quarter of FY 2008. While on-site, the co-chairs discussed the benefits and accomplishments of the projects with the sites' local leadership. A consolidated final report was drafted in FY 2008, and is currently under review for approval by the HEC co-chairs. At the end of June 2008, a compilation of lessons learned from the demonstration projects was developed and made available for review and use by other VA/DoD sharing sites as applicable. The consolidated final report and individual site reports will be available once approval by the HEC co-chairs is complete.

The seven demonstration sites approved by the HEC were as follows:

Budget and Financial Management

VA Pacific Islands HCS/TAMC

The goal of this demonstration project was 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. Development of the document and referral management electronic tool continued through FY 2008, and concluded with user acceptance testing and implementation. Data continues to be collected to determine product effectiveness. This project's final report was completed during the fourth quarter of FY 2008.

Alaska VA HCS/Elmendorf AFB, 3rd MDG

This project was designed to achieve the following goals: (1) evaluate areas of business collaboration as VA moved its operations to the existing joint venture hospital; (2) develop and generate individual patient bills which allowed both facilities to compare current per diem and set fee rates with Current Procedural Terminology billing methodology to better capture cost for health care services; and (3) use the existing VA fee program to capture workload and patient-specific

health information across agency lines. The Alaska demonstration project successfully concluded in FY 2007, with all desired goals being met and no additional efforts in FY 2008.

Coordinated Staffing and Assignment

Augusta VA HCS/Eisenhower AMC

This project was intended to integrate human resources processes and systems for joint recruitment and training. The goals of this project were to: (1) employ the Augusta VA HCS successful recruitment initiative to aid DoD in hiring staff for direct patient care positions they 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. This project identified numerous barriers to VA/DoD joint recruiting and staffing and has worked on new methodologies and processes to resolve and enhance joint recruiting and staffing issues and initiatives. Joint training initiatives were implemented and continue to benefit both facilities after the project concluded. The final demonstration site report was finalized and approved during the second quarter of FY 2008.

Hampton VAMC/Langley AFB, 1st MDG

The goals of this project were 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 included the development and testing of a formal and objective process to identify product lines that are good candidates for sharing. The process uses the Air Force/VA data mart tool to identify, extract, manipulate, and report patient and clinical purchased care data. The developed processes provide a methodology to validate sharing opportunities that may potentially benefit VA and DoD medical facilities and beneficiaries, and are exportable to any VA or DoD health care facility interested in exploring joint initiatives. The final demonstration site report was finalized and approved during the second quarter of FY 2008.

Medical Information and Information Technology

El Paso VA HCS/William Beaumont AMC

This project had three major IT goals: (1) implement LDSI; (2) implement BHIE; and (3) participate in the design, development and validation of sharing of radiology images. During FY 2008, the final project report was developed to document accomplishments in all three areas. In addition, activities related to testing and implementation for LDSI and image sharing continued in FY 2008.

LDSI for chemistries was initially implemented in FY 2005. LDSI for anatomic pathology (AP) and microbiology laboratory order entry and results retrieval was successfully tested and implemented in FY 2008. The demonstration project team also documented lessons learned and collected and reported on utilization metrics throughout FY 2008.

BHIE was successfully implemented and subsequently upgraded to make additional data available to VA and DoD providers, in addition to documenting lessons learned and metrics.

A goal added during 2006 was to develop, demonstrate and validate a bidirectional medical image sharing capability that leverages existing enterprise capabilities in both VA and DoD such as Digital Imaging Network - Picture Archiving and Communications System (DINPACS) and VistA Imaging. The first iteration of this capability, sharing of compressed (reference quality) x-rays and computed tomography (CT) studies, was completed in FY 2007. The second iteration of the digital imaging capability, which enabled sharing of uncompressed (full quality) x-rays, CT studies, and MRI, was completed in FY 2008. The success of the medical image sharing capability demonstration has led to several expansions of the sharing capability at other VA and DoD facilities.

Puget Sound VA HCS/Madigan AMC

The Team Puget Sound (TPS) project had three goals: (1) implement BHIE and include a capability to exchange inpatient documentation; (2) define requirements for the user interface to view BHIE data; and (3) develop technical documentation to assist in standardizing information exchange. Goals 2 and 3 were achieved in FY 2007. In 2008, the BHIE inpatient documentation sharing capabilities continued to be used and additional metrics and lessons learned were collected. Additionally, the team developed and tested the capability to exchange additional note types, and developed and submitted the project's final report.

South Texas VA HCS/Wilford Hall Medical Center/Brooke AMC

This initiative consisted of two projects with the following goals: (1) implement LDSI for 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 for chemistries was successfully implemented in late FY 2005. In FY 2007, this capability was extended to support the North Central Federal Clinic; utilization metrics and lessons learned from that site were added to the demonstration documentation. LDSI AP and micro was successfully implemented and tested in the third quarter of FY 2007, and continued to be used in a live environment throughout FY 2008. The CCQAS/VetPro interface effort was completed in FY 2006. The credentialing interface demonstration site final report was finalized in FY 2007 with no additional efforts conducted in FY 2008.

SECTION 4.4 - EDUCATION AND TRAINING

Graduate Medical Education

The HEC GME Work Group has continued to advance inter-Departmental collaboration in GME. In FY 2008, the work group continued the Pilot program for military physician residents placed at VA affiliated university sites. As part of this program, DoD physician residents rotate through VA facilities and university sites, providing care to both VA and non-VA patients. A new Pilot program, Seamless Transition for Trainees, was initiated, and San Diego, CA was selected as the program site. The Pilot is focused on developing policies and procedures for sharing trainees between San Diego VAMC and the Naval Medical Center, San Diego. In FY 2008 the work group considered an expansion of its charter to include other accredited training programs such as psychology internships, but these discussions are still in progress.

Continuing Education and Training

During FY 2008, the Continuing Education and Training Work Group achieved significant progress on collaborative joint continuing education training initiatives including the continued refinement and implementation of the shared training strategic plan; the development of processes and strategies for enhancing the distributed learning architecture between VHA and DoD; the design, development, and deployment of projects and programs in support of increased sharing of continuing education; and training between the two Departments.

In FY 2008, a plan for maximizing shared training through the efficient use of distributed learning architectures was implemented. The components of the plan include the enhanced use of satellite and web-based training technology to deploy shared training between the agencies; collaboration in the design and development of shared training materials in support of shared training and the development of a strategy for identifying high priority client training needs; and the optimal modality for quickly and efficiently delivering training to meet those needs. In addition, initiatives were undertaken to address enhanced shared training, data management, and the use of Learning Management Systems (LMS) and Learning Content Management Systems (LCMS) as a means of sharing web-based training; develop a strategy for more efficiently vetting and distributing shared training in DoD; enhance the use of web-based training and streaming video as training modalities; and deliver training to the desktop. The architectural shift in shared training being implemented by the work group with regard to the modes by which training is delivered is expected to continue with web-based training and streaming video, including on-demand and individualized training, assuming an increasing important role in the delivery of training within and between VA and DoD

The work group supports and manages a VA/DoD facility based educators community of practice to increase communication between and among VA

and DoD facility based educators to facilitate increased shared training and to enhance the quality and timeliness of shared training at the facility level in VHA and DoD. In the last year the work group has significantly enhanced and focused the membership of this community. Additionally, it developed an architecture composed of a knowledge management site, email group, and virtual and face to face meetings to support the community of practice. As part of its support for the community the work group, in collaboration with the members of the community, has developed and deployed training resources to enhance the volume of shared training at the local level.

The continued implementation of the shared training plan resulted in 396 programs being shared between VHA and DoD, a 56 percent increase over the FY 2007. Shared programs between VHA and DoD generated a cost avoidance of $15,168,555 in FY 2008, a 103 percent increase over FY 2007 and 151 percent of the FY 2008 planning target of $10 million.

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

As outlined in the VA/DoD JSP, joint communication efforts are very important to both Departments. The Joint Communications Work Group was established under the HEC to facilitate collaboration in communications to beneficiaries, stakeholders, and the public. In FY 2008 the Communications work group was formed with co-chairs from VA and Office of the Secretary of Defense Public Affairs. The work group immediately began to develop strategies, key messages, coordinated casualty/wounded warrior data and tactics to highlight in the news media, and the much improved efforts to achieve a seamless transition of care for servicemembers between the two health care systems.

VA and DoD participated in several conferences together in FY 2008. The Army hosted the annual Joint Venture Conference in Waikiki, HI. This conference provided an opportunity for all current and potential joint ventures to meet together with enterprise-level representatives and share their lessons learned and accomplishments. The conference focused on the best practices of the eight joint venture sites and facilitated discussion regarding implementing the best practices in other areas. Other topics that were briefed included the Air Force/VA data mart tool, billing and reimbursement, an update on IM/IT, and the VistA Fee Intra-Governmental Payment and Collection System Interoperability Project.

VA and DoD also gave joint presentations at the 2008 MHS Conference. Topics covered included progress updates from the eight joint venture sites, successes on JIF projects, and breakout sessions on areas such as new paradigms in warrior care for case management Centers of Excellence on resilience and recovery and the Center for the Intrepid. Coordinated VA/DoD sessions were also given at the 2008 Communications and Customer Service Conference in the areas of case management, Polytrauma systems of care, and VA “101.”

In addition to the joint participation in various conferences, there were several joint communication efforts including joint interviews and news releases that highlighted the many accomplishments in the area of health care resource sharing.

VA and DoD participated in external communication efforts to generate media interest and reach external stakeholders in support of VA/DoD joint initiatives by regularly soliciting input from VA and Military Department representatives for "good news" stories. Based on this input, the VA/DoD Coordination Program Office wrote stories on a monthly basis and distributed the Good News letter throughout TMA and VA communities. Topics that have been covered in the newsletter over the past year include successes from the demonstration projects, groundbreakings held at the Captain James A. Lovell FHCC and the Pensacola JACC, VA and DoD sharing successes in IM/IT, and the success of several JIF projects.

In FY 2008, VA and DoD began participation in a regular column for *U.S. Medicine* magazine on VA/DoD sharing initiatives on behalf of the Principal Deputy Assistant Secretary of Defense for Health Affairs. These columns focus on particular areas of sharing and are coordinated with Military Department representatives and VA when appropriate. Topics that have been highlighted in *U.S. Medicine* include the *President's Report on the Commission on Care for America's Returning Wounded Warriors*, the benefits of sharing relationships through JIF, the success of the Captain James A. Lovell FHCC and how it can be used as a model for other joint sharing areas, and the success of the Defense Centers of Excellence.

The DoD/VA Program Coordination web site continued to be updated with web site features on sharing projects.[7] Some of the items added include the demonstration projects' lessons learned report, the JSP for FY 2008-2010, and the *Good News* letters. The site also featured press releases related to any issues concerning services or benefits for servicemembers and veterans.

[7] http://www.tricare.mil/DVPCO/default.cfm

SECTION 5 – NEXT STEPS

We believe that in the last two JEC Annual Reports, VA and DoD have demonstrated enormous strides toward improving the multiple areas of joint responsibility that have a direct effect on the care and benefits of our servicemembers and veterans. This report was prepared in such a way as to convey these accomplishments, and our sincere commitment to increasing our respective Departments' responsiveness to the needs of our beneficiaries. However, the accomplishments detailed in this report are not endpoints for the changes in our working relationships. They are progress updates in strategic areas that will continue to evolve until these business process reengineering and policy initiatives become fully institutionalized into everyday operations.

With an eye to the future, the JEC will continue to work closely with the SOC, which has been extended through December 31, 2009. The JEC incorporated into the JSP for FY 2009-2011 all of the joint VA/DoD recommendations made by the Commissions and task forces, along with all of the strategies and objectives developed by the SOC to address these recommendations. Accordingly, the JSP will be considerably expanded, and performance in meeting our joint goals will be rigorously monitored. Finally, as was the case last year, the Departments are firm in our resolve to ensure the momentum of rapid improvement gained in FY 2008 is harnessed and carried over into all of the ongoing initiatives described in this report throughout the upcoming year.

