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Report to Congressional Committees

March 2006

VA AND DOD HEALTH CARE

Opportunities to Maximize Resource Sharing Remain

GAO-06-315

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Highlights

Highlights of GAO-06-315, a report to congressional committees

Why GAO Did This Study

The National Defense Authorization Act for Fiscal Year 2003 required that the Departments of Veterans Affairs (VA) and Defense (DOD) implement programs referred to as the Joint Incentive Fund (JIF) and the Demonstration Site Selection (DSS) to increase health care resource sharing between the departments. The act requires GAO to report on (1) VA's and DOD's progress in implementing the programs. GAO also agreed with the committees of jurisdiction to report on (2) the actions taken by VA and DOD to strengthen resource sharing and opportunities to improve upon those actions and (3) whether VA and DOD performance measures are useful for evaluating progress toward achieving health care resource-sharing goals.

What GAO Recommends

The Secretaries of VA and DOD should (1) develop an evaluation plan for documenting and recording the advantages and disadvantages of each DSS project, an activity that will assist VA and DOD in replicating successful projects systemwide, and (2) develop performance measures that would be useful for determining the progress of their health care resource-sharing goals.

VA and DOD concurred with GAO's recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-06-315.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Laurie Ekstrand at (202) 512-7101 or ekstrandl@gao.gov.

What GAO Found

VA and DOD are making progress in implementing two programs required by legislation in December 2002 to encourage health care resource sharing and collaboration—JIF and DSS. While JIF projects experienced challenges because of delays resulting from the initial absence of funding mechanisms and, in some cases, the need for additional acquisition and construction approvals, as of December 2005, 7 of 11 selected 2004 projects were operational. The DSS program also experienced challenges as some sites reported difficulty putting together project submission packages, noting confusion over the timelines and approval process as well as frustration with the amount of paperwork and rework required. Nonetheless, as of December 2005, 7 of the 8 DSS projects were operational. However, the Joint Executive Council (JEC) and Health Executive Council (HEC), VA and DOD entities established to facilitate collaboration and health care resource sharing between the departments, have not established a plan to measure and evaluate the advantages and disadvantages of DSS projects—information that will be useful for determining if projects that produce cost savings or enhance health care delivery efficiencies can be replicated systemwide.

VA and DOD are creating mechanisms that support the potential to increase collaboration, sharing, and coordination of management and oversight of health care resources and services. The departments have taken steps to create interagency councils and workgroups to facilitate collaboration and sharing of information, establish working relationships among their leaders, and develop communication channels to further health care resource sharing. In addition, the departments developed a Joint Strategic Plan outlining six goals. However, JEC and HEC have not seized upon a number of opportunities to further collaboration and coordination. For example, JEC and HEC have not developed a system for collecting and monitoring information on the health care services that each department contracts for from the private sector—such as individual VA medical center or military treatment facility contracts for dialysis, laboratory services, or magnetic resonance imaging. If such a system were in place, the departments could use it to identify services that could be exchanged from one another or possibly obtain better contract pricing through joint purchasing of services, thus promoting systemwide cost savings and efficiencies. Furthermore, JEC and HEC have not directed that a joint nationwide market analysis be conducted to obtain information on what their combined future workloads will be in the areas of services, facilities, and patient needs.

VA and DOD lack performance measures that would be useful for evaluating how well they are achieving their health care resource-sharing goals. For example, of the 30 measures contained in the departments' joint strategic plan, 5 were not developed at the time the plan was issued and 11 lacked longitudinal information. For the remaining 14 that require periodic measurement, there was variation in the rigor or specificity in the types of data to be collected or the analysis to be performed.

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Abbreviations

BEC	Benefits Executive Council
BHIE	Bidirectional Health Information Exchange
BRAC	base realignment and closure
CARES	Capital Asset Realignment for Enhanced Services
CCQAS	Centralized Credentials Quality Assurance System
CHCS I	Composite Health Care System I
CHCS II	Composite Health Care System II (renamed the Armed Forces Health Longitudinal Technology Application in November 2005)
CMAC	Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge
CPC	VA/DOD Construction Planning Committee
DOD	Department of Defense
DSS	Demonstration Site Selection
GME	graduate medical education
GPRA	Government Performance and Results Act of 1993
HEC	Health Executive Council
JEC	Joint Executive Council
JIF	Joint Incentive Fund
LDSI	Laboratory Data Sharing Initiative
MRI	magnetic resonance imaging
MTF	military treatment facility
NDAA	National Defense Authorization Act for Fiscal Year 2003
OMB	Office of Management and Budget
PMA	President's Management Agenda
VA	Department of Veterans Affairs
VAMC	VA medical center
VISTA	Veterans Health Information Systems and Technology Architecture

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United States Government Accountability Office
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March 20, 2006

Congressional Committees

Combined, the Department of Veterans Affairs (VA) and Department of Defense (DOD) provided health care services to about 13.5 million beneficiaries in fiscal year 2004 at a cost of about $57 billion—$26.8 billion for VA and $30.4 billion for DOD.[1] For decades the Congress has encouraged VA and DOD to increase their resource-sharing activities to achieve the most cost-effective use of health care resources and deliver health care services more efficiently. Further, the President's Management Agenda (PMA) contains an initiative that specifically focuses on improving coordination of VA and DOD programs and systems by increasing the sharing of services that will lead to reduced cost and increased quality of care.

The Congress included in the National Defense Authorization Act for Fiscal Year 2003 (NDAA) a provision that VA and DOD implement two programs—the joint incentive program[2] and the demonstration program[3]—to increase the amount of health care resource sharing taking place between VA and DOD. In addition, the act required that we report on VA and DOD's progress in implementing the programs and, as agreed with the committees of jurisdiction, the extent projects funded under the programs

[1]VA provided health care to an estimated 5.2 million of its 7.4 million enrolled beneficiaries in fiscal year 2004. DOD provided health care to approximately 8.3 million of the estimated 9.2 million beneficiaries who were eligible for DOD health care in fiscal year 2004.

[2]Bob Stump National Defense Authorization Act for Fiscal Year 2003, Pub. L. No. 107-314, § 721, 116 Stat. 2458, 2589-95, required VA and DOD to establish a joint incentive program to identify and provide incentives to implement, fund, and evaluate creative health care coordination and sharing initiatives between VA and DOD. VA and DOD refer to this program as the Joint Incentive Fund program.

[3]Bob Stump National Defense Authorization Act for Fiscal Year 2003, Pub. L. No. 107-314, § 722, 116 Stat. 2458, 2595-99, required VA and DOD to establish the Health Care Resources Sharing and Coordination Project to serve as a test for evaluating the feasibility, advantages, and disadvantages of programs designed to improve the sharing and coordination of health care resources between VA and DOD. VA and DOD refer to this program as the Demonstration Site Selection program.

are operational.[4] Further, the committees of jurisdiction asked us to describe the actions taken by VA and DOD to strengthen the sharing of health care resources between the two departments and opportunities to improve upon these actions as well as to assess whether VA and DOD performance measures are useful for evaluating progress toward achieving health care resource-sharing goals.

To assess VA's and DOD's progress in implementing the Joint Incentive Fund (JIF) and Demonstration Site Selection (DSS) programs, we conducted site visits at six project sites and interviewed department officials responsible for the development of each of the projects.[5] In addition, we contacted VA and DOD officials from seven additional sites.[6] For all of the sites, we reviewed project documentation for JIF projects selected in fiscal year 2004 and DSS projects that consisted of a detailed description of the project, a timeline for development and implementation, associated risks, costs, potential cost savings (if applicable), staffing requirements, and quarterly progress reports for each project.[7]

To obtain information on the actions taken by VA and DOD to strengthen the sharing of health care resources, we spoke with officials from VA's Office of Policy, Planning, and Preparedness and the Veterans Health Administration—including the VA/DOD Liaison Office and VA medical center (VAMC) staff at several locations engaged in the sharing of health care resources. We interviewed officials from DOD's TRICARE Management Activity;[8] the DOD/VA Program Coordination Office; the

[4]We have previously reported on the Joint Incentive Fund program in fiscal years 2004 and 2005. See GAO, *DOD and VA Health Care: Incentives Program for Sharing Resources*, GAO-04-495R (Washington, D.C.: Feb. 27, 2004), and *DOD and VA Health Care: Incentives Program for Sharing Health Resources*, GAO-05-310R (Washington, D.C.: Feb. 28, 2005).

[5]We visited VA and DOD medical facilities at six sites—Augusta, Georgia; Honolulu, Hawaii; North Chicago, Illinois; El Paso, Texas; San Antonio, Texas; and Puget Sound, Washington.

[6]Those seven additional sharing sites were located in the following areas: Alaska, California, Kansas, New York, North Dakota, South Carolina, and Virginia.

[7]Under the JIF program, 12 projects were selected for implementation for fiscal year 2004, but 1 project was removed due to legal concerns. For fiscal year 2005, 18 JIF projects were selected, but 1 project was removed due to asset realignment issues. Under the DSS program, 8 projects were selected.

[8]DOD provides health care through TRICARE—a regionally structured program that uses civilian contractors to maintain provider networks to complement health care services provided at MTFs.

military services' surgeons general offices, which coordinate sharing activities; and several military treatment facilities (MTF) engaged in the sharing of health care resources. We also interviewed officials from Joint Executive Council (JEC) committees and Health Executive Council (HEC) workgroups[9] to determine what policies, procedures, and guidance have been promulgated to promote health care resource sharing and coordination between VA and DOD. Further, we spoke with officials from the Office of Management and Budget (OMB). We analyzed the charters and briefing updates for each JEC committee and HEC workgroup and reviewed OMB's evaluation of the departments' efforts to implement the PMA initiative. In addition, we analyzed workload, cost, and sharing agreement data between VA and each branch of military service.

To assess whether VA and DOD performance measures are useful, we interviewed senior VA and DOD officials about how the sharing of health care resources is measured. In addition, we analyzed the departments' Joint Strategic Plan for Fiscal Year 2005, the departments' JEC annual report to the Congress on sharing, and each department's individual strategic plan. We also obtained and reviewed VA and DOD policies governing sharing and reviewed relevant department reports, including those from the DOD Inspector General and DOD contractors, along with our prior work. We performed our work from January 2005 through March 2006 in accordance with generally accepted government auditing standards. For more details on our scope and methodology, see appendix I.

Results in Brief

VA and DOD are making progress in implementing two programs required by the Congress in December 2002 to encourage health care resource sharing and collaboration between VA and DOD—JIF and DSS. While JIF projects experienced challenges because of delays resulting from the initial absence of funding mechanisms and, in some cases, the need for additional acquisition and construction approvals, as of December 2005, 7 of 11[10] selected 2004 projects were operational. The DSS program also

[9]VA and DOD established JEC along with four additional interagency councils/committees to further facilitate collaboration between the departments. HEC and its workgroups, which are under the purview of JEC, were developed as a mechanism to specifically further the sharing of health care resources between VA and DOD.

[10]Originally 12 projects were selected; however, 1 project was removed due to legal concerns. VA and DOD's offices of general counsel determined after the selection process that VA and DOD did not possess legal authority to pursue the project. Subsequently, this project was removed from the program and funding was reallocated.

experienced challenges as some sites reported difficulty putting together project submission packages, noting confusion over the timelines and approval process as well as frustration with the amount of paperwork and rework required. Nonetheless, as of December 2005, 7 of the 8 DSS projects were operational.[11] However, JEC and HEC have not established a plan to measure and evaluate the advantages and disadvantages of DSS projects—information that will be useful for determining whether projects that produce cost savings or enhance health care delivery efficiencies can be replicated systemwide.

VA and DOD are creating mechanisms that support the potential to increase collaboration, sharing, and coordination of management and oversight of health care resources and services. The departments have taken steps to create interagency councils and workgroups to facilitate the sharing and collaboration of information, establish working relationships among their leaders, and develop communication channels to further health care resource sharing. In addition, the departments have worked together to develop a Joint Strategic Plan outlining six goals. However, JEC and HEC have not seized upon a number of opportunities to further health care resource sharing, collaboration, and coordination. For example, JEC and HEC have not developed a system for collecting, tracking, and monitoring information on the health care services that each department contracts for from the private sector. Such a system could promote systemwide cost savings and efficiencies as the departments could exchange services from one another or possibly obtain better contract pricing through joint purchasing of services. In one case in northern California, VA and the Air Force were independently contracting with private providers for dialysis services—information that is not stored in a database to be shared with all VA and DOD health care facilities. During discussions with each other, local VA and Air Force officials recognized they were paying a high cost for dialysis services, got together to analyze their costs and determine the best approach for obtaining these services, and worked together to open a joint dialysis clinic. In this case, had VA and the Air Force known about their individual contracting

[11]In their technical comments to this report the departments stated that all eight projects are operational. However, a project in Hawaii is not fully operational. The goal of that project is to conduct and execute the findings of studies in four key areas: (1) Health Care Forecasting, Demand Management, and Resource Tracking; (2) Referral Management and Fee Authorization; (3) Joint Charge Master Based Billing; and (4) Document Management. The project is not fully operational since, as DOD reported on February 27, 2006, the policies and procedures have only been updated in one of the four areas—Referral Management and Fee Authorization.

arrangements, they could have combined their contracting needs and negotiated services at a lower cost or opened a joint clinic earlier. Furthermore, JEC and HEC have not directed that a joint nationwide market analysis be conducted to obtain information on what their combined future workloads will be in the areas of services, facilities, and patient needs.

