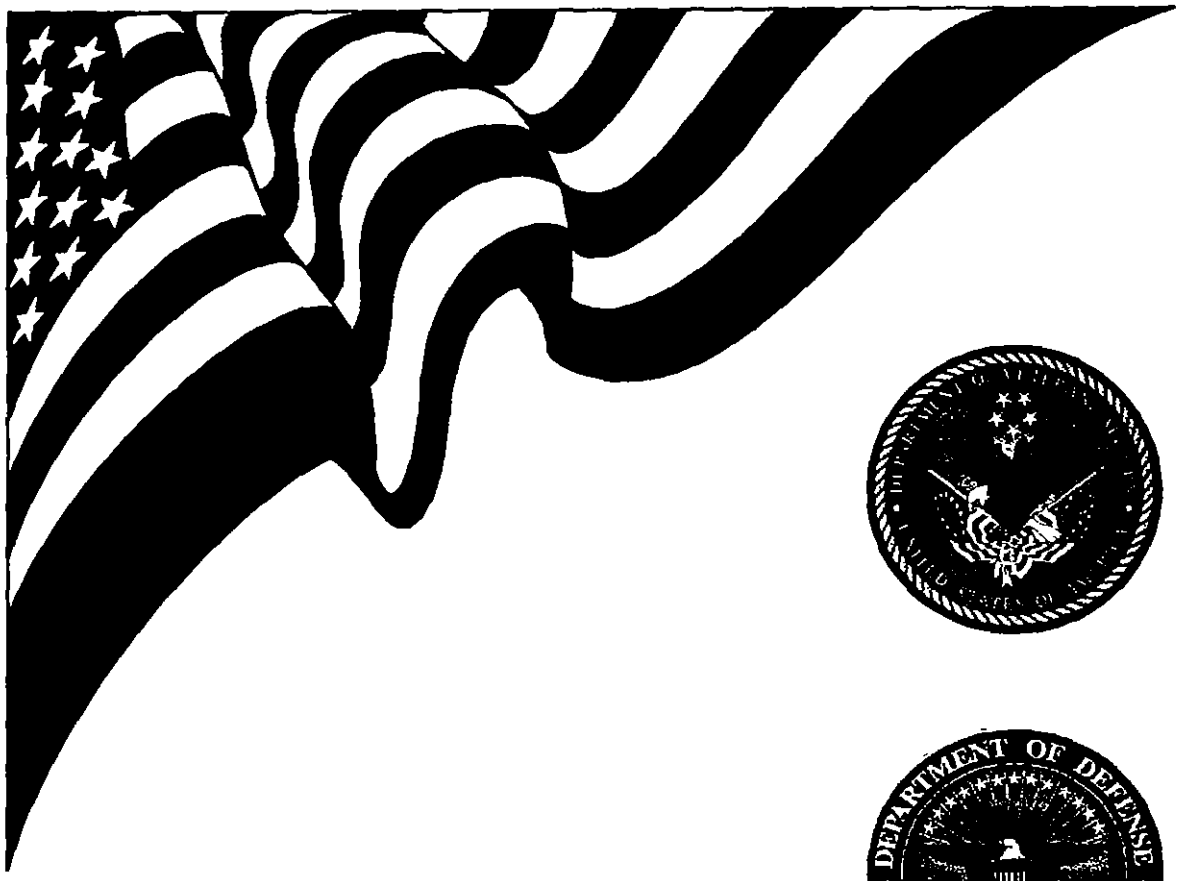

VA/DOD JOINT EXECUTIVE COUNCIL
ANNUAL REPORT
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VA/DOD JOINT EXECUTIVE COUNCIL
Annual Report – Fiscal Year 2004

EXECUTIVE SUMMARY

Public Law 108-136, Section 583, established the Department of Defense-Department of Veterans Affairs Joint Executive Council to recommend to the Secretary of Veterans Affairs and the Secretary of Defense a strategic direction for the joint coordination and sharing of efforts between and within the two Departments. The Department of Veterans Affairs (VA) and the Department of Defense (DoD) established the VA/DoD Joint Executive Council (JEC) in February 2002. The VA/DoD JEC has incorporated the responsibilities of this Executive Council into its charter. The law further requires the JEC submit to the two Secretaries and Congress an annual report. Attached is the first Annual Report.

