DOD/VA JOINT INCENTIVE FUND GUIDE

May, 2014

DoD/VA Joint Incentive Fund- Guide

INTRODUCTION ..... - 1 -
Background of the Joint Incentive Fund ..... - 1 -
Approved Uses of the Joint Incentive Fund ..... - 1 -
Limitation on the Use of Incentive Funds ..... - 2 -
Link to MOA- DOD/VA Health Care Sharing Incentive Fund ..... - 2 -
UNDERSTANDING THE RULES OF THE PROGRAM ..... - 3 -
How is My Proposal Evaluated? ..... - 3 -
The Bottom Line ..... - 3 -
How the Funding Works ..... - 3 -
SUBMISSION PROCESS FOR LOCAL PROPOSALS ..... - 5 -
Submission Process (local) ..... - 5 -
DEVELOPING A SUCCESSFUL PROPOSAL ..... - 6 -
Before You Start ..... - 6 -
Explain Why Your Initiative Should Be Funded ..... - 6 -
Measurable and Achievable Goals ..... - 6 -
Timeline Summary ..... - 7 -
Risk Assessment ..... - 7 -
Sustainment Plan ..... - 7 -
Lessons Learned ..... - 7 -
Power of Partnership ..... - 8 -
KEYS TO FINANCIAL ANALYSIS ..... - 9 -
Cost Categories ..... - 9 -
Identifying Costs ..... - 9 -
Benefit Categories ..... - 10 -
Identifying and Projecting Benefit ..... - 10 -
The Analysis ..... - 11 -
Link to Financial Analysis Tool ..... - 11 -
POST-SELECTION ..... - 12 -
Interim Progress Reports (quarterly) ..... - 12 -
Project Changes and Funds Transfers ..... - 12 -
Sharing Agreement & Final Report ..... - 12 -
Project Failure ..... - 13 -
PROJECT MANAGEMENT TIPS ..... - 14 -
Project Scope ..... - 14 -
Managing Your Resources ..... - 14 -
Schedule Management ..... - 14 -
HELPFUL LINKS ..... - 16 -
APPENDIX A: PROPOSAL TEMPLATE, TIPS, AND EXAMPLES ..... - 17 -
Proposal Template ..... - 17 -
Example of Successful Local Proposal (1) ..... - 20 -
Example of Successful Local Proposal (2) ..... - 28 -
Example of Successful Enterprise Proposal (3) ..... - 37 -
APPENDIX B: FUNDING CERTIFICATION FORM ..... - 53 -
APPENDIX C: INTERIM PROGRESS REPORT TEMPLATE ..... - 54 -
APPENDIX D: FINAL REPORT TEMPLATE ..... - 60 -

INTRODUCTION

The DoD/VA Joint Incentive Fund (JIF) Guide provides information and direction to the Department of Defense (DoD) and Department of Veterans Affairs (VA) on the JIF program, how to draft and submit a successful proposal, and what is required once an initiative has been selected for funding. This document also contains project management tips and considerations to assist with the implementation of funded projects.

Background of the Joint Incentive Fund

The National Defense Authorization Act 2003, Section 721, amended Section 8111 of title 38, United States Code to authorize the DoD-VA Health Care Sharing Incentive Fund, which became known as the Joint Incentive Fund (JIF). The purpose of JIF is to provide "seed" money for creative sharing initiatives at DoD/VA facility, regional and national levels to facilitate the mutually beneficial coordination, use, or exchange of health care resources, with the goal of improving the access to, and quality and cost effectiveness of, the health care provided to beneficiaries of both Departments. Minimum VA and DoD contributions to the fund are $15 million from both Departments ($30 million per year) beginning fiscal year (FY) 2004. Since FY 2004, over 170 initiatives have been funded.

The Veterans Health Administration (VHA) administers the fund under the policy guidance and direction of the Health Executive Committee (HEC). The VHA Chief Financial Officer (CFO) will provide periodic status reports of the financial balance of the fund to the Defense Health Agency (DHA) CFO and to the HEC. The VHA CFO along with the DHA CFO provides oversight of the JIF as co-Chairs of the HEC Financial Management Work Group (FMWG). The FMWG membership consists of representatives from DHA, VHA and the Services and is responsible for all JIF activities to include review, approval and funds management.

For a listing and description of some approved Joint Incentive Fund projects/ initiatives, please visit http://www.tricare.mil/DVPCO/joint-init.cfm. This is a great resource if you are in the brain storming stage of developing an initiative. Contact your organization's DoD/VA Resource Sharing POC for detailed information on past projects and proposals. Past projects can serve as a framework for future initiatives.

Approved Uses of the Joint Incentive Fund

Potential Uses	Authorized	Not Authorized
Major Capital Equipment	X	
Minor Capital Equipment	X	
Salary & Benefits- Civilian Personnel	X	
Salary & Benefits- Military Personnel		X
Major Construction Projects		X
Minor Construction Projects	X	
Major Information Technology Systems		X

Joint VA/DoD Major Construction Planning	X	
Capital Leases	X	
Operating Leases	X	
One-time Investment Costs (other than above)	X	
Recurring Operating Costs	X	

Limitation on the Use of Incentive Funds

There are no limitations other than the broad categories listed in the chart above. For example, allocated Incentive Funds can be used for one-time investments and/or limited operations. To ensure continuity of operations of projects involving recurring operations, the Incentive Fund allocations can be used for more than the first year, but not more than two years, of operation unless approved by the HEC (limited by business case pay back analysis described in the Financial Analysis Section). The reason for limiting the use of the Incentive Fund for recurring requirements is to ensure that the Fund resources are available to achieve the purposes envisioned by the authorizing legislation.

Link to MOA- DOD/VA Health Care Sharing Incentive Fund

http://www.tricare.mil/DVPCO/downloads/MOAforJIF.pdf

UNDERSTANDING THE RULES OF THE PROGRAM

How is My Proposal Evaluated?

Each proposal is evaluated based off of the same general criteria. These are areas you will want to focus on and highlight in your proposal. The following are the criteria used in scoring proposals:

1. Improves Quality of Care
    - Direct - An improvement that can clearly be tied back to the beneficiaries
    - Indirect - A secondary positive outcome such as upgraded infrastructure or enhanced working environment for staff
2. Corporate Priority/Supports Joint Strategic Plan
    - Make sure this isn't just a local fix that is already being addressed with an enterprise wide solution
3. Improves Access of Care
    - Enhances or provides a service that meets projected long term demand
4. Return on Investment
    - The long term financial benefit of the project; see Financial Analysis section
5. Measurable Performance Data
    - Includes data to prove success of the project, for example cost savings/avoidance, access to care percentages, improved outcome statistics, customer satisfaction metrics
6. Size and Scope of Impact (local, regional, or national)
    - For example; does it only apply to one MTF/VA medical facility (local) or does it impact an entire TRICARE Region and/or VISN (Regional)?
7. Approved Projects for this Site
    - First-time submitters get added points to encourage broader use of the fund
8. Other Intangible Benefits (not measurable)
    - All other benefits that don't fit into the above categories

The Bottom Line

If your proposed initiative touches on the above criteria and is thoroughly prepared, it will be strongly considered.

How the Funding Works

Funding for JIF projects is unique. In accordance with the authorizing legislation, allocations from the Incentive Fund shall remain available until expended. This means that the funds contributed by each Department are not subject to the same time limitations or restrictions as their donor appropriations, e.g., one-year or two-year funds become no-year funds when placed in the Incentive Fund.

Typically, funds are split among the participating organizations. It is very important to determine the most effective distribution. This component is largely dependent on how the joint initiative and compensation agreement is structured. Some considerations include:

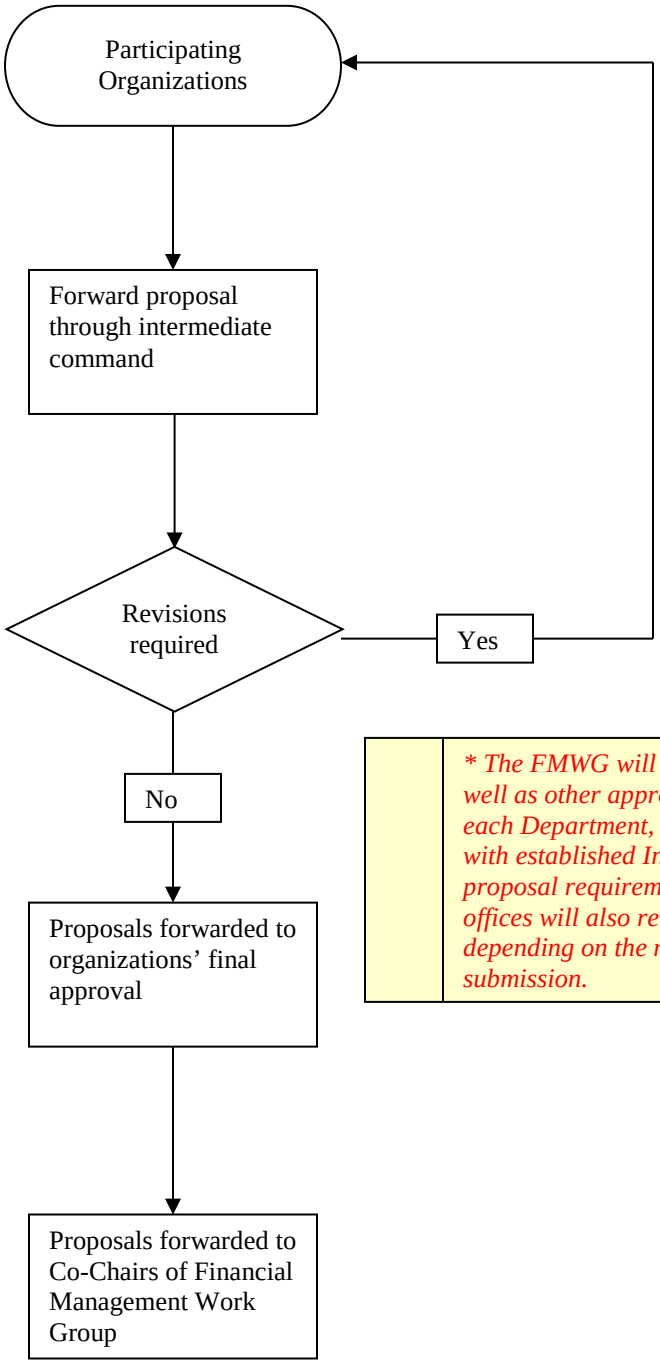
- Is one organization particularly skilled at the acquisition of the personnel and/or equipment required?
- Will one organization be providing the bulk of the manpower and infrastructure required?
- Is the funding distribution consistent with the implementation plan?
- Is the funding distribution consistent with the sustainment plan?
- In our proposal, have we clearly delineated how funding is to be broken down between the participating organizations?

Things to consider:
The JIF was set up as a transfer allocation. We have found that the JIF line of accounting will not process correctly within the VA's civilian personnel pay system, nor in DoD's Defense Travel System for personnel assigned to DHA. Keep these limitations in mind as you put proposals together.

SUBMISSION PROCESS FOR LOCAL PROPOSALS

NOTE: Formal calls for Incentive Fund initiatives are released at least annually. Departments and facilities are required to adhere to the suspense dates and follow the process below, or as directed by your Service/VA POC when submitting local mutually agreed upon proposals. Enterprise level proposals will route through the appropriate HEC Work Group and/or DHA/VHA office/organization rather than following the process below.

Submission Process (local)



** The FMWG will review proposals, as well as other appropriate staff from each Department, to ensure compliance with established Incentive Fund proposal requirements. Other program offices will also review these, depending on the nature of the submission.*

See Appendix A, Proposal Template, Tips, & Examples

DEVELOPING A SUCCESSFUL PROPOSAL

Before You Start

There are several keys to drafting a successful proposal. The most important is to **BEGIN EARLY and DESIGNATE a CLEAR LEAD PARTNER**. Gathering accurate information, consulting with all involved parties, and condensing it all into a clear/concise message is very time intensive. JIF proposals have been submitted annually since FY 2004. Don't re-invent the wheel! If someone has already drafted a successful proposal that you could use as guidance, use it.

Before diving into the draft of your proposal, it is suggested that you break the project down into individual, digestible components. This will allow you to build a solid outline and identify critical factors to be fully addressed in your project plan. In developing the structure of your proposal, it is important to think through potential pitfalls/roadblocks. You don't want to get too far into the project (and worse yet, have it approved and funded) and realize that there is a critical "show stopper" that you didn't consider (further discussed in Risk Assessment).

Explain Why Your Initiative Should Be Funded

As you draft your proposal, make it clear up front why this is an important initiative to be funded. Just like any written piece, you want to peak your audiences' interest from the start. Write about the specific opportunity your organization has. Tell the reader the nature of the opportunity at the local level, the number of persons or organizations impacted and how this initiative improves upon business as usual. The reader should have answers to the following questions:

1. How and when did you identify the opportunity?
2. What is the problem you are proposing to solve (statement of need)?
3. Do you have a thorough understanding of the scope and impact?
4. Do you cite recent statistics and research conducted?
5. Are you seeking funds for an initiative that is sustainable after two years?

