



# DoD VA Health Care Collaboration



# Agenda



- DoD/VA Program Coordination Office
- History
- Joint Committee Structure
- DoD/VA Partnership Achievements
- Joint Strategic Plan
- Annual Report to Congress
- Program Elements
  - Sharing Agreements/MOUs/MOAs
  - VA Role in TRICARE Network
  - Joint Incentive Fund
  - Joint Ventures
  - Demonstration Project – James A. Lovell Federal Health Care Center
  - Base Access
  - Interagency Care Coordination Committee (IC3)
  - Choice Program and Potential Impact to DoD-VA Resource Sharing



# DoD/VA Program Coordination Office (DVPCO)



## Responsibilities:

Serve as the central entity within HA/DHA to monitor all VA/DoD Health Care Resource Sharing activities, Interagency Agreements, DoD/VA Contractor Relationships, Joint Ventures, and Health Systems Studies

Serve as the HA/DHA clearinghouse for all related information

Generate and submit reports on the costs and utilization of sharing activities (JIF's), as required

Provide administrative and operational support to the Health Executive Committees (HEC), (5 Business Lines), and Joint Executive Committee (JEC) as requested

Prepare HEC section of Joint DoD/VA Annual Report to Congress and provide input to the Joint Strategic Plan

Coordinate and provide responses to external requests for information from Government Accounting Office, Office of Management & Budget, members of Congress, and external Stakeholders



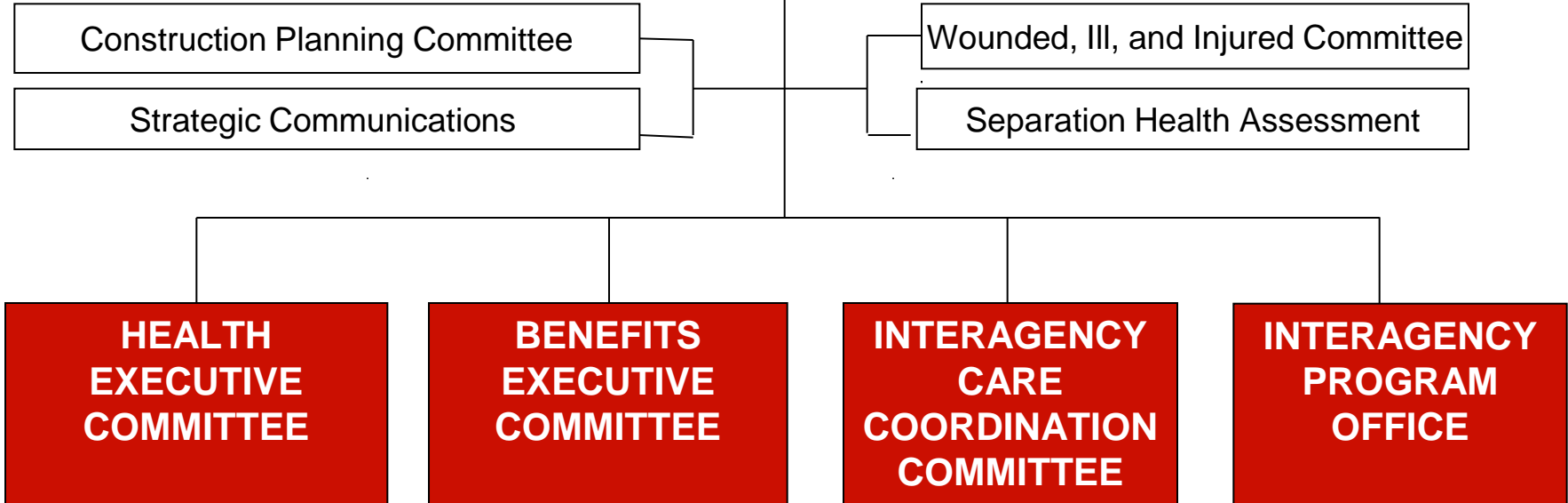
# DoD/VA Partnership History



- 1982 - DoD/VA authorized to share resources
- 1995 –VA authorized to treat CHAMPUS beneficiaries (1994 – TRICARE)
- 2002 - President’s Management Agenda and Joint Incentive Fund
- 2003 - NDAA codifies Joint Executive Committee and “mandates” resource sharing
- 2004 -DoD and VA required to consult as part of major capital investments (facility construction)
- 2007 - Senior Oversight Committee (SOC) to address wounded warrior care and benefits issues
- 2010 – NDAA authorized 5 year Demonstration project for integrated federal facility
- 2012 – SOC is combined with the JEC