VA/DoD Joint Executive Council Strategic Plan Fiscal Years 2009 - 2011

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January 2009

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Performance Measures (PMs) within each strategy are numbered according to the specific sub-strategy they relate to. If the PM relates back to the overall strategy a key word reference is used versus a sub-strategy number.

Appendix A
Department of Veterans Affairs and Department of Defense Joint Strategic Plan for Fiscal Years 2009 - 2011

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 Department of Veterans Affairs and Department of Defense partnership.

VISION STATEMENT

A world-class partnership that delivers seamless, cost-effective, quality services to 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.

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) will maintain a leadership framework to oversee and promote successful partnerships, institutionalize change, and foster momentum and collaboration into the future. This framework consists of the VA/DoD Joint Executive Council (JEC), Health Executive Council (HEC), Benefits Executive Council (BEC), Interagency Program Office (IPO) and other necessary sub-councils or working groups (WGs). The JEC is responsible for developing a plan to increase the exchange of knowledge and information between the Departments, and with external stakeholders.

VA and DoD established the Senior Oversight Committee (SOC), co-chaired by the Deputy Secretary of each Department to address high-priority issues regarding Wounded, Ill, and Injured servicemembers. The following Lines of Action (LOAs) were created to address these issues.

- Disability Evaluation System
- Traumatic Brain Injury/Post Traumatic Stress Disorder
- Case Management
- DoD-VA Data Sharing
- Facilities
- Clean Sheet Analysis
- Legislation – Public Affairs
- Personnel – Pay – Finance Issues

All matters that the SOC is addressing related to both DoD and VA are aligned under the strategic goals and objectives of this Joint Strategic Plan (JSP). As the SOC efforts continue, joint VA/DoD responsibilities will continue to be supported by the JEC.

All recommendations from the following list of reports in calendar year 2008 have been reviewed and where relevant incorporated into this JSP.

- Veterans' Disability Benefits Commission (VDBC)
- West-Marsh Independent Review Group (IRG)
- Interagency Task Force On Returning Global War On Terror Heroes (GWOT)
- President's Commission on Care for America's Returning Wounded Warriors (PCCWW)
- DoD Mental Health Task Force (MHTF)
- Army IG Report

OBJECTIVE 1.1
Improve the access, quality, cost effectiveness, and efficiency with which benefits and services are provided to VA and DoD beneficiaries through increased resource sharing and organizational collaboration.

STRATEGY 1.1 – VA/DoD Joint Executive Council
The JEC will provide strategic direction for VA/DoD collaboration with the development and publication of a JSP to include specific milestones and performance measures and WG designations to be responsible for ensuring the milestones are reached.

STRATEGY 1.1 (A) – VA/DoD Joint Executive Council
The JEC will monitor JSP progress at quarterly meetings.

STRATEGY 1.1 (B) – VA/DoD Joint Executive Council
The JEC quarterly meetings will provide a forum for issue resolution between the Departments.

STRATEGY 1.1 (C) – VA/DoD Joint Executive Council
The JEC will develop appropriate plans to overcome impediments to meeting stated goals and objectives when specific JSP strategies and initiatives are not met.

STRATEGY 1.1 (D) – VA/DoD Joint Executive Council
The JEC will invite representatives from other federal departments and agencies to the JEC meetings as appropriate. These representatives would be ad hoc, non-voting members.

PERFORMANCE MEASURE 1.1
Update and complete coordination of VA/DoD JSP for fiscal years (FYs) 2010 – 2012 by September 30, 2009 and will seek VA and DoD JEC co-chair approval by October 31, 2009.

OBJECTIVE 1.2
Improve stakeholder awareness of sharing and collaboration initiatives, and communicate and promote results and best practices throughout the two Departments and to external stakeholders.

The communications efforts in support of the JSP also reflect the values, mission, and goals of both the Military Health System Strategic Plan and the VA Strategic Plan.

STRATEGY 1.2 – VA/DoD Communications Working Group
The JEC Communications WG (CWG) 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) – VA/DoD Communications Working Group

The JEC CWG will foster and support communication of the ongoing collaboration and resulting best practices by using websites and detailing VA/DoD resource sharing initiatives and accomplishments. The websites will be updated regularly.

STRATEGY 1.2 (B) – VA/DoD Communications Working Group

All communications efforts will reflect the JEC's priorities. The key messages will be a proactive way to share the goals, accomplishments, and best practices of the JEC, HEC, BEC and IPO. Tailored strategic communications plans will be developed and implemented around each of the SOC's key messages.

For FY09, the key messages will incorporate the many different task force and commission recommendations and legislative provisions and will highlight the areas of most importance to both Departments.

(1) DoD and VA are committed to continued emphasis on the sharing of DoD and VA electronic medical records. The goal 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, which will allow for a seamless continuum of care.

(2) Continue to focus on the collaboration in the provision of specialized care to servicemembers and veterans. This includes mental health services and care of the severely wounded, particularly those with traumatic brain injury and post traumatic stress disorder.

(3) Both Departments have demonstrated that joint operations and resource sharing improve the effectiveness and efficiency of health care services and benefits to veterans, servicemembers, military retirees, and eligible dependents.

(4) Both the DoD and the VA are working to improve case management and standardize the delivery of care across the continuum; from illness or injury to recovery and beyond.

(5) DoD and VA are working closely to provide a seamless and transparent disability process, one that is appropriately coordinated or aligned by DoD and VA.

(6) It is important to ensure the compassionate, timely, accurate and standardized personnel pay and financial support is available for wounded, ill and injured servicemembers.

(7) DoD and VA recognize that legislation is necessary to implement certain recommendations of the PCCWW, and other task force and commission recommendations.

PERFORMANCE MEASURE 1.2 – JEC Reporting
An update on the joint communications efforts will be reported to the JEC quarterly.

PERFORMANCE MEASURE 1.2 – Communication Needs
The JEC, HEC, BEC and IPO will identify communication needs and opportunities to the CWG. Drawing on that input, the CWG will develop an umbrella strategic communications plan to include desired outcomes, key audiences, messages, activities and timeline. The CWG will establish process to oversee implementation of appropriate activities by the JEC, HEC, BEC and IPO.

PERFORMANCE MEASURE 1.2 – News Articles
Content analysis of news articles will be conducted to identify any changing attitudes reflected over time.

GOAL 2

High Quality Health Care

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

The Department of Veterans Affairs (VA) and the Department of Defense (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.

STRATEGY 2.1 (A) – HEC Patient Safety Working Group

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

(1) The VA National Center for Patient Safety (NCPS) and the DoD Patient Safety Center (PSC) will continue to share information on patient safety alerts and advisories potentially relevant to both health care systems. Examples of each shared alert or advisory will be reported in the respective HEC quarterly progress report, following the date the alert or advisory occurs.

(2) A signed DoD/VA Data Use Agreement regarding sharing data, information, and analyses on patient safety event categories is required before data sharing may begin. Obtain agreement by both Departments by October 1, 2008. The Patient Safety WG will assist in coordination; however these actions are outside the authority of their WG.

(3) VA NCPS and the DoD PSC will share data, information, and analyses on the patient safety event category of unintentionally retained surgical items (also referred to as “foreign bodies left in after a surgery or procedure”) by March 30, 2009.

(4) VA NCPS and the DoD PSC will share data, information, and analyses on the patient safety event category of incorrect surgery or invasive procedures (wrong site, wrong side, wrong patient, etc.) by March 30, 2009.

(5) VA NCPS and the DoD PSC will share data, information, and analyses on the patient safety event category of patient falls that cause serious injury, i.e. resulted in fractures, head injuries, etc., by January 31, 2009.

(6) VA NCPS and the DoD PSC will share data, information, and analyses on the patient safety event category of inpatient suicides by January 31, 2009.

(7) VA NCPS will share information on the patient safety event category of pressure ulcers with the DoD PSC by January 31, 2009.

PERFORMANCE MEASURE 2.1 (A) (2) & (3)

The Patient Safety WG quarterly progress report for 2nd Quarter (QTR) 2009 will include summary reports related to patient falls, inpatient suicides and pressure ulcers. The summary reports will show analyses of selected subtypes of events, and information on root causes and contributing factors that lead to these types of adverse events in health care systems, as well as examples of interventions implemented in both systems.

PERFORMANCE MEASURE 2.1 (A) (5)
The Patient Safety WG quarterly progress report for 3rd QTR 2009 will include a summary report related to unintentionally retained surgical items and incorrect surgery or invasive procedures. The summary report will show analyses of selected subtypes of events, and information on root causes and contributing factors that lead to these types of adverse events in health care systems, as well as examples of interventions implemented in both systems.

STRATEGY 2.1 (B) – HEC Evidence Based Practice Working Group

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

(1) For each EBCPG, include recommendations for at least one performance measure that is based on a Level I or Level II-1 evidence. (e.g. 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 provider education tools no later than twelve months after the EBCPG is issued.

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

(4) The Evidence Based Practice WG will collaborate with national professional health organizations when judged to be beneficial to VA and DoD to develop clinical practice guidelines.

PERFORMANCE MEASURE 2.1 (B)
Achieve National Guidelines Clearinghouse approval and recognition on all issued EBCPGs within one year after submission.

PERFORMANCE MEASURE 2.1 (B) (2)
One hundred percent (100%) of EBCPGs will have implementation tools developed within 12 months of issue.

PERFORMANCE MEASURE 2.1 (B) (4)
The four approved EBCPG for each fiscal year (FY) will be introduced on the website within six months of their completion date.

PERFORMANCE MEASURE 2.1 (B) (2-4)
Develop marketing strategies for improved awareness of clinical practice guidelines for the health care team and consumers/patients. This strategy includes monitoring of activity to the newly developed web platform, to include focus group activities, and survey questionnaire to our end users.

STRATEGY 2.1 (C) – Traumatic Brain Injury and Psychological Health

To facilitate DoD and VA in leading the nation in prevention, identification, treatment, recovery, and reintegration for military personnel and veterans who are at risk for, or are experiencing mental health (MH) conditions or traumatic brain injury (TBI) the DoD and VA will jointly:

(1) Enhance state-of-the-art care for TBI and MH through the development of evidence-based clinical practices and classification codes.[1]

(2) Develop TBI and MH screening and assessment measurements and procedures and validate them.[2]

(3) Standardize and develop information collection and management documentation strategies for TBI and MH disorders, including information sharing between the VA and DoD.[3]

(4) Establish a coordinated Federal research strategy with specific long-term plan for TBI and relevant MH research.[4]

(5) Monitor shared training programs for TBI and MH to increase the use of evidence-based treatment approaches in both Departments.[5]

(6) Develop a anti-stigma public education campaign. [6]

(7) Conduct a 5-year Pilot Program to assess the effectiveness of providing assisted living services for Veterans with TBI.[7]

(8) Establish cooperative agreements with appropriate public or private entities that have established long-term neurobehavioral rehabilitation and recovery programs.[8]

(9) Support servicemembers affected by TBI/MH conditions undergoing transition of duty status, including discharge and disability evaluations, and transition of care between military medical treatment facilities (MTFs).[9]

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[1] As identified in "Rebuilding the Trust" Independent Review Group Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center (IRG), President's Commission on Care for America's Returning Wounded Warriors Report (PCCWW), and the conference by the Veterans' Disability Benefits Commission (VDBC).
[2] As identified in the Task Force on Returning Global War on Terror Heroes Report (GWOT), IRG, "An Achievable Vision: Report of the Department of Defense Task Force on Mental Health" (MHTF), the National Defense Authorization Act (NDAA) for FY 2008, and the VDBC.
[3] As identified in the MHTF and VDBC.
[4] As identified in the MHTF and VDBC.
[5] As identified in the IRG, MHTF, PCCWW, and VDBC.
[6] As identified in the MHTF.
[7] As identified in the NDAA for FY 2008.
[8] As identified in the MHTF, NDAA FY 2008, and PCCWW.
[9] As identified in the MHTF and NDAA FY 2008.