During Fiscal Year 2004 (FY 2004) the VA/DoD JEC met quarterly to review existing policies, procedures, and practices to improve beneficiary access to quality health care and benefits and to strengthen resource sharing. Opportunities for change and improvement were identified and the Council oversaw implementation of over a dozen VA/DoD cooperative and sharing initiatives. These new cooperative initiatives are discussed in greater detail in the report.

Based on a review of past and current practices in VA/DoD collaboration, Congressional proceedings, GAO reports, and the findings of the President's Task Force to Improve Health Care Delivery for Our Nations Veterans (PTF), the JEC concluded that the most effective way to improve VA/DoD sharing was through the development of a Joint Strategic Plan to guide the Departments' future relationship.

The initial VA/DoD Joint Strategic Plan (JSP) was approved by the JEC on April 15, 2003 (see Appendix A). The first document of its kind, the plan represented a significant step forward in institutionalizing VA and DoD collaboration. The JSP articulated a vision for collaboration; established priorities for partnering; launched processes to implement interagency policy decisions and develop joint operation guidelines; and instituted performance monitoring to track the Departments' progress in meeting the specific goals and objectives defined in the plan. The JSP goals include Leadership Commitment and Accountability; High Quality Health Care; Seamless Coordination of Benefits, Integrated Information Sharing; Efficiency of Operations; and Joint Medical Contingency/Readiness Capabilities.

In FY 2004 the JEC reviewed and updated the JSP. During the planning process, the JEC clarified roles and responsibilities of the entities under the Executive Council structure, included specific performance metrics, introduced a more

strategic planning horizon, and committed to linking VA/DoD JSP goals and objectives to Departmental strategic plans. The Fiscal Year 2005 (FY 2005) Joint Strategic Plan is located at Appendix B of the Annual Report.

The JEC closely followed the activities of the PTF and reviewed the recommendations on improving VA/DoD sharing contained in their Final Report (May 2003). The majority of the PTF's recommendations have been implemented by the Departments or incorporated in the JSP. The Departments' response to the PTF Final Report is located at Appendix C.

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I. BACKGROUND

Public Law 108-136, Section 583, established the Department of Defense-Department of Veterans Affairs Joint Executive Council to recommend to the Secretary of Veterans Affairs and the Secretary of Defense the strategic direction for the joint coordination and sharing efforts between and within the two Departments and to oversee the implementation of those efforts. The law further requires the Council to submit to the Secretaries and to Congress an annual report highlighting major accomplishments and containing recommendations the Council considers appropriate.

II. THE VA/DOD JOINT EXECUTIVE COUNCIL

Established in February 2002, the Department of Veterans Affairs (VA) - Department of Defense (DoD) Joint Executive Council (JEC) is co-chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness. Membership is comprised 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. The JEC was established 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 improve resource utilization and 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.

In November 2003, the National Defense Authorization Act (P.L. 108-136) codified the JEC under USC Title 38, Section 8111 The statute requires the JEC to submit to the Secretary of Veterans Affairs, the Secretary of Defense, and Congress an annual report containing such recommendations as the JEC considers appropriate to enhance VA/DoD sharing and collaboration.

III. THE EXECUTIVE COUNCIL STRUCTURE

VA and DoD have undertaken unprecedented efforts to assert and support mutually beneficial collaboration and sharing opportunities by establishing four additional interagency councils/committees: the VA/DoD Health Executive Council (HEC), co-chaired by the VA Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs, the VA/DoD Benefits Executive Council (BEC), co-

chaired by the VA Under Secretary for Benefits and the Principal Deputy Under Secretary of Defense for Personnel and Readiness; the Joint Strategic Planning Committee (JSPC) co-chaired by the VA Principal Deputy Assistant Secretary for Policy, Planning, and Preparedness and the Principal Deputy Assistant Secretary of Defense for Health Affairs; and the Capital Asset Planning and Coordination Steering Committee (CAPC), co-chaired by the VA Principal Deputy Assistant Secretary for Management and the Deputy Assistant Secretary of Defense for Health Budgets and Financial Policy. The co-chairs of each of these groups are members of the JEC and actively participate in the joint strategic planning process. The JEC's primary responsibility within this structure is to set strategic priorities for the HEC, BEC, JSPC, and CAPC, monitor the development and implementation of the Joint Strategic Plan; and ensure appropriate accountability is incorporated into all joint initiatives.