VA and DOD lack performance measures that would be useful for evaluating how well the departments are achieving their health care resource-sharing goals. For example, of the 30 measures contained in the departments' joint strategic plan, 5 that were called for in the plan were not developed at the time the plan was issued and 11 lacked long-term or longitudinal information. For the remaining 14 that require periodic measurement, there was variation in the rigor or specificity in the types of data to be collected or the analysis to be performed.

We are recommending that the Secretaries of Veterans Affairs and Defense direct JEC and HEC to take two actions to advance health care resource-sharing activities between the departments. In commenting on a draft of this report, VA and DOD concurred with our recommendations.

Background

VA operates one of the nation's largest health care systems. In fiscal year 2004, VA provided health care to approximately 5.2 million veterans at 157 VAMCs and almost 900 outpatient clinics nationwide.[12] In fiscal year 2004, DOD provided health care to approximately 8.3 million beneficiaries,[13] including active duty personnel and retirees, and their dependents. DOD health care is provided at more than 530 Army, Navy, and Air Force MTFs worldwide and is supplemented by TRICARE's network of civilian providers. Through its TRICARE contracts, DOD uses civilian managed health care support contractors to develop networks of primary and specialty care providers and to provide other customer service functions, such as claims processing. DOD's policy encourages inclusion of all VA health care facilities in its networks.

[12]In fiscal year 2004, there were approximately 7.4 million veterans enrolled to receive care from VA. However, not all enrollees seek health care from VA.

[13]In some cases, DOD beneficiaries may also be eligible for health care benefits from VA.

Health care expenditures for VA and DOD are increasing. VA's expenditures have grown—from about $12 billion in fiscal year 1990[14] to about $26.8 billion in fiscal year 2004—as an increasing number of veterans look to VA to meet their health care needs. DOD's health care spending has gone from about $12 billion in fiscal year 1990[15] to about $30.4 billion in fiscal year 2004—in part, to meet additional demand resulting from congressional actions to expand program eligibility for military retirees, reservists, members of the National Guard, and their dependents, along with the increased needs of active duty personnel involved in conflicts in Afghanistan (Operation Enduring Freedom) and in Iraq (Operation Iraqi Freedom). Today, VA and DOD officials are reporting that many of their facilities are at capacity or exceeding capacity. The nature of sharing has shifted from one of utilizing untapped resources to one of partnering and gaining efficiencies by leveraging resources or buying power jointly. For example, VA and DOD have achieved efficiencies and cost avoidance through a concerted effort to jointly procure pharmaceuticals.[16]

Congressional Initiatives to Increase Health Care Resource Sharing

The Congress has had a long-standing interest in expanding VA and DOD health care resource sharing. In 1982, the Congress passed the Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act (Sharing Act).[17] The act authorizes VA and DOD to enter into sharing agreements to buy, sell, and barter health care resources to better utilize excess capacity. The head of each VA and DOD medical facility can enter into local sharing agreements. However, VA and DOD headquarters officials review and approve agreements that involve national commitments, such as joint purchasing of pharmaceuticals. VA and DOD sharing activities have typically fallen into three categories.

- Local sharing agreements allow VA and DOD to take advantage of their facilities' capacity to provide health care by being providers of health services, receivers of health services, or both. Health services shared under these agreements can include inpatient and outpatient care;

[14]Adjusted for inflation, this would equal about $17 billion in fiscal year 2004.

[15]Adjusted for inflation, this would equal about $17 billion in fiscal year 2004.

[16]See GAO, *DOD and VA Pharmacy: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs*, GAO-01-588 (Washington, D.C.: May 25, 2001).

[17]Pub. L. No. 97-174, 96 Stat. 70.

ancillary services, such as diagnostic and therapeutic radiology; dental care; and specialty care services, such as treatment for spinal cord injuries. Other examples of services shared under these agreements include support services, such as administration and management; research; education and training; patient transportation; and laundry. The goals of local sharing agreements are to allow VAMCs and MTFs to capitalize on their combined purchasing power, exchange health services to maximize use of resources, and provide beneficiaries with greater access to care.

- Joint venture sharing agreements, as distinguished from local sharing agreements, aim to avoid costs by pooling resources to build a new facility or jointly use an existing facility. Joint ventures require an integrated approach, as two separate health care systems must develop multiple sharing agreements that allow them to operate as one system at one location.
- National sharing initiatives are designed to achieve greater efficiencies, that is, to lower cost and improve access to goods and services when they are acquired on a national level rather than by individual facilities—for example, VA and DOD's efforts to jointly purchase pharmaceuticals and surgical instruments for nationwide distribution.

Later, in January 2002, the Congress passed legislation requiring VA and DOD to conduct a comprehensive assessment that would identify and evaluate changes to their health care delivery policies, methods, practices, and procedures in order to provide improved health care services at reduced cost to the taxpayer.[18] To facilitate this, VA and DOD hired a contractor (at a cost of $2.5 million) to conduct the Joint Assessment Study that was completed on December 31, 2003.[19] Unlike previous studies conducted by VA and DOD, the Joint Assessment Study combined VA and DOD beneficiary populations into a single market by geographic site.[20] The contractor examined collaboration and sharing opportunities in three VA and DOD market areas: Hawaii; the Gulf Coast (Mississippi to Florida); and Puget Sound, Washington. Specifically, the study included a detailed

[18]Department of Defense and Emergency Supplemental Appropriations for Recovery from and Response to Terrorist Attacks on the United States Act, 2002, Pub. L. No. 107-117, § 8147, 115 Stat. 2230, 2280-81.

[19]Findings and Recommendations from the DOD/VA Joint Assessment Study presented to Office of Special Programs TRICARE Management Activity, December 31, 2003, Mitretek Systems.

[20]The combined beneficiary market included VA beneficiaries, DOD beneficiaries, and beneficiaries eligible for care from both VA and DOD.

independent review of options to colocate or share facilities and care providers in areas where duplication and some excess capacity may exist; optimize economies of scale through joint procurement of supplies and services; and partially or fully integrate VA and DOD systems to provide tele-health services, provider credentialing, cardiac surgical programs, rehabilitation services, and administrative services.

The NDAA, passed in December 2002, required that VA and DOD implement two programs—JIF and DSS—to increase the amount of health care resource sharing taking place between VA and DOD. Under JIF, the departments are to identify and provide incentives to implement, fund, and evaluate creative health care coordination and sharing initiatives. Under DSS, the departments are to select projects to serve as a test for evaluating the feasibility, advantages, and disadvantages of programs designed to improve the sharing and coordination of health care resources. The NDAA also required VA and DOD jointly to develop and implement guidelines for a standardized, uniform payment and reimbursement schedule for selected health care services. In response, the departments established a standardized reimbursement methodology effective October 2003, between VA and DOD medical facilities through a memorandum of agreement implementing standardized outpatient billing rates based on the discounted Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charges (CMAC)[21] schedule.

Guidance Related to Strategic Planning and Performance Measures

The NDAA also required VA and DOD to develop and publish a joint strategic plan to shape, focus, and prioritize the coordination and sharing efforts within the departments and incorporate the goals and requirements of the joint strategic plan into the strategic plan of each department.[22] We have reported that there is no more important element in results-oriented management than an agency's strategic planning effort.[23] This is the starting point and foundation for defining what the department seeks to accomplish, identifying the strategies it will use to achieve desired results, and then determining how well it succeeds in reaching goals and achieving

[21]To reimburse civilian physicians, DOD has established a CMAC rate. It is the amount DOD will pay civilian providers for medical services for DOD patients.

[22]Bob Stump National Defense Authorization Act for Fiscal Year 2003, Pub. L. No. 107-314, § 721, 116 Stat. 2458, 2589-95.

[23]GAO, *Agencies' Strategic Plans Under GPRA: Key Questions to Facilitate Congressional Review*, GAO/GGD-10.1.16 (Washington, D.C.: May 1997).

objectives. We also previously reported that traditional management practices involve the creation of long-term strategic plans and regular assessments of progress toward achieving the plans' stated goals.[24]

Moreover, the Government Performance and Results Act of 1993 (GPRA) requires agencies to set goals, measure performance, and report on their accomplishments.[25] Performance measures are a key tool to help managers assess progress toward achieving the goals or objectives stated in their plans. They are also an important accountability tool to communicate department progress to the Congress and the public.

Program performance measurement is commonly defined as the regular collection and reporting of a range of data, including a program's

- inputs, such as dollars, staff, and materials;
- workload or activity levels, such as the number of applications that are in process, usage rates, or inventory levels;
- outputs or final products, such as the number of children vaccinated, number of tax returns processed, or miles of road built;
- outcomes of products or services, such as the number of cases of childhood illnesses prevented or the percentage of taxes collected; and
- efficiency, such as productivity measures or measures of the unit costs for producing a service.

Other data might include information on customer satisfaction, program timeliness, and service quality. Managers can use the data that performance measures provide to help them manage in three basic ways: to account for past activities, to manage current operations, or to assess progress toward achieving planned goals and objectives. When used to look at past activities, performance measures can show the accountability of processes and procedures used to complete a task, as well as program results. When used to manage current operations, performance measures can show how efficiently resources, such as dollars and staff, are being used. Finally, when tied to planned goals and objectives, performance measures can be used to assess how effectively a department is achieving the goals and objectives stated in its long-range strategic plan.

[24]GAO, *Program Performance Measures: Federal Agency Collection and Use of Performance Data*, GAO/GGD-92-65 (Washington, D.C.: May 4, 1992).

[25]Pub. L. No. 103-62, 107 Stat. 285.

OMB, through the PMA released in the summer of 2001, has emphasized improving government performance through governmentwide and agency-specific initiatives. OMB is responsible for overseeing the implementation of the PMA and tracking its progress. According to OMB's mission statement, its role is to help improve administrative management, develop better performance measures and coordinating mechanisms, and reduce any unnecessary burdens on the public. For each initiative, OMB has established "standards for success" and rates agencies' progress toward meeting these standards. Among the PMA initiatives, one specifically focuses on improving coordination of VA and DOD programs and systems by increasing the sharing of services that will lead to reduced cost and increased quality of care.

Although JIF and DSS Programs Experienced Start-up Challenges, More Than Half of the Projects Are Operational

While JIF projects experienced challenges caused by delays resulting from the initial absence of funding mechanisms and, in some cases, the need for additional acquisition and construction approvals, as of December 2005, 7 of 11[26] selected 2004 projects were operational. DSS also experienced challenges as some sites reported difficulty putting together project submission packages, noting confusion over the timelines and approval process as well as frustration with the amount of paperwork and rework required. Nonetheless, as of December 2005, 7 of the 8 DSS projects were operational.

JIF Projects Slowly Becoming Operational

The JIF program is to identify, fund, and evaluate creative health care coordination and sharing initiatives. Under the program, VA and DOD solicit proposals from their program offices, VAMCs, or MTFs for project initiatives at least annually. Legislation requires that the Secretaries of VA and DOD each contribute a minimum of $15 million from each department's appropriation into a no-year[27] account established in the U.S. Treasury for each of fiscal years 2004 through 2007. From December 2002 through May 2005, VA and DOD developed JIF program guidelines,

[26]Originally 12 projects were selected; however, 1 project was removed due to legal concerns. VA and DOD offices of general counsel determined after the selection process that VA and DOD did not possess legal authority to pursue the project. Subsequently, this project was removed from the program and funding was reallocated.

[27]Under the statute, 38 U.S.C. § 8111(d)(2), the funding is not required to be obligated and expensed within a single fiscal year. The funds may be obligated and expensed over a multiyear period.

solicited and reviewed proposals, established an account within the U.S. Treasury for funding projects, and selected and funded projects. A memorandum of agreement entered into by VA and DOD assigned the Financial Management Workgroup—a group established by HEC—as the administrator of JIF. The Financial Management Workgroup has oversight responsibility for the implementation, monitoring, and evaluation of the JIF program. The members of the workgroup review concept proposals for selection and provide their recommendations to HEC for final approval. They developed the following criteria[28] to be used for evaluating the concept proposals and selecting the final projects:

- support DOD and VA's joint long-term approach to meeting the health care needs of their beneficiary populations;
- improve beneficiary access;
- ensure exportability to other facilities;
- maximize the number of beneficiaries who would benefit from the initiative;
- result in cost savings or cost avoidance;
- develop in-house capability at a lesser cost for services now obtained by contract; and
- demonstrate that the project would be self-sustaining within 2 years. If funding is needed beyond 2 years, the local facility, the Surgeon General's office, or the Veterans Integrated Service Network[29] must agree to provide it.