PERFORMANCE MEASURE 2.1 (C) (1)

- TBI and MH considerations are coordinated with the HEC Evidence Based Guidelines WG to annually assess clinical practice guidelines by October 31, 2009, 2010, and 2011.
- Establish joint DoD/VA requirements for dissemination, training, education, consultation, and policy guidance for evidence-based clinical practice.
- Establish joint DoD/VA requirements to assess the use of evidence-based clinical practices (e.g., compliance with EBCPGs).
- Monitor progress of current TBI code revision proposal with the National Center for Health Statistics.
- Following the publication of TBI/MH ICD-9 code revision by the National Center for Health Statistics, DoD will update AHLTA.
- Following the publication of TBI/MH ICD-9 code revision by the National Center for Health Statistics, VA will update VistA.

PERFORMANCE MEASURE 2.1 (C) (2)

- Screening and assessment requirements are monitored and assessed annually by September 30, 2009, 2010, and 2011.

PERFORMANCE MEASURE 2.1 (C) (3)

- Establish requirements to collect and link operational and health data for the advancement of treatment practices for TBI and MH by September 30, 2009.

PERFORMANCE MEASURE 2.1 (C) (4)

- Joint DoD/VA coordination of requirements for a database of all current TBI/MH esearch efforts are defined in FY09.
- Research initiatives are evaluated (e.g. special populations) against the database to identify gaps by October 31, 2009.
- Research strategy and long-term plan is established to include funding requirements by October 31, 2010.
- Implementation of research strategy and plan is monitored and evaluated by October 31, 2011.

PERFORMANCE MEASURE 2.1 (C) (5)

- Annual number of trainees for each training program is reported annually to the HEC from the previous FY by October 31, 2009, 2010, and 2011.

PERFORMANCE MEASURE 2.1 (C) (6)

- Anti-stigma public education campaign is implemented by November 30, 2008.
- Anti-stigma public education campaign is monitored and assessed annually by November 30, 2009, 2010 and 2011.

PERFORMANCE MEASURE 2.1 (C) (7)

- Assisted living pilot program is initiated by March 31, 2009.
- Interim report on assisted living pilot program is completed by April 30, 2010.

PERFORMANCE MEASURE 2.1 (C) (8)

- Network of experts is monitored and evaluated, and assessment is reported by March 30, 2009.

PERFORMANCE MEASURE 2.1 (C) (9)

- Transition of Care policies and procedures are reviewed and analyzed, and gaps are identified by May 31, 2009.
- Transition of Care policies and procedures are monitored and assessed annually by May 31, 2010 and May 31, 2011.

STRATEGY 2.1 (D) – HEC Mental Health Working Group

The HEC MHWG will explore mechanisms to identify individuals with serious MH issues or who are at risk for suicide in order to ensure appropriate assessment and indicated treatment is offered.

(1) HEC MHWG will assess the extent to which referrals made to Veterans Health Administration (VHA) resources for MH evaluation and care at Post Deployment Health Re-Assessments (PDHRA) result in follow-up VHA evaluations and ongoing MH care.

(2) HEC MHWG will explore methods for assessing VA and DoD MH data to determine whether Post Deployment Health Assessment and/or PDHRA responses are predictive of which returning servicemembers come to VHA for evaluation and care.

(3) HEC MHWG will monitor MH staffing levels for sufficiency against established staffing plans.[10]

(4) HEC MHWG will monitor achievement of established MH access to care standards.[11]

(5) HEC MHWG will coordinate with the Suicide Prevention and Risk Reduction Committee to standardize measures and definitions of suicide nomenclature between VA and DoD.

(6) DoD and VA will collaborate to enhance suicide prevention and risk reduction programming.

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[10] As identified in the IRG, MHTF, and PCCWW.
[11] As identified in the MHTF.

PERFORMANCE MEASURE 2.1 (D) (1 & 2)

- The rate of follow-up for referral (1) evaluation and (2) MH care will be determined by September 30, 2009.

PERFORMANCE MEASURE 2.1 (D) (3)

- Adequacy of MH staffing is monitored quarterly by the HEC MHWG beginning 3rd QTR 2009.

PERFORMANCE MEASURE 2.1 (D) (4)

- Adequacy of access to care is monitored quarterly by the HEC MHWG beginning 2nd QTR 2009.

PERFORMANCE MEASURE 2.1 (D) (5)

- Both Departments will publish policy memoranda which establish common nomenclature and data or crosswalks between alternative systems for metrics regarding suicide within 90 days after the Centers for Disease Control and Prevention publishes suicide nomenclature recommendations.

PERFORMANCE MEASURE 2.1 (D) (6)

- Departments will track suicide prevention and risk reduction VA/DoD collaborations on a monthly basis.

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.

STRATEGY 2.2 (A) – HEC Graduate Medical Education Working Group

The HEC GME WG will examine opportunities for greater VA/DoD GME collaboration and present findings and recommendations to the HEC by September 30th annually.

STRATEGY 2.2 (B) – HEC Graduate Medical Education Working Group

The HEC GME WG will evaluate 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 within 6 months of issuance of final BRAC report. Include list of residency programs in National Capitol Area by specialty/sub-specialty area, accreditation sponsor, number of residents per program, potential redundancy or duplication in programs that overlap; rank programs that will likely be adversely impacted by BRAC and report preliminary findings to the HEC. Following completion of needs assessment, report semi-annually on progress in merging duplicate programs, and in collaborations with VA.

STRATEGY 2.2 (C) – HEC Graduate Medical Education Working Group

The HEC GME WG will pilot a Seamless Transition for Trainees Program at San Diego, CA through June 30, 2009.

(1) Evaluate and report results/recommendations to HEC by October 31, 2009.

STRATEGY 2.2 (D) – Cross Cultural Education of Healthcare Professionals

The VA and DoD will explore the feasibility of implementing a healthcare professional exchange programs at the local level to facilitate the cross cultural education of healthcare professionals to promote awareness of the capabilities, standards of care, and services provided in their counterpart agencies to better facilitate the transition and coordination of care of mutual beneficiaries.

PERFORMANCE MEASURE 2.2 (D)

The VA and DoD will provide quarterly status updates to the HEC.

STRATEGY 2.2 (E) – HEC Continuing Education and Training Working Group

The HEC Continuing Education and Training WG will enhance the existing shared training partnership between VA and DoD to provide additional and improved shared training by optimizing the distributed learning architecture[12] for definition) which supports the sharing of continuing education and in-service training programs for health care professionals in VA and DoD. The WG will:

(1) Develop and implement a strategy for integrating the training acquired from federal agencies other than VHA and DoD by the Interagency shared training partnership managed by the VHA Employee Education System (EES) into the resources being shared by the VHA DoD shared training partnership by December 31, 2008.

(2) Align the distributed learning architectures within VA and DoD to support increased shared training between the departments utilizing distance learning modalities while minimizing the additional resources necessary to support shared training. (Ongoing)

(a) Explore the use of on demand video as a shared training modality in DoD by March 31, 2009.
(b) In collaboration with federal, national and international governing and oversight bodies develop and refine the Shareable Content Object Reference Model (SCORM) Conformant web based training standards and practices which serve as architectural elements for shared training between VHA and DoD. (Commenced December FY 2008.)

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[13] LMS as used in this context is a web based training tracking system used to collect and report education and training data. Many Federal agencies including DoD, the uniformed Services and VA are in various stages of implementing their respective LMSs. Due to variability of implementation and platforms, there are a number of technical requirements that will need to be met before the LMS systems can be used to generate reports on participation in shared training.

(3) Encourage the ongoing use of shared training strategies between VA and DoD and within the uniformed Services, taking advantage of the VA and DoD distributed learning architectures and minimizing the resources necessary to share training. (Ongoing)

(4) Establish a committee to coordinate the identification, vetting and distribution of shared training within DoD and between VA and DoD by December 31, 2008. (Dependant on the approval of senior officials in VHA and DoD.)

(a) Seek formal approval of a committee to coordinate the identification, vetting and distribution of shared training within DoD and between VA and DoD by December 31, 2008.
(b) Conduct a pilot to test and refine the shared training vetting and distribution architecture in the uniformed Services by March 31, 2009.

(5) Develop and implement a strategy for utilizing the Learning Management Systems (LMSs)[13] to assess the participation of VA and DoD personnel in shared training by September 30, 2010. (Note: achieving this objective is dependent upon the successful deployment of the LMS in VA and DoD.) (In progress)

(a) Develop a strategy for utilizing the VA and DoD LMSs to quantify the participation of VA and DoD personnel in shared training by September 30, 2008. (In progress)
(b) Pilot a strategy for utilizing the VA and DoD LMSs to assess the participation of VA and DoD personnel in shared training by September 30, 2009.
(c) Implement a fully operational system for utilizing VA and DoD LMSs to quantify the participation of VA and DoD personnel in shared training by September 30, 2010.

PERFORMANCE MEASURE 2.2 (E)
In FY 2009, maintain the FY 2008 overall volume of shared training which represents a 150% increase over FY 2005 and generate a cost avoidance of $8,000,000 while increasing the amount of shared web based training by 25% over FY 2007. Continue to leverage selected emerging technologies to enhance shared training (e.g. IP3 based training, streaming video to the desk top and cell phone delivery of training).

PERFORMANCE MEASURE 2.2 (E) (1)
Commence sharing of training programs acquired by the EES Interagency Shared training Consortia within the VHA DoD shared training partnership by December 30, 2008.

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[12] For the purpose of this report, Distributed Learning Architecture is defined as 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.

PERFORMANCE MEASURE 2.2 (E) (2) (a)
Assess the efficacy of enhancing the use of video on demand as a shared training modality by March 31, 2009.

PERFORMANCE MEASURE 2.2 (E) (2) (b)
Assume a leadership role in the development and refinement of SCORM web based training standards for clinical and clinically related training to be provided by federal agencies.

PERFORMANCE MEASURE 2.2 (E) (4)
Report quarterly to the HEC on the volume of shared training and cost avoidance generated as a result of shared training. (On going)

PERFORMANCE MEASURE 2.2 (E) (4) (b)
Assuming DoD accepts the WG recommendation and authorizes the formation of a vetting and distribution oversight body for the uniformed Services conduct a pilot of the vetting and distribution process in support of shared training by March 31, 2009.

PERFORMANCE MEASURE 2.2 (E) (5) (b)
Conduct a pilot of a strategy for collecting and analyzing shared training participant data by September 30, 2009. (This performance measure is dependent upon the status of the implementation of the enterprise level LMS in VHA and DoD.)

PERFORMANCE MEASURE 2.2 (E) (5) (c)
Implement a fully operational system for utilizing VA and DoD LMSs to quantify the participation of VA and DoD personnel in shared training by September 30, 2010.

STRATEGY 2.2 (F) – HEC Continuing Education and Training Working Group
The HEC Continuing Education and Training WG will continue to facilitate the development and management of a VA/DoD Facility Based Educators community of practice[14] to increase shared training initiatives between VA Health Care Facilities and DoD Military Treatment Facilities.

(1) Enhance and improve the performance of the VA DoD Facility Based Educators Community of Practice by May 31, 2009.

(2) Manage and facilitate a virtual forum (email group, virtual meeting room, and knowledge management site) for the members of the Facility Based Educators Community of Practice to increase communications and the development of shared training between VA and DoD Health Care Facilities. (On going)

[14] For the purpose of this report, community of practice will be defined as 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.

(a) Manage and facilitate an email group as part of the virtual forum by to support the members of the Facility Based Educators Community of Practice. (On going)
(b) Manage and facilitate a Knowledge Management site as part of the virtual forum by to support the members of the Facility Based Educators Community of Practice. (On going)
(c) Manage and facilitate a virtual meeting room site as part of the virtual forum by to support the members of the Facility Based Educators Community of Practice. (On going)

(3) Continue to expand the community of local VA and DoD facility based educators and provide them with in-service training in the area of shared training utilizing the virtual forum developed in Strategy 2.2 (E) (2). (On going)

(4) Launch special training initiatives for selected high priority clients[15] which can benefit from shared training. (In progress)

(a) Complete a pilot of a strategy for providing shared training to high priority clients by June 30, 2009 utilizing the CAPT James A. Lovell - Federal Health Care Center (FHCC), joint venture site as the pilot. (In progress)

(1) Develop an in-service training program for joint venture site leaders and managers by December 31, 2008.