The more information you have on the initiative, the easier it is to write a winning statement of need. You won't be grasping for straws or generalizing; instead, you'll be able to be able to give the panel some true and hard facts.

Measurable and Achievable Goals

Along with making your purpose clear up front, you will have to set specific and measurable goals. Ensure that these goals are easily quantifiable and you know exactly how you are going to capture the performance data. Many people fall into the pitfall of setting goals that they will not be able to effectively track. Not being able to objectively show the progress of your initiative will decrease the chances for long term sustainability.

Detailing accurate cost estimates and funding requirements is a critical component that is discussed further in the Business Case Analysis portion of this guide.

Timeline Summary

A timeline is critical in managing any project and a summarized version should be included in your proposal. There are a lot of variables to consider, so consult closely with key agencies (i.e. certification of funds, contracting, facility management, training staff, etc...). Any project is the sum of several tasks. At the task level, make sure to determine time to complete and the responsible party.

Risk Assessment

Assessing risk is a critical task before undertaking any initiative. When developing your proposal, clearly identify major potential risk areas that may temporarily or permanently derail the project. Common areas of risk are cost, schedule, acquisitions, technical, etc… We recommend developing a best, worst, and most likely case scenario. This will help you to think through and plan on the most appropriate course of action as the project develops.

Sustainment Plan

JIF funding is considered "seed" money that allows the participating organizations to get the project off the ground. Once the project is operational, it is the responsibility of the organizations to sustain the funding stream to allow operations to continue. There is a lot of effort that goes into developing proposals and implementing projects, so it is absolutely imperative that a realistic and executable sustainment plan is developed. Common methods used to fund ongoing operations include savings or cost avoidance, reimbursement from either department, increased third party collections, increased recapture of private sector care expenditures, and increased operational budgets. Regardless of how the project will be sustained, the plan must be certified by the Service SG/CFO and VHA/VISN Director or, in the case of Enterprise-level proposals, the DHA/VHA Program Office that has agreed to sustainment funding.

The following are specific issues that should be addressed in the details of your sustainment plan:

1. What will you do if the plan turns out not to be financially self-sustaining (i.e. cancel or continue)?
2. Do you have a contingency plan in the case that you require additional JIF funds?
3. If you plan to continue the initiative even though it is not self-sustaining, have you identified the necessary program offsets?
4. Have you effectively communicated to your chain of command the future budgetary requirements to sustain this initiative?
5. Does your plan include an exit strategy in the case that it doesn't succeed?

Lessons Learned

- Proposals that involve recruitment of professional staff have experienced difficulty hiring part-time personnel. Sites should anticipate and look for alternatives.

- Sites attempting to hire radiologists should anticipate much higher costs and should consider contracting readings and methods for transmitting radiological studies and images as an alternative to hiring radiology staff.
- MRI technicians are difficult to hire as civil servants due to more attractive salary levels in the private sector. Sites should be aware of this and consider contracting.
- Take the time to obtain realistic cost estimates before submission of a proposal.
- Do not combine several initiatives into one proposal. Simple, verifiable projects with good supporting data have a better chance of being selected.
- Take the time in the beginning to develop a solid proposal and think through operational level details in close coordination with your sharing partner. Projects which transform into something different between scoring rounds have less chance of being selected.
- Ensure that projects have been submitted up both chains of command. Projects which do not have support by both a DoD and VA partner, including support of headquarters Service, VISN or Program Office, will not be scored.
- Do not attempt to justify proposals based on workload outside the DoD or VA.
- Projects involving information management/information technology (IM/IT) solutions should ensure that they are congruent with corporate direction and do not duplicate work being developed.
- If your project includes hiring civilian personnel, consider the effect of pay banding which has been implemented in DoD. Adjust grades and steps within the financial analysis tool to account for this.
- For DoD, some proposals which transfer care from the private sector to VA will require a transfer of funding from Budget Activity Group (BAG) 2 (private sector care) to BAG 1 (in-house care). Work through your appropriate chain of command to request movement of funds between BAGs.
- It is important to determine at what point the JIF funding will end and when billing should begin. This will depend upon the point at which operating costs are no longer paid by the JIF, and is not the same for every project.

Power of Partnership

Joint Incentive Fund proposals by nature require coordination. To put it simply, the more coordination with your VA or DoD partner, the better. The most successful JIF projects always boast a strong relationship between the participating organizations. It is common sense, but cannot be stressed enough.

There are entire books dedicated to the subject of writing successful business proposals and the above are just a few major things to consider. The bottom line is to be realistic and think long term. If you're submitting a proposal to meet a short term challenge or one that doesn't demonstrate clear benefit, you should consider seeking alternative solutions and other sources of funding.

KEYS TO FINANCIAL ANALYSIS

Rule #1 of any good financial analysis is to perform due diligence. It is very important that you have accurate cost estimates and funding requirements. Those numbers can only be based on solid data captured from all involved parties. The following are the key components.

Cost Categories

Any new project/initiative is comprised of two types of costs; start-up and sustainment. Start-up costs are one-time expenditures associated with setting up a new service or operation. These costs are the initial capital outlay that builds the foundation of any ongoing operation. Examples include new equipment, facility renovations, hiring bonuses, initial advertisement of new service/program, permits, etc...

Once the foundation is built, you begin incurring sustainment costs. Sustainment costs represent the cost of doing business. They can be broken down further into fixed and variable costs. Fixed costs are your overhead costs that remain the same irrespective of output level. They include costs such as rent, salaries/wages, and scheduled maintenance. Variable costs are expenses that change in proportion to the activity of the service/operation. A common variable cost item is supplies.

Identifying Costs

There are two critical reasons why it is important to accurately capture all costs associated with your project. The first is to ensure you request the appropriate amount of funding. If there is cost overrun in your project, there is no guarantee that the shortfall will be funded with JIF dollars. The second is for sustainment planning purposes. After the JIF funding stream has run dry, you must have a clear plan on how you will financially sustain the project. This requires projecting the costs associated with ongoing operations.

The following are some suggested sources for pricing information (not an exhaustive list):

Department	Type of Costs
Medical Logistics/Acquisitions	equipment, supplies, services
Finance/Resource Management	personnel, private sector care expenditures
Managed Care Support Contractor	private sector care expenditures
Contracting	personnel, service
Facility Management	lease, construction, renovation
Medical Equipment Maintenance	equipment maintenance, equipment repair
Practice Administrators	operation costs
Human Resources (Civilian Personnel Office)	personnel
Information Management and Technology	software, hardware
Education and Training	training

Due diligence and accurateness of cost estimates cannot be stressed enough. Being overly optimistic and underestimating costs in an attempt to boost your return on investment can come back to bite you if there is a significant cost overrun (not uncommon in facility projects). Not to mention that it doesn't accurately reflect the value of your project. Being too conservative can result in under execution of funds that could have been allocated to another valuable project.

Benefit Categories

There are two basic categories of financial benefit, direct and indirect. Indirect benefits (soft) are those things on the periphery that are positively impacted by the new or enhanced service your project offers. These benefits typically come in the form of cost reduction or avoidance. Some examples include reduced cost of errors, decrease in training costs, and decrease in patient travel costs. Direct benefits (hard) are those benefits directly attributable to your new or enhanced service. Examples include purchased care savings, increased 3rd party collections and increased sharing reimbursement.

Identifying and Projecting Benefit

Just as when identifying costs, gathering data from the appropriate source is the key to demonstrating an accurate benefit to your project. The list of cost sources above also applies in the search for calculating benefit. Again, it is not an exhaustive list, but those departments can assist in determining what your savings and reimbursement will be. Determining how to project benefits can often be difficult, with many variables to consider. A key point to remember is that projects take time to get off the ground. It is very (stress very) rare that a project will see benefit from day 1. From a benefits perspective, projects typically go through three general stages:

1. Start-Up- It is unlikely that you will reap any financial benefit during this stage. This is the foundation building prior to start of new service/operation.
2. Learning curve stage- At this stage, you have built the foundation (i.e. purchased equipment/supplies, hired staff) and are in the initial stages of operations. Operational processes/issues are being refined and it will take time before the service reaches its full capability. Benefit during this phase is limited and should be projected such (i.e. 50% of fully operational unit).
3. Fully Operational- At this stage, your project is running to full capacity and achieving maximum benefit.

The benefit calculation must be based on solid logic. Avoid falling into the trap of "just go with the high number". In addition, future benefit projections should be in current year dollars (no inflation added) since the Real Interest Rates are used for discounting. This is further explained in the next section. Financial analysis is not a marketing exercise; it is to be fact based.

The Analysis

After inputting your cost and benefit data into the financial analysis tool, your project's net present value (NPV), payback period, and return on investment (ROI) will be automatically calculated.

- Net Present Value: the total present value of a time series of cash flows. It is a standard method for using the time value of money to appraise long-term projects.
    - The "Discount Rate" is the interest rate used to discount or calculate future costs and benefits so as to arrive at their present values. This term is also known as the opportunity cost of capital involved. The rate is set by the Office of Management and Budget (OMB) and **SHOULD NOT BE CHANGED.**

- Return on Investment: the ratio of money gained or lost on an investment relative to the amount of money invested. It is used to evaluate the efficiency of an investment or to compare the efficiency to a number of different investments (i.e. JIF initiatives).

- Payback Period: the period of time required for the return on investment to "repay" the sum of the original investment. For example, a $1000 investment which returned $500 per year would have a two year payback period.

There are limited funds to distribute each year and your proposal's financial benefit will be compared to others. Although demonstrating a strong position financially (i.e. high ROI, short payback period) will reflect positively on your proposal, it is not the only component considered. The review panel is looking for a comprehensive business plan, which addresses the full range of benefits your initiative offers.

Link to Financial Analysis Tool

Please contact your DoD or VA JIF point of contact for the most recent financial analysis tool.

POST-SELECTION

Interim Progress Reports (quarterly)

Required quarterly progress reports are conducted using a specific interim progress report (IPR) format that will be sent to you from the VHA sharing office. This format was created with input from the Services, DHA, and VA. The focus of the IPRs is to demonstrate progress in implementing your project and showing the success of the project once it is up and running. Of particular interest is the status of financial obligations and the timeliness of implementation along with the return on investment (ROI) and cash flow. JIF projects are funded for two years with the expectation that once funds are received, the project will be up and running before or close to that two year timeframe. The IPR is the reporting mechanism to show that the project is on track or to report on issues delaying the project's implementation. Failure to properly update your schedules and obligations and/or issues can result in funds being pulled back for lack of progress. The IPR includes updates, performance measures, financial updates, metrics, issues, and other key items. These progress reports follow the same routing process as your JIF proposal and are reviewed by the Financial Management Working Group (FMWG). See Appendix C, Quarterly IPR Template for the current IPR requirements. On the notes page of each slide, there is an explanation of information to report.

Project Changes and Funds Transfers

Throughout the years that the JIF program has been in effect there have been several instances where the scope of a project needs to change for one reason or another. Often it is due to the inability to contract for a particular specialist so the decision will be made to contract another type employee. Regardless of the reason for the change in scope of the project, it must be approved before any action can take place by the project managers. If the scope needs to change, document it thoroughly in your IPR and provide a detailed summary of the changes with sufficient justification for the FMWG to make a decision. If the change affects the financial requirements of the project, an updated BCA is required along with the IPR and summary. This information will be reviewed and discussed at the FMWG and a decision provided regarding the requested change made and sent out to the project managers listed on the IPR.

In the event funding needs to be transferred between DoD and VA or between one Service to another, this request must also come up from the site to the FMWG for consideration and appropriate action. Since this does not impact the ROI or the overall financial requirements, an updated BCA is not required. Funding transfer requests can be requested in the quarterly IPR or be done with an email through the Service and VA appropriate chain of authority. Make sure the funding information is exact and includes all pertinent information to facilitate the transfer.

Sharing Agreement & Final Report

Once your project is fully obligated, you will be required to draft a final report (see Appendix D: Final Report Template). At this point, your initiative has been implemented, become fully operational, and, from the FMWG's perspective, is set for sustainment. In the event you have excess funds, these funds will need to be returned to

the JIF Treasury Account. Excess funds cannot be used for other JIF projects or used for sustainment.

As your project goes into the sustainment phase, you will also be required to draft a formal sharing agreement that encompasses the newly created joint services. The sharing agreement can be a stand-alone agreement or be added to a larger sharing agreement already in existence. Many sites heavily involved in resource sharing employ a master sharing agreement that is updated as circumstances change. Contact your organization's DoD/VA Resource Sharing POC for further direction.