A. VA/DoD Health Executive Council (HEC)

Comprised of senior leaders from each organization, the Health Executive Council (HEC) works to institutionalize VA and DoD sharing and collaboration to ensure the efficient use of health services and resources. The HEC oversees the cooperative efforts of each agency's health care organizations.

The HEC has charged work groups to focus on specific high-priority areas of national interest. Through these work groups, the Departments have achieved significant success in improving interagency cooperation in key areas such as pharmacy, procurement, deployment health, clinical guidelines, contingency planning, graduate medical education, information management/information technology, financial management, joint facility utilization, and benefits coordination. Local and regional cooperation has increased due to innovative projects that extend resources and increase operational readiness through shared staffing, services, and facilities.

Through the HEC, VA and DoD have worked closely to ensure coordination of health care services to our military and newest veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

B. VA/DoD Benefits Executive Council (BEC)

The Benefits Executive Council (BEC) is 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 service members' awareness of potential benefits. In addition, the BEC provides advice and recommendations to the 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. The BEC has made significant progress in meeting the objectives set forth in the JSP.

C. VA/DoD Joint Strategic Planning Committee

In October 2002 the JEC established the VA/DoD Joint Strategic Planning Committee (JSPC). The JSPC 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. Based on a review of past and current practices in VA/DoD sharing, Congressional proceedings, GAO reports, and the findings of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF), the JSPC developed the JSP to guide the Departments' future sharing and collaboration.

D. VA/DoD Capital Asset Planning and Coordination Steering Committee

The JSPC chartered the Capital Asset Planning and Coordination Steering Committee in August 2003 The CAPC 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 and is mutually beneficial to both Departments. The CAPC provides the oversight necessary to ensure that collaborative opportunities for joint capital asset planning are maximized, and will serve as the final review and approval of all joint capital asset initiatives recommended by any element of the JEC structure.

IV. The VA/DoD Joint Strategic Plan

The initial VA/DoD Joint Strategic Plan (JSP) was approved by the JEC on April 15, 2003 (see Appendix A). The first document of its kind, the plan represented a significant step forward in institutionalizing VA and DoD collaboration. The JSP articulated a vision for collaboration; established priorities for partnering; launched processes to implement interagency policy decisions and develop joint operation guidelines; and instituted performance monitoring to track the Departments' progress in meeting the specific goals and objectives defined in the plan The JSP goals include: Leadership Commitment and Accountability; High Quality Health Care; Seamless Coordination of Benefits; Integrated Information Sharing; Efficiency of Operations; and Joint Medical Contingency/Readiness Capabilities.

In FY 2004 the JEC reviewed and updated the JSP. During the planning process, the JEC clarified roles and responsibilities of the entities under the Executive Council structure, included specific performance metrics, introduced a more strategic planning horizon, and committed to linking VA/DoD JSP goals and objectives to Departmental strategic plans. The Fiscal Year 2005 (FY 2005) Joint Strategic Plan is located at Appendix B of the Annual Report.

A. Summary of Performance on Key Strategic Goals

The VA/DoD Joint Strategic Plan identified six strategic goals essential to meaningful collaboration between the Departments. Each goal has specific objectives and performance measures to assess the progress made toward achievement The following summary is structured around the six strategic goals.

GOAL 1: Leadership Commitment and Accountability: Promote accountability, commitment, performance measurement, and enhanced internal and external communication through a joint leadership framework.

A formal Executive Council Structure was established under the umbrella of the VA/DoD Joint Executive Council. The VA/DoD Health Executive Council, Benefits Executive Council and a Capital Asset and Coordination Steering Committee were created and charters approved. The Joint Strategic Planning Committee (JSPC) was established by the JEC to develop and maintain a joint strategic plan. The councils serve as a forum for senior leaders of both Departments meet on a regular basis to provide oversight and direction on the joint strategic plan, discuss and plan for future joint initiatives, and assist in resolving organizational impediments to collaborative efforts. Additionally, the Councils ensure joint strategic objectives and accomplishments are communicated to the Departments' internal and external stakeholders and appropriate media outlets.