(2) Develop an in-service training program for joint venture site staff by March 31, 2009.

(3) Develop an orientation program for joint venture site new employees by June 30, 2009.

(b) Begin providing all joint venture sites with shared training upon request based on the lessons learned at the CAPT James A. Lovell – FHCC, joint venture site by September 30, 2009.

(1) Deploy the VHA portion of the joint venture site training programs to other joint venture sites as needed by March 31, 2009.

(2) Deploy the Navy portion of the joint venture site training programs to those joint venture sites in which the Navy is a partner by June 30, 2009.

(3) Develop joint venture site training for the Air Force and Army to complement the VHA training at joint venture sites in which the Air Force or Army are partners by September 30, 2009.

[15] High priority client' as used in this context refers to learners designated by VHA or DoD leadership as having special training needs which are essential in meeting the VHA and or DoD health care mission.

(5) Develop a strategy for identifying high priority clinical or clinical related training clients in VHA and DoD and their in-service and continuing education needs by December 31, 2008.

(a) Conduct a pilot program to identify selected high priority clinical or clinical related training clients in VHA and DoD by November 30, 2008.
(b) Identify the in-service and continuing education training needs of selected high priority clinical or clinical related training clients by December 30, 2008.
(c) Implement a program to meet the in-service and continuing education training needs of selected high priority clinical or clinical related training clients in VHA and DoD by February 28, 2009.

(6) Develop and implement a strategy by December 31, 2008, for resolving the ongoing problem in VHA and DoD regarding the need for VHA and DoD staff serving in the partner agency settings to meet all security/ privacy/ethics training and other mandatory training requirements in order to be authorized to work in the partner setting.

PERFORMANCE MEASURE 2.2 (F) (1)
Increase the membership of the VA/DoD community of practice incorporating the members of existing facility based educator communities of practice in VA, DoD and the uniformed Services by December 30, 2009.

PERFORMANCE MEASURE 2.2 (F) (2)
Provide three virtual on-line meetings for the VHA DoD Facility Based Educators Community of Practice addressing high priority facility based training issues by August 31, 2009.

PERFORMANCE MEASURE 2.2 (F) (3)
Provide an in-service training program in the area of shared training for local VA and DoD facility based educators by May 31, 2009.

PERFORMANCE MEASURE 2.2 (F) (4) (b)
Develop and deploy training programs for leaders and managers; the in-service training of existing employees; Orientation of new employees at the CAPT James A. Lovell – FHCC by March 31, 2009.

PERFORMANCE MEASURE 2.2 (F) (4) (c)
Deploy training programs for leaders and managers; the in-service training of existing employees; Orientation of new employees comparable to that developed for the CAPT James A. Lovell – FHCC at other VHA DoD joint venture sites by September 30, 2009.

PERFORMANCE MEASURE 2.2 (F) (5)
Design, develop and deploy training programs to meet the needs of selected high priority clients by December 31, 2008.

PERFORMANCE MEASURE 2.2 (F) (6)
Develop and implement a strategy by December 31, 2008, for resolving the on-going problem in VHA and DoD regarding the need for VHA and DoD staff serving in the partner agency settings to meet all security/privacy/ethics training and other mandatory training requirements in order to be authorized to work in the partner setting.

OBJECTIVE 2.3

The HEC Deployment Health WG 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.

STRATEGY 2.3 (A) – HEC Deployment Health Working Group

The HEC Deployment Health WG (DHWG) will identify opportunities to share information between DoD and VA on health surveillance and assessment of military populations, including identification of cohorts with specific exposures or diseases.

(1) Annually review DoD's identification of cohorts who participated in the testing of chemical and biological warfare agents from 1942 to 1975, DoD's ongoing provision of data to VA on these cohorts, and VA's outreach efforts to these cohorts.

(2) Annually review DoD's identification of servicemembers who were injured in combat or non-combat incidents and who have embedded fragments, DoD's provision of data to VA on these individuals, and VA's medical follow-up activities.

(3) Annually review DoD and VA efforts related to TBIs, including DoD and VA efforts to identify servicemembers and veterans who were diagnosed with TBI and track the health of the cohort over time.

(4) Annually review the deployment health-related data from the Millennium Cohort Study.

(5) Review the VA and DoD efforts to establish a new VA National Veterans' Registry, a list of all 25 million living veterans.

PERFORMANCE MEASURE 2.3 (A) (1)
Provide an assessment to the HEC on the adequacy of the DoD and VA sharing efforts on identification and outreach to cohorts exposed to chemical and biological warfare agents from 1942 to 1975 by September 30th annually.

PERFORMANCE MEASURE 2.3 (A) (2)
Provide an assessment to the HEC on the adequacy of the DoD and VA sharing efforts on the identification and surveillance of the embedded fragment cohort by September 30th annually.

PERFORMANCE MEASURE 2.3 (A) (3)
Provide an assessment to the HEC on the adequacy of the DoD and VA sharing efforts on the identification and surveillance of the TBI cohort by September 30th annually.

PERFORMANCE MEASURE 2.3 (A) (4)
Provide an assessment to the HEC on the adequacy of the DoD and VA sharing efforts on the deployment health-related data from the Millennium Cohort Study by September 30th annually.

PERFORMANCE MEASURE 2.3 (A) (5)
Provide an assessment to the HEC on the adequacy of efforts to identify and integrate VA and DoD databases to establish the VA National Veterans' Registry by September 30, 2009.

STRATEGY 2.3 (B) – HEC Deployment Health Working Group
The HEC DHWG will identify opportunities to share information between DoD and VA on follow-up medical care of deployed populations.

(1) Annually review the medical follow-up of individuals in the embedded fragment cohort.

(2) Annually review the DoD and VA data on the medical follow-up of individuals in the TBI cohort.

PERFORMANCE MEASURE 2.3 (B) (1)
Provide an assessment to the HEC on the adequacy of the medical follow-up of individuals with embedded fragments by September 30th annually.

PERFORMANCE MEASURE 2.3 (B) (2)
Provide an assessment to the HEC on the adequacy of the DoD and VA data on the medical follow-up of individuals with TBI by September 30th annually.

STRATEGY 2.3 (C) – HEC Deployment Health Working Group
The HEC DHWG will compare and foster research initiatives on military and veteranrelated health research to include deployment health issues.

(1) Conduct an annual inventory and catalog current research on deployment health issues in each Department annually by September 30th.

(2) Maintain a continuing VA/DoD forum to share findings of deployment healthrelated research.

(3) Develop an analysis of the ongoing deployment health-related research on an annual basis.

PERFORMANCE MEASURE 2.3 (C) (1)
DoD and VA will provide an ongoing forum on a routine basis at DHWG meetings for subject matter experts to share deployment health-related information, including research outcomes and progress.

PERFORMANCE MEASURE 2.3 (C) (2)
Report to the HEC on all DoD and VA deployment health-related research by September 30th annually.

STRATEGY 2.3 (D) – HEC Deployment Health Working Group

The HEC DHWG, 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.

PERFORMANCE MEASURE 2.3 (d) (1)
Report to the HEC and summarize the joint health risk communication products that were developed by September 30th annually.

PERFORMANCE MEASURE 2.3 (d) (2)
Report to the HEC on deployment related health risk communication products that have been coordinated among the appropriate federal agencies by September 30th annually.

GOAL 3

Seamless Coordination of Benefits

The Department of Veterans Affairs (VA) and the Department of Defense (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
To improve participation in the BDD program nationwide and ensure servicemembers are afforded the single cooperative examinations where available.

STRATEGY 3.1 – BEC Benefits Delivery at Discharge Working Group

(1) The BEC will align the BDD program as appropriate with concurrent efforts within DoD and VA dedicated to accelerating or streamlining delivery of VA benefits for separating and retiring servicemembers.

(2) The BEC will calculate and analyze BDD participation rate at memorandum of understanding (MOU) sites using approved methodology, establish other more timely performance metrics, and adjust the marketing plan and information delivery methods as necessary to raise awareness and improve program participation.

(3) The BEC will engage the military Services to instill ownership in the BDD program in operational commanders to ensure separating and retiring servicemembers are encouraged to participate in the BDD program.

PERFORMANCE MEASURE 3.1 (2)
The annual BDD participation rate is the number of BDD claims filed per fiscal year divided by the total number of VA claims filed in the same FY from servicemembers who have separated from a BDD intake site with an MOU.

PERFORMANCE MEASURE 3.1 (3)
Performance measures will be established to provide commanders with current indications of BDD program participation.

OBJECTIVE 3.2
Jointly develop, test, and expand to new locations, as directed, an improved Disability Evaluation System (DES) process that is faster, seamless, and transparent to servicemembers and veterans, and that consolidates the Departments' disability systems to the degree allowed by current law.

STRATEGY 3.2 – Improve the Disability Evaluation System
Implement a single, joint DES that is faster, seamless and transparent, is appropriately coordinated or aligned by DoD and VA, and that incorporates the features highlighted by Commission, Task Force, Study Groups and Audit findings and recommendations to the degree allowed by public law.

(1) Expand the scope of the DoD-VA DES pilot while executing a continuous process improvement strategy to further standardize and streamline DES procedures.

(2) Implement a single physical examination process, utilizing VA examination templates and worksheets, which will serve the needs of the DoD in determining fitness for duty, and the VA in determining degree of disability.

(3) Implement a process in which the DoD determines fitness for duty and the VA provides disability ratings that are binding upon both Departments.

(4) Develop a joint, comprehensive, multidisciplinary medical, psychological, and vocational evaluation for members applying for disability compensation through the DES.

(5) Develop and implement a paperless joint DES processing program.

(6) Implement a process for the DoD to recommend updates to the Veterans Affairs Schedule for Rating Disability through the Disability Advisory Council (DAC) and BEC.

PERFORMANCE MEASURE 3.2 (1)
Expand the pilot test of the integrated DoD-VA DES to new locations as directed by senior leaders.

PERFORMANCE MEASURE 3.2 (2)
Eliminate the performance of duplicate disability physical examinations by the DoD and VA at integrated DoD-VA DES pilot test locations.

PERFORMANCE MEASURE 3.2 (5)
Process all DES pilot participants using a paperless application by September 30, 2010.

PERFORMANCE MEASURE 3.2 – Policy Conditions & Standards
Assist the Military Departments in reducing the time spent by the servicemember in the DES by providing proper policy conditions and standards.

PERFORMANCE MEASURE 3.2 – Minimize Enrolled Time
Minimize time servicemembers spend enrolled in the DES Pilot Program from the time of DES referral to issuance of the VA benefits letter.

PERFORMANCE MEASURE 3.2 – Servicemember & Stakeholder Satisfaction
Assess servicemember and stakeholder satisfaction with the DES pilot using DoD instruments and by measuring the number of appeals of Physical Evaluation Board decisions. Goal: upward trend on satisfaction/downward trend in number of appeals.

PERFORMANCE MEASURE 3.2 – Veteran Satisfaction
Assess Veteran satisfaction with the DES pilot one-year post separation using VA instruments. Goal: upward trend on satisfaction.

OBJECTIVE 3.3
DoD servicemembers of all components are aware of and know how to obtain information about their VA and DoD benefits.

STRATEGY 3.3 – Communication of Benefits and Services

The Communicating VA/DoD Benefits Working Group (WG) will expand efforts to disseminate information on benefits and services available to military members and VA/DoD beneficiaries throughout the military personnel lifecycle.

(1) Expand communication of benefits by using military and VA websites (e.g., Military OneSource, VA website, Defense Knowledge Online, etc.), providing information for the eBenefits portal, assisting DoD with the content of a Compensation and Benefits Handbook (for distribution at Military Treatment Facilities [MTFs], BDD sites, military installations, VA Centers, and VA Regional Offices), and delivering information to servicemembers via email.

(2) By July 1, 2009, conduct a random survey of personnel concerning VA and DoD information on Military OneSource (i.e., is the information understandable, is it complete, solicit suggestions on how to improve, etc.). Survey can be conducted via Army Knowledge Online, Navy Knowledge Online, and Air Force Portal, with personnel randomly selected from each Service.