Project Failure

While most projects are successful, there are some over the years that simply did not work out as planned. There are many reasons this can occur, but generally, with careful planning and good preliminary data gathering, the projects are successful. However, if after every attempt to save the project is exhausted, and the project is determined to be unsuccessful, termination may be the only option remaining. This can be accomplished by following the following actions:

1. All parties involved with the project must be in agreement that the project cannot be saved and be willing to inform their chain of authority of the same.
2. A request, signed by the Commanders/Directors of each applicable party to terminate the project must be submitted through their chains of authority to the HEC FMWG that outlines what actions were taken and why the project cannot continue.
3. A complete accounting of all financial actions along with the exact amount of remaining dollars must be included with the termination request.
4. All activities need to cease on the project until a response from the HEC FMWG POCs is received.
5. Once permission is granted to terminate the project, the remaining JIF dollars will need to be returned to the HEC Treasury Account in accordance with financial guidance from each parties respective finance managers.
6. As the dollars are being returned, a final report on the project must be submitted through all parties' respective chains of authority to the HEC FMWG that discusses all actions taken and provides detailed lessons learned for the HEC FMWGs future planning/decisions.

Once all paperwork is completed and all remaining monies returned, the project will be terminated and no future reporting will be required.

PROJECT MANAGEMENT TIPS

Project Scope

The long-term success of your initiative is largely dependent on effective project management, from implementation to sustainment. The following are some tips to consider as you get started.

First and foremost, you must fully understand the project scope. The scope is the definition of what the project is supposed to accomplish and the budget (time and money) that has been created to achieve these objectives. It is absolutely imperative that any change to the scope of the project have a matching change in budget, either time or resources. If a piece of equipment you originally planned to purchase is outdated and you must purchase an upgraded version, it is likely that time and budget will be affected. An adjustment to your plan should be made immediately.

Usually, scope changes occur in the form of "scope creep". Scope creep is the piling up of small changes that by themselves are manageable, but in aggregate are significant. You cannot effectively manage the resources, time and money in a project unless you actively manage the project scope. When you have the project scope clearly identified and associated to the timeline and budget, you can begin to manage project resources.

Managing Your Resources

As the project lead, your primary resources to manage are people and money. It is critical that each major component of the project have a clear responsible individual with the right skills. It is your job to ensure they know what needs to be done, when and how. You must motivate them to take ownership of the project too. Managing direct employees normally means managing the senior person in each group of employees assigned to your project. Remember that these employees also have a line manager to whom they report and from whom they usually take technical direction. It is your job to provide project direction to them.

There is nothing that can bring a project to a screeching halt faster than running out of money. In the review process for JIF projects, money execution is the primary focus item. Execution of funds ties in closely with effectively managing the project timeline. Any project can be broken down into a number of tasks that have to be performed.

Schedule Management

To prepare the project schedule, the project manager has to figure out what the tasks are, how long it will take, what resources they require, and in what order they should be done. If you omit a task, the project won't be completed. If you underestimate the length of time or the amount of resources required for the task, you may miss your schedule. The schedule can also be blown if you make a mistake in the sequencing of the tasks.
Build the project schedule by listing, in order, all tasks that need to be completed. Assign duration to each task and allocate the required resources. Determine predecessors (what tasks must be completed before) and successors (tasks that can't start until after) each task. It's a pretty simple straightforward process.

The difficulty in managing a project schedule is that there are seldom enough resources and enough time to complete the tasks sequentially. Therefore, tasks have to be overlapped so several happen at the same time. There are many excellent software programs that greatly simplify the tasks of creating and managing the project schedule by handling the iterations in the schedule logic for you.

When all tasks have been listed, resourced, and sequenced, you will see that some tasks have a little flexibility in their required start and finish date. This is called float. Other tasks have no flexibility, zero float. A line through all the tasks with zero float is called the critical path. All tasks on this path, and there can be multiple, parallel paths, must be completed on time if the project is to be completed on time. The Project Manager's key time management task is to manage the critical path.

Successful project management is an art and a science that requires strong organization and people skills. The ideas presented above help give you a basic framework, but consider it only a beginning. Good luck!

HELPFUL LINKS

1. *DoD/VA Program Coordination Office: http://www.tricare.mil/DVPCO/default.cfm*
2. *AF/VA Resource Sharing Program (must register for use of this site): https://kx2.afms.mil/kj/kx3/DoDVASharing/Pages/home.aspx*
3. *AMEDD/VA Healthcare Resource Sharing Program: http://vadodrs.amedd.army.mil/*
4. *Bureau of Medicine and Surgery (BUMED): http://www.med.navy.mil/BUMED/Pages/default.aspx*
5. *VA/DoD Interagency Program Office (site currently off-line): http://www.tricare.mil/tma/ipo/*
6. *DoD/VA Joint Strategic Plan FY 2013-2015: http://www.va.gov/op3/docs/StrategicPlanning/VA_DoD_JEC_JSP_FY_2013_2015.pdf*
7. *UBO: http://www.tricare.mil/ocfo/mcfs/ubo/billing.cfm*
8. *Veterans Health Administration: http://www.va.gov/health/*

APPENDIX A: PROPOSAL TEMPLATE, TIPS, AND EXAMPLES

A **NOTE: Below is the descriptive proposal template you will complete and submit for your JIF initiative. Text in RED is intended as guidance as you complete each portion.**

Proposal Template

Descriptive Information:
Initiative Name:

Location: DoD Facility/Program Office:
VA Facility/Program Office:

Point of Contact: *(Name/Phone/email address/ * designates the Lead Partner)*
DoD Functional POC:
DoD Execution POC:
VA Functional POC:
VA Execution POC:

1. Project Description:

- Provide a one paragraph summary description of the project.
- List the initiative's goals and objectives.
- Describe how this project will improve efficiency or effectiveness of health care services.
- Describe how this initiative will impact access to care. *(For example, how many additional appointments will be made available as a result of this proposal)*
- Describe how this initiative will impact quality of care. *(Cite specific quality outcomes expected as a result of this project)*
- Briefly describe how this initiative supports the DoD/VA Joint Strategic Plan. http://www.va.gov/OP3/docs/StrategicPlanning/VA_DoD_JEC_JSP_FY_2013_2015.pdf (*Cite the smart objective(s) within the JSP and describe how they are met by this project)*
- Describe how this project fills a current functional gap or need of the two Departments.
- Include information related to space renovation or leasing. *(if applicable).*
- Answer the 5 W's (who, what, when, where, why) of the project

2. Financial Information:

- ✓ **The financial analysis format must accompany this submission to be considered for scoring**
- ✓ **Round up to the next thousand**
- Briefly describe the costs related to this proposal and justification for personnel. Be aware that hiring freezes may impact civilian employee staffing. *(Consider contract staff)*

- Briefly describe the expected financial benefits and workload impact.
- Briefly describe both the tangible and intangible benefits.
- Return on Investment or Cost Avoidance – Describe how and when it will be achieved in both qualitative and quantitative measures.

3. Project/Program Sustainment:

- Written "Specific" Sustainment Plan – Describe how you will fund subsequent recurring costs and sustain this project/program once the approved funding is expended. (planning to Program Objective Memorandum (POM) or Unfinanced Requirements (UFR) for sustainment funding is not acceptable)
- For recurring operational costs beyond the period approved for Joint Incentive Fund support, the respective VHA organizational element or Military Service/DoD Program Office commits to funding subsequent recurring costs, if not self-sustaining, from their existing budgets as a condition of receiving the above allocation from the Joint Incentive Fund. Incentive Fund projects will not be approved without signed certification.
- This is very important! You must have a solid plan on how you will sustain the initiative once JIF funding has been exhausted.
- Recurring costs can be paid for in a number of ways. To include:
    - Reimbursement from services being provided
    - Cost savings that allow budget allocation to proposed initiative

4. Performance Measures:

- Metrics – Describe the qualitative and quantitative performance measures that will be used to determine project success, and define the methodology and data source used.
- Identify a date when the performance measurement(s) will begin; and the frequency that the data will be collected. i.e. monthly or quarterly.
- Metrics must be quantifiable and clear. When setting performance criteria, make sure you know how you will capture this data for future reporting. It is very important that you clearly demonstrate progress.

5. Information Management/Information Technology:

- ✓ **Note: JIF funding cannot be provided for major IT projects which are required to be included in the OMB 300 Budget Exhibit.**
- List interoperability requirements and how are you addressing them.
- Describe the IT impact on and ability to integrate with existing DoD and VA IT legacy systems or applications.
- For new IT systems or components, describe the adoption and integration of National Health Data standards.
- Address the review and approval by the following areas in DoD and VA:
    1. Infrastructure and Enterprise Architectures
    2. Electronic Health Record (EHR) modernization efforts
- Describe the project's compliance with VA and DoD IT, Information Assurance, Security Certification and Accreditation Processes.
- If this project involves DHA or VA enterprise level IM/IT offices, identify which offices you coordinated with and received approval from for this proposal.

- State if this project requires additional DoD and/or VA infrastructure or communication lines.

6. <u>Other Supporting Information:</u>

- List any potential weaknesses or threats that could halt the initiative if not overcome.
- Describe any unique circumstances involved in this project.
- Include any additional information you feel is relevant to the selection/approval of this project.

Example of Successful Local Proposal (1)

I. ***Descriptive Information***:

A. Initiative: DoD/VA Joint Dialysis Center

B. Point of Contact

DoD	Name	(000) 000-000
	Email Address	
VA	Name	(000) 000-000
	Email Address	

C. Location

Host 60th Medical Group
David Grant USAF Medical Center
101 Bodin Circle
Travis AFB, CA 94535

DoD: Region 10 **VA:** VISN 21

D. Initiative Description

The Dialysis Clinic at the 60th Medical Group, David Grant USAF Medical Center (DGMC) currently has five dialysis machines and treats DoD beneficiaries. Four patients may be dialyzed at once, with one machine being reserved for emergent/acute care. The clinic currently runs one 12-hour shift, three days a week. With the current staffing/equipment, the clinic offers two dialysis sessions per day, providing dialysis for eight patients a day.

The project includes renovation of existing space and expands to eight chairs for chronic dialysis care with a ninth machine located in the inpatient unit for acute/emergent needs, and one machine for backup during routine maintenance. Routine maintenance currently occurs on days the clinic is not performing dialysis. A backup machine will be necessary when the unit expands to 6 days a week so that routine maintenance does not affect patient treatment. The unit would be jointly staffed, with the DoD Nephrology Clinic providing physician oversight.

TRICARE patients with End Stage Renal Disease are eligible for Medicare after 3 months. At this time, TRICARE becomes a secondary payer to Medicare for off-base dialysis care. TRICARE paid approximately $148,000 in FY03 to purchase dialysis care for 28 DGMC Prime enrollees. Of this amount, approximately $45,000 was for patients residing within 30 minutes of David Grant Medical Center. Estimated referral costs that VA Northern California Health Care System (VANCHCS) spent in FY03 are in excess of $2,800,000 for 59 dialysis patients. This represents a cost per patient of $47,457 each year. The reason for the disparate cost is due to VA's requirement to pay all dialysis costs for enrolled patients. The Veterans Millennium Health Care and Benefits Act of

1999 states that once a veteran is enrolled and receiving dialysis treatments, the VA cannot shift those costs and responsibility to Medicare at any time. Both VANCHCS and DGMC see escalating referral costs associated with our chronic dialysis patients.

E. Goals and Objectives

Approval of this initiative creates a DoD-VA Joint Dialysis Center that:

(1) Recoups over $800,000 per year in purchased dialysis care costs. Because of the lower capital costs with the joint initiative, an ROI of $10 for every capital dollar invested are realized, leading to a payback in less than 1 year of $10 for every dollar spent (see Attachment 3, Proposal Summary)

(2) Increases patient volume and complexity for residency education and training

(3) Allows for expansion of the current 4-station Dialysis Center at the David Grant Medical Center (DGMC) into an 8-station unit

(4) Upgrades the current dialysis stations with five new dialysis machines, eight new chairs, as well as other improvements

(5) Helps to achieve VA/DoD Performance Measures through activation of new sharing opportunities

F. Outcomes

An eight-chair hemodialysis unit would dialyze up to 48 VA and DoD chronic dialysis patients each week. All five current chairs, purchased in 1999, are in poor condition and need replacement. Renovation to this unit would expand capacity from four to eight stations. Space constraints limit the clinic to a maximum of eight stations. By purchasing five new dialysis machines (to complement the existing five machines) and eight new chairs, the unit would have a total of 10 machines: eight for treatment, one for inpatient/acute needs, and one for backup during routine maintenance. New equipment and joint staffing will allow the unit to operate three sessions per station each day on 12-hour shifts.

G. Waivers, Deviations, or Certifications Necessary

Specialized training certification is not required, however specialized training is. A 6-week program is provided at DGMC while employees are on the job. A standardized curriculum is used which enables staff to be certified by the State of California in six months, with national certification once the staff member has completed one year of on the job training of full time employment.

H. What Approvals or Authorizations are Required?

Leadership at both agencies was required to review the proposal during the initial incentive fund request to ensure that after incentive funding, the program would remain viable. Air Mobility Command (AMC) and the VISN 21 Director were also apprised of the joint venture proposal prior to submission.

I. Exportable for Other Joint Venture or DoD/VA Sharing Sites?

Absolutely. The existing sharing agreement between VANCHCS and DGMC has been in effect since the early nineties. The ease of a venture such as this one is as a result of

good communication, mutual benefit in terms of cost or training, and cost savings to the Government. This joint venture could and should be a benchmark service, which has long term gain in sharing.