GOAL 2: High Quality Health Care: Improve the access, quality, effectiveness and efficiency of health care for beneficiaries through collaborative activities.

Patient Safety. VA and DoD are collaborating on 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.

Clinical Practice Guidelines: VA and DoD are collaborating in the creation and publication of jointly used clinical practice guidelines for disease management. DoD and the Veterans Health Administration (VHA) are now using the same explicit clinical practice guidelines to improve patient outcomes. Clinical guidelines have provided consistent, high-quality health care delivery in both Departments Guidelines have been published for the following clinical areas: asthma, chronic kidney disease, chronic obstructive pulmonary disease (COPD), cardiovascular disease, (including hypertension, hyperlipidemia, ischemic heart disease and chronic heart failure), depression, diabetes mellitus, dysuria in women, low back pain, medically unexplained symptoms, (including chronic pain and fatigue), post-operative pain management, post deployment health, substance abuse, uncomplicated pregnancy, stroke rehabilitation and tobacco cessation. The Work Group also completed work on guidelines for use of opioids in the management of chronic pain, post-traumatic stress disorder, and a pocket card related to blast injuries. Other guidelines that are pending or planned for 2005 include updates for

tobacco use cessation, hypertension, dyslipidemia, post-deployment including a module on amputation and psychoses with a module on bipolar disorder and a new guideline pertaining to obesity The Work Group also conducted joint reviewer training, three satellite broadcasts and four face-to-face meetings to disseminate new and updated guidelines and facilitate implementation. Tools for each guideline were also made available to providers. Patient brochures, CD-ROMs, pocket cards, and other self-study continuing education are available on the web. Guideline products have also been presented at national meetings throughout the year. On September 8, 2004, the revised charter was signed to enhance the continued collaboration and further champion the implementation of evidence-based clinical advances into practice.

Deployment Health: The HEC established the Deployment Health Work Group to enhance health care available to service members returning from an 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 Examples of initiatives include: administering pre- and post-deployment health assessments; identifying and tracking health care utilization of individual personnel returning from deployments; providing targeted outreach and education through personal letters, pocket cards, web sites, and targeted briefings; enhancing clinical and staff education to facilitate early identification of potential health risks, and sharing appropriate, relevant medical and service information between VA and the military services.

Pharmacy: The goal of the VA/DoD Federal Pharmacy Executive Steering Committee of the HEC is to improve the management of pharmacy benefits for both VA and DoD beneficiaries. Joint partnerships for contracting for pharmaceuticals have been very successful. The Departments have conducted a pilot test where VA Consolidated Mail Out Pharmacy (CMOP) Leavenworth refills outpatient prescription medications from DoD's Military Treatment Facilities (MTF) at the option of the beneficiary. The original DoD sites were Naval Medical Center San Diego, California; Fort Hood Army Community Hospital, Killeen, Texas; and 377th Medical Group, Kirtland Air Force Base, New Mexico. The Departments have reviewed analysis of the joint VA/DoD CMOP Pilot prepared by Center for Naval Analysis (CNA) and have found the program to be feasible, with high participation by DoD beneficiaries, and high satisfaction among users of the program The Departments are also aware that DoD has deemed the CNA report inconclusive on whether the CMOP program is cost-effective for DoD. Relative cost data will continue to be assessed by DoD. The United States Government Accountability Office is conducting an in-depth analysis of the pilot program and is expected to issue a report in the near future DoD continues to be interested in exploring this joint activity with the VA; however, DoD will not centrally fund the effort. For Fiscal Year 2005, continuation of CMOP services to the pilot sites will be at the discretion of each MTF Commander and respective Service. Current status at the pilot sites: Fort Hood discontinued the service effective September 30, 2003; however, the

Army is considering continuation of the program; Naval Medical Center San Diego continues to participate at a rate of approximately 500,000 prescriptions per year; Kirtland Air Force Base continues to participate at a rate of approximately 60,000 prescriptions per year.