(3) Twelve (12) months prior to scheduled separation, notify personnel about VA and DoD benefits via comments on their Leave and Earnings Statement (LES). The comment will list websites, publications, and offices the military member can contact to learn specifics about benefits. By March 31, 2009, select a random sample of 100 personnel from each Service scheduled to separate at the end of FY09, and include information on their LES. A website will be established for them to register their acknowledgement within 30 days.

(4) Measure awareness of VA benefits among servicemembers and veterans through the VA's National Survey of Veterans, which will be conducted in 2009. This survey will benchmark awareness. The same survey will be administered in 2011.

PERFORMANCE MEASURE 3.3 (1)

- By March 31, 2009, develop a strategy with the Services to contact personnel electronically.
- By September 30, 2009, conduct a pilot for one installation for at least two Services.
- By September 30, 2010, be able to contact at least 85% of scheduled separations 180 days prior to discharge.

PERFORMANCE MEASURE 3.3 (2)
Analyze the survey results on VA/DoD benefits information. If a comment(s) appears in at least 20% of respondents, make appropriate adjustments to the websites.

PERFORMANCE MEASURE 3.3 (3)
The percentage of responses received from servicemembers acknowledging they are aware of websites, publications, and offices military members can contact to learn specifics about benefits as listed on their LES will serve as a measure as to how many military members are being reached through notification of benefits and services on their LES. This will serve as a benchmark for LES communication. If this test reaches 50% or more (as measured by registrations to the website) by the end of FY09, the test will be deemed a success. If the test is not a success, DoD and VA will ascertain why, then devise a notification strategy that includes the installation and unit chain of command (e.g., installation and unit commanders will have to report metrics through the Service chain of command, therefore, the metrics would become a formal part of their performance evaluation system). If the test is a success, then DoD and VA will increase the percentage of contacts to 85% by September 30, 2010.

PERFORMANCE MEASURE 3.3 (4)
Conduct national survey of veterans by December 31, 2009. Analysis of this survey will be completed and reported to Congress in 2010. The intent is to ascertain veterans' awareness of benefits. If the results indicate less than 85% are aware of their benefits, then the VA and DoD will reassess the effectiveness of websites, LES notifications, and displays at MTFs to determine why the target audience is being missed.

OBJECTIVE 3.4

VA and DoD will coordinate to respectively implement and market the Quick Start program to ensure maximum awareness and participation by all separating or retiring servicemembers, especially National Guard and Reserve members who are demobilizing or separating/retiring from Service, who do not meet the timeline to participate in the BDD program.

STRATEGY 3.4 – Quick Start Program

(1)The BEC will develop and execute an aggressive marketing campaign to get the word out regarding the Quick Start program.

(2) The BEC will establish a participation baseline for Quick Start.

(3) The BEC will analyze the Quick Start participation rate, paying particular attention to National Guard and Reserve participation.

(4) The BEC will adjust the Quick Start marketing plan and information delivery methods as necessary to raise awareness and improve program participation.

(5) The BEC will collect feedback to determine if Quick Start is meeting the unique needs of each component, particularly Reserve and National Guard Components, and make recommendations for program adjustments as necessary.

PERFORMANCE MEASURE 3.4
Performance measures for Quick Start will be established pending determination of the Quick Start participation rate baseline for both overall participation and for National Guard/Reserve member participation.

OBJECTIVE 3.5
The BEC Medical Records WG will systematically examine all phases of the military paper Service Treatment Record (STR) Life-Cycle Management Process, with an emphasis on promptly providing accurate and complete STR related information for all servicemembers in all components and veterans to DoD and VA designated benefits determination decision makers.

STRATEGY 3.5 – Military Service Treatment Record
VA and DoD will collaborate to develop a media-neutral, 21st century solution for managing the STR life cycle. This solution will serve as a bridge between maintaining and transferring a completely paper-based record and managing the record in its current hybrid state containing both paper-based and electronic information until the Departments implement a complete electronic health record. This collaborative effort will result in the prompt availability of and improved accuracy, readability and completeness of medical treatment information documented in the STR.

(1) DoD and VA will coordinate with the National Archives and Records Administration (NARA) to ensure paper-based STR issues and recommended solutions are consistent with federal records keeping requirements.

(2) Develop Department specific and individual component/organization (e.g., Department of the Army and VA Records Management Center) guidance and procedures with internal controls and accountability to ensure consistency.

(3) Ensure continuous quality improvement for STR Life-Cycle Management via a vigorous monitoring program that emphasizes compliance with policy and tandardized execution of new business processes.

PERFORMANCE MEASURE 3.5 (2)
Finalize update of the Memorandum of Agreement (MOA) between DoD and VA relating to transfer and maintenance of military STR for benefits processing and obtain approval and signatures by June 30, 2009.

PERFORMANCE MEASURE 3.5 (3)
Draft, update, and finalize DoD-VA policies to include STR forms, content, management, and transfer, to include internal control and accountability mechanisms by June 30, 2009.

PERFORMANCE MEASURE 3.5 (1)
Draft and finalize the records disposition schedule for the military STR and obtain NARA approval and signatures by August 31, 2009.

PERFORMANCE MEASURE 3.5 – Establish 95% Baseline
By September 30, 2009, establish a baseline of 95% for VA access to accurate and complete STR information on all servicemembers and veterans within 10 days of request.

PERFORMANCE MEASURE 3.5 – Reduction of Late Flowing Documents
Reduce the volume of late flowing documents being transferred to VA from DoD by 95% by September 30, 2009 (from 3,800,000 late flowing documents received annually to 190,000).

OBJECTIVE 3.6

Provide comprehensive, coordinated care and benefits to recovering servicemembers, veterans, and their families from recovery through rehabilitation to reintegration. This comprehensive care is provided through a network of medical and non-medical care managers. The coordination of care, benefits, services and resources is provided by the Federal Recovery Coordination Program (FRCP) and the Recovery Coordination Program (RCP).

The overarching objective is to develop a strategy for oversight and joint policy development for the recovery coordination programs.

STRATEGY 3.6 (A) – DoD/VA Federal Recovery Coordination Program

The FRCP will continue to provide and improve coordination of care, benefits, services and resources to severely injured or ill recovering servicemembers, veterans, and their families. Servicemembers enrolled in the FRCP incurred a severe injury or illness and are highly unlikely to return to duty, and will most likely be medically separated from the military.

(1) The FRCP will further develop and standardize policies and procedures for all aspects of the Program.

(2) The FRCP will create a data element dictionary for its current data management system.

(3) The FRCP will develop a framework for future data management needs.

(4) The FRCP will develop and test a tool(s) for the purpose of measuring and recording intensity of services required by clients and to better balance Federal Recovery Coordinators' (FRC) workload.

(5) The FRCP will develop a complete and long-term program evaluation strategy to include process and outcomes measures, as well as client and family satisfaction surveys.

(6) The FRCP will develop information and outreach strategies.

(7) The FRCP will develop a strategy for hiring placement, and personnel support of FRCs.

PERFORMANCE MEASURE 3.6 (A) (1)
Establish policies and procedures for all aspects of the Program by March 31, 2009.

PERFORMANCE MEASURE 3.6 (A) (2)
Complete data element dictionary by November 30, 2009.

PERFORMANCE MEASURE 3.6 (A) (3)
Complete framework for future data management system by January 31, 2009.

PERFORMANCE MEASURE 3.6 (A) (4)
Complete draft "intensity" tool by March 31, 2009 for field testing.

PERFORMANCE MEASURE 3.6 (A) (5)

- Complete satisfaction survey tools by November 30, 2008.
- Complete baseline satisfaction surveys by March 30, 2009.
- Complete long-term program evaluation tools by November 30, 2009.

PERFORMANCE MEASURE 3.6 (A) (6)

- Develop a plan to identify veterans who might need FRCP assistance by January 31, 2009.
- Develop a web presence for the FRCP by January 31, 2009.
- Develop a standard presentation for outreach purposes by February 28, 2009.

PERFORMANCE MEASURE 3.6 (A) (7)
Identify and analyze data to develop FRC staffing and placement model by March 31, 2009.

STRATEGY 3.6 (B) – Recovery Coordination Program

The RCP will provide comprehensive, coordinated care, benefits, services and resources to seriously injured or ill recovering servicemembers, veterans, and their families from recovery through rehabilitation to community reintegration. Servicemembers enrolled in the RCP incurred a serious injury or illness and may require more than 180 days to recover. They may or may not return to active duty.

(1) The RCP will develop and standardize uniform policies and procedures for all aspects of the Program.

(2) The RCP will create a data element dictionary for its data management system.

(3) The RCP will develop a framework for data management needs.

(4) The RCP will develop and test a tool(s) for the purpose of measuring and recording intensity of services required by clients and to better balance Recovery Care Coordinators' (RCCs) workload.

(5) The RCP will develop a complete program evaluation strategy to include process and outcomes measures, as well as recovering servicemember and family satisfaction surveys.

(6) The RCP will develop information and outreach strategies.

(7) The RCP will develop, in collaboration with the Military Service Wounded Warrior Programs, a strategy for hiring, placement, personnel support and supervision of RCCs.

PERFORMANCE MEASURE 3.6 (B) (1)
Establish DoD guidance through a Directive-Type Memorandum and a DoD Directive for all aspects of the program by December 31, 2008 and February 28, 2009, respectively.

PERFORMANCE MEASURE 3.6 (B) (2)
Modify and accommodate the FRCP data element dictionary by January 31, 2009.

PERFORMANCE MEASURE 3.6 (B) (3)
Complete draft "intensity" tool for field testing by March 31, 2009.

PERFORMANCE MEASURE 3.6 (B) (4)

- Complete program evaluation tools by November 30, 2009.
- Complete satisfaction survey tools by January 31, 2009.
- Complete baseline satisfaction surveys by March 31, 2009.

PERFORMANCE MEASURE 3.6 (B) (5)
Develop a web presence for the Program by January 31, 2009.

PERFORMANCE MEASURE 3.6 (B) (6)
Identify and analyze initial data to predict need for RCC staffing and placement by March 31, 2009.

STRATEGY 3.6 (C) – Program Interoperability

Key to the success of these programs, and to the coordination of care, benefits, resources and services to recovering servicemembers, veterans, and their

families, is the interaction of policies, procedures, and personnel between the FRCP and RCP.

(1) Develop joint standard operating procedures, guidance and handbook that define roles and responsibilities between the two programs and other medical and nonmedical case and care managers.

(2) Develop combined educational strategy that addresses initial and ongoing educational requirements for both programs.

(3) Develop a joint framework for a common data management system.

PERFORMANCE MEASURE 3.6 (C) (1)
Establish policy guidance for FRCP and RCP by May 31, 2009.

PERFORMANCE MEASURE 3.6 (C) (2)

- Establish a joint educational resource library by June 30, 2009.
- Develop common orientation and training modules for FRCP and RCP by January 31, 2009.
- Develop common continuing medical education requirements by January 31, 2009.

PERFORMANCE MEASURE 3.6 (C) (3)

- Identify existing data management systems by January 30, 2009.
- Create information technology business plans by February 28, 2009.
- Explore data integration strategies by March 31, 2009.

STRATEGY 3.6 (D) – Communications Outreach Program

The National Resource Directory provides information on, and access to, services and resources for wounded, ill, and injured servicemembers, veterans, and their families and those who support them from recovery and rehabilitation to community reintegration.

PERFORMANCE MEASURE 3.6 (D) (1)
Establish a business plan to ensure ongoing content management by December 31, 2009.

GOAL 4

Integrated Information Sharing

The Department of Veterans Affairs (VA) and the Department of Defense (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 that ensures appropriate Departments, Agencies, servicemembers, veterans, and family members have immediate and secure access to reliable and accurate personnel and beneficiary data that supports their needs.

STRATEGY 4.1 – Personnel and Benefits Information Sharing/ Information Technology

The BEC Information Sharing/Information Technology Working Group (WG) will collaborate in developing net-centric solutions for the enhancement of services and benefits delivery to servicemembers and veterans, and increase data sharing between the two Departments.