J. Beneficiaries Impacted

Nationally, the demand for dialysis is growing at a rate of 8 percent a year based on information from the American Society of Nephrology. By the year 2010, the number of dialysis patients is expected to jump to 650,000, from more than 300,000 in 2001. The demand for dialysis is growing as people are living longer and kidneys fail with age, and the number of cases of diabetes, which may lead to kidney failure, continues to rise.

DGMC: Current capacity limits chronic treatments to eight per day. In the previous quarter there have been seven new patients started which required movement and placement to outside facilities.

VANCHCS: Of the 103 VANCHCS veterans who are receiving dialysis on FEE, 19 veterans reside in Solano County. As noted above, dialysis cases are projected to grow at 8% per year. This project will allow for up to 24 patients over the next several years. However, with this growth rate, demand for dialysis will double current levels in 9 years.

K. Interoperability Requirements

Staffing will be totally integrated within 6 months of startup. Maintenance of equipment will be provided by DGMC with the VA sharing in the cost of maintenance. VANCHCS will also pay for supplies consumed by VANCHCS beneficiaries. The joint dialysis center will be located at DGMC, therefore DGMC will be the host and the scope of care and other JCAHO requirements will fall under DGMC. Lastly, DoD will reimburse nephrologists and any associated ancillary support and space to DGMC at the established sharing agreement rate. Outpatient pharmaceutical requirements will be provided by VANCHCS. Inpatient Pharmacy support will be provided by DGMC under the pre-existing sharing agreement.

L. If submission contains more than one component/system, prioritize each of the components of the proposal. Not Applicable to this proposal.

M. Alternative Solutions

In addition to the proposed joint initiative, two alternatives were addressed. ***Alternative 1***, the Status Quo, assumes that DGMC would continue to provide dialysis care for its beneficiaries and VA would continue to fee workload into the community. A market survey in Solano County was conducted for waiting lists in a roughly 50-mile radius from DGMC. Of the clinics contacted, there were 10 openings spread sporadically through the community with many facilities reporting waiting lists. The facilities contacted within a 25-mile radius of DGMC, there were only three openings. In January of 2004, there were waiting lists for patients needing chronic dialysis in the Fairfield and Vallejo areas. In addition to the waiting times, is the risk of poor continuity of care between the contract and VANCHCS. Lastly, the cost of Fee dialysis is quite high as aforementioned and is seen in Attachment 3.

Alternative 2 calls for each agency to pursue their growth needs independently through in-house projects. VA would build a dialysis annex adjacent to the existing Fairfield OPC. DGMC would increase use of existing chairs to accommodate greater need. See Attachment 3.

N. Unique Circumstances

Because the dialysis center is located on base, we will work with the 60th Security Forces to ensure access for VA patients who are receiving care. In the past, our veterans have experienced few delays unless the base was on lockdown, which prevents anyone from entering or leaving the base for a short period of time.

O. Program Management

The joint DoD and VA personnel will staff 12-hour shifts Monday through Friday. The VA would staff the Saturday shift in exchange for the DoD staff pulling after hours call. The VA would hire two RNS and three LVNs to support the increase in shifts. DGMC billets remain unchanged (one vacant medical technician position will be filled when the patient load increases). Care of all patients would fall under the supervision of the DGMC Nephrology Staff. VA hires will be oriented to DGMC. Annual performance reviews for VANCHCS will be initiated by the senior VA RN and signed off by the nurse manager of the center. After the 2-year incentive fund support is withdrawn, VANCHCS will assume the salary cost for assigned VA staffing support. This joint staffing arrangement can be utilized to support vacancies when DoD personnel deploy.

P. Contractors

No contracting will be required under this proposal.

Q. Oversight by Decision Authorities

Dialysis staff will participate in regularly scheduled meetings currently in place within DGMC. The joint clinic will be a recurring agenda item briefed on a monthly basis at the Joint Initiatives Working Group co-chaired by DGMC and VANCHCS. Additionally, metrics will be briefed at the quarterly Executive Management Team meeting co-chaired by the DGMC commander and VANCHCS Director.

It is assumed that the GAO will play a role in oversight of incentive fund sites to ensure best use of Government dollars.

R. What type of management information systems will be used?

Dialysis patients will be entered into CHCS. Patients receiving inpatient care, or other consultative services not available in VANCHCS will also be entered into CHCS. VANCHCS staff located in the VA Outpatient Clinic next to DGMC have access to CHCS to view ancillary testing and other results. DGMC nephrology and dialysis staff will be trained in the use of CPRS to view the full electronic record of dialysis patients for consultations that were provided by VANCHCS as well as enter consultation requests to VANCHCS. Referrals/pharmacy prescriptions to be conducted/filled by VANCHCS will be entered into CPRS. VA and DGMC have separate pharmacies located at Travis AFB.

S. Show stoppers

There is a proposal being considered by the Air Force to end the Internal Medicine residency program at DGMC and double the size of the Family Practice Residency program. Since the Family Practice program would remain, there is still a need for certain sub-specialties to support their Internal Medicine rotations that are part of their training. Initial guidance indicates DGMC would retain the two Nephrologist authorizations. However, if DGMC lost all Nephrologist authorizations, both the VA and Air Force would develop a plan to hire this support either through the VA or contracted staff in order to maintain the dialysis center.

T. Address any concerns included in the comments column in Attachment

Medical Maintenance will be provided by DGMC with VANCHCS sharing in the cost of repair and maintenance of IT and medical equipment located in dialysis center.

U. Stakeholder comments and concerns

Stakeholders were not contacted during Round Two. It is assumed that veterans residing in the outlying areas of Solano County will not embrace this proposal, as this patient population has already pre-established relationships with their current caregivers. Given the growth in dialysis need, new veterans will be offered dialysis at DGMC where the veteran can enjoy on site consultation for all ancillary and specialty requirements he or she may need.

V. Does this proposal have the support of the DoD or VA counterpart?

Yes. This joint proposal was discussed and approved by the Executive Management Committee (EMT), co-chaired by the DGMC Commander/Office of the Lead Agent and VANCHCS Director in December 2003.

W. Does this initiative support the Joint Strategic Plan?

Yes. In July 2003, the Joint Initiatives Working Group (co-chaired by DGMC Administrator and VANCHCS Planning) requested an analysis to determine whether the EMT should consider dialysis as a joint strategic initiative. Found to be viable, this initiative is part of the DGMC/VANCHCS Joint Strategic Planning Grid.

II. ***Financial Information*:**

A. Required Investment (costs)

How much funding is being requested from the Incentive Fund?

$ 1,343,780

B. Year One and Year Two Incentive Fund Requests

Year 1	$803,300	**Year 2**	$540,480

C. Provide an approximate breakout of benefit to VA and DoD

Table II C-1

DoD/VA Joint Incentive Fund- Guide

			Proposed Initiative: Joint 8 Bed Unit, DGMC	Alternative 1: Status Quo	Alternative 2: VA 8 Bed Unit, Fairfield OPC
		Net present value of investment:	$2,965,125	$4,390,094	$8,919,679
		ROI of investment:	$10	$0	($1)
		IRR of investment:		$0	$0
		Payback period of investment:	0.1	Does not breakeven	Does not breakeven
Estimated cost savings/avoidance between Proposed Initiative and Alternatives.				($1,424,970)	
					($5,954,554)

Table II C-1 above provides financial summary data for the proposed joint venture and for addressing dialysis program needs. As can be seen, the proposed Joint 8-bed Dialysis Unit at DGMC has the lowest cost or most favorable NPV of the three options considered. With an NPV of $2.9 Million over the five years analyzed, the proposed initiative has an advantage of $1.4 Million over the Status Quo (Alternative 1- Fee Workload) and $5.9 Million over Alternative 2, which builds a new VA dialysis unit at Fairfield OPC. Because of the lower capital costs with the joint initiative, an ROI of $10 for every capital dollar invested are realized, leading to a payback in less than 1 year.

Because of the template design, it is difficult to breakout individual savings between both agencies. In terms of dollars, VA realizes significantly greater savings due to VA's requirement to pay all dialysis costs for enrolled patients. DGMC will realize approximately $166,000 annually in sharing revenue alone and approximately $45,000 in TRICARE recapture per year based on private sector care costs for patients living within 30 minutes of DGMC.

D. How will recurring costs be supported after Incentive Funding is no longer available?

Both agencies are committed to continuing to carry the program once funding has expired and willing to showcase the venture of its successes and lessons learned.

E. Tangible/Economic Benefits

This proposal allows both agencies to combine resources to recoup referral health care dollars for chronic dialysis patients. It is projected that both agencies will save over $800K annually in future referral costs. Although these savings will be predominantly for the VA, the DoD would see some reduced costs in purchased care for dialysis patients.

F. Intangible Benefits

Increasing dialysis patients seen at DGMC will have a positive impact on the AF's Graduate Medical Education Program. VA patients may receive all associated consultation on site from either VA or DoD.

III. *Other Supporting Information*

A. Impact on Waiting Times or Access

Currently, access is limited to 8 dialysis patients a week (excluding acute visits) in the DGMC Dialysis Clinic. Approximately 10 DGMC-enrolled (TRICARE Prime) patients are disengaged each year to the local community for hemodialysis due to limited access. Additionally, DoD patients not enrolled in TRICARE Prime can only be treated at DGMC on a very limited basis. Expanding the unit would allow these patients to be treated at DGMC reducing overall healthcare costs. All VA patients currently must be seen in the community for dialysis.

B. Impact on Quality of Care

Continuity appears to be the greatest driver in quality. Patients simply don't receive dialysis treatment. Their disease results in numerous consultations. Part of their disease includes consultations for nutrition, social services, interventional radiology, vascular surgery and cardiology to name a few. The VA outpatient clinic at Fairfield is located at Travis Air Force Base and is adjacent to DGMC where the patients can receive much of their consultative support. Other support not available will be provided by DGMC under the existing sharing agreement.

C. Capital Asset Realignment for Enhanced Services (CARES) Impact

The North Valley Market submitted a plan to close the gap for increased demand in Specialty Care Services. The Market Plan included continued and greater sharing between DGMC and VANCHCS and more specifically included identifying opportunities to expand access to Specialty Services for Veterans at David Grant Medical Center. Joint dialysis care was among the specifics addressed in the VISN 21 Network Market Plan. Both agencies have enjoyed a trusting relationship and continue to find ways to address needs that benefit both organizations.

D. Metrics

(1) Reduction in purchased care costs for VA and TRICARE Prime beneficiaries
(2) Increase in number of VA and DoD patients dialyzed at DGMC
(3) Customer Satisfaction Surveys
(4) VA/DoD Sharing Performance Goals

E. Milestones

- May 2004 Submit Round 2 Proposal
  - Await Go-No Go Decision

- July 2004 (if approved)
  - Prepare paperwork necessary for new VA FTEE positions
  - Confirm requirements needed for renovation

- Announce VA FTEE positions

- August 2004
  - Letters to VA beneficiaries indicating new dialysis center
  - DoD and VA staff briefed on joint service and process for referral and contacts
  - Order equipment/supplies
  - Select new FTEE
  - Begin renovation

- September 2004
  - Complete renovation
  - Complete hiring requirements and begin orientation
  - Test medical equipment
  - Contact patients
  - Notify Travis Security Police

- October 2004
  - Install and test new equipment
  - Complete orientation
  - Build metrics
  - Market grand opening

- November 2004
  - Activate Joint Dialysis Center

DoD-VA Health Care Sharing Incentive Fund
Radiology Health Initiative
Concept Proposal
Submitted by:

Louisville VA Medical Center (VAMC)
Ireland Army Community Hospital (IACH), Fort Knox

Utilizing the template set forth for applications for proposals for the DoD-VA Health Care Joint Incentive Fund, the following proposal is submitted for consideration.

Initiative Name:

Radiology Initiative

Point of Contact:

VA POC: Chief Administrative Officer, VA/DoD Sharing Office, Louisville, VAMC
DoD POC: Management Analyst, Business Operations Division, IACH, Fort Knox

Project Description:

Using a collaborative effort between IACH, Fort Knox, VAMC, Louisville and the University of Louisville our intent is to jointly develop, implement, and manage a continuum of Radiology Services for both VA and DoD beneficiaries.

Objectives:

To build upon a proven VA/DoD Partnership that delivers seamless, cost effective, quality services for both VA and DoD beneficiaries.

To fill a critical ancillary deficiency associated with a shortage of DoD and VA services available to current beneficiaries.

To decrease the DoD Network cost of $1M by 25% for FY05, 30% for FY06, and 40% by FY07.

To deliver services that are cost competitive with commercial alternatives but which are focused on the unique needs and risk issues associated with the DoD and VA beneficiary populations.

DoD/VA Joint Incentive Fund- Guide

Background:

The Louisville VAMC and IACH, Fort Knox have long cooperated to implement opportunities for sharing of healthcare resources between the VA and DoD to improve access to essential services for both beneficiary groups and to achieve overall cost savings to the government through joint use of resources wherever possible.