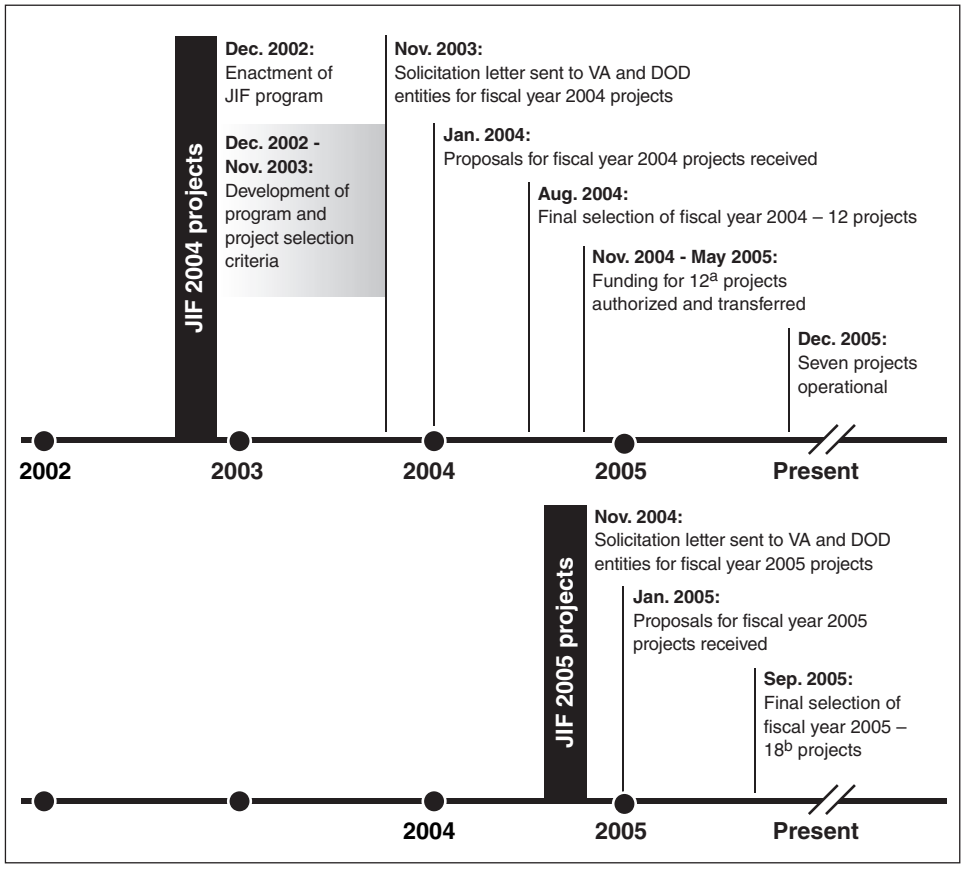
VA and DOD officials completed their review of 58 concept proposals that were submitted for the fiscal year 2004 funding cycle and ultimately selected 12 projects (subsequently reduced to 11) for funding in November 2004. VA and DOD issued a request for project proposals for the fiscal year 2005 funding cycle in November 2004. Submissions were due by January 2005, and according to VA and DOD officials, 56 concept proposals were submitted. VA and DOD reviewed the concept proposals in September 2005 and selected 18 for funding (subsequently reduced to

[28]These criteria were used to evaluate fiscal year 2004 proposals; VA and DOD reported in February 2006 that the criteria have been slightly refined.

[29]The management of VA's hospitals and other health care facilities is decentralized to 21 regional networks referred to as Veterans Integrated Service Networks.

17).[30] See figure 1 for a timeline and associated events affecting the implementation of the JIF program.

Figure 1: JIF Program Implementation Timeline



Source: GAO analysis of VA and DOD documents.

[a]Originally 12 projects were selected; however, 1 project was removed due to legal concerns.

[b]Originally 18 projects were selected; however, 1 project was removed due to asset realignment issues.

[30]Originally 18 projects were selected; however, 1 project was removed due to asset realignment issues.

Beginning in fiscal year 2004, each department as required by law, began contributing $15 million annually into the U.S. Treasury account established for funding JIF.[31] VA and DOD report that as of January 2006, $54.3 million of the $90 million they contributed has been allocated to specific projects, and $5.3 million has been obligated. (See table 1.) For the 2004 JIF projects, project selection took place in August 2004. Initial funding for some of the projects began in November 2004. However, it was not until May 2005—about 2½ years after the program was established—that initial funding was provided to the last of the approved projects.

Table 1: JIF Program Funding

Dollars in millions

Fiscal year	Department required contributions	Allocated[a]	Obligated[b]
2004	$30	$0	$0
2005	30	15.3	5.3
2006	30	39.0[c]	- -
2007 (projected)	30	- -	- -
Total	**$120**	**$54.3**	**$5.3**

Sources: VA and DOD.

[a]For the purposes of this report, allocated represents the amount of money designated for specific projects.

[b]For the purposes of this report, obligated represents the amount of allocated funds that have been committed to project activities.

[c]Of the $39.0 million, $7.7 million was allocated toward year 2 funding for 2004 projects and the remaining $31.3 million was allocated for 2005 projects.

According to officials from both departments, funding delays occurred for a number of reasons. VA and DOD needed time to set up the U.S. Treasury account and to establish funding mechanisms to facilitate the transfer of funds from the account to individual VAMCs or MTFs. Further, funding could not be provided until project officials and the surgeons general for DOD's Departments of the Army, Navy, and Air Force completed required administrative actions. These actions included obtaining assurance from the surgeons general that service-specific department protocols for disbursing funds were followed and obtaining certification from project officials that projects would be self-sustaining within 2 years.

[31]The Congress directed VA and DOD to commence funding in fiscal year 2004.

While all approved fiscal year 2004 projects have now received funding, those still in the development phase are in the process of acquiring needed equipment, staff, or space. In addition to the delays caused by VA and DOD administrative processes to fund projects, the individual projects experienced delays for other reasons. For example, officials from both departments reported that additional approvals for acquisition of equipment and minor construction were needed before some projects could be initiated. Specifically, VA and DOD officials in North Chicago, Illinois, stated that in addition to the approvals required from HEC's Financial Management Workgroup and the Navy Surgeon General's Office, they were also required to seek and obtain acquisition approval from the National Acquisition Center for the mammography unit requested in their project. The officials stated that these three distinct approval processes for their JIF project should have been merged into a single approval process. Further, VA and DOD officials in Honolulu, Hawaii, reported that because of delays in obtaining acquisition approvals, pricing increases occurred, resulting in increased cost to the government. Initial project approval occurred in August 2004; however, final contract approval was not granted as of December 2005, over a year later.[32]

As of December 2005, 4 of the 11 JIF fiscal year 2004 projects were still in the development stage, with 7 of 11 operational. Some of the projects that were operational include a joint dialysis unit located at Travis Air Force Base, Fairfield, California, that according to VA and DOD officials, improves access for VA and DOD beneficiaries and lessens the cost to the government by reducing purchased services from the private sector; a tele-radiology unit located at the VAMC in Spokane, Washington, that is providing tomography scans for DOD beneficiaries; and an imaging services unit at Elmendorf Air Force Base in Anchorage, Alaska, that allows VA and DOD to pool their imaging needs and provide services in-house instead of contracting for them at very expensive fees charged by providers in this remote area. See appendix II for details about JIF projects selected in fiscal years 2004 and 2005.

Most Demonstration Site Projects Are Operational

DSS projects are piloting different approaches to sharing health care resources in three areas—budget and financial management, coordinated staffing and assignment, and medical information and information technology. Further, each DSS project contains individual goals that have

[32]DOD commented that the contract was awarded on February 23, 2006.

the potential to promote VA and DOD health care resource sharing and collaboration. The objective of each project is aligned with VA's and DOD's strategic goal to jointly acquire, deliver, and improve health care services. From July 2003 through August 2004, VA and DOD developed DSS program guidelines, solicited and reviewed proposals, and began funding projects. Eight projects were approved by HEC in October 2003; project funding began in August 2004; and as of December 2005, seven projects were operational.

The DSS program is to serve as a test for evaluating the feasibility and the advantages and disadvantages of projects designed to improve sharing. The Joint Facility and Utilization Workgroup—a group established by HEC—is responsible for DSS project selection and oversight. Projects selected by the workgroup must be approved by HEC. As required by the statute, there must be a minimum of three VA and DOD demonstration sites (projects) selected. Also, at least one project was required to be tested in each area.

As required by law, each department was required to make available at least $3 million in fiscal year 2003, at least $6 million in fiscal year 2004, and at least $9 million for each subsequent year in fiscal years 2005 through 2007 to fund DSS projects.[33] During fiscal year 2003 no funds were allocated or obligated to projects because, according to VA and DOD officials, the business plans for the sites had not been finalized. During fiscal years 2004 and 2005, approximately $6.2 million and $12.7 million, respectively, of the $36 million made available by VA and DOD, were allocated to specific DSS projects, and $14.4 million was obligated. See table 2 for the amount of funds made available, allocated, and obligated for the DSS program.

[33]Pub. L. No. 107-314, § 722(e), 116 Stat. 2595-98.

Table 2: DSS Program Funding

Dollars in millions			
Fiscal year	**Funds made available by VA and DOD**	**Allocated[a]**	**Obligated[b]**
2003	$6	$0[c]	$0
2004	12	6.2	4.9
2005	18	12.7	9.5
2006 (projected)	18	10.2	- -
2007 (projected)	18	9.7	- -
Total	**$72**	**$38.8**	**$14.4**

Sources: VA and DOD.

[a]For the purposes of this report, allocated represents the amount of money designated for specific projects.

[b]For the purposes of this report, obligated represents the amount of allocated funds that have been committed to project activities.

[c]According to VA and DOD officials, funding was not allocated in 2003 because the business plans for the sites had not been finalized.

From July 2003 through October 2003, VA and DOD developed program guidelines and solicited and reviewed project proposals. Each proposal was reviewed and scored by members of the Joint Facility and Utilization Workgroup for each category for which it had been submitted. For example, according to VA and DOD officials, under budget and financial management, one of the criteria for selection included whether a project allowed managers to assess the advantages and disadvantages—in terms of relative costs, benefits, and opportunities—of using resources from either department to provide or enhance the delivery of health care services to beneficiaries of either department. For coordinated staffing and assignment projects, criteria included whether the project could demonstrate agreement on staffing responsibilities in providing joint services and the development of a plan to provide adequate staffing in the event of deployment or contingency operation. Criteria related to medical information and information technology included whether a project could communicate medical information and incorporate minimum standards of information quality and information assurance related to either credentialing, consolidated mail outpatient pharmacy, or laboratory data sharing. According to VA and DOD officials, upon selection DSS projects are to be monitored via periodic progress assessments to ensure that project activities align with the cost, schedule, and performance parameters outlined in the submitted business plan.

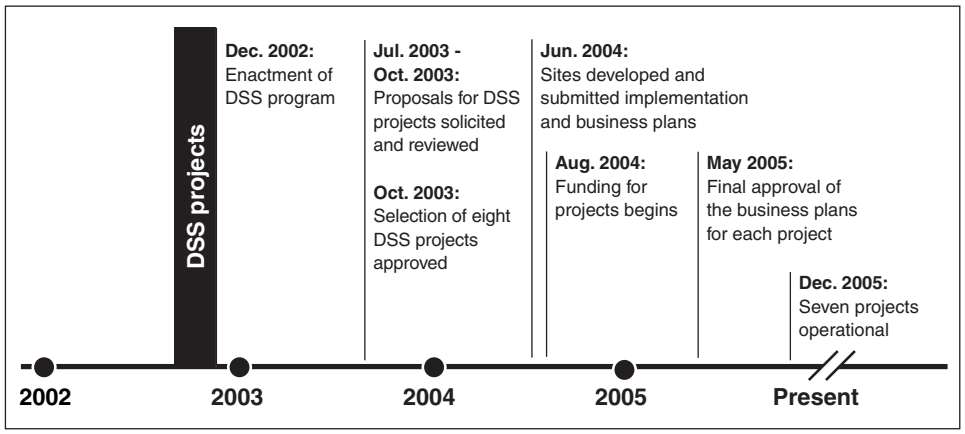
The Joint Facility and Utilization Workgroup forwarded eight DSS project proposals to HEC, which approved them in October 2003. However, sites reported some difficulty putting together the project submission packages. For example, one site noted there was initial confusion over the timelines and approval process as each department had differing requirements. Another site expressed frustration with the amount of paperwork and rework required. Nevertheless, by June 2004 the sites developed and submitted for VA and DOD approval proposed implementation and business plans for their projects, in August 2004 VA and DOD began project funding, and in May 2005 VA and DOD reported that they had approved all the proposed project business plans. As of December 2005, VA and DOD reported that the following seven DSS projects were operational:

- A project at San Antonio, referred to as the Laboratory Data Sharing Initiative (LDSI), has been successful in enabling each department to conduct laboratory tests and share the results with each other. This project allows a VA provider to electronically order laboratory tests and receive results from a DOD facility, and conversely, a DOD provider can electronically order laboratory tests and receive results from a VA facility. An early version of what is now LDSI was originally tested and implemented at a joint VA and DOD medical facility in Hawaii in May 2003. The San Antonio LDSI demonstration project built on the Hawaii version and enhanced it. According to the departments, a plan to export LDSI to additional sites has been approved.
- An electronic data exchange project at El Paso successfully exchanged laboratory orders and results as well as limited patient information—demographic, outpatient pharmacy, radiology, laboratory, and allergy data.
- An electronic data exchange project at Puget Sound has also achieved similar results by exchanging limited patient information—demographic, outpatient pharmacy, radiology, allergy data, and discharge summaries. The results of the project are scheduled to be replicated at five additional VA and DOD sites during the first quarter of fiscal year 2006.
- A project at Augusta to coordinate the staffing and sharing of nurses at VA and DOD facilities has yielded savings in terms of cost, time, and training resources.
- A project in Alaska is producing itemized bills for each individual VA patient seen at the DOD facility. The cost for each patient visit is then credited in VA's accounting system to capture the workload.
- A project at San Antonio has successfully shared credentialing data for licensed VA and DOD providers through an interface between the two departments' individual credentialing systems.