(1) Support current and future task force recommendations, while further aligning the HEC and BEC data sharing efforts, to streamline information sharing across the DoD and VA for the delivery of benefits and health care.

(2) Develop flexible and adaptable IT solutions to support non-clinical case management activities that allow for quick additions and adaptations of new and changing business requirements.

(a) Enhance the Veterans Tracking Application to maintain a common database of severely disabled servicemembers in support of the Disability Evaluation System (DES) pilot.
(b) Develop changes in business processes that support the Defense Integrated Military Human Resources System (DIMHRS) as the authoritative source for information shared between DoD and VA as DIMHRS is deployed to the military Services.

(3) Complete the implementation of the Identity Management Common Military Population Strategy and Work Plan in order to begin facilitating unique identification, access management, and on-line service, which will assist the delivery of benefits to servicemember and veterans as well as the management of patients in DoD/VA shared medical facilities.

(4) Develop an interactive “My eBenefits” website that provides a single information source for servicemembers as directed in the President’s Commission on the Care for America’s Returning Wounded Warriors, July 2007.

PERFORMANCE MEASURE 4.1 (2) (a)

By December 1, 2008, a common database to track severely disabled servicemembers through the DES process will be established.

PERFORMANCE MEASURE 4.1 (4) – eBenefits/Links

By December 31, 2008, eBenefits will have initial operating capacity with links to existing major self-service portals, as well as relevant information.

PERFORMANCE MEASURE 4.1 (4) – eBenefits/Centric Experience
By June 30, 2009, eBenefits will include enhancements to provide a servicemember/veteran centric experience, which will include the health, benefits, and support needs specific to the individual.

PERFORMANCE MEASURE 4.1 (4) – eBenefits/Migrate to Final Product
By September 30, 2009, eBenefits will migrate from links and viewable information toward the final product, and support single sign-on capability.

PERFORMANCE MEASURE 4.1 (4) – eBenefits/Access
By September 30, 2010, eBenefits will provide benefits access across federal agencies and the civil sector.

OBJECTIVE 4.2
VA and DoD will structure their health enterprise architectures to support sharing of timely, consistent health data.

STRATEGY 4.2 (A) – DoD/VA Health Architecture Interagency Group
The DoD/VA Health Architecture Interagency Group (HAIG) will continue participating in and contributing to standards related organizations such as Healthcare Information Technology Standards Panel (HITSP) and Health Level 7(HL7) in order to improve the availability of shared health information in support of consumer-driven health care and interoperable health information for DoD/VA beneficiaries.

(1) The HAIG will analyze and report to the HEC Information Management/ Information Technology (IM/IT) WG on current processes and opportunities to promote health care quality and efficiency through information sharing to empower our beneficiaries by June 30, 2009.

STRATEGY 4.2 (B) – DoD/VA Health Architecture Interagency Group
The DoD/VA HAIG will continue examining the activities in the VA and DoD health architectures that further evolve the areas of provision of health care delivery.

(1) Continue to refine and report to the HEC IM/IT WG on VA and DoD health architectural models and specific components that support the shared health architecture in such areas as:

- Case Management by June 30, 2009;
- Disability Determination by June 30, 2009; and
- Health Continuity of Care for our wounded warriors by June 30, 2009.

(2) Continue to develop and report to the HEC IM/IT WG on DoD and VA common services framework to facilitate the secure use of shared architectures by June 30, 2009.

(3) Continue to refine the current version of the Joint Common Services Framework by September 30, 2009.

OBJECTIVE 4.3
Facilitate the adoption of Health Information Technology (HIT) standards for greater interoperability between health systems.

STRATEGY 4.3 – DoD/VA Health Architecture Interagency Group

VA and DoD will exhibit leadership in the national and Government-wide HIT standards harmonization and implementation arena by participating in the development of health standards, and when mature and available, jointly utilizing health information technology systems and products that meet recognized interoperability standards.

(1) National HIT standards recommended for implementation will be reviewed by September 30, 2009.

(2) The HAIG will report to the HEC IM/IT WG, on incorporating recognized interoperability standards into targeted DoD and VA shared technology profile(s), by September 30, 2009.

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, and support the health IT initiatives agreed to by the Wounded, Ill, and Injured Senior Oversight Committee.

STRATEGY 4.4 (A) – HEC IM/IT Working Group

The HEC IM/IT WG will continue sharing electronic health information at the time of a servicemember's separation, while maintaining appropriate security, and supporting the electronic bidirectional sharing of health information in real-time for shared patients between VA and DoD and to meet the President's Commission requirements for making all essential health data viewable by September 30, 2008 and to support interoperable electronic health records by September 30, 2009.

(1) VA and DoD will begin a phased approach to the implementation of the automated activation of active dual consumer patient capability by April 30, 2009.

(2) VA and DoD will develop a schedule for completing implementation of the automated activation of active dual consumer patient capability by March 31, 2009.

(3) VA and DoD will begin sharing computable chemistry and hematology laboratory results in real-time and bidirectional for shared patients between all sites by October 31, 2009.

(4) For the data elements approved by the HEC, VA and DoD will develop milestones and timelines for requirements definition by October 31, 2008.

(5) Led by the prioritized requirements identified by the Interagency Clinical Informatics Board and approved by the HEC, VA and DoD will achieve interoperable electronic health records by September 30, 2009.

(6) VA and DoD will receive input on data elements to potentially be shared in FY 2010 or later from the Interagency Clinical Informatics Board by June 30, 2009.

(7) DoD will begin implementing technical solutions to support the capture and display of automated neuropsychological assessment data by January 31, 2010.

(8) The HEC IM/IT Working Group will propose at least 2 common services pilot projects to the HEC for approval by February 28, 2009.

STRATEGY 4.4 (B) – HEC IM/IT Working Group

The HEC IM/IT WG will support the electronic sharing of images for shared VA/DoD patients.

(1) A plan to provide DoD healthcare providers in continental United States facilities access to Theater radiological images will be developed by January 31, 2009.

(2) DoD will begin implementing technical solutions to ensure that radiological orders and patient demographics are sent to the Theater Picture Archiving and Communication Systems and that the corresponding radiological reports are incorporated in the Theater electronic health record by April 30, 2010.

(3) DoD will monitor and report to the HEC IM/IT WG on Service implementation of additional bandwidth in Theater to support image sharing by March 31, 2009.

(4) To continue leveraging the El Paso, Texas National Defense Authorization Act imaging project, DoD and VA will report progress toward deployment schedules and milestones to the HEC IM/IT WG by September 30, 2008, January 31, 2009, May 30, 2009, and September 30, 2009.

(5) DoD will begin implementing technical solutions to support global access and global awareness of scanned patient records by September 30, 2009.

STRATEGY 4.4 (C) – HEC IM/IT Working Group

The HEC IM/IT WG will continue to increase the amount of shared inpatient electronic health data between DoD and VA.

(1) DoD and VA will present recommendations based on evaluation of the

Joint Inpatient Electronic Health Record Report, Analysis of Technical Solutions to the HEC IM/IT WG by October 31, 2008.

(2) DoD will develop an Essentris deployment schedule by October 31, 2008.

(3) DoD will report to the HEC IM/IT WG progress against the Inpatient System deployment schedule by March 31, 2009 and September 30, 2009.

(4) VA and DoD will begin exchanging inpatient clinical notes (various note types) on shared patients in an interagency test environment by June 30, 2009.

(5) VA will complete enterprise deployment of the inpatient clinical note (various note types) capability for shared patients by September 30, 2009.

PERFORMANCE MEASURE 4.4
Monitor information sharing metrics and report progress to the HEC IM/IT WG and to the HEC and JEC as requested. Metrics will include, but not be limited to:

- The number of DoD servicemembers with historical data transferred to VA;
- The number of patients flagged as "active dual consumers" for VA/DoD electronic health record data exchange purposes;
- The number of Pre- and Post-Deployment Health Assessment (PPDHA) forms and Post Deployment Health Re-Assessments (PDHRA) forms transferred to VA;
- The number of individuals with PPDHA and PDHRA forms transferred to VA;
- The percentage of DoD inpatient beds covered by Essentris implementations.

OBJECTIVE 4.5
VA/DoD will foster secure computing and communications infrastructure for electronic patient data sharing.

STRATEGY 4.5 (A) – HEC IM/IT Working Group
The HEC IM/IT WG will facilitate the development and implementation of a trusted network security and communications partnership in support of electronic health data sharing.

(1) VA and DoD will implement a secure network to support health data exchange and provide redundancy by June 30, 2009.

(2) VA and DoD will monitor, assess, and report bandwidth and network performance to the HEC IM/IT WG by March 31, 2009 and September 30, 2009.

(3) VA and DoD will implement a secure network to support health data exchange and enterprise redundancy at the CAPT James A. Lovell – Federal Health Care Center, North Chicago by June 30, 2009.

STRATEGY 4.5 (B) – HEC IM/IT Working Group

In alignment with and in support of the Office of the National Coordinator (ONC) Nationwide Health Information Network (NHIN) initiative, VA and DoD will study infrastructure interoperability with commercial healthcare providers to foster infrastructure interoperability that would be accomplished through participating in NHINConnect Federal Consortium. VA and DoD will submit a White Paper to ONC summarizing the results of the study by January 30, 2010.

(1) DoD will begin an in-depth analysis to identify communications data sharing requirements between managed care support contractors and DoD by March 31, 2009.

(2) VA and DoD will monitor the HITSP and HL7 for information on the maturity of electronic health record infrastructure, to include security standards, and report to the HEC IM/IT WG by January 31, 2009.

OBJECTIVE 4.6

The DoD/VA Interagency Program Office (IPO) will act as a single point of accountability in the development and implementation of electronic health record systems or capabilities as well as accelerating the exchange of health care information to support the delivery of health care by both Departments. The IPO will also have responsibility for oversight and management of personnel and benefits electronic data sharing between the Departments.

STRATEGY 4.6 – DoD/VA Interagency Program Office

DoD and VA will continue to provide oversight and management of electronic health records interoperability through the IPO.

(1) The Director, IPO will be identified and will assume this role by October 31, 2008.

(2) The Deputy Director, IPO will be identified and will assume this role by October 31, 2008.

(3) IPO DoD and VA staff will be in the recruitment and hiring process by December 31, 2008.

(4) The IPO will monitor and track progress by DoD and VA to achieve interoperable electronic health records by September 30, 2009.

(5) The IPO will monitor and report progress annually, on joint electronic health records interoperability to Congress beginning January 1, 2009, and concluding on January 1, 2014.

(6) The IPO will provide updates to the DoD/VA Information Interoperability Plan by September 30, 2010.

GOAL 5

Efficiency of Operations

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

The Department of Veterans Affairs (VA) and the Department of Defense (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 evaluate joint collaborative capital asset planning opportunities based upon the capital requirements identified by both Departments.

STRATEGY 5.1 (A) – JEC Construction Planning Committee
The CPC will explore collaborative opportunities to make the best use of DoD Military Construction (MILCON)/VA major and minor construction funds where appropriate.

PERFORMANCE MEASURE 5.1 (A)
The CPC will meet quarterly and action items will be identified and tracked. An update of CPC activities will be submitted to the JEC on a quarterly basis.

STRATEGY 5.1 (B) – JEC Construction Planning Committee
The CPC will participate in joint market evaluations and survey efforts from the Joint Facility Utilization and Resource Sharing Workgroup (WG) and other groups as appropriate.

PERFORMANCE MEASURE 5.1 (B)
The CPC will review all future DoD MILCON and VA major and minor construction projects for joint facility collaborative opportunities.

STRATEGY 5.1 (C) – JEC Construction Planning Committee
The CPC and Joint Facilities Utilization and Resource Sharing WG will collaborate and share information on a continuing basis.

OBJECTIVE 5.2
Leverage joint purchasing power in the procurement of pharmaceuticals, prosthetics, medical/surgical supplies, high-tech medical equipment and dental and laboratory supplies.

STRATEGY 5.2 (A) – HEC Acquisition and Medical Materiel Management
The HEC Acquisition and Medical Materiel Management (A&MMM) WG 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 annually by end of 1st Quarter (QTR), with requests for regulatory changes as needed.