The Louisville VAMC has engaged in sharing agreements with IACH, Fort Knox covering referrals to radiology since the late 1980's however, it wasn't until 2003 that the scope of the radiology sharing agreement expanded to include the use of a mobile Medical Resonance Imaging (MRI). Currently this sharing agreement allows for 10 MRI's daily, 4 days a week has been a cost effective measure to decrease the amount of dollars spent on Network MRI's for VA and DoD beneficiaries.

This proposal builds on the success of an existing VA/DoD sharing agreement-based Venture Capital Initiative. That initiative, for a mobile MRI located at Ireland Army Community Hospital, was developed based on a thorough analysis of cost savings/cost avoidance opportunities and was undertaken jointly with VA Medical Center, Louisville. The mobile MRI initiative is designed to strengthen the clinical programs of IACH while simultaneously reducing the total cost for imaging services by avoiding purchases of MRI studies from TRICARE network sources through a less costly on-site mobile MRI. The initiative proposed to produce 6,347 MRI studies over three fiscal years. The projected cost avoidance was $3.846 million for this workload, by not purchasing the studies and interpretation in the TRICARE network, but by accomplishing the studies and interpretation at the MTF at less cost results from Revised Financing, Supplemental Care, and TRICARE standard savings. The projected Government Savings to Cost Ratio (GSCR) for the three-year project was 1.3. At the end of the first year of Venture Capital funding of this initiative 2,058 studies were completed compared to a planned 1,882. Net savings for the first year were $209,340 with an actual GSCR of 1.24, not including additional savings that may be achieved through the success of the Third Party Collection program.

This initiative is evidence of the savings that may be achieved by a properly designed and managed initiative. In addition to the documented monetary advantage of this initiative, several qualitative achievements were a direct result of this partnership. Active duty soldiers, especially trainees, experienced less loss of duty time to obtain required diagnostic clinical studies. Medical staff members were able to obtain more responsive scheduling of requested studies and all patients experienced greater convenience in obtaining their needed care.

Goals:

1) To provide VA and DoD beneficiaries with quality and accessible ancillary Radiology services.
2) To provide local access both at VAMC and IACH, in a timely manner for Radiology services needed by the beneficiaries to meet access standards.
3) To improve beneficiary quality of life by providing timely reports to the beneficiaries physician.

4) To reduce patient driving time by providing the Radiology services in-house thus increasing patient satisfaction.
5) To initiate cost avoidance of Radiology services by not purchasing the studies and interpretation in the TRICARE network, but by accomplishing the studies and interpretation at the MTF at less cost results from Revised Financing, Supplemental Care, and TRICARE standard savings.

Outcomes:

Louisville VAMC and IACH, Fort Knox would like to jointly provide 2 full-time Radiologists to provide services to both groups of beneficiaries. This would greatly reduce Network costs to DoD and provide greater in-house Radiology services to both VA and DoD beneficiaries. It would be more convenient to the patients, decrease wait time for Radiology services, and increase patient satisfaction.

IACH, Fort Knox services a seven-state area. Beginning in March, IACH and VAMC expect a large increase in Medical Holdover soldiers based on troop rotation and demobilization. IACH is expected to receive over 400 Medical Holdover soldiers. Currently, with the radiologists on staff between Louisville VAMC and IACH, Fort Knox, the demand will far exceed the availability of services meaning that more of the services will be sent out to the Network, resulting in a large increase of Network costs.

IACH, Fort Knox, would potentially decrease wait times for ancillary Radiology services (to include MRI, CT, Ultrasound, X-Ray and other radiology services) thus increasing patient satisfaction on the Provider Level Patient Satisfaction Survey by 20% (average for FY04 was 76%).

Increase transmission rates of radiology images for radiologist's interpretation and for clinician review on Vista Imaging at the Community Based Outpatient Clinic located at IACH, Fort Knox.

Increase the capacity for MRI exams at IACH by 50 exams weekly and LVAMC by 30 appointments weekly with technical staff.

Tangible/Economic Benefits:

Projected cost avoidance by keeping services in-house for FY05 $250,250, projected for FY06 $300,300, and projected for FY07 $400,400. Total projected network savings for a three-year period $950,950.

Intangible Benefits:

By having two additional radiologists, both the Louisville VAMC and the IACH patients will have care available in-house, opposed having to drive anywhere from 15 to 50 miles. Louisville VAMC and IACH patients will receive services at the time of the appointment and possibly have their exams interpreted before leaving the appointment so they don't have to come back to see their primary care physician a second time, thus freeing up

additional appointments for other patients. Customer satisfaction will improve tremendously.

Additional intangible benefits include the following:

- Improved access for DoD beneficiaries who would otherwise be sent to the TRICARE Network for services.
- Decrease wait times (increase access) for both VA and DoD beneficiaries.
- Cost avoidance with reduced cost, overhead and reliance on DoD contractor for performance of core functions.

Waivers, deviations, or certifications:

There are no waivers, deviations, or certifications necessary for the implementation and execution of our joint proposal.

Exportability:

Components of this radiology initiative will be exportable to other Joint Venture or VA/DoD sharing sites and will afford models for improving clinical appropriateness, cost effectiveness, and enhanced access to care ranging from routine x-rays being read from an off-site facility to increasing MRI appointments.

Approvals or Authorizations:

There are no approvals or authorizations necessary for the implementation and execution of our joint venture proposal.

Beneficiaries impacted by this proposal:

Enrollment Site	Enrollment Site Name	Ben Cat Common	Enrollee Count
0061	FT KNOX – IRELAND ACH	ADFM	10,891
0061	FT KNOX – IRELAND ACH	RET	3,220
0061	FT KNOX – IRELAND ACH	RET FM/OTH	5,939
0061	FT KNOX – IRELAND ACH	AD	6,754
Total DoD			**26,804**
CBOC	FT KNOX – IRELAND ACH	ALL	4,300
VMAC	LOUISVILLE, KY	ALL	48,892
Total VA			**53,192**

Interoperability Requirements including IM/IT:

DoD/VA Joint Incentive Fund- Guide

This initiative will enable the efficient sharing of beneficiary data between the VA Computerized Patient Record System (CPRS) and the DoD Composite Health Care System (CHCS) as CPRS will be utilized to capture patient data from services provided at VAMC locations.

IACH's innovative purchase of Digitalized Radiology equipment throughout the MEDDAC (including outlying clinics) will enhance the ability to share between the Louisville VAMC and IACH. Exams can be interpreted from sites other than where the exam was performed by radiologists associated with both the VAMC and IACH. X-rays can be transmitted both to and from the VAMC and IACH, thus cutting down on producing film to transport to other facilities. The digitalized exam can be burned to a CD at little cost to either facility.

Alternative Solutions:

IACH, Fort Knox can continue to pay the Network an estimated $1M a year or decrease costs and increase patient satisfaction by keeping the ancillary Radiology services in-house for both Louisville VAMC and IACH beneficiaries.

Unique Circumstances:

Beginning in March, IACH and VAMC expect a large increase in Medical Holdover soldiers based on troop rotation and demobilization. IACH is expected to receive over 400 Medical Holdover soldiers. Currently, with the Radiologists on staff between Louisville VAMC and IACH, Fort Knox, the demand will far exceed the availability of services meaning that more of the services will be sent out to the Network, resulting in a large increase of Network costs.

LVAMC has a contract for all professional services, radiologist. The contract can be expanded to include interpretations for IACH. Since IACH is located 50 miles from LVAMC, recruitment for a radiologist to be assigned fulltime at IACH to assist with procedures will be done separately.

Oversight of Contract Personnel and Decision Authority Oversight Maintenance:

The Fort Knox VA/DoD Chief Administrative Officer in conjunction with the Radiology Managers at IACH and VAMC will be responsible for the oversight of this proposal.

"Show Stoppers:"

None.

Joint Strategic Plan Support Goals:

VA and DoD jointly support this proposal and its submission reflects the same.

DoD/VA Joint Incentive Fund- Guide

This joint initiative is directly supportive of a number of the strategic goals of the VA/DoD Joint Strategic Planning Initiative. In particular, it is aligned with Goal 2 – High Quality Healthcare, and will contribute to service expansion and improved access, quality, effectiveness and efficiency of radiology services provided for both VA and DoD beneficiaries. Through the integration of the MTF, the VAMC, Louisville and the University of Louisville, this initiative fosters the development and delivery of innovative healthcare services. This proposal and its interconnected components are designed to enhance the quality of care delivered.

It also supports Goal 3 – Seamless Coordination of Benefits, and will support radiological services for both VA and DoD beneficiaries. It is especially timely as active duty service members from all services process through Fort Knox and subordinate mobilization and demobilization platform sites in Camp Atterbury, Indiana and Fort McCoy, Wisconsin and transition either back to their units or to veteran status.

Although not specifically aligned with Goal 4 – Integrated Information Sharing, the operational mechanisms envisioned for this joint initiative permit information sharing through existing department-unique information systems. Our credentialing of key providers at both facilities to enable their access to data in the independent systems is essential to information sharing with existing technologies.

Finally, the sharing relationships facilitated by this joint initiative are directly aligned with Goal 5 – Efficiency of Operations. The avoidance of duplication of services and providing services required by both beneficiary communities from a common program setting achieves the goal of efficiency of operations.

Financial Information:

Radiology Initiative		
Start-up Cost:		
1x 4 monitor diagnostic workstation for the extra radiologist/exams at VA	$ 45,000	
Metro Ethernet connection fee-VA	$ 3,150	
Metro Ethernet connection fee-UL	$ 3,150	
Metro Ethernet connection fee-IACH	$ 3,150	
Metro Ethernet connection fee-BCC	$ 3,150	
Total Start-up Cost	**$ 57,600**	
Reoccurring Cost:		
Monthly Ethernet rate-VA=$2850.00	$ 34,200	
Monthly Ethernet rate-UL=$2850.02	$ 34,200	
Monthly Ethernet rate-IACH=$2850.03	$ 34,200	
Monthly Ethernet rate-BCC=$2850.03	$ 34,200	
Radiologist-VA Contract	$ 300,000	

Radiologist-IACH	$ 300,000	
Total Annual Recurring Cost	**$ 794,400**	

DoD Network Cost for FY04					
Type of X-Ray	**AD**	**ADFM**	**RET**	**RET FM/OTH**	**Grand Total**
CT	$15,622.15	$55,048.07	$59,510.43	$78,990.18	$209,170.83
MRI	$15,940.20	$115,927.81	$70,355.67	$102,287.03	$304,510.71
OTH	$33,800.06	$45,090.41	$149,162.42	$127,916.41	$355,969.30
RADIATION	$4,948.26		$22,398.04	$24,530.28	$51,876.58
ULTRASOUND	$583.46	$10,604.21	$1,072.13	$3,199.61	$15,459.41
X-RAY	$3,050.14	$29,602.42	$11,866.71	$21,416.11	$65,935.38
Grand Total	$73,944.27	$256,272.92	$314,365.40	$358,339.62	$1,002,922.21
DoD Direct Care for FY04					
Tmt DMIS ID	**DMIS Desc**	**Ben Cat Common**	**Full Cost, Total**		
0061	IACH	ADFM	$348,048.90		
0290	RI	ADFM	$2,009.59		
0290	RI	RET	$976.29		
0061	IACH	RET FM/OTH	$43,103.74		
0290	RI	RET FM/OTH	$1,360.43		
0061	IACH	AD	$63,993.03		
0290	RI	AD	$1,807.95		
1928	TMC 5	AD	$288.35		
7198	NELSON	AD	$9,941.48		
			$471,529.76		

How will recurring cost be supported after incentive funds are no longer available?

IACH and Louisville VAMC will work to incorporate the cost into their strategic planning process / business plans after the two-year funds are no longer available and will be supported by our Strategic Plans.

Other Supporting Information:

Impact on waiting time or access times:

DoD/VA Joint Incentive Fund- Guide

The VAMC has a 4-week waiting time for MRI appointments. Increasing the technical staff to extend appointments in the evening and Saturday will add 30 additional appointments weekly.

Impact on quality of care:

This initiative will fund connectivity to a 100 megabyte Ethernet ring that will encompass IACH, the VAMC CBOC at IACH, radiology department at the University of Louisville and the Louisville Brown Cancer Center. This will provide faster access for the radiologists to interpret the specialized exams from the University of Louisville, consultations for VA and DoD. Patients will benefit at the Louisville Brown Cancer Center as well as increased speed and access for CBOC providers to view images on Vista Imaging.

VA – Impact on Capital Asset Realignment for Enhanced Services (CARES) study recommendations for Louisville VAMC:

This Radiology Services Initiative is consistent with VISN 9 CARES Plan and addresses functional VA/DoD collaboration between VA and DoD regardless of the implementation of the CARES Plan.

Performance Objectives/Tracking:

See Attached Performance Tracking Metric.

In addition to Performance Tracking, the following Performance Objectives Baselines will be established once the initiative is in place:

- TRICARE Access Standards for DoD Beneficiaries
- Community established Access Standards for VAMC Beneficiaries
- Access Standards for Medical Holdover Soldiers
- Patient Satisfaction for ancillary Radiology Services
- Cost effectiveness for ancillary Radiology Services
- Utilization review for ancillary Radiology Services
- Enhanced ancillary care and treatment of patients via this initiative as compared to the local network
- Reduce MRI Waiting times by 50%, 2 weeks.
- Additional radiologists will decrease the turnaround times for verified reports, a national performance measure. (90.5% within 48 hours of exam).