# JOINT EXECUTIVE COMMITTEE





# Health Executive Committee Business Lines & Sub-Components



## Professional Development Business Line

DoD Lead: Director, Education & Training, DHA  
VA Lead: Chief Learning Officer, VHA

- Continuing Education & Training
- Health Professions Education Ad Hoc
- Evidence Based Clinical Guidelines

## Financial Operations & Business Operations Business Line

DoD Lead: DASD (Health Resources Management & Policy), HA  
VA Lead: Chief Financial Officer

- Acquisition & Medical Materiel Management
- Financial Management
- Shared Resources
- JAL FHCC Advisory Board

## Research Business Line

DoD Lead: Director, Research & Development Policy & Oversight, HA  
VA Lead: Chief Research and Development Officer, VHA

- Medical Research
- Deployment Health
- Vision Center of Excellence
- Hearing Center of Excellence
- Extremities Trauma & Amputation Center of Excellence

## Clinical Operations Business Line

DoD Lead: DASD (Health Services Policy & Oversight), HA  
VA Lead: ADUSH Patient Care Services

- Credentialing & Privileging
- Pain Management
- Patient Safety
- Pharmacy Ad Hoc
- Psychological Health
- Telehealth
- Traumatic Brain Injury
- Women's Health

## Health Data Sharing Business Line

DoD Lead: Deputy Program Executive Officer, Defense Healthcare Management Systems, DHA  
VA Lead: Chief Medical Informatics Officer

- Interagency Clinical Informatics Board
- Health data sharing for Clinical Care Transitions Sub-group
- Health data sharing for Separating Service Members Sub-group
- Health data sharing for Integrated Disability Evaluation System & Benefits Adjudication Sub-group
- Health data sharing for Patient Empowerment Sub-group
- Health data sharing for Population Health & other Non-clinical use Sub-group





# HEC Business Lines' Co-leads Responsibilities



- Delegated decision making authority for business lines' portfolios
- Manage progress of portfolios and develop and use metrics to track progress which will demonstrate mutual accountability
- Drive strategic direction on joint initiatives
  - Assess business line portfolio to ensure all initiatives provide strategic value to Departments
  - Collaborate and communicate with other Business lines to ensure all stakeholders involved
  - Ensure alignment with strategic directions of Departments
  - Elevate issues that need resolution to HEC



# DoD/VA Partnership Achievements



- **Increased Access, Services and Cost Savings through Joint Sharing:** Joint Incentive Fund (JIF) Initiatives have supported increased in-house patient workload and referrals that have improved patient access and medical readiness; maximized joint utilization of personnel, space and equipment; and optimized existing medical capabilities including ambulatory surgery, vascular surgery, pain management, tele-health, hematology/oncology centers, and enhanced amputee care for veterans and wounded warriors. For example, the Charleston-Beaufort Joint Venture provided care to 4,200 enrolled veterans and 11,000 TRICARE Prime beneficiaries yielding a federal health care cost avoidance of \$1.3M (VA - \$724K, DoD - \$600K).
- **Expanded Data Sharing:** DoD now transmits electronic health information on over 4.1 million patients to the Federal Health Information Exchange (FHIE) data repository for access by VA, including over 2.1 million Pre- and Post-deployment Health Assessments on more than 859,000 individuals, with expanded Bidirectional Health Information Exchange (BHIE) capability for outpatient data at all VA and DoD sites, and certain inpatient discharge summary data at all VA sites and 13 large DoD sites.