(2) Pursue additional opportunities for joint purchasing consolidation during each calendar year (CY) and report to the HEC by December 31st each year for the previous fiscal year (FY).

(3) Will use approved JIF project to pursue analysis of dollar savings achieved from the negotiation of joint contracts.

(4) Increase collaborative logistics and clinical participation in standardization programs across DoD and VA. Share standardization business processes and identify opportunities for DoD/VA standardization.

(a) Analyze and develop new programs and criteria on a continuing basis.
(b) Share spend analysis in areas with opportunities for VA/DoD standardization.
(c) Involve clinical participation from VA and DoD in regional and national standardization programs, trials, and processes, as appropriate.

STRATEGY 5.2 (B) – HEC Acquisition and Medical Materiel Management

The HEC A&MMM WG will increase the value of joint contracts, targeting commonly used manufacturers for joint contract initiatives and continuing to seek new opportunities for joint contracts.

(1) The A&MMM WG will track the number and dollar value of joint contracts and provide joint contract sales.

PERFORMANCE MEASURE 5.2 (B) (1)

The VA National Acquisition Center and the Defense Logistics Agency will report dollars expended within their programs on a quarterly basis. The data provided will include:

- Percent of total sales by the two commodities (medical/surgical and medical equipment).
- Percent of joint contractual sales as a percentage of total sales.
- Dollar value of each of the commodities (medical/surgical and medical equipment) showing total sales and joint contract sales.

STRATEGY 5.2 (C) – HEC Pharmacy Working Group

The HEC Pharmacy WG 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 1st QTR.

(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 1st QTR.

(3) Evaluate 100% of all expiring joint national contracts and report the total dollar value of the contracts over the life of the contract and the total dollar value for the previous year to the HEC on an annual basis.

(4) The HEC Pharmacy WG will evaluate the number and estimated dollar value of purchases for both existing and newly established joint contracts and report the previous FY data to the HEC on an annual basis, at the first meeting after the end of the 1st QTR of the new FY.

PERFORMANCE MEASURE 5.2 (C)
Award a specified number of joint contracts each year.

FY 2009	8
FY 2010	10
FY 2011	13

PERFORMANCE MEASURE 5.2 (C) (1)
Maximize Joint National Contract Prime Vendor Purchases as percentage of Total Prime Vendor Purchases.*

	VA	DoD
FY 2009	6.1%	2.6%
FY 2010	6.5%	2.7%
FY 2011	5.6%	2.8%

PERFORMANCE MEASURE 5.2 (C) (4)
Maximize Joint National Contract Prime Vendor Purchases expressed as dollar volume (millions).*

	VA	DoD
FY 2009	$211 M	$49 M
FY 2010	$229 M	$50 M
FY 2011	$205 M	$51 M

***Endnote:**

- The following factors may decrease Pharmaceutical Prime Vendor (PPV) purchases.
  - Between CY 2007 and CY 2012, drugs with a total commercial value of approximately $99 billion have the potential to become generic.
  - In June 2006, simvastatin (Zocor) became generic, VA's drug with the highest volume and highest total expenditures. In the year prior to becoming generic (FY 2005) simvastatin PPV purchases were approximately $196M. In FY 2006 simvastatin purchases were approximately $173M ($93M PPV purchases and $73M direct purchases). With increasing competition in the simvastatin generic market VA anticipates purchases to drop to approximately $23M annually.
  - Of VA's top 15 drugs based on total PPV purchases, 2 became generic between CY 2004 and CY 2005, with current PPV.
  - Of VA's top 15 drugs based on total PPV purchases, approximately 8 have the potential to become generic between CY 2007 and CY 2012, with current PPV purchases totaling approximately $596M per year.
  - Molecular entity patent expiration does not necessarily guarantee the drug will be marketed. Other issues such

as formulation patents, exclusivity, on going litigation and final Food & Drug Administration approval may delay generic competition. These issues may affect the price and availability of product in sufficient quantity.

  - DoD's prime vendor purchases are decreasing by estimated 2% each year. The decrease is a result of several widely used and expensive products becoming generically available and increase in the number of products moved to 3rd tier which make them unavailable at the Military Treatment Facility.

- The following factors may increase PPV purchases.
  - There were 27 new biological and oncology drugs approved and marketed since 2004.
  - In 2004 these drugs accounted for $1.6M PPV purchases and in 2006 these drugs accounted for $30M annual purchases. Most of the new products are in specialty distribution and are not part of the PPV contract.
  - Cholinesterase Inhibitors: The use of these items has increased over the years. In FY 2004 VA purchased approximately $51M and in FY 2006 VA purchased $89 million.
  - Platelet Aggregation Inhibitors: The use of these items has increased over the years. In FY 2004 VA purchased approximately $148M and in FY 2006 VA purchased $202 million.

OBJECTIVE 5.3
Establish a common electronic catalog for Medical Surgical items.

STRATEGY 5.3 (A) – HEC Acquisition and Medical Materiel Management

The HEC A&MMM WG 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 A&MMM WG.

STRATEGY 5.3 (B) – HEC Acquisition and Medical Materiel Management

The HEC A&MMM WG will provide methods at the national and facility level to automatically identify the lowest contracted price on medical surgical items.

(1) Deploy the Data Sync eZ SAVe initiative to 40 planned VA sites and 40 planned DoD sites by March 31, 2009.

(2) Develop an implementation plan for deployment of price reduction tools to potential DoD/VA purchasing site.

(3) Develop an implementation plan to integrate the Common Catalog functionality into DoD and VA logistical systems by December 31, 2011.

PERFORMANCE MEASURE 5.3 (B)

Deploy the Data Sync eZ SAVe initiative to 40 planned VA sites and 40 planned DoD sites by March 31, 2009.

OBJECTIVE 5.4
VA and DoD will collaborate to improve business practices related to financial operations.

STRATEGY 5.4 (A) – HEC Financial Management Working Group

The CAPT James A. Lovell – Federal Health Care Center (FHCC) will be integrated to the point of having only one financial management system. Consequently, a reimbursement methodology must be developed which takes into account the unique organizational structure. The HEC Financial Management WG will assist

in the development of the financial allocation/reconciliation methodology to be implemented at the CAPT James A. Lovell – FHCC, determine a mechanism to transfer funds and any legislation required to support funds transfer.

(1) Analyze data and refine methodology between January 1, 2008 and September 30, 2009.

(2) Test methodology by September 30, 2010.

(3) Fully implement by September 30, 2011.

(4) Document lessons learned as progress continues for future similar organizations between October 1, 2006 and September 30, 2011.

(5) Pursue legislation needed to facilitate funding methodology at the CAPT James A. Lovell – FHCC.

STRATEGY 5.4 (B) – HEC Financial Management Working Group

The HEC Financial Management WG will continue to solicit and recommend JIF projects to the HEC, and will monitor and report the progress of approved projects quarterly.

PERFORMANCE MEASURE 5.4 (B) – 85% Acceptance Rate

Report quarterly to the HEC the percent of JIF projects meeting a minimum 85% acceptable progress rate as reported in the Interim Progress Reports.

PERFORMANCE MEASURE 5.4 (B) – New MOAs from JIFs

Report to the HEC by September 30th annually on percent of completed JIF projects that result in new Memoranda of Agreement for project sustainment.

STRATEGY 5.4 (C) – HEC Financial Management Working Group

Explore additional methods of financial analyses and alternative methods of financing, (ie: bartering) to increase VA-DoD sharing initiatives.

OBJECTIVE 5.5

VA and DoD will collaborate to explore and identify opportunities for increased sharing in the areas of joint facility utilization and resource sharing.

STRATEGY 5.5 (A) – HEC Joint Facility Utilization and Resource Sharing Working Group

The HEC Joint Facility Utilization and Resource Sharing WG, through its Joint Market Opportunities (JMO) project, will assess health care markets serving large, multiservice, DoD and VA populations.

(1) Continue monitoring of joint venture models and other sites included in Phase I.

(a) Conduct In-Progress Reviews with sites, semi-annually at a minimum.
(b) Report progress on Phase I sites, to include resolution of identified barriers, to the HEC by September 30th annually.
(c) Make lessons learned available via the DoD/VA Program Coordination Office website, the VA intranet, conferences, or any appropriate venue and report to the JEC by December 31st annually.
(d) Incorporate accomplishments into JEC FY Annual Report.

(2) Conduct Phase II multi-market study.

(a) Review and update Phase II multi-market area list and develop site visit schedule by October 31, 2008.
(b) Obtain funding for Phase II visits.
(c) Conduct Phase II site visits through August 31, 2009.

(3) Report status of the JMO studies to the Office of Management and Budget annually by June 30th.

PERFORMANCE MEASURE 5.5 (A) (2)
Analyze data from Phase II and work with sites to develop initial sharing strategies by October 31, 2009.

PERFORMANCE MEASURE 5.5 (A) – Accomplishments / Barriers
Report to JEC on accomplishments as well as any identified barriers to sharing annually by December 31st.

PERFORMANCE MEASURE 5.5 (A) – Joint Sharing Guidance
Issue a joint sharing guidance memorandum to clarify the expectations of joint sharing to the joint venture Models and other sites by February 28, 2009.

STRATEGY 5.5 (B) – HEC Credentialing Policy Ad Hoc Working Group
A HEC Credentialing Policy Ad Hoc WG will be formed to explore current policy and initiate policy changes to allow for the acceptance of credentialing actions between the VA and DoD. The WG will:

(1) Commence 30 days subsequent to HEC co-chair approval;

(2) Report a plan of action to the HEC no later than 90 days after HEC co-chair approval;

(3) Develop new policies as needed, and implement methods to monitor effectiveness of policy changes within 30 days of policy issuance;

(4) Provide status report for each HEC meeting.

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:

- Joint planning to ensure VA support of DoD contingency requirements;
- Collaborative training and exercise activities to enhance joint contingency plans; and
- Improvement of joint readiness capabilities.

OBJECTIVE 6.1
Ensure that joint contingency and scenario-based planning supports VA and DoD requirements.

STRATEGY 6.1 (A) – HEC Contingency Planning Working Group

The HEC Contingency Planning Working Group (WG) 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 April 1, 2009.

(1) Publish an Assistant Secretary of Defense (Health Affairs) memo designating DoD Federal Primary Receiving Centers and requesting Services begin implementation by October 1, 2008.

(2) Military Departments and Veteran Health Administration provide Service level program implementation guidance to support the VA/DoD Contingency Plan by March 1, 2009.

(3) All PRCs develop local plans by April 1, 2009.

(4) Publish DoD Instruction, "DoD and VA Responsibilities Regarding VA Furnishing Health Care Services to Members of the Armed Forces During a War or National Emergency and Joint Contingency Plan/Readiness Programs." Estimated Completion Date: April 1, 2009.

STRATEGY 6.1 (B) – HEC Contingency Planning Working Group

The HEC Contingency Planning WG will complete the first annual review of joint contingency readiness capability activities seeking inclusion of VA capabilities and capacities and report findings to the HEC no later than September 30, 2009.

OBJECTIVE 6.2
Collaborate on training and exercise activities that support the VA/DoD Contingency Plan.

STRATEGY 6.2 (A) – HEC Contingency Planning Working Group

In order to establish a unified frame of reference for planning and training, the HEC Contingency Planning WG will facilitate the cooperation of selected VA and DoD training organizations.

(1) By October 31, 2008, complete a MOA between DoD and VA permitting individuals from each Department to attend contingency plans and operations training courses without the payment of course fees, and with all costs borne by the sponsoring Department, to the effect allowed by law.

(2) By March 1, 2009, ensure that at least one representative from each DoD and VA Primary Receiving Center has received training in DoD contingency patient movement and reception operations.

STRATEGY 6.2 (B) – HEC Contingency Planning Working Group

The HEC Contingency Planning WG/Exercise sub-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 outcome of the next review of the Joint Staff Exercise Program by September 30, 2009.

(2) Report to the HEC on joint exercise participation by January 31st of each year.