- A project at Hampton is using an automated tool to evaluate staffing shortfalls and mitigate identified gaps in the resources needed to provide health care services to VA and DOD beneficiaries.

According to VA and DOD officials, they plan to evaluate whether the eight projects were successful and if they can be replicated at other VA and DOD medical facilities. However, as of November 2005, VA and DOD had not developed an evaluation plan for making these assessments. See appendix III for additional details about the DSS projects. See figure 2 for a timeline and associated events affecting the implementation of the DSS program.

Figure 2: DSS Program Implementation Timeline



Source: GAO analysis of VA and DOD documents.

VA and DOD Have Taken Actions to Strengthen Health Care Resource Sharing, but Important Opportunities Remain

VA and DOD have taken steps to create interagency councils and workgroups to facilitate the sharing and collaboration of information, establish working relationships among their leaders, and develop communication channels to further health care resource sharing. However, JEC and HEC have not seized upon a number of opportunities to further collaboration and coordination.

Actions Taken to Enhance Health Care Resource Sharing

In addition to the development of congressionally mandated JIF and DSS programs, VA and DOD have created mechanisms to enhance health care resource sharing by forming JEC and through a proposed federal health care facility in North Chicago. The two departments have also worked together to develop a Joint Strategic Plan outlining six goals.

Joint Executive Council

In February 2002, VA and DOD established JEC to enhance VA and DOD collaboration; ensure the efficient use of federal services and resources; remove barriers and address challenges that impede collaborative efforts; assert and support mutually beneficial opportunities to improve business practices; facilitate opportunities to enhance sharing arrangements that ensure high-quality, cost-effective services for both VA and DOD beneficiaries; and develop a joint strategic planning process to guide the direction of joint sharing activities.[34] JEC is co-chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness.[35] Membership consists of senior leaders from both VA and DOD, including VA's Under Secretary for Benefits and Under Secretary for Health and DOD's Principal Deputy Under Secretary of Defense for Personnel and Readiness and Assistant Secretary for Health Affairs. JEC established two interagency councils and two interagency committees to facilitate collaboration: (1) Benefits Executive Council, (2) HEC, (3) VA/DOD Construction Planning Committee (CPC), and (4) Joint Strategic Planning Committee.

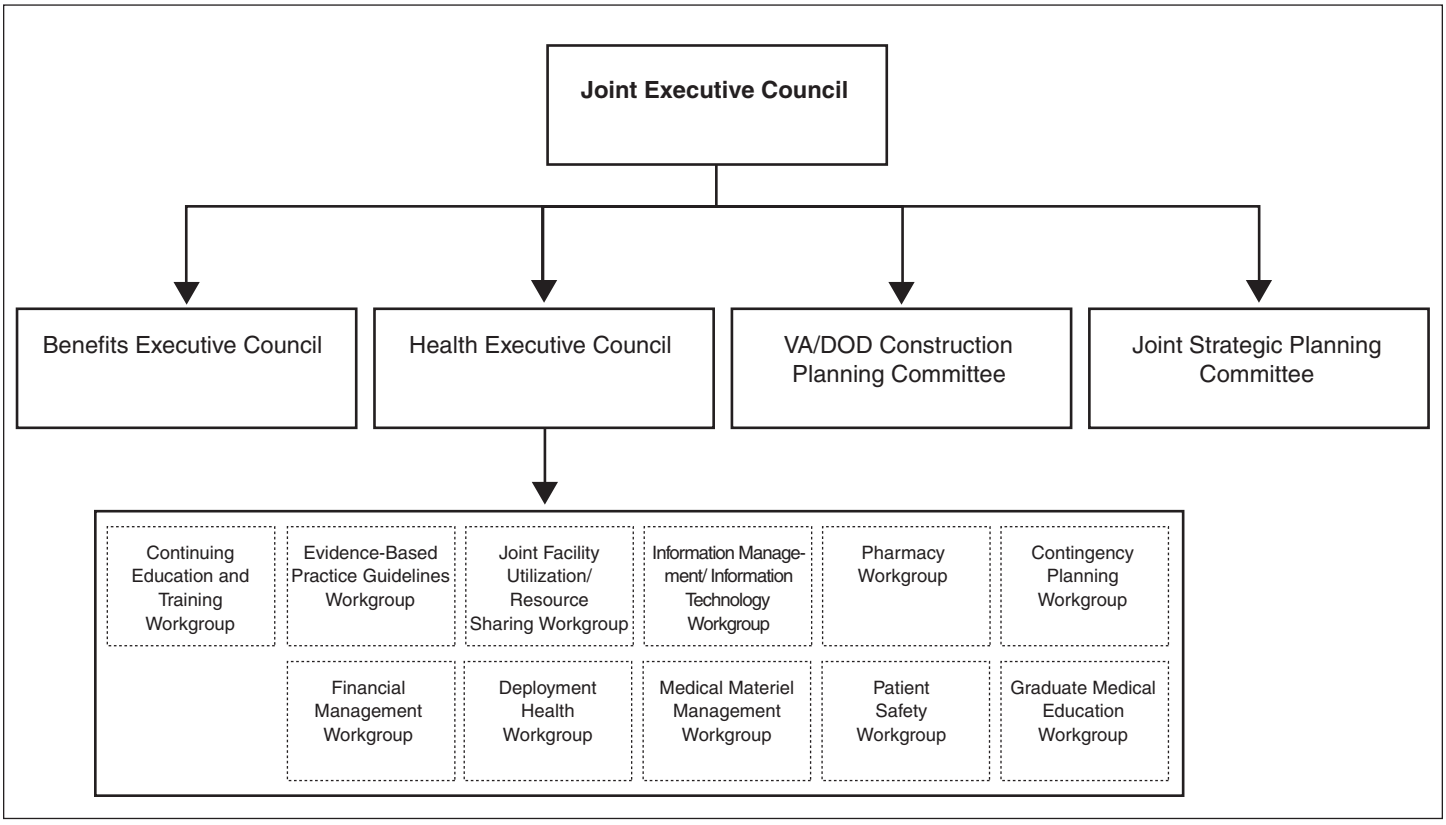
HEC was placed under the purview of JEC specifically to advance VA and DOD health care resource sharing and collaboration. Through HEC, VA and DOD have developed policies and procedures for facilitating health care resource-sharing activities. Together, the two departments are working to create, implement, and adhere to joint standards in the areas of clinical guidelines, information technology, deployment health policies, and purchasing of medical and surgical supplies. HEC has organized itself into 11 workgroups—on subjects such as financial management, pharmacy, and deployment health—in order to carry out its mission (see

[34]National Defense Authorization Act for Fiscal Year 2004, Pub. L. No. 108-136 § 583, 117 Stat. 1392, 1490-92, required VA and DOD to establish a joint executive committee. VA and DOD use their JEC structure to fulfill this legislative requirement.

[35]In 1997, VA and DOD established HEC—a precursor to JEC, which was co-chaired by the VA Under Secretary for Health and the Assistant Secretary of Defense (Health Affairs). In fiscal year 2002, JEC was established to further engage VA and DOD senior leadership, including VA's Deputy Secretary and DOD's Under Secretary for Personnel and Readiness, who serve as co-chairs for JEC.

fig. 3).[36] HEC's mission includes formulating VA and DOD joint policies that relate to health care, facilitating the exchange of patient information, and ensuring patient safety. HEC membership includes senior leaders from VA and DOD. HEC is co-chaired by VA's Under Secretary for Health and DOD's Assistant Secretary of Defense for Health Affairs. DOD membership also includes the surgeons general for the military services. See appendix IV for a description of VA's and DOD's councils, committees, and workgroups.

Figure 3: VA/DOD JEC Organizational Chart, as of October 2005



Sources: VA and DOD.

[36]On February 27, 2006, DOD stated that the departments have added an additional workgroup—the Mental Health Workgroup.

HEC workgroups, such as Joint Facility Utilization/Resource Sharing, Deployment Health, and Evidence-Based Practice Guidelines, develop and implement changes in policy and guidance approved by HEC. For example, the Deployment Health Workgroup has developed medical and public health policy for active duty service members who have been exposed to tuberculosis, to be treated by VA without co-payment. This policy allows separating service members to continue to receive antituberculosis prophylactic treatment at a VA facility following their separation from active duty military service. Further, the Deployment Health Workgroup has developed a roster identifying Operation Enduring Freedom and Operation Iraqi Freedom veterans who are separating or who have separated from active duty military service. VA is using this roster to mail letters to individuals thanking them for their service and advising them of their VA benefits based on their service in a combat theater. VA is also using this roster to determine postdeployment VA health care utilization by this population of veterans. Other efforts include the Evidence-Based Practice Guidelines Workgroup's development of standardized guidelines to improve patient outcomes for both VA and DOD beneficiaries. In fiscal year 2005, the workgroup began revising four of its guidelines, including rehabilitation for servicemembers with amputations. Completed guidelines are presented at various national meetings. Tools such as CD-ROMs, pocket cards, and patient brochures are made available for VA and DOD providers in order to enhance communications with their patients.

North Chicago Federal Health Care Facility

JEC and HEC are also promoting integration through the establishment of a combined VA and DOD federal health care facility in North Chicago. According to VA and DOD, it was through discussions during JEC and HEC meetings that the combined federal facility in North Chicago was envisioned. According to a DOD official, the combined facility will be a hospital. The current plan is to build an ambulatory care clinic that will be attached to the current VA medical center. According to the DOD official, for the first time VA and DOD will operate a facility under a single chain of command that would integrate the budget and management for providing medical services from both departments to achieve one cohesive medical facility that serves VA and DOD beneficiaries. This management structure differs significantly from joint ventures in which separate VA and DOD management structures coexist. The North Chicago Federal Health Care Facility is scheduled to be operational in fiscal year 2010.

Joint Strategic Plan

VA and DOD also developed a strategic plan in December 2004 that includes six joint goals.[37] Each of JEC's councils and committees and HEC's workgroups has been assigned responsibility for meeting some aspects of the goals outlined in the joint strategic plan. For example, according to VA and DOD officials, the Financial Management Workgroup developed a standardized business case analysis template for the JIF program to increase efficiency of operations. VA and DOD staff utilize this template when requesting funding for joint projects. Previously, the individual branches of the service had their own templates, all of which were slightly different. The departments' joint goals are as follows:

- **Goal 1: Leadership Commitment and Accountability**. Promote accountability, commitment, performance measurement, and enhanced internal and external communication through a joint leadership framework.
- **Goal 2: High-Quality Health Care**. Improve the access, quality, effectiveness, and efficiency of health care for beneficiaries through collaborative activities.
- **Goal 3: Seamless Coordination of Benefits**. Promote coordination of benefits to improve understanding of and access to benefits and services earned by servicemembers and veterans through each stage of life, with a special focus on ensuring a smooth transition from active duty to veteran status.
- **Goal 4: Integrated Information Sharing**. Ensure that appropriate beneficiary and medical data are visible, accessible, and understandable through secure and interoperable information management systems.
- **Goal 5: Efficiency of Operations**. Improve management of capital assets, procurement, logistics, financial transactions, and human resources.
- **Goal 6: Joint Medical Contingency/Readiness Capabilities**. Ensure the active participation of both departments in federal and local incident and consequence response through joint contingency planning, training, and exercising.

Opportunities to Strengthen Health Care Resource Sharing Remain

While progress has been made, JEC and HEC—which are responsible for advancing VA and DOD health care resource sharing and collaboration—have not seized upon a number of opportunities to promote sharing and collaboration. For example, during the course of our audit work, we found

[37]Department of Veterans Affairs/Department of Defense, *VA/DOD Joint Strategic Plan* (Washington, D.C.: December 2004).

that JEC and HEC have not developed a system for jointly collecting, tracking, and monitoring information on the health care services that VA and DOD contract for from the private sector; directed that a joint nationwide market analysis be conducted that contains information on what the departments' combined future workloads will be in the areas of services, facilities, and patient needs; disseminated in a timely manner the information or the tools developed by a congressionally required study (the Joint Assessment Study) for assessing collaboration and sharing opportunities; or established standardized inpatient reimbursement rates—initiatives that would be useful for maximizing health care resource-sharing opportunities and promoting systemwide cost savings and efficiencies.

System for Tracking VA and DOD Purchased Services

Though the Army, Air Force, and Navy each record the amount of care that is purchased from the private sector, they do not collectively merge that information or combine it with VA's total expenditures for services purchased from the community. As a result, a systematic approach for collecting, tracking, and monitoring information on the services that each department contracts for from the private sector is lacking.