Resource Sharing: The Joint Facility Utilization and Resource Sharing Work Group was established by the HEC to examine issues such as removing barriers to resource sharing and streamlining the process for approving sharing agreements. The Work Group 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 work group was responsible for providing oversight of the VA/DoD Joint Assessment Study mandated by the FY 2002 National Defense Appropriations Act. A contract was awarded in November 2002, for a study of beneficiary utilization within three federal health care markets: Puget Sound, Hawaii; and along the Gulf Coast between Biloxi, MS, and Panama City, FL. The study was submitted to Congress on September 20, 2004.

The Work Group also had responsibility for overseeing compliance with Sections 722, and 723 of the FY 2003 National Defense Authorization Act. These activities are discussed under Goal 5 in this report.

The HEC established the North Chicago-Great Lakes Task Force to recommend short and long term actions to improve resource sharing between the North Chicago Veterans Affairs Medical Center (VAMC) and the Naval Hospital Great Lakes. Current activity includes initiation of the construction project to modernize the NCVAMC surgical emergency/urgent care facilities. Discussions are underway on funding for site and space planning for the Navy Ambulatory Care Center on adjacent to the North Chicago VAMC. Discussions are planned on potential governance models for integrating operations of the two facilities.

GOAL 3: Seamless Coordination of Benefits: Promote the coordination of benefits to improve the understanding of, and access to, benefits and services earned by service members and veterans through each stage of life, with a special focus on ensuring a smooth transition from active duty to veteran status.

Transition Assistance: The BEC supports the enhancement of collaborative efforts to educate active duty, Reserve and National Guard personnel on VA and DoD benefits programs, eligibility criteria and application processes. A pilot initiative is underway to ensure wide dissemination of VA benefits information to VA and DoD beneficiaries at the time of accession. VA's brochure: "A Summary of VA Benefits" will be provided to each enlistee beginning in October 2004.

The Department of Labor, the Public Health Service and the Coast Guard participates with VA and DoD in a BEC Work Group established to enhance

collaborative efforts to educate active duty, Reserves and National Guard personnel. DoD promotes pre-separation participation in the Transition Assistance Program (TAP) and the Disabled Transition Assistance Program (DTAP) for all service members. The possibility of posting TAP and DTAP information on a central transition website is being explored. The VA Homepage provides information of specific interest to returning Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans and their families and has hyperlinks to relevant sites including Readjustment Counseling Centers, DoD Family Services, and Guard and Reserve specific policies.

Benefits Delivery at Discharge: The Benefits Delivery at Discharge (BDD) program is designed to facilitate the adjudication process for service members filing claims for disability compensation at the time of their separation/retirement from active duty At the time of separation service members usually have ready access to their service personnel and medical records which provide the documentation necessary to support a disability claim. Providing a comprehensive physical examination in support of a disability claim at the time of separation eliminates the need for an additional examination post discharge, expediting the adjudication process. VA and DoD have been working together to develop a cooperative physical examination process that meets both the services' separation examination requirements and VA's compensation examination criteria. A test protocol has been piloted at 28 BDD sites located at, or in close proximity to, Army, Navy and Air Force bases across the country Based on the success of the pilots a national Memorandum of Agreement has been developed, outlining the conditions, stipulations, and responsibilities of each party in support of the Cooperative Physical Examination initiative. The MOA is on schedule to be completed and approved by both Departments by the end of first quarter of FY 2005, and implementation guidelines issued during the second quarter of that same year.

GOAL 4: Integrated Information Sharing: Enable the efficient sharing of beneficiary data, medical records, and other information through secure and interoperable information management systems

The Information Management/Information Technology (IM/IT) Work Group of the HEC is responsible for developing and implementing joint policy for improving exchange of health data between the Department of Defense and the Department of Veterans Affairs. Highlights of key HEC IM/IT initiatives for FY 2004 include:

Joint Electronic Health Records Interoperability (JEHRI) Initiative: VA and DoD strongly support the need for appropriate sharing of electronic health information. To strengthen VA/DoD electronic medical information exchange while leveraging Departmental systems investments, VA and DoD are working to ensure the interoperability of the Departments' electronic health records systems by the end of FY 2005. JEHRI includes implementation of standards, technical and data architectures, hardware, and software design and development required to achieve the ability to securely exchange electronic health information.