# DoD/VA Partnership Achievements



- **Increased Cutting-Edge PTSD/TBI Research:** DoD and VA are now coordinating two consortia studies designed to investigate the long-term health effects of PTSD and TBI, representing an unprecedented collaboration by DoD and VA in terms of joint oversight with a total funding of \$107 million during a five-year period.
- **Greater Cost Savings through Joint Acquisition:** The Medical Product Data Bank (PDB), a business intelligence tool used to reduce material costs by identifying lower cost alternatives and tracking buying behavior at the treatment facility level, has yielded savings to-date of \$138.8M (2005-2014).
- **Improved Clinical Competencies:** Between FY 2011-2014 DoD conducted 666,428 veterans encounters within DoD MTFs, providing an acuity level needed to keep DoD staff current in critical skills that a young Active Duty patient population cannot provide, and contributing to improved efficiencies that result from increased MTF bed occupancy.



# DoD/VA Partnership Achievements



- **Expanded Education and Training Collaborations:** VA and DoD now collaborate on 347 clinical and clinically-related programs, with an overall increase of 67 shared training programs that offered 276 continuing medical education hours in FY14 for physicians, nurses, dentists, social workers, psychologists, occupational therapists and counselors.
- **Intensified Mental Health Care Initiatives:** VA/DoD collaboration has intensified under the Interagency Task Force on Mental Health (ITF) to address the requirements of the 2012 Executive Order (EO) 13625, the 2014 Cross-Agency Priority Goal (CAPG) on Mental Health, and the 19 additional Executive Actions (EAs) released in 2014.



# JEC Annual Report to Congress



- Submitted by Secretaries of Defense and Veterans Affairs to Congress as required by law
- Details the accomplishment of the Committees to include:
  - Summary of health care coordination and sharing activities
  - Assessment of further opportunities for sharing of health-care resources between the two Departments
  - A review of the sharing agreements and a summary of activities and results in improving access to, and the quality and cost effectiveness of, the health care provided to beneficiaries



# Joint Strategic Plan Strategic Framework



**Mission:** Optimize the health and well being of Service members, Veterans and their eligible beneficiaries

**Vision:** Provide a single system experience of lifetime services through an interdependent partnership that establishes a national model for excellence, quality, access, satisfaction, and value



# Joint Strategic Plan Strategic Framework



- Joint VA-DoD efforts are aligned under three primary goals:
  - Benefits & Services: Deliver comprehensive benefits and services through an integrated client centric approach that anticipates and addresses client needs
  - Health Care: Provide a patient-centered health care system that delivers excellent quality, access, satisfaction, and value, consistently across the Departments
  - Efficiencies of Operation: Establish a national model for the effective and efficient delivery of benefits and services through joint planning and execution



# Key DoD/VA Program Elements



- Sharing Agreements/MOUs/MOAs
- VA Role in TRICARE Network
- Joint Incentive Fund
- Joint Ventures
- Demonstration Project – Federal Health Care Center
- Base Access for Veterans
- Interagency Care Coordination Committee (IC3)
- Choice Program and Potential Impact to DoD-VA Resource Sharing





# Direct Care Sharing Agreements



- In FY 2014, 61 VA medical facilities partnered with 97 medical treatment facilities (MTFs), for a total of 187 direct sharing agreements in delivery of 117 unique services
  - Examples include: Graduate Medical Education (GME), Laundry, Administration, Specialty Services, Surgical Services, Ambulatory Care Services, Ancillary Services
- Department – level Agreements
  - MOU: Traumatic Brain Injury, Spinal Cord Injury, Blind Rehabilitation, Contingency Planning, and Data Sharing Agreements



# TRICARE Agreements



- All VA Medical Centers (VAMCs) participate as TRICARE Network Providers
- VAMCs mostly provide specialty services
- TRICARE agreements may be negotiated locally by VAMCs or regionally by Veterans Integrated Service Networks (VISNs)
- VAMCs submit bills for care to the Managed Care Support Contractors



# Joint Incentive Fund (JIF)



- The Joint Incentive Fund (JIF) provides incentives for creating innovative DoD/VA sharing initiatives at the facility, regional and national levels.
- NDAA 2003 requires each Department to contribute \$15M annually
- Funding is used to “start-up” critical investments affecting DoD/VA access and key areas of improvement, including joint patient safety, joint longitudinal hazard exposure records, and joint lead coordination systems for wounded warriors.
- Approved projects demonstrate a clear and convincing value proposition that is aligned with the Joint Strategic Plan (JSP) to provide benefit to both Departments.
- Projects must show great potential value in improving access, quality or safety measures; generating time or cost savings; creating productivity increases; and/or streamlining workflows.
- 66 Joint Incentive Fund (JIF) projects are currently active
- Currently authorized through FY 2015
  - Rescission of Funds in FY 2014 (\$15M) and again in FY 2016 (\$50M)