Such an approach could help VA and DOD achieve systemwide cost savings and efficiencies, as has been demonstrated at the local level where officials at certain sites compare their analyses and seek to exchange services from one another or possibly obtain better contract pricing through joint purchasing of services. For example, for fiscal year 2003, a VA official at one site estimated that VA reduced its cost by $1.7 million as compared to acquiring the same services in the private sector through its agreements with the Army; he also estimated that the Army reduced its cost by about $1.25 million as compared to acquiring the same services in the private sector. For instance, the site jointly leased a magnetic resonance imaging (MRI) unit. The unit eliminated the need for beneficiaries to travel to more distant sources of care. According to a VA official, the purchase reduced MRI cost by 20 percent as compared to acquiring the same services in the private sector.

The availability of such information would be helpful to VA and DOD sites at the local level for sharing information on services they have independently contracted for from the private sector. For example, VA and the Air Force at a northern California site were able to create efficiencies after recognizing that they had been independently contracting for the same services. Both VA and the Air Force had been sending patients to private providers for dialysis services—information that is not stored in a database to be shared with all VA and DOD health care facilities. During

discussions, local VA and Air Force officials recognized they were paying a high cost for dialysis services, got together to analyze their costs and determine the best approach for obtaining these services, and worked together to open a joint dialysis clinic. In this case, had VA and the Air Force known about their individual contracting arrangements, they could have combined their contracting needs and negotiated services at a lower cost or opened a joint clinic earlier.

Nationwide Market Analysis

In response to our concerns and those of the Congress, VA initiated a review of its capital assets under the Capital Asset Realignment for Enhanced Services (CARES) program. The review was to provide a comprehensive, long-range assessment of VA's health care system's capital asset requirements. In May 2004, the Secretary's CARES decision document was issued and, according to VA, serves as a road map for aligning its facilities with the health care needs of 21st century veterans.[38] The CARES report addresses partnering with DOD. It outlines existing and potential areas of sharing at the local level and opportunities for joint ventures.

DOD was authorized to assess its infrastructure and provide base realignment and closure (BRAC) recommendations in 2005 to an independent commission for its review.[39] An objective of the 2005 BRAC Commission, in addition to realigning DOD's base structure to meet post-Cold War force structure, was to examine and implement opportunities for greater sharing with VA. Joint cross-service groups were tasked with analyzing common business-oriented functions, such as health care. The Medical Joint Cross-Service Group was chartered to review DOD's health care functions and to provide BRAC recommendations based on that review. As we reported in July 2005, our examination of the BRAC process found that while the medical group examined the capacity and proximity of VA facilities to existing MTFs in its analysis, it did not coordinate with VA to determine whether military beneficiaries who normally receive care at MTFs could also receive care at VA facilities in the vicinity.[40]

[38]Department of Veterans Affairs, Office of the Secretary, *Secretary of Veterans Affairs CARES Decision* (Washington, D.C.: May 2004).

[39]See Defense Base Closure and Realignment Act of 1990, Pub. L. No. 101-510, as amended, codified at 10 U.S.C.A. § 2687 note (2004 Supp.).

[40]GAO, *Military Bases: Analysis of DOD's 2005 Selection Process and Recommendations for Base Closures and Realignments*, GAO-05-785 (Washington D.C.: July 1, 2005).

Each department has individually analyzed its health care needs—in part through VA's efforts to realign its capital assets under the CARES process and through DOD's BRAC process. Each department issued reports, which contained references to sharing or partnering with one another in the future. However, JEC and HEC have not conducted a nationwide integrated review and market analysis that would provide information on what their combined future health care workloads and needs may be. Such information is necessary to fully evaluate, and maximize the potential for, health care resource-sharing opportunities. In its February 27, 2006, comments DOD stated that HEC has established a BRAC Impact and Opportunity Ad Hoc Workgroup to explore and identify opportunities for local collaboration and health care partnerships between VA and DOD in areas potentially affected by BRAC action. The work of this group would be a step in obtaining information on VA's and DOD's combined future health care workloads and needs.

Dissemination of Results from the Joint Assessment Study

Furthermore, JEC and HEC have not disseminated in a timely manner the information or the tools developed by the DOD/VA Joint Assessment Study that examined the collaboration and health care sharing opportunities for three VA and DOD sites. For example, officials at one site stated that they did not receive the study findings until almost a year after it was completed. At that point, the officials stated that the market information was outdated and of little use to the site in forecasting and planning for future work. In addition, the study also produced a tool for combining VA and DOD beneficiary populations by geographic site. Utilizing this information, the contractor was able to forecast local market demand for health services—potentially allowing VA and DOD officials to plan and provide services to their "combined market." Further, the contractor formulated "crosswalk" tables to assist VA and DOD in matching similar health care services. Historically, VA and DOD have captured health services information in varying formats and could not always account for their workloads in the same manner. The tool would provide VA and DOD health care managers within geographic areas with information on the health care needs of the combined beneficiary populations—information that could be useful to them for sharing and joint purchase decisions. However, 2 years after development of the tool, it is currently being utilized at one site.

Beneficiary Care

During the course of our audit work, we also found instances in which HEC could have asserted itself in local decision making to maximize resource-sharing opportunities as well as to help ensure continuity of care for beneficiaries. For example, see the following:

- In Honolulu, Hawaii, we were informed by DOD that Tripler Army Medical Center (Tripler) had resources available to meet the health care needs of certain VA beneficiaries, yet VA chose to send them to its medical center in Palo Alto, California, for their care. Hawaii VA officials told us it does this because the cost of care is borne by Palo Alto and not by the Hawaii VA medical center, which would have to reimburse Tripler for the care. Under this scenario, the federal government is paying for underutilized resources and providers at Tripler. We believe HEC has an opportunity to step in and ensure that Tripler resources are fully maximized—an initiative that would ultimately result in overall savings to the government. More important, beneficiaries treated at Palo Alto return to Hawaii and require follow-up care, and in some cases emergency care, that is often provided by Tripler—a situation that could raise continuity of care issues. By fully maximizing resources at Tripler, HEC would be helping to ensure that initial treatments are provided closer to a beneficiary's home and that continuity of care is maintained.
- In San Antonio, Texas, we found that VA contracts out approximately $1.5 million for diagnostic services to various private sector laboratories even though local MTFs have the capacity to provide these services. According to VA, it contracts out to the private sector because the costs are less than what DOD facilities charge. While it is understandable that VA would seek to purchase services at the best prices possible, this practice may result in greater costs to the government as it is incurring VA's costs as well as the costs to maintain underutilized DOD facilities. In this case, JEC and HEC have not taken the initiative to determine the most cost-effective strategy for meeting VA's and DOD's laboratory service needs—information that would be useful for VA and DOD to ensure good stewardship of federal resources.

Standardized Inpatient Reimbursement Rates

Finally, we found that HEC could be more proactive in establishing joint policies or guidance in a timely manner that facilitates health care resource sharing. For example, in December 2002 legislation required VA and DOD to establish a national standardized uniform payment and reimbursement schedule for selected health care services. In 2003, VA and DOD established a reimbursement rate for outpatient services. However, VA and DOD have not yet established an inpatient reimbursement rate. Though HEC reports it is in the process of soliciting input and developing guidance for an inpatient rate, we found that without an established inpatient rate local officials were forced to negotiate rates among themselves—an activity that consumed staff time and often created tension between partners.

OMB's Evaluation of VA and DOD Sharing Activities

In addition to our observations on opportunities for VA and DOD to strengthen health care resource sharing, OMB, the agency responsible for

improving administrative management in the executive branch, also sees room for improvement in achieving the President's goal to increase VA and DOD health care resource-sharing activities. OMB evaluates VA and DOD's health care resource-sharing activities by providing an overall or composite score on their ability and progress to

- exchange patient medical record information between VA and DOD electronically,
- adopt governmentwide information technology standards for health records,
- develop a plan for VA to use DOD's enrollment and eligibility data,
- establish the DSS program,
- develop a graduate medical education pilot program,
- increase nongraduate medical education training and education opportunities,
- utilize one examination for separating servicemembers that meets the needs of VA and DOD, and
- purchase medical supplies and equipment jointly.[41]

OMB uses a color code—green, yellow, and red—to score the current status and progress of health care resource-sharing activities. A score in the green status would indicate that the departments are achieving the degree of health care resource sharing agreed upon by the departments and the administration. Yellow status means the coordination of VA and DOD health care resource-sharing activities are yielding mixed results and not meeting their timelines. A red score would indicate that the departments are not achieving the degree of health care resource sharing agreed upon by the departments and the administration. Since OMB first began scoring the departments in 2001, the score for "current status" of health care resource sharing has remained yellow and the score for "progress in implementation" has dropped from the best score of green to a score of yellow.

[41]OMB's scorecard for PMA Initiative 14—VA/DOD Sharing—does not score each of these factors individually, rather it uses them to develop two composite scores: (1) Current Status and (2) Progress in Implementation.

VA and DOD Lack Useful Performance Measures to Evaluate Health Care Resource Sharing

VA and DOD health care resource-sharing activities are guided by a joint strategic plan—the *VA/DOD Joint Strategic Plan*, December 2004. However, the plan does not contain performance measures that are useful for evaluating how well the departments are achieving their health care resource-sharing goals.

For example, the plan mentions 30 measures that could be used to assess the departments' progress in sharing health care resources. We reviewed the plan and found that the measures could be placed into one of three categories: (1) a measurement that would be developed in the future, (2) a measurement that took place only once, and (3) a measurement that was taken periodically.

We placed 5 of the 30 measures in the first category because the plan states that these measures will be developed in the future. For example, the plan states that a communication effectiveness measure will be developed as part of the communication strategy. The plan also states that VA and DOD will develop performance measures related to joint education and training opportunities by December 2006.

Further, we placed 11 of the 30 measures in the second category because they call for a single event measurement, such as "increase the number of collaborative research projects completed by VA and DOD by December 2007," or they state a goal, such as a system "will be fully operational and providing VA benefit eligibility information by December 2008." While measurements of this type may provide useful snapshot information of output for a point-in-time prospective, they are not periodic and thus do not provide long-term or longitudinal information for evaluating the usefulness of specific activities.

Finally, in the third category we placed the plan's remaining 14 measures that call for periodic measurement. We found there was variation in the rigor or specificity in the types of data to be collected or the analysis to be performed. For example, CPC is tasked with reporting to JEC quarterly; however the tasking does not specify the types of data to be collected or the analytical assessments to be performed. Another performance measure from the plan states that the "Amount of electronic health data available to the other department is higher each quarter reported." The lack of specificity with this performance measure raises questions about the usefulness of the information for evaluating how well the departments are achieving their health care resource-sharing goals.

Furthermore, VA and DOD have not established a performance measure that would track their progress in jointly obtaining health care services—such as difficult-to-fill occupations, laboratory tests, and diagnostic equipment. For example, while VA and DOD are in the process of jointly acquiring five MRI units to help with their diagnostic needs through the JIF program, other opportunities for sharing MRI units may exist. During our review, we did not find evidence that VA and DOD top management set an expectation for their medical facility managers to consider partnering prior to purchasing MRI equipment. Without such an expectation and a specific measurement tool or metric to track the joint acquisition and utilization of MRI services, VA and DOD are not in a position to determine on a nationwide basis the most cost-efficient way to obtain and deliver MRI services.

Conclusions

When the idea of health care resource sharing was originally conceived and sanctioned by the Congress in the early 1980s, it was based on the premise of excess capacity. However, the set of circumstances that confront VA and DOD today are quite different, as both departments strive to serve an increasing number of beneficiaries. VA and DOD officials state that many of their facilities are at capacity or exceed capacity. The nature of sharing has shifted from one of utilizing untapped resources to one of partnering and gaining efficiencies by leveraging resources or buying power jointly. Implementing such a process across all components involved with the delivery of VA and DOD health care should yield positive results as resource sharing becomes an integral part of a systemwide decision-making process. However, while VA and DOD, through JEC and HEC, have created mechanisms that support the potential to increase collaboration, sharing, and coordination of management and oversight of health care resources and services, more can be done to capitalize on this relationship throughout the departments.

The Congress provided additional sharing opportunities for local entities through the establishment of JIF and DSS. These programs have laid the foundation for new sharing relationships and, in other cases, have deepened existing relationships. The goals of each of the projects are aligned with VA's and DOD's goals to jointly acquire, deliver, and improve health care services. Both the JIF and DSS programs provide a congressionally driven mechanism to help increase the number of new sharing agreements between VA and DOD partners. However, VA and DOD have not yet developed a standardized evaluation plan for documenting and recording the advantages and disadvantages of each project and whether they can be replicated at other VA and DOD medical facilities.

Without an established evaluation plan to measure and determine the results of the projects, VA and DOD may lose an opportunity to obtain information that will be useful for determining whether projects can be replicated systemwide.

The Joint Strategic Plan is a positive first step toward outlining VA and DOD sharing goals and measures. However, useful specific quantitative performance measures for VA and DOD to track the progress of their health care resource-sharing activities have not been established. Such measures would be a useful tool for VA and DOD to help ensure that health care sharing is optimized and that the departments are cost efficiently achieving their resource-sharing goals.