Summary:

This proposal provides a cost effective means for responding to the clinical deficiency of the absence of VA or DoD treatment options for VA and active duty DoD patients, who require radiology services. It will establish radiology services to both VA and DoD beneficiary groups by connecting existing sharing relationships in the area of radiologist services. Further, the Fort Knox VA/DoD Sharing Program continues to play a significant role in gaining outside revenues for the VAMC, Louisville while reducing the

cost, overhead and reliance of IACH, Fort Knox on the TRICARE network for performance of core functions.

Joint Incentive Fund Initiative Proposal

Descriptive Information: ***Date: 2/1/2013***

Initiative Name:	Decentralized Evidence-Based Psychotherapies (EPBs) Mental Health Provider Training and Consultation to Improve Quality and Access to Care
Location: DoD and VA Facility/Program Office:	10 Military Treatment Facilities (MTFs) where there are existing American Psychological Association (APA) accredited psychology internships Mental Health Services, VA Central Office (decentralized)
Point of Contact: *(Name/Phone/email address/ * designated the Lead Partner)*	National Mental Health Director, Psychotherapy and Psychogeriatrics Mental Health Services, VA Central Office * Deputy Director, Psychological Health Strategic Operations Force Health Protection & Readiness
HEC or JEC Working Group	Health Executive Council (HEC) Psychological Health and Traumatic Brain Injury Work Group (PH/TBI WG)

3. Project Overview:

a. Provide a one paragraph summary description of the project:

The current proposal seeks to broaden dissemination and promote sustainability of evidence-based psychotherapies (EBPs) through the establishment of decentralized training and consultation capacity in the Department of Defense (DoD), as well as Department of Veterans Affairs (VA), and establish local EBP "Champion-Consultants" strategically at DoD installations as well as enhance the VA's decentralized consultation infrastructure. The proposed initiative will focus primarily on providing training and consultation in applying two types of EBPs for Posttraumatic Stress Disorder (PTSD): Prolonged Exposure Therapy (PE) and Cognitive Processing Therapy (CPT). The program will build on existing VA and DoD training programs for these therapies, particularly the highly successful, competency-based EBP training in VA (Karlin et al., 2010, 2012). The program will initially involve the placement of EBP Champion-Consultants at 10 DoD MTFs to support a decentralized implementation strategy, which is

modeled after the similar, successful initiative within VA, whereby a Local EBP Coordinator has been appointed at each VA medical center to promote awareness of EBPs among mental health staff, non-mental health staff, and patients; implement local clinical infrastructures for the delivery of EBPs; track the delivery of EBPs; and provide ongoing support to providers in sustaining EBP skills. Building on VA's infrastructure and EBP dissemination activity to date, the proposal will place one staff person within the Psychotherapy and Psychogeriatrics Section in Mental Health Services, VA Central Office (VACO), to establish and coordinate decentralized EBP training and consultation capacity, which is critical to broadening EBP dissemination (including EBPs beyond PTSD-focused EBPs) and promoting sustainability over time. This staff person will also provide support to and share resources and best practices with DoD as it develops new EBP training programs and develops EBP consultation capacity. This proposed initiative will leverage existing resources and will involve significant cross-agency collaboration, strengthening continuity of care throughout the Service member's transition from active duty to Veteran status. Although the initial focus of this initiative is on EBPs for PTSD, the ultimate goal is to develop a system that will serve as a model and provide the infrastructure for future cross-departmental collaboration with respect to other EBPs. This will involve efforts to implement EBPs for a range of additional mental health issues, as well as increasing the rapidity with which new advances in EBPs can be disseminated as they become available.

4. Market Analysis

a. What is the problem or issue the project is addressing? What is the evidence this is a problem?

The VA/DoD Clinical Practice Guideline for PTSD recommends evidence-based psychotherapies for the treatment of PTSD at the highest level, indicating that such treatments are "always indicated and acceptable." EBPs have been disseminated and implemented throughout VA with dedicated funding and a robust infrastructure. However, in DoD, there have been significant challenges to implementing ongoing training and consultation for EBPs. While DoD has attempted to implement several EBP training initiatives, the primary focus has been didactic workshops. The efforts to date have not included an infrastructure to support clinicians in engaging in ongoing consultation, nor have they addressed any clinic practices or work requirements that would be needed at the clinic administrator level to allow clinicians to take advantage of consultation, were it available. Without ongoing mentoring, consultation and support, clinicians tend to return to their usual practices after an initial didactic training (Karlin et al., 2012).

Unlike VA clinicians who may spend entire 20 or 30 year careers in a single clinic/hospital, military providers are highly mobile and often leave the Military Health System (MHS) after a relatively short time (4 – 8 years). Therefore, the MHS is faced with a continual group of providers who will be in need of training and ongoing consultation. In FY 2011 & 2012, DoD had

125 staff receiving ongoing consultation for EBP for PTSD, versus VA which had 1341 staff receiving ongoing consultation for EBP for PTSD. Thus, it is necessary to continue to build and maintain resources in DoD capable of delivering frequent, high quality training and ongoing consultation in order to ensure that the current MHS providers are delivering the most effective treatments available. After high quality, workshop training, consultation becomes essential to ensure development of competency and ongoing implementation of EBPs. Adding to the need for a permanent program of EBP training is the growing emphasis on developing and testing new and more effective treatments for psychological health issues (other than PTSD).

While VA has made significant progress in disseminating EBPs through centralized training mechanisms, further development of decentralized training and consultation capacity is needed to allow for broader dissemination (including opportunities for training trainees who are not eligible to participate in the centralized training) and to promote sustainability over time. Having centralized staff to oversee and coordinate decentralized training and consultation is essential for the full development and success of a comprehensive decentralized training system. These staff will also establish close coordination with DoD Champion-Consultants and program leadership to share resources and best practices and further institutionalize the decentralized training model across both enterprises.

b. What other activities have been conducted in the area to address the problem/issue?

Through work on Integrated Mental Health Strategic Action #9 (IMHS #9), Training in EBPs, 2,400 DoD providers and more than 1,900 VA providers have been trained in EBPs for PTSD as of September 30, 2012. In that same timeframe, over 1,500 providers across both departments received training in EBPs for mental health conditions other than PTSD. Additionally, IMHS SA #9 has added 22 new DoD trainers/consultants to provide training and consultation on implementing EBPs.

c. How does your project either address the gaps in previous efforts or build on those efforts?

Since 2010, the VA/DoD IMHS #9 has worked to implement common and coordinated training, evaluation and clinical documentation of EBPs for PTSD and other psychological health conditions between the Departments. The current proposal will expand on this effort, broaden dissemination, and promote sustainability of EBPs through the establishment of decentralized training and consultation capacity in DoD, as well as VA, and establish local EBP Champion-Consultants strategically at DoD installations. Champion-Consultants will ensure that ongoing consultation, training, and implementation occurs. Champion-Consultants in both agencies will meet regularly to coordinate on decentralization strategies to successfully promote training and consultation in EBPs.

5. <u>Project Description:</u>

A. List the initiative's goals and objectives. Be specific including how it will target enterprise issues and be deployed enterprise-wise.

- Initiative Goals:
  - By providing consultation and support, enable EBPs, recommended at the highest level in the VA/DoD Clinical Practice Guidelines, and reaffirmed by the Institute of Medicine, to reach more Service members and Veterans.
  - Ensure effective care delivered with fidelity to EBP protocols.
  - Develop a system that will serve as a model and provide the infrastructure for future cross-departmental collaboration in efforts to implement EBPs for a range of additional mental health issues, as well as increasing the rapidity with which new advances in EBPs can be disseminated as they become available.
  - Strengthen continuity and consistency of care with EBPs for Service members moving between the DoD and VA, providing continuous treatment with EBPs for Service members and Veterans.

- Initiative Objectives:
  - Establish EBP Champion-Consultants at 10 MTFs across the MHS enterprise to provide training and consultation to providers in EBPs for PTSD
  - Provide ongoing consultation in EBPs for PTSD as well as train a cadre of decentralized consultants who will then continue to train additional providers and develop an infrastructure at MTFs for ongoing consultation in EBPs for PTSD.
  - Through continued cross collaboration and communication with VA counterparts and Champion-Consultants across the DoD enterprise, promote the use of standardized tools for clinical implementation of EBPs for PTSD, establish guidelines and best practices for measuring clinic advancement towards implementation as well as the development of performance improvement programs for clinics to document successful implementation of EBPs across clinics.
  - Promote awareness and effectiveness of EBPs to Service members and their families.
  - Encourage participation throughout VA and DoD in the decentralized training and consultation model, through the establishment of a decentralized training coordinator in VA.

B. Describe how this project will improve efficiency or effectiveness of health care services and the impact on quality of care.

This initiative will increase the utilization of EBPs across the MHS enterprise and VA to significantly improve patient outcomes, personnel retention, military readiness and the well-being of DoD personnel as well as ease the transition from the DoD to the VA for Service members receiving treatment. The use of EBPs is associated with reduced provider burn-out and reduced health care costs. EBPs are very effective treatments for mental health problems that are of major importance to DoD and VA, such as PTSD, depression and insomnia, as has been demonstrated in national program evaluation within VA (Eftekhari, Ruzek, Crowley, Rosen, Greenbaum, & Karlin, in press; Karlin et al., 2012; Karlin, Trockel, Taylor, Gimeno, & Manber, under review). Further, research has repeatedly shown that competently delivered EBPs outperform the usual treatment in mental health clinics (Feske, 2008; Monson et al., 2006; Nacasch et al., 2011). Therefore, the use of Champion-Consultants will increase the competence of EBP delivery and thereby significantly improve patient outcomes, personnel retention, military readiness and the well-being of DoD personnel that will in turn enhance the functioning of military families across the Services. In fact, data within VA demonstrate that consultation with ongoing feedback on the clinician's implementation of therapy is essential to the development of competency in EBPs (Karlin et al., 2012).

Extrapolating from data on the effectiveness of EBPs for PTSD (Feske, 2008; Nacash et al, 2010; Tuerk, Yoder, Grubaugh, Myrick, Hamner & Acierno, 2011), we can assume that 67% to 75% of those entering EBPs will complete this form of treatment. In the few studies that have compared EBP to "treatment as usual" 80% to 90% of patients assigned to the EBP group have been found to complete the specified number of treatment sessions. Effectiveness studies suggest that 50% to 67% of those who complete EBPs for PTSD are no longer diagnosed with the disorder after treatment. In comparison, estimates of PTSD remission in "treatment as usual" conditions typically fall between 15% and 20%. Therefore, we can estimate that 40% of those entering EBPs vs. 15% of those entering "treatment as usual" will no longer have PTSD when they complete treatment.

C. Describe how this initiative supports the Joint Strategic Plan. (*Cite the specific goals within the JSP and describe how they are met by your project)*

1. The initiative directly supports the Joint Strategic Plan (JSP) Fiscal Year 2011-2013 Objective

   2.1.H, "Promote a common standard of care for mental health treatment for Service members, Veterans and their families by training providers and trainers/consultants in the use of EBPs for PTSD, depression, and other psychological health conditions."

2. This initiative also supports the objectives of IMHS #9, which focuses on the implementation of

common and coordinated training, evaluation, and clinical documentation of evidence-based psychotherapies for PTSD and other psychological health conditions.

3. This initiative also affirms President Obama's Executive Order, Improving Access to Mental Health Services for Veterans, Service Members, and Military Families, released on August 31, 2012.

4. This initiative also supports the goals of the Military Health System's Quadruple Aim, which seeks to enhance health outcomes by encouraging healthy behaviors; ensure satisfaction with accessible, high quality and patient centered care; achieve maximum force readiness at all times; and manage per capita health costs.

D. Provide the number of beneficiaries impacted by this proposal – those in and out of the Network

(be specific to this proposal – do not include the total number of beneficiaries in the catchment area)

In the period between 2000 and 2011, 102,549 active duty Service members were diagnosed with PTSD and another 303, 880 were diagnosed with Depression. At 100% implementation of EBPs for PTSD across DoD enterprise, there is a potential to impact all of the affected Service members. This number is even higher when taking into account the potential number of Reserve, National Guard, and veterans that could be reached.