# Joint Incentive Fund (JIF) Restructuring



## Summary

- In early-to-mid 2014, DHA performed a comprehensive review of JIF program/processes including timelines, submission/selection protocols, program management challenges, periodic program reviews, and JIF financial management.
- Substantial improvements have been made to JIF program management in the last year
  - **Project Evaluation:** Developed improved JIF guidance – includes updated policies, templates and training to speed project initiation and reduce unnecessary variation
  - **Project Planning:** Implemented more stringent review and vetting processes to ensure only those projects with the greatest potential return on investment are selected
  - **Project Management:** New JIF change control process with a continually monitored scope/timeline to prevent scope “creep”, mitigate risks and meet stakeholder expectations for project outcomes, cost and schedule
  - **Project Execution:** Distributed a new cross-agency JIF reporting template and schedule to every active project to collect timely and accurate financial performance data



# JIF Improvements and Work Products



<b>Revamped JIF Policy, Guidance, Approvals</b>	<ul style="list-style-type: none"><li>• Embed IT, Clinical, PM, and Review considerations upfront (RACI - HIT, HEC WG, FMWG, VHA) in the JIF guidance and in the MOA for JIF. Voting/ scoring board with disinterested IT/Clinical SMEs.</li></ul>
<b>Explore More Disciplined PPBE process</b>	<ul style="list-style-type: none"><li>• Deliberate planning to support agencies' goals. In-depth assessments. Enforce shutdown of unsuccessful JIFs or increase footprint of successful initiatives</li></ul>
<b>JIF MAX Website</b>	<ul style="list-style-type: none"><li>• Includes JIF templates, training materials, electronic proposal submission, guidance, resources, etc.</li></ul>
<b>JIF PM training for Approved Initiatives</b>	<ul style="list-style-type: none"><li>• Training for best practice PMP-based program management, with easy-to-use managerial and reporting templates, and resources to guide JIF PMs</li></ul>
<b>Re-engineered Standard Operating Procedures</b>	<ul style="list-style-type: none"><li>• Scope changes, additional funding requests will only be considered with full impact assessment, revised BCA, updated project timeline, approval thresholds</li></ul>
<b>Update Business Case Analysis</b>	<ul style="list-style-type: none"><li>• Easier BCA, completion with support of business analyst, with quick communication tools (A3)</li></ul>
<b>Financial Management</b>	<ul style="list-style-type: none"><li>• A new, monthly, financial report for JIF that mirrors the DoD's 1002 report with individual JIF project codes to track funding, obligation &amp; disbursement</li></ul>
<b>Metrics</b>	<ul style="list-style-type: none"><li>• Suggested metrics, publish standards, and capture key performance indicators for local and national JIFs</li></ul>



# JIF Way Forward



- Clean up languishing projects (those older than 2 years or not making sufficient progress) and make funds available for new initiatives
  - \$10.39 M expected to be retrieved to date, with \$6.2 M already returned
- Continue to strengthen program management (from “up front” project manager training to streamlined IPRs to near real time financial reporting capabilities to timely closeout)
- Explore a more disciplined PPBE process for project origination/management that drives higher quality projects returning a better ROI for both agencies





# Joint Ventures

## What is the correct definition for a Joint Venture?

- According to DoDI 6010.23:

A Joint Venture is a VA and DoD mutually approved, locally negotiated partnership that will generate increased access to and/or an enhanced level of services for the beneficiaries of both agencies in a mutually beneficial, efficient and cost sharing manner that may or may not involve joint capital planning and coordinated use of existing or planned facilities. But unlike ordinary resource sharing relationships, joint ventures function like strategic alliances between DoD and VA for more than 5 years to facilitate comprehensive cooperation, shared risk and mutual benefit.