STRATEGY 6.2 (C) – HEC Contingency Planning Working Group

The HEC Contingency Planning WG, using the Joint Incentive Fund (JIF), will facilitate up to 24 joint patient movement/reception exercises at DoD and VA PRC's over a two year period.

(1) Provide an update on submitted JIF proposal request by October 31, 2008.

(2) Coordinate exercise schedules by March 31, 2009.

Appendix B
Memorandum of Understanding: Between the Department Of Veterans Affairs and the Department Of Defense Health Care Resources Sharing Guidelines, July 1983

This Memorandum of Understanding (MOU) rescinds and replaces the "VA/DoD Health Care Resources Sharing Guidelines" MOU between the Department of Veterans Affairs (VA) and the Department of Defense (DoD), dated July 29, 1983.

I. PURPOSE

The Secretary of Veterans Affairs and the Secretary of Defense shall enter into agreements for the mutually beneficial coordination, use, or exchange of use of the health care resources of VA and DoD. The goal is to improve the access, quality, and cost effectiveness of the health care provided by the Veterans Health Administration and the Military Health System to the beneficiaries of both Departments.

II. AUTHORITY

The Secretary of Veterans Affairs and the Secretary of Defense establish these guidelines pursuant to the authorities in and requirements of Title 38, United States Code, section 8111 (38 U.S.C. §8111), entitled "Sharing of Department of Veterans Affairs and Department of Defense Health Care Resources," and the authorities contained under Title 10, United States Code, section 1104 (10 U.S.C.§ 1104), entitled "Sharing of Resources with the Department of Veteran's Affairs," which incorporates Title 31, United States Code, section 1535 (31 U.S.C. §1535), entitled "Agency Agreements," also known as the "Economy Act." These guidelines assist in the implementation of these statutes.

III. JOINT EXECUTIVE COUNCIL (JEC)

A. Definition: In accordance with 38 U.S.C. §320, the JEC is established as an interagency council co-chaired by the Under Secretary of Defense (Personnel and Readiness) and the Deputy Secretary of VA. Its members are composed of other designated officers and employees of both Departments.

B. Responsibilities: The JEC shall:

1. Establish and oversee the implementation of the strategic direction for the joint coordination and sharing efforts between the two Departments.
2. Oversee the activities of, and receive recommendations from, the Health and Benefits Executive Councils and all designated committees and working groups.
3. Submit an annual report to the Secretaries of Defense and Veterans Affairs and to the Congress.

IV. SHARING AGREEMENTS

A. Policy: The head of a medical facility or organization of either Department shall agree to enter into a proposed sharing agreement with the head of a medical facility or organization of the other Department in accordance with the guidelines in this MOU, including without limitations section IV.D.1., below. The VA Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs or the Secretaries of the Military Departments may authorize regional or national sharing agreements, subject to the approval process stated in this MOU. Such sharing shall not affect adversely the range of services, the quality of care, the established priorities for care, or result in delay or denial of services to primary beneficiaries of the providing Department. Additionally, sharing agreements shall not adversely affect readiness or the deployment capability requirement of DoD personnel. Facilities must base sharing agreements on jointly conducted business case analyses demonstrating mutual benefit to both parties and using analysis templates prescribed by both Departments.

B. Eligibility: Military Treatment Facilities (MTFs) and other DoD organizational components may provide health care to VA beneficiaries eligible for care under 38 U.S.C. §101 et seq. on a referral basis under the auspices of a sharing agreement. VA facilities may provide health care to DoD beneficiaries eligible for care under 10 U.S.C. §1071 et seq. on a referral basis under the auspices of a sharing agreement.

C. Reimbursement and Rate Setting: The authority of the Secretaries of the two Departments to establish and modify mutually beneficial, uniform payment and reimbursement schedules for VA/DoD sharing agreements is delegated to the VA-DoD Health Executive Council (HEC). Although most sharing agreements will use the reimbursement methodology outlined in the VA/DoD Outpatient and Inpatient guidance agreed to by the Departments, DoD and VA facilities are authorized to provide services in kind provided the exchange is clearly documented in the sharing agreement and can be expressed by a monetary value.

D. Scope of Agreements:

1. Sharing agreements include agreements between the two Departments; between Service regions of each Department; or between the heads of individual DoD and VA medical facilities where health care resources are acquired or exchanged between VA and DoD. A Memorandum of Agreement (MOA) shall accompany each VA Form 10-1245c and identify the health care or other health-related resources to be shared and demonstrate that the agreement is in the best interest of both Departments' beneficiaries and mission. In general, health care resources covered under these agreements include hospital care, medical services, rehabilitative services, and any other health care services including health care education, training, and research as the providing Department has authority to conduct; and any health care support or administrative resource or service in support of VA medical facilities or Service MTFs.

2. Joint ventures are characterized by specific resource sharing agreements encompassing multiple services resulting in joint operations. These arrangements resemble strategic alliances between DoD and VA for the purposes of longer term commitments of more than 5 years to facilitate comprehensive cooperation, shared risk, and mutual benefit. Joint ventures may or may not involve joint capital planning and coordinated use of existing or planned facilities. Joint ventures exist along a continuum in which the medical facility missions and operations are connected, integrated or consolidated. Joint ventures are characterized by regular and ongoing interaction in one or more of the following areas: staffing, clinical workload, business processes, management, information technology, logistics, education and training, and research capabilities. Joint ventures are established in accordance with DoD Instruction 6010.23 and VA policy.

3. In accordance with 38 USC §8111(e)(3), all sharing agreements shall include, at a minimum, the following information if an individual is a primary beneficiary of one Department and is to be provided health care at a facility or service region of the other Department:

    a. a statement that the provision of this care is on a referral basis;
    b. a statement that the provision of this care will not affect adversely the range of services, the quality of care or the established priorities for the care provided to the primary beneficiaries of the providing Department;
    c. a complete statement of the specific health care resources to be shared under the agreement and,
    d. the reimbursement rate or mechanism previously approved by the HEC for the cost of the health care resources provided under the agreement.

E. Dual Eligibility: VA/DoD beneficiaries provided care under a VA/DoD sharing agreement will be the responsibility of the party to the agreement that is making the referral of the patient to the other party. All questions regarding financial responsibility for care provided to these beneficiaries may be referred to and resolved by the designated officials of the parties to the agreement under which the care is being provided.

F. Approval Process: VA and DoD shall concurrently submit proposed sharing agreements to the respective approval authorities. The authority to approve/disapprove VA/DoD resource sharing agreements and joint ventures is delegated to the Secretaries of the Military Departments (or their designees) for DoD and to the appropriate VA Central Office designees for VA. The designated approval authority for both DoD and VA must approve or disapprove a proposed agreement within 45 days of receipt. If action is not communicated to both signatories to the agreement at the end of the 45-day period, the agreement is considered as approved on the 46th day.

G. Modification, Termination, and Renewal: Except as noted in section D2 above, relating to joint ventures, sharing agreements may be written for a period of up to 5 years. Each sharing agreement and joint venture shall include a statement on how the agreement may be modified or terminated. Either party may terminate a sharing agreement with a minimum of 30 days written notice to the other party. For joint ventures, the agreement must set forth the terms and conditions for dissolution of the joint venture in the event of unforeseen exigencies that require the agreement to be rescinded, with a minimum of 180 days written notice to the other party from the original approving authority. Examples would include Base Realignment and Closure (BRAC) or VA Capital Assets Realignment for Enhanced Services (VA CARES) decisions or significant demographic changes. Sharing agreements shall provide for modification or termination in the event of war or national emergency, as necessary. Annual reviews of sharing agreements are required by all involved agencies for VA/DoD health care sharing agreements. Military Departments, working with their VA counterpart, shall ensure that decisive action is taken to approve or disapprove requests for renewal of sharing agreements prior to the expiration of the sharing agreement. In the event the renewed or amended agreement is not completed prior to the expiration date, written requests for extension of the agreement must be forwarded to the Military Departments' approval authority. Renewals may be written for up to 5 years. Amendments that are required prior to the renewal of an agreement must last only as long as the agreement upon which it is based.

V. EFFECTIVE DATE AND MODIFICATION OF GUIDELINES

A. Duration: This memorandum becomes effective on the date of the last

signature and remains in effect until either terminated by either party upon 180 days written notice to the other party or amended by mutual agreement of both parties.

B. Review Authority: These guidelines shall be reviewed every 5 years to determine continued applicability or need for modification.

C. Departmental Policies: For VA: VHA Handbook 1660.4, *VA-DoD Direct Sharing Agreements Handbook*: **http://www1.va.gov/vapubs/**. For DoD: DoD Instruction 6010.23, *DoD and VA Health Care Resource Sharing Program*: **http://www.tricare.osd.mil/DVPCO/default.cfm**

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Gordon H. Mansfield
Deputy Secretary of Veterans Affairs
October 31, 2008

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Gordon England
Deputy Secretary of Defense
October 31, 2008

APPENDIX C
COST ESTIMATE TO PREPARE CONGRESSIONALLY MANDATED REPORT

Title of Report: VA/DoD 2008 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	$67,080
Contract(s) Cost	0
Production and Printing Cost	$12,500
Total Estimated Cost to Prepare Report	$79,580

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 2008 hourly rate structure for the metropolitan Washington, DC area. The calculated net labor costs were multiplied by the fiscal year 2008 fringe benefit amount of 23%. The reported information in the cost statement reflects the sum of direct labor hour costs and fringe benefits.

Glossary of Abbreviations and Terms used in the VA/DoD FY 2008 Annual Report

AMC - Army Medical Center
BDD - Benefits Delivery at Discharge
BEC - Benefits Executive Council
BHIE - Bi-directional Health Information Exchange
CM - Case Management
CBO - Community Based Organization
DCoE - Defense Center of Excellence for Psychological Health and Traumatic Brain Injury
DES - Disability Evaluation System Pilot
DoD - Department of Defense
Dole/Shalala - President's Commission on Care for America's Returning Wounded Warriors
DU - Depleted Uranium
EHR - Electronic Health Record
FHCC - Federal Health Care Center
FHIE - Federal Health Information Exchange
FRC - Federal Recovery Coordinator
FRCP - Federal Recovery Coordinator Program
GWOT - Task Force on Returning Global War on Terror Heroes
HEC - Health Executive Council
ICIB - VA/DoD Interagency Clinical Informatics Board
IIP - VA/DoD Information Interoperability Plan
IM/IT - Information Management/Information Technology
IPO - VA/DoD Interagency Program Office
JEC - VA/DoD Joint Executive Council
JIF - Joint Incentive Fund
JMO - Joint Market Opportunities
JSP - Joint Strategic Plan
LDSI - Laboratory Data Sharing Interoperability Initiative
LOA - Line of Action
LMS - Learning Management Systems
MEB - Medical Evaluation Board
MCS - Millennium Cohort Study
MOU - Memorandum of Understanding
MTF - Medical Treatment Facility
NDAA - National Defense Authorization Act
PEB - Physical Evaluation Board
PM - Performance Measures -- outcome-based measures of effectiveness
PRC - Polytrauma Rehabilitation Center
PTSD - Post Traumatic Stress Disorder

SI - Seriously Injured
SOC - Senior Oversight Committee
STR - Service Treatment Record
SW - Social Worker
TBI - Traumatic Brain Injury
VA - Department of Veterans Affairs
VA Clinics - VA Community Based Outpatient Clinics
VAMC - VA Medical Centers
VBA - Veterans Benefits Administration
VDBC - Veterans Disability Benefits Commission
VSI - Very Seriously Injured
VTA - Veterans Tracking Application
OEF/OIF - Operation Enduring Freedom/Operation Iraqi Freedom
VA OEF/OIF PM - Operation Enduring Freedom/Operation Iraqi Freedom Program Managers
VA Poly CM - VA Polytrauma Case Managers
VA Vet Centers - VA Community Based Vet Centers
WII - Wounded, Ill, and Injured Servicemembers

VA/DoD Joint Executive Council
Fiscal Year 2008 Annual Report

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To access or download report:

Department of Veterans Affairs
http://www1.va.gov/op3/docs/VADoD2008.pdf

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www.tricare.osd.mil/DVPCO