The Under Secretary of Defense for Personnel and Readiness and the Deputy Secretary for Veterans Affairs signed the Executive Decision Memorandum defining the goals of the VA/DoD Joint Electronic Health Records Interoperability Initiative at the September 2002 JEC meeting. This initiative, which has been approved by the Office of Management and Budget, addresses the Departments' long-range plan to improve sharing of health information; adopt common standards for architecture, data, communications, security, technology and software; seek joint procurement and/or building of applications, where appropriate; seek opportunities for sharing existing systems and technology, and explore convergence of VA and DoD health information applications consistent with mission requirements. JEHRI also responds to the recommendations of the PTF.

VA and DoD are committed to exchanging appropriate health information in the most efficient and effective means possible while continuing to meet unique agency needs. VA and DoD are in the process of finalizing the JEHRI Program Management Plan (PMP). The JEHRI PMP guides the management oversight, progress reporting, and continued development of JEHRI projects. JEHRI projects are laying the ground work for the clinical information exchange that will enable a consolidated view of health data from VA and DoD medical records.

Health Information Technology Standards: VA and DoD play key roles as lead partners in the Consolidated Health Informatics (CHI) initiative. The goal of the CHI initiative is to establish Federal health information interoperability standards as the basis for electronic health data transfer in all activities and projects among all agencies and departments.

In March 2003, the Departments of Health and Human Services (HHS), Defense, and Veterans Affairs announced the first set of uniform standards to be adopted from the CHI effort. They included standards in clinical laboratory results, health messaging, prescription drug codes, digital imaging, and connectivity of medical devices to computers. The standards adopted will be used in new acquisitions and systems development initiatives.

On May 6, 2004, HHS, VA, and DoD announced the adoption of 15 additional standards recommended by CHI including:

- Health Level 7 (HL7) vocabulary standards for demographic information, units of measure, immunizations, and clinical encounters and HL7s Clinical Document Architecture standard for text based reports;

- College of American Pathologists (CAP) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) for laboratory result contents, non-laboratory interventions and procedures, anatomy, diagnosis and problems, and nursing;

- Logical Observation Identifier Name Codes (LOINC®) for electronic exchange of laboratory test orders;

- Health Insurance Portability and Accountability Act (HIPAA) transactions and code sets for electronic exchange of health related information to perform billing or administrative functions;

- Food and Drug Administration's (FDA) names and codes for ingredients, manufactured dosage forms, drug products and medication packages; National Library of Medicine's RxNORM for describing clinical drugs; and VA's National Drug File Reference Terminology (NDF-RT) for specific drug classifications;

- Human Gene Nomenclature (HUGN) for the role of genes in biomedical research;

- Environmental Protection Agency's Substance Registry System (SRS) for non-medicinal chemicals of importance to health care.

Both VA and DoD are engaged in discussions regarding CHI Phase II and the necessity for an updated CHI Phase II Memorandum of Understanding in light of CHI now being a workgroup under the Federal Health Architecture initiative.

For CHI Phase II there are three key activities:

1) Implementation of adopted standards,

2) Maintenance and enhancement of adopted standards, and

3) Continuation of new standards adoption needed to support business priorities.

VA and DoD are co-chairing the CHI Phase II new standards development effort with particular emphasis on e-Prescribing and allergy standardization.

VA and DoD are also leading partners in many national standards development efforts. Both Departments participate in multiple standards boards to collaborate and share expertise. The VA/DoD Standards Convergence Group continues to work towards leveraging synergies and avoiding duplication and inconsistencies with their respective Enterprise Architecture (EA) development. EA links the business mission, strategy, and processes of an organization to its Health Technology strategy.

The Federal Health Information Exchange (FHIE): The FHIE is the initial VA/DoD effort at sharing appropriate clinical health data electronically. The transfer of data

on service members at the point of separation is a one time (per beneficiary) transfer, in keeping with applicable privacy laws and regulations, from DoD's Composite Health Care System (CHCS) to VA's Veterans Health Information System and Technology Architecture (VistA) for use by VA providers and benefits claims specialists.