6. <u>Project Dissemination/Rollout to enterprise VA/DoD (intention for Enterprise JIF funding to benefit VA/DoD at large</u>

A. Describe with a timeline the period for initial implementation/pilot and subsequent roll-out

		Objective 1: Promote Awareness and VA/DoD collaboration of EBPs for PTSD	**Objective 2: Establish EBP Champion – Consultants & Establish VA Coordinator**	**Objective 3: Provide Ongoing Consultation for EBP for PTSD**	**Objective 4: Train a Cadre of Consultants for EBP for PTSD & encourage participation in decentralized training and consultation across VA/DoD**

DoD/VA Joint Incentive Fund- Guide

JIF Year 1	Quarter 1	• Begin regular meetings between DoD and VA Coordinators • DoD coordinate with VA on materials for promoting EBPs and development of decentralized training and consultation model • Develop "Lessons Learned Manual" based on experience of disseminating EBPs in DoD, in collaboration with lessons learned in VA	• Hire Champion Coordinator • Recruit 10 EBP Champion-Consultants • Hire VA Coordinator	• Hire Consultation Coordinator	• Define criteria for EBP consultants • Through cross-coordination between VA and DoD, begin encouragement of participation in the decentralized training model
	Quarter 2	• Distribute lessons learned manual and promotional materials to VA Coordinator and Champion – Consultants • Champion – Consultants begin to use promotional materials to raise awareness of EBPs	• Hire 10 EBP Champion - Consultants • Train Champion-Consultants • VA Coordinator actively works with DoD coordinator	• Identify providers to receive consultation during Year 1	• Identify providers who will be trained as consultants
	Quarter 3	• Champion – Consultants actively promote EBPs for PTSD	• Continue to train Champion-Consultants • VA Coordinator actively works with DoD coordinator	• Provide consultation to 50 DoD providers	• Confirm qualifying materials for providers who will be trained as consultants

	Quarter 4	• Champion – Consultants and VA coordinator actively promote EBPs for PTSD • Promotional materials revised based on experience of Champion – Consultants and VA Coordinator • Lessons – learned manual revised based on experience of Champion – Consultants and VA Coordinator ; included in this manual are best practices for measuring clinic advancement towards implementation as well as the development of metrics for programs and clinics to document successful implementation of EBPs	• Champion – Consultants fully operational at 10 DoD MTFs • VA Coordinator actively works with DoD coordinator	• Continue consultation to initial 50 DoD providers • Identify providers to receive consultation in Year 2 (1st half)	• Train 10 DoD Consultants, include emphasis on decentralized training and coordination, include collaboration with VA counterparts • Identify second group of providers to be trained as consultants
JIF Year 2	Quarter 5	• Distribute revised lessons learned manual and promotional materials to Champion – Consultants and VA Coordinator • Champion – Consultants and VA coordinator use revised promotional materials to raise awareness of EBPs	• Champion – Consultants fully operational at 10 DoD MTFs • VA Coordinator actively works with DoD coordinator	• Provide consultation to 50 additional DoD providers (total 100 providers)	• Newly trained consultants begin to support consultation effort at each MTF and encourage decentralized training and consultation model as well as collaboration with VA counterparts • Confirm qualifying materials for providers who will be trained as consultants
	Quarter 6	• Champion – Consultants and VA coordinator actively promote EBPs for PTSD	• Champion – Consultants fully operational at 10 DoD MTFs • VA Coordinator actively works with DoD coordinator	• Continue consultation to 50 DoD providers • Identify providers to receive consultation in Year 2 (2nd half)	• Train second group of 10 DoD providers to be consultants; include emphasis on decentralized training and coordination, include collaboration with VA counterparts

	Quarter 7	• Champion – Consultants and VA coordinator actively promote EBPs for PTSD	• Champion – Consultants fully operational at 10 DoD MTFs • VA Coordinator actively works with DoD coordinator	• Provide consultation to 50 additional DoD providers (total 150 providers)	• Newly trained consultants begin to support consultation effort at each MTF
	Quarter 8	• Champion – Consultants and VA coordinator actively promote EBPs for PTSD	• Champion – Consultants phase out of operation at 10 MTFs	• Continue consultation to final 50 DoD providers	• DoD consultants continue to provide consultation and encourage decentralized training and consultation model as Champion – Consultants and Coordinators are phased out

B. List which sites/populations will be included in dissemination of the initiative

There is an existing relationship with 10 of the tri-service MTFs that house American Psychological Association (APA) -accredited psychology internship programs. Given that these sites are already training focused, this would allow an opportunity to work with a group of MTFs who are oriented towards implementing EBPs. It is recommended that these 10 sites be included in the dissemination of the initiative. Populations served by these MTF clinics include active duty Service members.

C. Describe coordination to-date with these potential roll-out sites

IMHS#9 provides program oversight and funding for training in consultation at MTFs that house APA accredited psychology internship program, already supporting the training and supervision of the psychology interns as well as staff clinicians.

7. <u>Financial Information:</u>

A. The financial analysis format must accompany this submission to be considered for scoring

Please see accompanying financial analysis.

B. Briefly describe the costs *(personnel, supplies, equipment, minor construction)* Round to the nearest thousand.

DoD Costs:

Personnel: $2,098,000 (Year 1); $2,161,000 (Year 2)-
Travel: $35,000 (Year 1); $25,000 (Year 2)
Supplies/Equipment: $90,000 (Year 1); $39,000 (Year 2)
Training: $38,000 (per year)
Indirect Costs: $442,000 (Year 1);$442,000 (Year 2)
Total DoD Cost: 5,408,000

VA Costs:
Personnel: $168,000 (per year)
Travel: $10,000 (per year)
Supplies: $75,000 (per year)
Training: $15,000 (per year)
Total VA Costs: $536,000

Total Costs (VA/DoD): $5,944,000

C. Briefly describe the expected financial benefits. Round to the nearest thousand.

The expected financial benefit during in the initial roll-out period (12 -18 months): $1,857,000

The above represents the expected minimum annual benefit following the initial implementation; it is expected that the total financial benefit will increase as the number of providers are trained in EBPs and the number of Service members receiving EBP also increases. Potential financial benefit if optimally implemented across the 10 pilot sites in the DoD may reach upwards of $60 million in cost savings related to both decreased health care utilization and reductions in personnel training (see section 6B below for additional detail).

D. Provide an approximate breakout of benefit to VA or DoD *(e.g., if the request is for $500K, please indicate $250K benefit to each Department, or whatever the approximate breakout)*

During the initial roll-out period (12-18 months), we conservatively estimate 500 Service members with PTSD will be treated with EBPs for PTSD, resulting in:

DoD = $1,500,000 reduced training costs (associated with increased Service member retention). Estimate $178,500 reduced medical care costs.

VA = $178,000 (estimated reductions in medical care costs)

*This estimate does not include reduced societal costs; also does not consider the longer term impact of training consultants to train additional providers who will then treat additional Service members with EBPs for PTSD beyond the initial roll out period.

E. List Tangible and Intangible Economic Benefits.

Researchers found that during their first year of VA care, Veterans with psychiatric disorders utilized 55% more healthcare (excluding psychiatric care) than their counterparts without a psychiatric disorder, and those with PTSD use 91% more outpatient medical care. Based on Veterans Health Administration (VHA) utilization data and estimates of the number of DoD patients diagnosed with PTSD, we estimate the overall added medical care costs attributable to PTSD as high as $357 million per year, or $1,785 per Service member or Veteran (Taylor et al., 2012). If we assume a 40% reduction in medical care costs due to the reduction in PTSD (a conservative estimate because many individuals treated with EBP will experience a significant reduction in PTSD symptom severity even if they retain the diagnosis), universal treatment with EBPs would reduce overall medical care costs by $143 million annually, or $714 per Service member or Veteran. The 10 sites chosen for this proposal are responsible for the medical treatment of approximately 20% of active duty military personnel, therefore it is estimated that full implementation of EBPs for PTSD at these sites would result in an annual reduction of over medical costs by $29 million across the DoD and VA. It is also estimated that the full utilization of EBPs to treat PTSD and depression among OEF/OIF Veterans would reduce the overall societal costs attributable to these injuries by $138 million (15%) over the first two years post injury. Ongoing consultation and training is essential to ensuring this cost savings; without an ongoing support system for clinicians, they are likely to defer to their previous techniques to treat PTSD rather than continue to implement EBPs. Long-term savings related to reduced health-care utilization and improved retention of military personnel could be considerably higher, beyond two years.

The development of a more robust training and ongoing consultation infrastructure for the dissemination and implementation of EBPs within the DoD to treat PTSD and other mental health disorders will increase the delivery of first-line, evidence-based treatments that will likely reduce the flow of Service members in need of VA services by providing recommended EBPs early and reducing the need for ongoing treatment in the VA system. For those that continue to receive treatment for a mental disorder after leaving the DoD; Veterans will find increased continuity and consistency of care between the DoD and the VA.

8. <u>Performance Measures:</u>

A. Metrics – Describe how the success of this project will be measured. (Specify the performance measures that will be used) Be specific with objective quantifiable targets and a timeline

Proposed Measurement Framework

DoD/VA Joint Incentive Fund- Guide

Objective	Proposed Measures	Proposed Data Sources
Objective 1	1. Number of activities conducted to educate service members and family members regarding EBP effectiveness at 10 identified MTFs 2. Number of providers reporting an increased awareness of EBPs at 10 identified MTFs 3. % of facilities promoting awareness of EBP effectiveness 4. Timely completion of "Lessons Learned" manual; inclusive of VA and DoD "lessons learned"	**1. Follow-up survey of 10 MTFs with Champion-Consultants** **2. Brief assessment of providers at 10 MTFs with Champion-Consultants**
Objective 2	1. Number of Champion- Consultants trained 2. Number of fully operational Champion-Consultants 3. Number of providers who are delivering EBPs at the 10 identified MTFs 4. Number of MTFs (of the 10 identified) utilizing EBPs for PTSD 5. Successful hiring and placement of VA Coordinator 6. DoD and VA Coordinator satisfaction with collaboration and cross-sharing of lessons learned and resources	**1. CDP training reports** **2. Brief assessment of 10 MTFs with Champion-Consultants** **3. Brief assessment of providers at 10 MTFs with Champion-Consultants** **4. Follow-up assessment with DoD and VA Coordinators**
Objective 3	1. Number of providers receiving EBP consultation 2. Number of providers who have reached EBP proficiency 3. % of facilities reporting providers are actively receiving consultation for EBPs 4. Provider satisfaction with use of EBPs for treating PTSD	**1. CDP consultation reports** **2. Follow-up assessment of 10 MTFs with Champion-Consultants** **3. Brief assessment of providers at 10 identified MTFs**
Objective 4	1. Number of trained DoD Consultants 2. Number of MTFs (of the 10 identified) with a trained consultant 3. Attitude of Champion-Consultants and trained providers towards decentralized training and consultation	**1. CDP consultation reports** **2. Follow-up assessment of 10 MTFs with Champion-Consultants** **3. Follow-up assessment with Champion-Consultants and trained providers on attitudes towards decentralized training and consultation**
Main-tenance	**<u>Overall</u>** **1. Identifying barriers and facilitators of maintenance during the program** **2. Registry of trained consultants within the DoD**	**Post-implementation qualitative interviews with:** **a. Champion-Consultants** **b. Leaders at 10 identified MTFs** **c. Trained DoD Consultants**

B. Return on Investment (ROI) – Describe how and when a return on investment will be achieved.

The following ROI estimates assume 100% implementation of EBPs across the DoD enterprise; this is a long term goal. However, they provide an example of the significant ROI that would be achieved as EBPs are implemented across the DoD:

- Increased competently delivered EBPs across the MHS enterprise and VA. Competently delivered EBPs outperform the usual treatment in mental health clinics. Given that an estimated 40% of those receiving EBPs vs. 15% of those receiving "treatment as usual" will no longer have PTSD when they complete treatment, this results in an estimated 25% improvement in treatment outcome

  Cost savings attributable to improved retention rates are difficult to calculate as the decision to remain in the military is based on many factors. However, we assume that 80% of service members diagnosed with PTSD would leave the military if left untreated and that 30% of those successfully treated for PTSD would remain in the military, then we can estimate cost savings attributable to the use of EBPs as follows: Of the estimated 200,000 personnel with PTSD, 160,000 would be expected to separate from the service due, at least in part, to PTSD. If those 160,000 individuals were treated with an EBP for PTSD then 64,000 (40%) would no longer be diagnosed with PTSD and 19,200 (30%) of these treated individuals would remain in the military. In comparison, only 24,000 (15%) would be successfully treated with "treatment as usual" resulting in the retention of merely 7,200 personnel. Estimating the costs of accession and training of new recruits at approximately $100,000 per recruit, the retention of 12,000 additional personnel treated with EBPs would result in cost savings of $1.2 billion. Using the above estimates and given that the 10 sites chosen for our proposal support 20% of active duty military personnel, we conservatively estimate full implementation of EBPs at these 10 sites could result in up to $60 million in reduced training costs through retention of 600 personnel (5% of 12,000; $100,000 saved per person in training costs). Based on the initial increased numbers of providers we expect to utilize EBPs for PTSD during the initial roll out period, we estimate a total of 500 Service members will be treated; if 30% of those treated with EBPs for PTSD would remain in the military, rather than leave the military, saving $1,500,000 ($100,000 per member who does not need to be replaced).

- Reduce overall medical care costs by $142.8 million annually compared to a reduction of $53.6 million for usual treatment; non-psychiatric medical care costs would be reduced by $17.4 million annually with EBPs compared to $6.5 million with "treatment as usual."

C. If contractors are involved, identify who will have management and oversight to ensure contractual requirements are met.