Joint Ventures entail VA and DoD medical facility missions and operations to be connected, integrated, or consolidated to the extent that ongoing interaction in several of the following areas: staffing, clinical workload, business processes, management, IT, logistics, education & training, and research.



# Joint Ventures Sites



- **Anchorage, Alaska** - 3rd Medical Group, Elmendorf AFB/Alaska VA Health Care System
- **Biloxi, Mississippi** - Keesler Air Force Base and Biloxi VA Medical Center
- **Honolulu, Hawaii** - Tripler Army Medical Center/VA Pacific Islands Health Care System (Spark M. Matsunaga Medical Center)
- **Key West, Florida** - Naval Branch Health Clinic Key West/Miami VA Health Care System (Community Based Outpatient Clinic)
- **El Paso, Texas** - William Beaumont Army Medical Center/El Paso VA Health Care System
- **Fairfield, California** - David Grant Medical Center, 60th Medical Group, Travis AFB/Northern California VA Health Care System
- **Las Vegas, Nevada** - 99th Medical Group, Nellis AFB/VA Southern Nevada Health Care System (Michael O'Callaghan Federal Hospital)
- **Albuquerque, New Mexico** - 377th Medical Group, Kirtland AFB/New Mexico VA Health Care System
- **Charleston, South Carolina** - Ralph A. Johnson Veterans Affairs Medical Center, 628<sup>th</sup> Medical Group Joint Base Charleston, and Naval Hospital Beaufort
- **Augusta, Georgia** - Charlie Norwood and Carl Vinson Veterans Affairs Medical Centers, Dwight D. Eisenhower Army Medical Center, Fort Gordon



# Demonstration Project Federal Health Care Center



- Captain James A. Lovell Federal Health Care Center (FHCC)
  - Combined North Chicago Veterans Affairs Medical Center and Naval Hospital Great Lakes
  - Opened 1 October 2010
  - The first federal healthcare facility with a single management structure
  - Integrates all clinical and administrative services under one line of authority
- Unique platform for learning the complexities of integration
  - Missions, staff, infrastructure, fiscal, cultural, patient information



# Federal Health Care Center Evaluation



- NDAA 2010 requires SECDEF and SECVA to submit a joint report to Congress (RTC) including:
  - an evaluation of the FHCC
  - recommendation whether to continue the demonstration
- DoD and VA jointly funded a contract to conduct an evaluation and draft a report
- Currently developing courses of action based on the evaluation report that will feed the development of the report to Congress
- Report is due to Congress in March 2016



# FHCC Evaluation Continued



- COAs being developed:
  - Continue FHCC as an integrated facility
  - Transition FHCC to a joint venture model
  - Discontinue FHCC relationship
- Functional areas being considered in development of COAs include:

Governance	Acquisition & Contracting
Information Technology	Quality Assurance
Budget/Finance	Education & Training
Personnel/Manpower	Contingency Planning
Facilities	Political Considerations



# FHCC Common Barriers/Constraints



- Lack of IM/IT interoperability
- Legislative/Regulatory/Policy barriers
  - Title 10 and Title 38 HR issues
  - Construction limitations
- Disparity of DoD and VA rules and regulations
  - Credentialing
  - Pharmacy Formulary
- Competitive Healthcare Job Market
- Service Line leadership; Structure Limits consolidation; Targeted Integration level maintains structure
- Automated Joint Business Processes
  - Accurate workload capture





# Veterans Base Access Issues



- In 2007, Shared Resources WG identified installation access as a challenge for Veterans without military ID, CAC or PIV cards at several of the VA-DoD joint venture sites.
- Military installation security and gate access guidance is provided in DoDI 5200.08 and DTM 09-012, however, implementing procedures are decentralized to base commanders; therefore, issues are resolved locally.
- GAO Report 12-992, identified base access procedure checks can take time and in some cases prevent Veterans from accessing care in a timely manner.
- Various solutions are currently used by military installation leadership at the local level. Examples include:
  - Photo ID (Driver's License / State Issued ID) + DD Form 214
  - Veteran Health Identification Card (VHIC) + Photo ID
  - Defense Biometrics Identification System (DBIDS) Card
  - Medical appointment list at gate + Photo ID



# Veterans Base Access REAL ID Act Background



- The REAL ID Act was enacted by Congress in 2005.
- The Act responds to a 9/11 Commission recommendation for the Federal government to set standards for the issuance of state-issued sources of identification, such as drivers licenses.
- On January 29, 2008, the Department of Homeland Security (DHS) promulgated a final rule implementing the requirements of the Act.
  - See 73 FR 5272; also 6 CFR part 37.
- On December 20, 2012, DHS began issuing determinations of compliance and deferred enforcement on states not determined to be compliant.