Recommendations for Executive Action

To further advance health care resource sharing within VA and DOD, the Secretaries of Veterans Affairs and Defense should direct JEC and HEC to take the following two actions:

- develop an evaluation plan for documenting and recording the reasons for the advantages and disadvantages of each DSS project, an activity that will assist VA and DOD in replicating successful projects systemwide, and
- develop performance measures that would be useful for determining the progress of their health care resource-sharing goals.

Agency Comments and Our Evaluation

We received comments from VA and DOD on a draft of this report. The departments concurred with our recommendations and also provided technical comments that we have incorporated as appropriate. VA's comments are included as appendix V and DOD's comments are included as appendix VI.

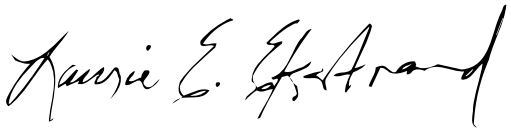
VA and DOD agreed with our recommendation to develop a DSS evaluation plan and described their plans and timelines for implementing it. The departments stated they have modified an in-progress review template to strengthen department information on the advantages and disadvantages of each project and whether they can be replicated systemwide. According to the departments, the template was distributed to the DSS sites in January 2006 and will be operational in the second quarter of fiscal year 2006.

VA and DOD also agreed with our recommendation to develop performance measures that would be useful for determining the progress of achieving health care resource-sharing goals. In their comments, the

departments stated that they have, since the work was completed for this report, issued the *VA/DOD Joint Executive Council Strategic Plan, Fiscal Years 2006-2008* (signed by VA and DOD on January 26, 2006)—a plan that revises and updates the *VA/DOD Joint Strategic Plan, December 2004* and contains performance measures that demonstrate measurable progress relative to specific strategic milestones. VA included a copy of the updated plan with its comments and noted that action on this recommendation has been completed as performance measures have been identified for each of the health care resource-sharing goals. We do not agree that the January 2006 plan fully addresses the concerns raised in the report, and maintain our recommendation that useful measures—those that provide specifics regarding time frames, implementation strategies, and the type of information that will be reported to program managers—need to be developed. For example, our review of the Joint Strategic Plan, Fiscal Years 2006-2008, showed that while goal 6—Joint Medical Contingency/Readiness Capabilities—has strategies and key milestones, it contained no performance measures for monitoring progress toward achieving the stated goal. Furthermore, 6 of the plan's 22 performance measures call for one point-in-time measurement and thus do not provide longitudinal information for evaluating the usefulness of specific activities.

We are sending copies of this report to the Secretaries of Veterans Affairs and Defense, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have questions about this report, please contact me at (202) 512-7101 or ekstrandl@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this report. Michael T. Blair, Jr., Assistant Director; Aditi Archer; Jessica Cobert; Kevin Milne; and Julianna Williams made key contributions to this report.



Laurie E. Ekstrand
Director, Health Care

List of Committees

The Honorable John Warner
Chairman
The Honorable Carl Levin
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Larry E. Craig
Chairman
The Honorable Daniel K. Akaka
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

The Honorable Duncan Hunter
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

The Honorable Steve Buyer
Chairman
The Honorable Lane Evans
Ranking Minority Member
Committee on Veterans' Affairs
House of Representatives

Appendix I: Scope and Methodology

To assess the Department of Veterans Affairs' (VA) and Department of Defense's (DOD) progress in implementing the Joint Incentive Fund (JIF) and Demonstration Site Selection (DSS) programs, including whether they are operational, we visited VA and DOD medical facilities at six sites—Augusta, Georgia; Honolulu, Hawaii; North Chicago, Illinois; El Paso, Texas; San Antonio, Texas; and Puget Sound, Washington, and interviewed department officials responsible for the development and implementation of each of the projects and conducted site visits at select sites. In addition, we contacted VA and DOD officials from seven additional sharing sites.[1] For all of the sites, we reviewed approved business case analyses for JIF projects selected in fiscal year 2004 and DSS projects that included detailed descriptions of the projects, timelines for development and implementation, associated risks, costs, potential cost savings (if applicable), staffing requirements, and quarterly progress reports. We also obtained and reviewed VA and DOD policies governing sharing and reviewed relevant department reports, including those from the DOD Inspector General and DOD contractors, along with our prior work.

To obtain information on the actions taken by VA and DOD to strengthen the sharing of health care resources, we interviewed officials from VA's Office of Policy, Planning, and Preparedness and the Veterans Health Administration—including the VA/DOD Liaison Office and VA medical center (VAMC) staff at several locations engaged in the sharing of health care resources. We interviewed officials from DOD's TRICARE Management Activity;[2] DOD/VA Program Coordination Office; the military services' surgeons general offices, which coordinate sharing activities; and several military treatment facilities (MTF) engaged in the sharing of health care resources. We also interviewed officials from Joint Executive Council (JEC) committees and Health Executive Council (HEC) workgroups[3] to determine what policies, procedures, and guidance have been promulgated to promote health care resource sharing and coordination

[1]Those seven additional sharing sites were located in the following areas: Alaska, California, Kansas, New York, North Dakota, South Carolina, and Virginia.

[2]DOD provides health care through TRICARE—a regionally structured program that uses civilian contractors to maintain provider networks to complement health care services provided at MTFs.

[3]VA and DOD established JEC along with four additional interagency councils/committees to further facilitate collaboration between the departments in areas such as strategic planning and health care. HEC and its workgroups, which are under the purview of JEC, were developed as a mechanism to specifically further the sharing of health care resources between VA and DOD.

between VA and DOD. Further, we spoke with officials from the Office of Management and Budget (OMB). We reviewed the charters, when available, and briefing updates for each JEC committee and HEC workgroup and OMB's scorecards for the President's Management Agenda initiative directed at VA and DOD sharing. We analyzed sharing data between VA and each branch of service that included workload, sharing agreements, and cost data. We also reviewed the actions taken by both VA and DOD to strengthen the sharing of health care resources. In addition, we evaluated whether health care resource-sharing activities were considered as part of Capital Asset Realignment for Enhanced Services and base realignment and closure decisions.

To assess whether VA and DOD performance measures are useful, we interviewed officials from VA's Office of Policy, Planning, and Preparedness and the Veterans Health Administration—including the VA/DOD Liaison Office and VAMC staff at several locations engaged in the sharing of health care resources. We also interviewed officials from DOD's TRICARE Management Activity; the DOD/VA Program Coordination Office; the military services' surgeons general offices, which coordinate sharing activities; and several MTF locations engaged in the sharing of health care resources. We analyzed the VA/DOD joint strategic plan,[4] VA's strategic plan,[5] DOD's Military Health System Strategic Plan,[6] VA's performance and accountability report,[7] DOD's performance and accountability report,[8] and VA/DOD's annual report to the Congress on sharing.[9]

We conducted our work from January 2005 through March 2006 in accordance with generally accepted government auditing standards.

[4]Department of Veterans Affairs/Department of Defense, *VA/DOD Joint Strategic Plan* (Washington, D.C.: December 2004).

[5]Department of Veterans Affairs, Office of the Secretary, *Strategic Plan 2003-2008* (Washington D.C.: July 2003).

[6]Department of Defense, *Military Health System Strategic Plan* (September 2002).

[7]Department of Veterans Affairs, Office of Management, *FY 2004 Annual Performance and Accountability Report* (Washington, D.C.: November 2004).

[8]Department of Defense, *Performance and Accountability Report, Fiscal Year 2004* (Nov. 15, 2004).

[9]Department of Veterans Affairs/Department of Defense, *VA/DOD Joint Executive Council Annual Report* (Washington, D.C.: December 2004).

Appendix II: Joint Incentive Fund Program

VA partner	DOD partner	Project description	Dollar amount of project
JIF fiscal year 2004 projects			
VA Pacific Islands Health Care System, Hawaii	Tripler Army Medical Center, Hawaii	Delta Systems II-Cad/Cam System: This is a fabrication technology system that produces molds for prosthetics and orthotics from lightweight foam through use of a laser scanner and mill. Installing this device at Tripler should allow for greater patient access; reduce clinic visits for casting, adjustments, and fittings; and allow for an increase in VA beneficiary access.	$542,000
Fargo Veterans Affairs Medical Center, North Dakota	319th Medical Group, Grand Forks Air Force Base, North Dakota	Joint TeleMental System: Acquiring videoconferencing technology should allow VA to provide mental health services to DOD beneficiaries approximately 80 miles away.	$14,000
VA Northern California Health Care System, California	60th Medical Group, Travis Air Force Base, California	Joint Dialysis Unit: Through upgrading equipment and increased staffing, Travis Air Force Base's dialysis unit is expected to be able to accommodate VA beneficiaries.	$1,568,560
North Chicago Veterans Affairs Medical Center, Illinois	Naval Hospital Great Lakes, Illinois	Mammography Unit Expansion: The purchase of new digital mammography equipment, a stereotactic unit, and hiring of support staff should now reduce wait times for DOD beneficiaries and allow for VA beneficiary access.	$655,000
Spokane Veterans Affairs Medical Center, Washington	92nd Medical Group, Fairchild Air Force Base, Washington	Teleradiology Initiative: This will upgrade DOD's system so it can download images from VA for radiological interpretation and is intended to allow VA to provide computed tomography scans for DOD patients.	$333,537
North Chicago Veterans Affairs Medical Center, Illinois	Naval Hospital Great Lakes, Illinois	Women's Health Center: This project proposes to create a comprehensive women's health center for VA and DOD beneficiaries by coordinating women's services and includes hiring gynecology, wellness, and case management staff.	$1,315,332
Alaska Veterans Affairs Health Care System, Alaska	3rd Medical Group, Elmendorf Air Force Base, Alaska	Enhanced Outpatient Diagnostic Services: The acquisition of diagnostic equipment is intended to provide in-house imaging services to VA and DOD beneficiaries.	$535,000
Syracuse Veterans Affairs Medical Center, New York	Fort Drum, New York	Telepsychiatry: The hiring of a full-time VA psychiatrist is intended to allow VA to provide mental health services to DOD patients via videoconferencing.	$330,000

VA partner	DOD partner	Project description	Dollar amount of project
Robert J. Dole Veterans Affairs Medical Center, Kansas	22nd Medical Group, McConnell Air Force Base, Kansas	Cardiac Catheterization Laboratory: Remodeling existing VA space is intended to accommodate new equipment and provide in-house cardiac services to VA and DOD beneficiaries.	$3,539,722
Dorn Veterans Affairs Medical Center, South Carolina	Moncrief Army Community Hospital and 20th Medical Group, Shaw Air Force Base, South Carolina	Expansion of Existing Magnetic Resonance Imaging Joint Venture: The acquisition of an open magnetic resonance imaging unit located at Moncrief Army Community Hospital is intended to provide in-house services to VA and DOD beneficiaries.	$2,014,000
South Texas Veterans Health Care System, Texas	Wilford Hall Medical Center, Texas	North Central San Antonio Clinic: The establishment of a joint VA/DOD clinic is intended to provide greater access for VA and DOD beneficiaries.	$11,974,197
JIF fiscal year 2005 projects			
Veterans Health Administration Central Office	DOD TRICARE Management Activity	Medical Enterprise Web Portals: The project is designed to standardize VA and DOD's Web portals—they both will have the same "look and feel" to them from a beneficiary perspective, including a requirement that each portal meets national standards regarding accessibility for people with disabilities.	$2,501,000
Veterans Health Administration Central Office	Defense Supply Center, Philadelphia	Medical/Surgical Supply Data Sync: This project is intended to create a joint VA and DOD medical/surgical supply catalog. According to the project plan, the catalog will ultimately allow VA and DOD to jointly identify common medical/surgical products procured and maximize joint buying power for these products through negotiated volume purchase contracts.	$4,500,000
Louisville Veterans Affairs Medical Center, Kentucky	Ireland Army Community Hospital, Fort Knox, Kentucky	Radiology: The hiring of additional radiologists is intended to fully utilize existing equipment and provide greater access for VA and DOD beneficiaries.	$1,185,684
Harry S. Truman Memorial Veterans' Hospital, Missouri	General Leonard Wood Army Community Hospital and 509th Medical Group, Whiteman Air Force Base, Missouri	Sleep Lab Expansion: The renovation and expansion, from two beds to four beds, of the VA Sleep Diagnostic and Treatment Lab is intended to decrease wait times for VA beneficiaries and allow for DOD beneficiary access.	$436,113
Veterans Affairs Puget Sound Health Care System, Washington	Madigan Army Medical Center, Washington	Cardiac Surgery: The consolidation of VA and DOD cardiac surgery programs into a coordinated single large cardiac program is intended to improve quality of care for VA and DOD beneficiaries while achieving efficiencies and economies of scale.	$1,626,427