The Behavioral Medicine Division within the Office of the Chief Medical Officer (DoD) will oversight for the DoD component. VA Mental Health Services will have oversight over the decentralized training coordinator (VA Mental Health Services term staff).

D. Identify who will have decision authority and maintain oversight of this initiative. (e.g., scheduled meetings, periodic reviews, *etc)*

Behavioral Medicine Division within the Office of the Chief Medical Officer

9. Sustainment Plan

Describe the plan after two years of JIF funding for sustainment. Be specific on

A. Resources required

To promote sustainment, training to be an EBP consultant ensures a pool of consultants for the future. Concurrent with this proposed initiative, training of consultants is currently offered through IMHS #9. In addition, we are considering options for use of a DoD/Health and Human Service (HHS) Memorandum of Agreement (MOA) that would place Public Health Service officers at identified sites to provide continuing consultation and training of consultants.

VA will consider providing term funding support based on need and available funding.

B. Funding mechanisms the project sponsors have pursued for sustainment

Currently, Program Objectives Memorandum (POM) funding is being sought simultaneous to the development of this program pilot.

Mental Health Services program office funding will be considered based on need and available funding.

C. Contingency plan if sustainment funds not secured

Absent continued funding, the Services would need to take responsibility for ensuring the sustainment of the program.

Additional, ongoing coordination and evaluation duties will be performed by VA EBP training program staff to the extent possible and needed. Once decentralized training and consultation capacity is established during the two-year period supported by JIF, additional funding and full-time, dedicated support may not be needed.

10. <u>Other Supporting Information:</u>

A. List any "show stoppers" that could halt the initiative if not overcome**.**

While the following are not "show stoppers," they are barriers which will need ongoing support, training and oversight in order to overcome:

- Experience in disseminating EBPs throughout the MHS/VA has confirmed the presence of systemic barriers, both structural and cultural, to the adoption and consistent implementation of EBPs at treatment facilities across the system.
- Providers have limited clinical time to implement EBP protocols due to the high volume of patients. For example, at some clinics patients are seen by their provider once per month rather than weekly.
- Additional clinical time and documentation requirements are perceived as threats to the clinicians Relative Value Unit (RVU) requirement.
- Some providers prefer to continue providing care with treatments that they are more familiar with.
- It has been challenging to provide consultation with providers throughout the DoD. Although receiving consultation on skill mastery and implementation of EBPs for PTSD is highly recommended, it is not required for providers within the DoD to receive such consultation. The absence of a consultation requirement and the presence of numerous other demands, providers have not consistently requested or sought out consultation services.
- Poor participation in consultation or competency development activities following initial EBP training. Without mentorship and support beyond the initial training, providers tend to return to their usual practices. Even those who diligently attempt to change their practices to accommodate delivery of EBPs may fail to effectively and/or efficiently implement the protocols without expert support and consultation.
- Consultants are not readily accessible at all sites, and often carry caseloads that make it difficult to provide office hours for consultation.
- Session recording for consultation has been problematic at some sites.

B. For VHA: Describe how this proposal may impact Capital Asset Realignment for Enhanced Services (CARES) study recommendations for this facility.
The current proposal is not anticipated to have any significant impact on CARES study recommendations.

C. Describe any unique circumstances involved in this project.
It is essential that the new decentralized training coordinator requested in this proposal be highly familiar and experienced with VHA, given the systems issues involved in this initiative.

D. Include any additional information you feel is relevant to the selection/approval of this project.
The dissemination and implementation of EBPs is a high priority for VA. Activities to date through the centralized training programs have yielded

significant success, as evidenced by significant reductions in symptoms and improvements in other domains of life (e.g., quality of life). The establishment of decentralized training and consultation is essential for allowing these therapies to reach a greater number of Veterans and for ensuring sustainability of EBP delivery over time. This initiative will continue to build on the successes of IMHS SA #9 in providing for collaboration and coordination between the DoD and VA on the implementation of EBPs and will facilitate further alignment of EBPs efforts across the departments.

COORDINATE THE FOLLOWING WITH THE HEC ICIB, IM/IT and Architecture Review Board working groups

11. Information Management/Information Technology:

- ✓ **JIF funding is not provided for major information technology projects which are required to be included in the OMB 300 Budget Exhibit, for >$50M projects, those which won't realize and impact within the two years and those without sustainment plans after the two years .**

- Not Applicable

APPENDIX B: FUNDING CERTIFICATION FORM

Project Name / Title:
Sponsor: (VAMC and MTF) or (VHA Program Office and DHA Program Office)

Please indicate the allocation of the amounts shown above to VA and DoD as well as the appropriation required.

Joint Incentive Fund Distribution *(Rounded up to the nearest thousand)*	**Year 1**	**Year 2**	**Total**
Army			
Navy			
Air Force			
VA			
DoD			
Total	$ -	$ -	$ -

For recurring operational costs beyond the period approved for Joint Incentive Fund support, the respective VHA organizational element or Military Service/DoD Program Office hereby commits to funding subsequent recurring costs, from their existing budgets as a condition of receiving the above allocation from the Joint Incentive Fund. The Financial Management Working Group (FMWG) reserves the right to terminate any ongoing JIF project (any JIF project still expending JIF dollars) that fails to maintain satisfactory progress toward project completion. The DoD, VA, Army, Air Force, and Navy each reserve the right to assess Service/Department JIF project equities and performance, and to terminate any JIF project that is not self-sustaining after JIF resources are expended. Incentive Fund projects will not be approved without this certification.

Certification Signatures: *(Modify titles as appropriate to specific project)*

NOTE: *Lead partner is responsible for obtaining both departments final approving authority signatures. Project Sponsor's will work with their respective approving authority and the Lead partner to ensure one fully signed certification form is submitted with the proposal.*

_____ _____

VHA VAMC Director/Chief Officer **Service Resource Manager**

_____ _____

VHA VISN Director **Service Surgeon General**

APPENDIX C: INTERIM PROGRESS REPORT TEMPLATE

Joint Incentive Fund

Interim Project Review

April 15, 2014

Project Title:

Location:

Submitted by

VA	DoD
Name	Name
Email	Email
Phone	Phone

1

Project Goals/ Objectives

- Goals and Objectives:
  - .
  - .
  - .
  - .
- Desired Outcomes:
  - .
  - .
  - .
  - .
  - .

2

Schedule of Activities

Owner *(DoD, VA or Both)*	Activity Name *(Sub Activity/ Task Description)*	Projected Start MM/DD/YY	Projected Completion MM/DD/YY	Completion MM/DD/YY	Comments

1

DoD Obligation Plan

($ in millions) *$9.575 = $9,575,000 or $0.123 = $123,000*

Funded JAN 2013	Year 1 1st Qrt	Year 1 2nd Qtr	Year 1 3rd Qtr	Year 1 4th Qtr	Year 2 1st Qrt	Year 2 2nd Qtr	Year 2 3rd Qtr	Year 2 4th Qtr	Year 3 1st Qrt	Year 3 2nd Qtr	Year 3 3rd Qtr	Year 3 4th Qtr	TOTAL
Civilian Pay	$ 0.980	$ -	$ -	$ 0.776	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.756
Civilian Pay	$ -	$ 0.980	$ -	$ 0.776	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.756
Contracts	$ -	$ 1.900	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.900
Contracts	$ -	$ 1.900	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.900
Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.095	$ -	$ -	$ -	$ -	$ -	$ 0.095
Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.095	$ -	$ -	$ -	$ -	$ -	$ 0.095
Leases	$ -	$ -	$ -	$ 0.500	$ -	$ 1.000	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.500
Leases	$ -	$ -	$ -	$ 0.500	$ -	$ 1.000	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.500
Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PLANNED	$ 0.980	$ 1.900	$ -	$ 1.276	$ -	$ 1.000	$ 0.095	$ -	$ -	$ -	$ -	$ -	$ 5.254
ACTUAL	$ -	$ 2.880	$ -	$ 1.276	$ -	$ 1.000	$ 0.095	$ -	$ -	$ -	$ -	$ -	$ 5.254
RATE (YEAR TO DATE)													100%

VA Obligation Plan

($ in millions) $9.576 = $9,576,000 or $0.123 = $123,000

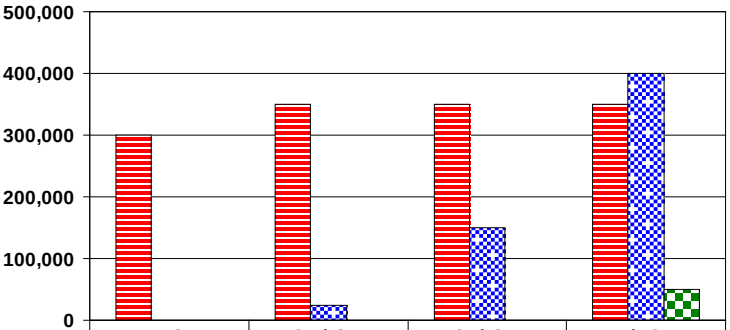
Funded JAN 2013	Year 1				Year 2				Year 3				TOTAL
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	
Civilian Pay	$ 0.980	$ -	$ -	$ 0.776	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.756
Civilian Pay	$ -	$ 0.980	$ -	$ 0.776	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.756
Contracts	$ -	$ 1.900	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.900
Contracts	$ -	$ 1.900	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.900
Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.095	$ -	$ -	$ -	$ -	$ -	$ 0.095
Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.095	$ -	$ -	$ -	$ -	$ -	$ 0.095
Leases	$ -	$ -	$ -	$ 0.500	$ -	$ 1.000	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.500
Leases	$ -	$ -	$ -	$ 0.500	$ -	$ 1.000	$ -	$ -	$ -	$ -	$ -	$ -	$ 1.500
Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PLANNED	$ 0.980	$ 1.900	$ -	$ 1.276	$ -	$ 1.000	$ 0.095	$ -	$ -	$ -	$ -	$ -	$ 5.254
ACTUAL	$ -	$ 2.880	$ -	$ 1.276	$ -	$ 1.000	$ 0.095	$ -	$ -	$ -	$ -	$ -	$ 5.254
RATE (YEAR TO DATE)													100%

Financial Variance

Date MMDDYY	Comments

6

Cost/Benefit Progress



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Obligations Total	300,000	350,000	350,000	350,000
Cumulative Benefit	0	25,000	150,000	400,000
Positive Cash Flow	0	0	0	50,000

5

Performance Measures

- List performance measures from the proposal and demonstrate progress toward meeting the goals.

6

Project Status Report

	Critical	Caution	Controlled	Complete
On Schedule				
Within Budget				
Personnel Hiring				
Contract Awards				
Return on Investment Progress				
Meeting Goals & Objectives				

Place "X" in block that applies to this project. See note pages for definitions.

7

Sustainment

- List requirements for sustainment beyond JIF funding period
  - VA requirements:
  - DoD requirements:
- Describe the plan for sustainment (agency responsible and agency providing funds)

10

Lessons Learned

- (Date) Provide noteworthy Lessons Learned

(See example in notes section)

8

Summary Comments

- Include summary remarks regarding the status of the project
- Provide points of emphasis where needed
- State if assistance and/or approvals are needed

9

APPENDIX D: FINAL REPORT TEMPLATE

Joint Incentive Fund Project
Final Report
Project Name (Site Name)

1. **Project Overview**: Provide background on the project based on concept proposal – what was the project established to accomplish; what was the hypothesis (i.e., implementation of this sharing capability should produce these benefits); what were the project goals and objectives; etc.

2. **Project Implementation**

a. Activities: *Describe the steps taken to accomplish the project goals and objectives. Identify accomplishments, products, deliverables, and/or processes associated with each activity***.**

b. Resources: *Provide high level budget information (the obligation slide from the IPR). Using the table below state the Return on Investment (ROI) identified in the business case analysis, the actual/achieved ROI to date, the projected ROI, and provide explanations/justifications for any deviation from the projected ROI.*

ROI identified in BCA	*$*
ROI actual/achieved to date	*$*
Projected ROI	*$*
Date ROI is projected to be achieved	*DD/MMM/YYYY*
Explain deviation if applicable:	

3. **Metrics**: *Discuss the metrics used to evaluate how well the project met the objectives stated in the concept proposal. Describe the metrics collection and analysis methodology and assumptions. Present the metrics in graphical form (from IPR). Discuss the conclusions drawn from the metrics.*

4. **Lessons Learned**: *Describe the major lessons learned (best practices/positive experiences or problems/ failures and associated corrective actions) that may be beneficial to others. Discuss risks, constraints and/or barriers you encountered, the impact they had, and how they were overcome.*

5. **Conclusions**: *Provide a summary of the overall conclusions of the demonstration project (overall, were project goals and objectives achieved).*

a. Sustainability: *Provide an assessment of why and how the sharing capability (or portions of the project products or processes) will be continued at this site after the JIF period ends. What are the advantages and disadvantages of sustaining the capability?*

b. Exportability: *Provide an assessment of whether or not this sharing capability (or*

portions of the project products or processes) would be useful at other locations. What are the advantages and disadvantages of using the capability elsewhere?

6. **Sharing Agreement**: *Provide the status of the sharing agreement associated with this project, e.g., completed, in development with projected completion date, added to master sharing agreement.*