# Veterans Base Access REAL ID Federal Agencies Requirements

- The Act restricts Federal agencies from accepting for official purposes driver's licenses and identification cards issued by non-compliant states.
  - The Act regulates the conditions under which Federal agencies may accept state-issued documents.
- The Act defines "official purpose" to include:
  - Accessing Federal facilities
  - Boarding federally regulated commercial aircraft
  - Entering nuclear power plants
- Under a grant of temporary deferment, Federal agencies may continue to accept driver's licenses and identity cards issued by all states.
  - Enforcement was scheduled to begin January 15, 2013, now underway across Federal Government.
  - DHS released a schedule for the phased enforcement to ensure that states are treated in a fair and proportional manner.
  - **DoD implementation October 2015.**



# Veterans Base Access DoD REAL ID Implementation



- Veterans without military ID, CAC or PIV cards, will be required to access DoD installations/facilities using REAL IDs (compliant driver's licenses or state issued identification cards).
- DoD to begin implementation in October 2015.
- DoD Physical Security and Policy Branch will modify DoDI 5200.08 with REAL ID enforcement language.
- Current plan is to use REAL ID for installation physical access and the VHIC as the justification for accessing the medical treatment facility, in lieu of an installation pass or card.
- Currently, the noncompliant list includes: American Samoa, New York, Louisiana, Minnesota, and New Hampshire



# Interagency Care Coordination Committee (IC3)



- The goal of the IC3 is to streamline, synchronize, coordinate, and integrate the full spectrum of care, benefits, and services provided to Service members (SMs) and Veterans (Vets) and their families as they transition between the two Departments and into the civilian community.



# Interagency Care Coordination Committee (IC3)



- The Department of Defense / Department of Veterans Affairs (DoD/VA) Interagency Care Coordination Committee (IC3) oversees implementation of the November 2012 Secretaries' Intent memorandum to achieve:
  - One Mission : Facilitate transition of Service members and Veterans (SMs/Vets) requiring complex care between DoD and VA through an Integrated Community of Practice (CoP)
  - One Policy : Establish Interagency overarching guidance and ensure policies are congruent
  - One Plan: Ensure effective utilization of a single, shared comprehensive plan for SMs/Vets in need of complex care and services.





# Interagency Care Coordination Committee (IC3)



- One Mission: The Lead Coordinator (LC) concept was approved by the JEC in September 2012 to train care coordinators in their role to manage the transition of clinical and non-clinical care for SMs/Vets.
  - LC training began out in July 2015 in the NCR and will be given nationwide through November 2015
  - Interim LC training and Awareness training will be recorded and provided virtually from November 2015 through January 2016.
  - Beginning January 2016, sustainment training will be available via “my VA electronic Health University”, or MyVeHU.



# Interagency Care Coordination Committee (IC3)



- One Policy: Overarching guidance and policies have been established and published
  - Joint MOU (July 2014) – establishes common definition terminology and requirements surrounding Complex Care Coordination
  - VA Directive (December 2014) – provides VA with overarching policy on complex care coordination as outlined in the MOU.
  - DoDI (May 2015) – provides DoD with overarching policy on complex care coordination as outlined in the MOU.
  - Official policies will bolster existing work and support a larger implementation strategy for interagency care coordination.



# Interagency Care Coordination Committee (IC3)



- One Plan: An Interagency Comprehensive Plan (ICP) to provide an information technology solution for care coordination to enable data exchange between VA and DoD care coordinators
  - Incorporation of a Lead Coordinator Checklist for use by LCs.
  - DoD and VA to sustain their own systems and work towards an interoperable solution. Interoperable development to begin by September 30, 2015.
  - DoD and VA will obtain Full Operational Capability by September 30, 2016.