DoD has transmitted over 95 million messages on 2.3 million unique patients containing information on laboratory results (clinical chemistry, blood bank information, microbiology, surgical pathology, and cytology); radiology results; outpatient pharmacy data from military treatment facilities, retail network pharmacies, and DoD mail order pharmacies; allergy information; discharge summaries (inpatient history, diagnosis, and procedures); admission, disposition, and transfer information (admission and discharge dates); consult reports (referring physician and physical findings); standard ambulatory data record (diagnosis and procedure codes, treatment provided, encounter date and time, and clinical services); and patient demographic information (name, social security number, date of birth, sex, race, religion, patient category, marital status, primary language, and address). This number continues to grow as health information on recently separated Service members is extracted and transferred to VA monthly.

VA providers at all VA Medical Centers and clinics nationwide have access to data on separated Service members. The FHIE data repository contains historical clinical health data from 1989 to the present that significantly contributes to the delivery and continuity of care and adjudication of disability claims of separated Service members as they transition to veterans.

Bidirectional Health Information Exchange (BHIE) (formerly known as CHCS/VistA Data Sharing Interface (DSI)): Building on FHIE and reusing a significant number of its products is the BHIE The focus of this interface is exchanging data on shared VA/DoD patients such as at joint venture sites and to support other local sharing agreements. While FHIE provides joint health care facilities access to pre-separation DoD health care data on separated service members, BHIE will provide secure, near real-time, bidirectional access to electronic health information on shared patients. This project is an incremental step in the accomplishment of the goal to create a bidirectional interface between DoD's and VA's health information systems.

The initial data shared, in the first Quarter of FY 2005, will be patient demographic data (name, patient category, social security number, gender, and date of birth), DoD and VA outpatient pharmacy data (Military Treatment Facility data for all shared beneficiaries, DoD mail order pharmacy and retail pharmacy network for separated service members, and VA pharmacy data), and allergy information. Additional data elements that will be added are: DoD mail order pharmacy and retail pharmacy network data for other shared beneficiaries, laboratory results (surgical pathology reports, cytology, microbiology, chemistry, hematology, and lab orders data), and radiology results.

DoD Clinical Data Repository (CDR) and the VA Health Data Repository (HDR) – (CHDR): To provide a more robust bidirectional real-time exchange of clinical health care data in the future, VA and DoD are working on interoperability between the DoD CDR and the VA HDR – (CHDR) utilizing the Departments' next generation of systems, DoD CHCS II and VA HealtheVet VistA.

Phase I of this effort is a pharmacy prototype. The Departments' technical and functional teams successfully completed a demonstration of the bidirectional pharmacy prototype in a lab environment on September 1, 2004. The data exchanged through the pharmacy prototype includes patient demographic data (sufficient to correlate patients), provider demographic data (sufficient to identify the ordering provider), medication lists, and allergy lists from one agency repository to the other. In addition, the prototype provides the capability for agency drug to drug interaction screening (based on the integrated VA/DoD medication list) and local (intra-agency) database drug to drug allergy interaction screening (based on the integrated VA/DoD allergy list).

Phase II will include the exchange of patient demographics, outpatient pharmacy (Military Treatment Facility, DoD mail order, and retail pharmacy network data), laboratory, and allergy information which will occur by October 2005.

FHIE, BHIE, and CHDR projects share clinical health care data and are complimented by the following projects which share supporting types of data:

Laboratory Data Sharing Interface (LDSI): LDSI focuses on sharing real-time laboratory order entry and laboratory results retrieval between DoD, VA, and commercial reference laboratories. Employing LDSI, a VA provider using VistA writes an order for lab work. That order is electronically transferred to DoD, which is acting as a reference lab to VA for fulfillment. The results are electronically transferred from DoD to VA and included in the patients' record in VistA. LDSI provides laboratory order portability between local VA/DoD sites that have a sharing agreement regarding laboratory services. Testing is underway on similar electronic order entry and results retrieval to support VA functioning as a reference lab for DoD. As part of the National Defense Authorization Act (NDAA) Demonstration Site initiative, the Departments will implement LDSI in San Antonio, Texas, for use by Wilford Hall Medical Center, Brooke Army Medical Center, and the South Texas Veterans Healthcare System, and in El Paso, Texas, for use by William Beaumont Army Medical Center and the El Paso Veterans Affairs Health Care System.