VA partner	DOD partner	Project description	Dollar amount of project
Veterans Affairs Puget Sound Health Care System, Washington	Madigan Army Medical Center, Washington	Neurosurgery Program: This project is intended to improve the provision of neurosurgical care to VA and DOD beneficiaries by jointly recruiting neurosurgeons.	$716,000
Veterans Affairs Pacific Islands Health Care System, Hawaii	Tripler Army Medical Center, Hawaii	Dialysis: By providing the staff necessary to optimally utilize an existing DOD dialysis center, this project is intended to increase access for VA beneficiaries.	$2,752,942
Veterans Affairs Pacific Islands Health Care System, Hawaii	Tripler Army Medical Center, Hawaii	Pain Management Improvement: Converting an anesthesiologist who specializes in pain rehabilitation from part-time to full-time is intended to recapture pain management workload that is currently being outsourced and decrease beneficiary wait times.	$707,000
North Chicago Veterans Affairs Medical Center, Illinois	Naval Hospital Great Lakes, Illinois	Joint Magnetic Resonance Imaging: The acquisition of an open field magnetic resonance imaging unit and the hiring of a radiologist are intended to reduce patient wait time, referrals for contract care, delays in treatment, and length of stay for acutely ill patients.	$3,449,000
North Chicago Veterans Affairs Medical Center, Illinois	Naval Hospital Great Lakes, Illinois	Clinical Fiber-Optics: By providing the necessary high-speed clinical connectivity between VA and DOD facilities, this project is intended to provide the bandwidth needed to transmit clinical images to VA.	$247,245
North Chicago Veterans Affairs Medical Center, Illinois	Naval Hospital Great Lakes, Illinois	Oncology: This project is intended to create a hematology-oncology program for VA and DOD beneficiaries, who are currently referred to the local community.	$600,000
South Texas Veterans Health Care System, Texas	Wilford Hall Medical Center and Brooke Army Medical Center, Texas	Digital Imaging: The seamless sharing of digital images, texts, and patient demographic information between clinical VA and DOD systems is intended to be a pilot data exchange program.	$3,450,000
South Texas Veterans Health Care System, Texas	Wilford Hall Medical Center and Brooke Army Medical Center, Texas	Hyperbaric Medicine: Modifications to the DOD facility to allow for the installation of a hyperbaric chamber that is intended to provide greater access and decrease surgical wait times for VA and DOD beneficiaries.	$1,170,000
Cheyenne and Sheridan Veterans Affairs Medical Centers, Wyoming	F. E. Warren Air Force Base, Wyoming	Mobile Magnetic Resonance Imaging: This project is intended to provide access to VA and DOD beneficiaries through the acquisition of a mobile magnetic resonance imaging unit.	$2,000,000

VA partner	DOD partner	Project description	Dollar amount of project
Boise Veterans Affairs Medical Center, Idaho	366th Medical Group, Mountain Home Air Force Base, Idaho	Mobile Magnetic Resonance Imaging: Site preparation and the acquisition of a mobile magnetic resonance imaging unit along with a digital printer are intended to recapture magnetic resonance imaging exams that are currently purchased in the local community, thereby improving access for VA and DOD beneficiaries.	$2,090,000
Veterans Integrated Service Network Support Service Center	Air Force Medical Operations Agency	Healthcare Planning Data Mart: This project plans to develop a joint VA and Air Force database to capture the amount of care each contracts for outside of its respective health care system. Through the creation of the database, VA and Air Force managers hope to identify areas in which they can jointly purchase services and achieve savings through leveraged buying power.	$1,067,756
Veterans Affairs Black Hills Health Care System, South Dakota	28th Medical Group, Ellsworth Air Force Base, South Dakota	Mobile Magnetic Resonance Imaging: The acquisition of a mobile magnetic resonance imaging unit is intended to recapture magnetic resonance imaging exams that are currently purchased in the local community, thereby improving access for VA and DOD beneficiaries.	$2,000,000

Sources: VA and DOD.

Note: Projects may be funded over a 2-year period.

Appendix III: Demonstration Site Selection Projects for Fiscal Years 2003 through 2007

VA partner	DOD partner	Category	Project description	Estimated total dollar amount of project
Veterans Affairs Pacific Islands Health Care System, Hawaii	Tripler Army Medical Center, Hawaii	Budget and Financial Management System	Joint Venture Operations Revenue Cycle—The goal of this project is to conduct and execute the findings of studies in four key areas. (1) Health Care Forecasting, Demand Management, and Resource Tracking: Define, test and implement a system that will combine VA and DOD data for beneficiaries receiving care in the Pacific Islands joint venture market. This will include all eligibility, insurance, administrative, clinical, staffing, and costing data that will allow VA and DOD to query and output information on utilization and demand, supply and capacity, combined costs, facility and staff, services, and beneficiary population. (2) Referral Management and Fee Authorization: Define, test, and implement a system that will provide the capability of timely tracking of authorizations, obligations, and provisions of clinical care to beneficiaries referred from one department to the other. (3) Joint Charge Master Based Billing: Define, test, and implement a system that will provide DOD with the capability for itemized billing and patient-level costing. (4) Document Management: Define, test, and implement a system that gives VA and DOD the capability to support all the business and clinical processes of sharing care.	$4,152,000
Alaska Veterans Affairs Health Care System, Alaska	3rd Medical Group, Elmendorf Air Force Base, Alaska	Budget and Financial Management System	Joint Venture Business Directorate—This project intends to achieve the following goals: (1) Through the use of a joint business office, evaluate areas of business collaboration as VA moves its main operation next door to the existing joint venture hospital. Areas for possible sharing include library, warehouse, radiology, ambulatory surgery, central sterile supply, GI procedure space, education facilities, physical plant utilities, security services, and patient transportation. (2) Generate itemized bills and utilize the existing VA fee program to capture workload and patient-specific health information. (3) Create a coordinated calculation of cost-based expenses to assist in market area procurement decisions.	$4,782,000

VA partner	DOD partner	Category	Project description	Estimated total dollar amount of project
Augusta Veterans Affairs Medical Center, Georgia	Eisenhower Army Medical Center, Georgia	Coordinated Staffing and Assignment System	Joint Staffing—VA and DOD plan to jointly to recruit, hire, and train staff for difficult-to-fill direct patient care occupations, which provide clinical and ancillary support services. Specifically, the project is designed to (1) utilize the Augusta VAMC's successful recruitment initiatives to aid DOD in hiring staff for direct patient care positions it has been unable to fill, (2) unite training initiatives so direct patient care staff may take advantage of training opportunities at either facility, and (3) hire and train a select group of staff that would service either facility when a critical staffing shortage occurred.	$2,880,000
Hampton, Veterans Affairs Medical Center, Virginia	1st Medical Group, Langley Air Force Base, Virginia	Coordinated Staffing and Assignment System	Coordinated Staffing Initiative—The goals of this project are intended to achieve the following: (1) Develop a process to identify department-specific needs to address staffing shortfalls for integrated services. (2) Create a method to compare, reconcile, and integrate requirements between facilities. (3) Determine a payment methodology to support the procurement process for staffing shortfalls. (4) Establish a joint referral and appointment process, to include allocation of capacity and prioritization of workload. (5) Maintain an ongoing assessment of issues and problem resolution.	$780,000
Veterans Affairs Puget Sound, Health Care System, Washington	Madigan Army Medical Center, Washington	Medical Information/ Information Technology Management System	Health Care Data Exchange—The goal of this project is to transmit a limited subset of currently available clinical data between VA and DOD. The intent of this project is to work with the developers of Composite Health Care System II (CHCS II), Bidirectional Health Information Exchange (BHIE), and Computerized Patient Record System, to exchange and view data such as discharge summaries.	$14,865,000

VA partner	DOD partner	Category	Project description	Estimated total dollar amount of project
El Paso Veterans Affairs Health Care System, Texas	William Beaumont Army Medical Center, Texas	Medical Information/ Information Technology Management System	Laboratory Data Sharing—with CHCS II modifications: Phase I is the implementation of the Laboratory Data Sharing Initiative (LDSI) with the CHCS II modification. LDSI implementation is intended to eliminate rekeying of orders entered by VA providers in VA's Veterans Health Information Systems and Technology Architecture (VISTA) into DOD's CHCS II, decrease errors caused by transcription, and increase speed of lab results availability to VA providers for treatment purposes. Phase II will be the implementation of the BHIE project, which is currently being deployed, with the CHCS II modification. Initial focus will be on data sharing related to patient demographic information, outpatient pharmaceuticals prescribed to patient populations, and allergy information. Phase III expands on the initial development of the BHIE project by including the data sharing of radiology reports (text) and laboratory results, including anatomic pathology.	$3,058,000
South Texas Veterans Health Care System, Texas	Wilford Hall Medical Center and Brooke Army Medical Center, Texas	Medical Information/ Information Technology Management System	Laboratory Data Sharing—VA's VISTA to DOD's Composite Health Care System I (CHCS I). LDSI is intended to meet the need of receiving electronic patient test results from reference labs, thereby eliminating manual data entry of such results. The goal is to create bidirectional communication between VISTA and CHCS I to facilitate ordering, sending, and receiving of all lab test subscripts (including chemistry, anatomic pathology, and microbiology). Tangible benefits include more efficient use of man-hours from not having to manually enter test results and improved turnaround time for the providers to receive results. Intangible benefits include increased patient safety via the elimination of manual test results.	$3,923,000

VA partner	DOD partner	Category	Project description	Estimated total dollar amount of project
South Texas Veterans Health Care System, Texas	Wilford Hall Medical Center and Brooke Army Medical Center, Texas	Medical Information/ Information Technology Management System	Joint Credentialing System—VA and DOD plan to jointly credential licensed providers based on an interface between DOD's Centralized Credentials Quality Assurance System (CCQAS) and VetPro, VA's credentialing system. The project is divided into four phases: Phase I–Implement the current version of CCQAS that is available at the time of implementation with the interface. Phase II–Create a means to provide the capability to view credentialing files and scanned primary source verification documentation in either system by VA or DOD staff. Phase III–Expand the use of credentialing in VetPro at VA and CCQAS at DOD to include nurses and other licensed professionals. Phase IV–Explore the feasibility of a local centralized site for primary source verification.	$2,554,000

Sources: VA and DOD.

Appendix IV: Description of VA's and DOD's Councils, Committees, and Workgroups

Joint Executive Council (JEC): Established in February 2002, VA and DOD's JEC was created to enhance VA and DOD collaboration, ensure the efficient use of federal resources, remove barriers and address challenges that impede collaborative efforts, assert and support mutually beneficial opportunities to improve business practices, and develop a joint strategic planning process to guide the direction of sharing activities. JEC is co-chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness. Membership consists of senior leaders from both VA and DOD, including VA's Under Secretary for Benefits and Under Secretary for Health and DOD's Principal Deputy Under Secretary of Defense for Personnel and Readiness and Assistant Secretary for Health Affairs. JEC has two interagency councils and two interagency committees to further facilitate collaboration and sharing opportunities: (1) the Benefits Executive Council, (2) the Joint Strategic Planning Committee, (3) the Construction Planning Committee, and (4) the Health Executive Council. JEC's primary responsibility is to set strategic priorities for the four interagency councils and committees, monitor the development and implementation of the Joint Strategic Plan, and ensure accountability is incorporated into all joint initiatives.

Benefits Executive Council (BEC): Established by JEC in August 2003, BEC was charged with examining ways to expand and improve information sharing, refine the process of records retrieval, identify procedures to improve the benefits claims process, improve outreach, and increase servicemembers' awareness of potential benefits. In addition, BEC provides advice and recommendations to JEC on issues related to seamless transition from active duty to veteran status through a streamlined benefits delivery process, including the development of a cooperative physical examination process and the pursuit of interoperability and data sharing.

Joint Strategic Planning Committee: Established by JEC in October 2002, the committee was charged with developing a joint strategic plan that through specific initiatives, would improve the quality, efficiency, and effectiveness of the delivery of benefits and services to both VA and DOD beneficiaries through enhanced collaboration and sharing.

VA/DOD Construction Planning Committee (CPC): Established by JEC in August 2003, CPC provides a formalized structure to facilitate cooperation and collaboration in achieving an integrated approach to capital coordination that considers both short-term and long-term strategic capital issues. CPC was charged with providing oversight to ensure that collaborative opportunities for joint capital asset planning are

maximized, and provides the final review and approval of all joint capital asset initiatives recommended by any element of JEC structure.

Health Executive Council (HEC): In 1997, VA and DOD established HEC—a precursor to JEC. HEC was co-chaired by the VA Under Secretary for Health and the Assistant Secretary of Defense (Health Affairs). JEC rechartered HEC in August 2003 to oversee the cooperative efforts of each department's health care organizations. HEC has charged workgroups to focus on specific high-priority areas of national interest. HEC has organized itself into 11 workgroups to carry out its mission—to institutionalize VA and DOD sharing and collaboration through the efficient use of health services and resources.

HEC Workgroups:

1. **Contingency Planning**: The workgroup is responsible for developing collaborative efforts in support of the VA and DOD Contingency Plan and the National Disaster Medical System. Through the workgroup, VA and DOD are in the process of jointly updating the memorandum of understanding regarding VA furnishing health care services to members of the armed forces during a war or national emergency.

2. **Continuing Education and Training**: The workgroup is responsible for developing a shared training infrastructure and for designing, developing, and managing the operational procedures to facilitate increased sharing of education and training opportunities between VA and DOD.