# Choice Act



## Background

- Veterans Choice and Accountability Act (VCAA) of 2014 is a three-year pilot program allowing veterans living more than 40 miles from a VA facility to access medical care from the local private sector. It is also open to veterans who cannot be seen by the VA within a reasonable time frame. \$10B in funds were provided to this program.
- VHA is working with contracted third party administrators (TriWest & Health Net) to build a Choice Network to manage patients referred under the Choice program.
- Under Choice, VA is a secondary payer for non-service connected conditions and DoD would have to collect OHI. This is a notable difference from VA's existing sharing agreements with DoD.



# Choice Act



## Major Choice Act Impacts To DoD Facilities:

- As of July 23, 2015, 12 sharing sites across all lines of service, and 5 of the top 10 sharing sites by volume have been impacted by VCAA and notified by their partner VAMC or VISN that referrals will cease
- The in essence termination of DoD/VA Resource Sharing Agreements will have numerous detrimental impacts on DoD facilities. Key aspects threatened include:
  - Military Health's readiness mission
  - GME and skill degradation in key surgical lines
  - Business and collaborative impacts of creating DoD/VA sharing agreements
  - Halting two OMB-directed studies that shape the future of streamlined and effective DoD/VA sharing and that inform the formulation of VA and DoD's budgets for health care costs.



# Choice Act Chronology



## Recent Progress to-date:

- On July 16<sup>th</sup>, DHA received notification that Nellis and Walter Reed had registered as VA Choice Providers. San Diego has also expressed desire to register as a VA Choice Provider.
- On July 23<sup>rd</sup>, Dr. Woodson met with VA Secretary McDonald and addressed the VA referral issue and impact to the DoD/VA Resource Sharing Program. The discussion highlighted the current issues with VA referrals to DOD facilities including MTF sites notified or impacted and 5 of the top 10 DOD/VA sharing sites affected .
- On July 31<sup>st</sup>, the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 passed, including a temporary authorization to use (until October 1, 2015) of Veterans Choice funds for other VA obligations, not to exceed \$3.3B. The DoD/VA Resource Sharing Program is among the other VA obligations included.
- On August 2<sup>nd</sup>, Janet Murphy (VA 10N) sent an email to VHA VISN Directors and VHA VISN CFOs as requested by Dr. Tuchschtmidt. Ms. Murphy advised the VHA VISN Directors and VHA VISN CFOs "To continue usual referrals to DOD under your sharing agreements. Due to passage of the bill providing funding for VA Community Care, funds are available for purchase DOD services. Please convey this message to your facilities."
- The week of August 3<sup>rd</sup>, Sen. McCain (R-AZ) introduced legislation to make the Choice Act pilot program permanent. It would also make all veterans eligible for the Choice program by removing the 40-mile residency requirement.





# Choice Act



## DoD's Continued Concerns

- Continued VA referrals to MTFs
- Future funding of DoD/VA Resource Sharing Agreements (RSAs), especially in FY16 (starting October 2015)
  - Current Choice Act funds realignment only valid through September 30, 2015
- Impact to DoD/VA RSAs if Choice Act pilot program becomes permanent
  - RSAs may no longer be funded
  - DoD may not have the business office capabilities to support collecting OHI or co-pays
- DoD is lowest cost venue of care, and should have the first right of refusal (where capability and capacity exists), currently not specified in Choice Act provisions
- Long term strategy to prevent funding defaults on the DoD/VA RSAs, as care is provided on a reimbursable basis



# Future Plans/Initiatives



- Comparative Analysis Pilot Study Completion and Validation
- Develop a Comprehensive Data Driven Selection and Evaluation Process for DoD-VA Collaboration Markets
- Standardized Master Sharing Agreement and BCA Process
- Obtain Legislative Relief for Construction of Minor Joint Facilities



# Contact information



- DVPCO
  - 703 681-4258
  - <http://www.health.mil/About-MHS/Defense-Health-Agency/Special-Staff/Defense-Health-Support/DoD-VA-Program-Coordination>
  - Legislative mandate for DoD/VA -sharing
  - Policies and reports
  - Reference material
  - Sharing examples



# Questions