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

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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]

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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.

(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]

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 research efforts are defined in FY09.
- Research initiatives are evaluated (e.g. special populations) against the database to identify gaps by October 31, 2009.

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[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.

- 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.

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.

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

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:

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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.

(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.)

(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)

[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.

(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.

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)

(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)

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[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.
[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.

(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.

(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 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.

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 veteran-related health research to include deployment health issues.

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

(2) Maintain a continuing VA/DoD forum to share findings of deployment health-related 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 standardized 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 non-medical 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 NHIN-Connect 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 purchases totaling approximately $117M per year.
  - 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, multi-service, 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.