3. **Deployment Health**: The workgroup is responsible for enhancing health care available to servicemembers returning from overseas deployment. Focusing on health risks associated with specific deployments, the group developed proactive approaches toward deployment health surveillance, health risk communication, and early identification and treatment of deployment-related health problems.

4. **Evidence-Based Practice Guidelines**: The workgroup is responsible for the creation and publication of jointly used guidelines for disease management.

5. **Financial Management**: The workgroup is responsible for developing and disseminating principles and procedures, interpreting current policies and guidance, establishing policies to be used in creating reimbursable arrangements, and resolving disputed issues related to such arrangements that cannot be resolved at local or intermediate

organizational levels. The workgroup is also responsible for the implementation of JIF.

6. **Graduate Medical Education (GME)**: The workgroup is responsible for reviewing the current state of the GME[1] program between both departments, and implementing the joint pilot program for GME under which graduate medical education and training is provided to military physicians and physician employees of DOD and VA through one or more programs carried out in DOD's military MTFs and VAMCs, as mandated by legislation in December 2002.[2]

7. **Joint Facility Utilization and Resource Sharing**: The workgroup is responsible for examining issues such as removing barriers to resource sharing and streamlining the process for approving sharing agreements. The workgroup was originally tasked with identifying areas for improved resource utilization through local and regional partnerships, assessing the viability and usefulness of interagency clinical agreements, identifying impediments to sharing, and identifying best practices for sharing resources. The workgroup was responsible for providing oversight of the DOD/VA Joint Assessment Study mandated by the Department of Defense and Emergency Supplemental Appropriations for Recovery from and Response to Terrorist Attacks on the United States Act, 2002.[3] The workgroup is also responsible for the implementation of DSS.

8. **Information Management/Information Technology**: The workgroup is responsible for developing interfaces and implementing standards to facilitate interoperability for improving exchange of health data between VA and DOD.

9. **Medical Materiel Management**: In lieu of a charter, VA and DOD officials signed a memorandum of agreement. Under the terms of the memorandum, the workgroup is to "combine identical medical supply requirements from both agencies and leverage that volume to negotiate better pricing."

[1]GME is the second phase of medical education, and prepares physicians for practice in a medical specialty or subspecialty.

[2]Pub. L. No. 107-314 § 725, 116 Stat. at 2599.

[3]Pub. L. No. 107-117 § 8147, 115 Stat. 2230, 2280-81.

10. **Patient Safety**: The workgroup is responsible for reviewing and developing internal and external reporting systems for patient safety. DOD has established a Patient Safety Center at the Armed Forces Institute of Pathology using the VA National Center for Patient Safety as a model.

11. **Pharmacy**: The workgroup is responsible for expanding participation by the VA Pharmacy Benefits Management Strategic Health Care Group and the DOD Pharmacoeconomic Center to evaluate high-dollar and high-volume pharmaceuticals jointly. According to the workgroup, it is overseeing joint actions, such as joint contracts involving high-dollar and high-volume pharmaceuticals, which are designed to increase uniformity and improve the clinical and economic outcomes of drug therapy in the VA and DOD health systems. The workgroup's goals include eliminating unnecessary redundancies that exist in areas of class reviews, contracting prescribing guidelines, and utilization management.

Appendix V: Comments from the Department of Veterans Affairs

THE DEPUTY SECRETARY OF VETERANS AFFAIRS
WASHINGTON

February 27, 2006

Commemorating 75 Years of Service

Ms. Laurie E. Ekstrand
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Ekstrand:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***VA AND DOD HEALTH CARE: Opportunities to Maximize Resource Sharing Remain*** (GAO-06-315). The Department agrees with GAO's overall findings and generally concurs with the recommendations. The enclosure provides additional discussion on the recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely yours,

Gordon H. Mansfield

Enclosure

Enclosure

THE DEPARTMENT OF VETERANS AFFAIRS (VA) COMMENTS
TO GOVERNMENT ACCOUNTABILITY OFFICE (GAO)
DRAFT REPORT

VA AND DOD HEALTH CARE: Opportunities to Maximize Resource Sharing Remain
(GAO 06-315)

To further advance resource sharing within VA and DOD, the Secretaries of Veterans Affairs and Defense should direct the JEC and HEC to:

- **Develop an evaluation plan for documenting and recording the reasons for the advantages and disadvantages of each DSS project, an activity that will assist VA and DOD in replicating successful projects system-wide.**

Concur

The Health Executive Council (HEC) Joint Facility Utilization and Resource Sharing Workgroup provides direct oversight over the DSS projects, and has developed a plan to measure the effectiveness and evaluate the advantages and disadvantages of each DSS project. The plan includes development of a template guide to improve the comprehensive, quarterly Interim Project Reviews (IPR). Workgroup members also participate in weekly or bi-weekly meetings with the DSS project teams to track progress. Subject matter experts from other HEC workgroups, such as those involved with information management and technology, provide appropriate assistance and expertise as necessary. The new IPR template has been modified to capture input about the advantages and disadvantages of projects system wide. It was distributed to the demonstration sites in January 2006 and is expected to be implemented with the second quarter Fiscal Year (FY) 2006 Interim Project Review.

The Joint Facility Utilization and Resource Sharing Workgroup has also developed a Standard Operating Procedure (SOP) and template to collect and catalogue a selection of lessons learned that can be applied to ongoing project implementation. This template was disseminated to the DSS sites in the Fall of 2005. The lessons learned repository will enable the DSS staff to consolidate and analyze lessons learned, identify trends, and facilitate development of guidance for replicating projects. DOD has advised that they will submit a copy of the plan with their comments to GAO.

This is in process.

- **Develop performance measures that would be useful for determining the progress of their resource sharing goals.**

Concur

As noted in the attached VA/DOD Joint Executive Council Strategic Plan (FYs 2006-2008), performance measures have been identified for each of the resource sharing goals.

This has been completed.

Appendix VI: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

FEB 27 2006

Ms. Laurie E. Ekstrand
Director, Health Care
U.S. Government Accountability Office
441 G. Street, N.W.
Washington, DC 20548

Dear Ms. Ekstrand:

This is the Department of Defense response to the Government Accountability Office (GAO) draft report, GAO 06-315, "VA AND DOD HEALTH CARE: Opportunities to Maximize Resource Sharing Remain," dated February 7, 2006 (GAO Code 290277).

The Department appreciates the opportunity to comment on the draft report and concurs with the GAO findings and recommendations with the enclosed comments.

Please direct any questions to my points of contact on this matter, Mr. Kenneth Cox (functional) at (703) 681-0039, ext. 3602 and Mr. Gunther J. Zimmerman (Audit Liaison) at (703) 681-3492, ext. 4065.

Sincerely,

For William Winkenwerder, Jr., MD

Enclosure:
As stated

GAO DRAFT REPORT – DATED FEBRUARY 7, 2006
GAO CODE - 290277/GAO-06-315

"VA AND DOD HEALTH CARE: OPPORTUNITIES TO MAXIMIZE RESOURCE SHARING REMAIN"

DEPARTMENT OF DEFENSE COMMENTS

This draft report provides a review of the Department of Veterans Affairs' (VA) and Department of Defense's (DoD) progress in implementing the Joint Incentive Fund (JIF) and Demonstration Site Selection (DSS) programs required by National Defense Authorization Act FY2003.

Overall Comments:

- Citing all references to a nationwide integrated review and market analysis:
  - The FY 2008-2013 Program Objective Memorandum/Budget Estimate Submission Programming Guidance, dated November 14, 2005, requires the military Services, TRICARE Management Activity, and the TRICARE Regional Offices to identify opportunities for DoD/VA resource sharing as part of their annual business plans when programming for resources.
  - The Air Force and VA are implementing a JIF proposal which is developing a tool to analyze purchased care in joint Air Force and VA markets across the country. After the tool is tested with the Air Force, the Departments plan to expand the initiative to the other two Services. Additionally, Tripler Army Medical Center (TAMC) is evaluating the feasibility of the Joint Assessment Study (JAS) model. The methodologies and crosswalks developed during the JAS are being used in the development of the VA/Air Force JIF project, creating an integrated tool.
- Page 29, first paragraph, last sentence – The JAS was disseminated and briefed to the Service Surgeons General offices and briefed at the 2004 TRICARE Conference. In October 2004, DoD conducted a two and a half day workshop at TAMC instructing how to use the JAS methodology. It is also available on DoD/VA website: http://www.tricare.osd.mil/DVPCO/reports.cfm.

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"VA AND DOD HEALTH CARE: OPPORTUNITIES TO MAXIMIZE RESOURCE SHARING REMAIN"

DEPARTMENT OF DEFENSE COMMENTS TO THE RECOMMENDATIONS

RECOMMENDATION 1: The GAO recommended that the Secretaries of VA and DoD should direct the Joint Executive Council (JEC) and the Health Executive Council (HEC) to develop an evaluation plan for documenting and recording the reasons for the advantages and disadvantages of each Demonstration Site Selection (DSS) project, an activity that will assist VA and DoD in replicating successful projects system-wide. (Page 34/GAO Draft Report)

DOD RESPONSE: DoD concurs with this recommendation. The Joint Facility Utilization/Resource Sharing Workgroup, under the HEC, has an evaluation process in place. A "lessons learned" template was disseminated to the DSS sites in Fall 2005, and the in-progress review (IPR) template has been modified to strengthen discussion on advantages, disadvantages, and replicating projects system-wide. The modified IPR template was distributed to the DSS sites in January 2006 and will be operational in the second quarter of FY06. A Standard Operating Procedure and template have been developed to gather "lessons learned". In addition, a "lessons learned" repository is being developed that will enable the DSS staff to consolidate and analyze lessons learned, identify trends, facilitate development of guidance for replicating projects, and improve oversight and management of the projects.

RECOMMENDATION 2: The GAO recommended that the Secretaries of VA and DoD should direct the Joint Executive Council and the Health Executive Council to develop performance measures that would be useful for determining the progress of their resource sharing goals. (Page 35/GAO Draft Report)

DOD RESPONSE: DoD concurs with this recommendation. This draft report commented on the 2005 Joint Strategic Plan (JSP). The JSP for Fiscal Year 2006-2008 has recently been issued. It revised and updated the 2004 JSP and contains performance measures that demonstrate measurable progress relative to specific strategic milestones.

- Army Comments: The efforts of the DSS and JIF projects have helped to illustrate the complexity and challenges of DoD/VA healthcare resources sharing. The concept of volume of sharing needs to be replaced with one of efficiency and effectiveness of DoD/VA sharing. As the DoD continues to refine and execute its business planning design, the JEC and the HEC should ensure that DoD/VA healthcare resources

sharing considerations, with identified performance measures, be incorporated. The VA should do the same. This action is more in-line with the reports findings on page 21, Joint Executive Council, 1st sentence and the report's Conclusions, page 33, 1st sentence.

- Navy Comments: The current performance measures in the VA/DoD JSP have made significant efforts over the last two years and will continue to work together to refine the performance measures.
- Air Force Comments: Significant effort has been made to refine the performance measures in the VA/DoD JSP in the past two years. While we acknowledge there is still a considerable amount of work to do to ensure all performance measures are adequate, the recommendation implies nothing has been done in this area. However, tracking of the performance metrics requires additional emphasis. Recommend the recommendation state "The Joint Executive Council and the Health Executive Council should continue to develop and refine the performance measures outlined in the Joint Strategic Plan and report to the Secretaries of Veterans Affairs (VA) and Defense on the progress of their resource sharing goals semi-annually."

Related GAO Products

Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies. GAO-06-15. Washington, D.C.: October 21, 2005.

VA and DOD Health Care: VA Has Policies and Outreach Efforts to Smooth Transition from DOD Health Care, but Sharing of Health Information Remains Limited. GAO-05-1052T. Washington, D.C.: September 28, 2005.

Computer-Based Patient Records: VA and DOD Made Progress, but Much Work Remains to Fully Share Medical Information. GAO-05-1051T. Washington, D.C.: September 28, 2005.

Mail Order Pharmacies: DOD's Use of VA's Mail Pharmacy Could Produce Savings and Other Benefits. GAO-05-555. Washington, D.C.: June 22, 2005.

DOD and VA Health Care: Incentives Program for Sharing Health Resources. GAO-05-310R. Washington, D.C.: February 28, 2005.

VA and DOD Health Care: Resource Sharing at Selected Sites. GAO-04-792. Washington, D.C.: July 21, 2004.

DOD and VA Health Care: Incentives Program for Sharing Resources. GAO-04-495R. Washington, D.C.: February 27, 2004.

DOD and VA Health Care: Access for Dual Eligible Beneficiaries. GAO-03-904R. Washington, D.C.: June 13, 2003.

VA and Defense Health Care: Increased Risk of Medication Errors for Shared Patients. GAO-02-1017. Washington, D.C.: September 27, 2002.

VA and Defense Health Care: Potential Exists for Savings through Joint Purchasing of Medical and Surgical Supplies. GAO-02-872T. Washington, D.C.: June 26, 2002.

DOD and VA Pharmacy: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs. GAO-01-588. Washington, D.C.: May 25, 2001.

VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies. GAO/HEHS-00-52. Washington, D.C.: May 17, 2000.

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