VHA's VetPro Credentialing System (VetPro) and DoD's Central Credentials Quality Assurance System (CCQAS): To improve the process of initial provider credentialing, the VetPro/CCQAS project enables the electronic sharing of provider credentialing data elements between VA and DoD. This allows both Departments to expend fewer resources to initially credential a provider that has already been credentialed in the other Department. The interface supports the exchange of

approximately 50 credentials data elements between the Departments. The interface meets the content of the Joint Commission for the Accreditation of Health Care Organization guidance regarding the acceptance of credentials data verified by another source.

Pilot testing of the interface between the VA and DoD credentialing systems took place at the following sites: Naval Hospital Great Lakes/North Chicago Veterans Health Care System/Hines VA Hospital, Illinois; Ireland Army Community Hospital/Louisville VAMC, Kentucky; and Mike O'Callaghan Federal Hospital in Las Vegas, Nevada. The pilot test was completed in the third quarter, FY 2004. Participants in the pilot test agreed that the integration reduced duplication and resulted in time savings. The Departments are now implementing VetPro/CCQAS credentials interface into the San Antonio area for use by Wilford Hall Medical Center, Brooke Army Medical Center, and the South Texas Veterans Healthcare System, as part of the NDAA Demonstration Site initiatives. This will provide a longer period of use and a more in-depth evaluation of the merits of the interface.

In the Benefits arena, VA and DoD made progress during FY 2004 in improving data exchange to enhance coordination of benefits for service members and veterans:

Expedited Information Exchange for Claims Processing: Efforts are underway to provide VA access to claimants' personnel information from the Defense Integrated Military Human Resources System (DIMHRS) through the DoD/Defense Manpower Data Center (DMDC) interface when it is fielded in late 2005. VA is also interfaced with the imaged Official Military Personnel Files for the Army, Navy and Marine Corps via the VA Personnel Information Exchange System (PIES) and the Defense Personnel Records Image Retrieval System (DPRIS). Within the last quarter of FY 2004, VA made access to Defense Enrollment and Eligibility Reporting System (DEERS) data, from within the Veterans Information System (VIS)*, available to VA Regional Offices and Medical Facilities for the purpose of early identification of recently discharged DoD service members. Through this process, recently discharged service members are routinely verified as being honorably discharged within two days of the discharge event; without the DEERS/VIS interface notification can take up to 90 days. VA and DoD are also expanding the scope of data VA receives from DMDC/DEERS so combat history and hazardous duty information on returning OIF/OEF service members will be available during the first quarter of FY 2005 VBA's original list of 100 data elements necessary to determine an individual service members' eligibility for benefits sent to the Joint Requirements and Integration Office (JR&IO) in June of 1998, has recently been updated and validated by VA and an interagency team of functional subject matter experts from the DIMHRS requirements and reengineering team and VBA.

* VIS is an online reference system of veteran service history data derived from DoD/DMDC, which is available from the VA intranet

GOAL 5: Efficiency of Operations: Improve management of capital assets, procurement, logistics, financial transactions, and human resources.

Capital Asset Coordination: The initial Joint Strategic Plan required VA and DoD to establish a capital coordination process to ensure an integrated approach to capital coordination between the two departments. As a result, the Capital Asset Planning and Coordination (CAPC) Steering Committee was created via charter on August 13, 2003.

The CAPC formed the Capital Budgeting Work Group to identify linkages between VA and DoD capital processes for upcoming budget cycles, identify joint requirements for analysis and planning, and establish funding principles for collaborative projects. The Work Group is finalizing its report, which contains both short and long-term recommendations for major capital collaborations. One of the more notable recommendations is the formation of a "core group," which will facilitate stability and consistency by protecting joint projects from vulnerabilities associated with changing leadership at local and regional levels. The core group will consist of permanent members from corporate headquarters in VA and DoD and variable members who will rotate through the core group based on the specific project or planning needs This core group is targeted to be piloted in FY 2005.

The CAPC also worked cooperatively with the Health Executive Council in the creation of the Joint Incentive Fund (JIF) Memorandum of Agreement (MOA) to ensure that the MOA had sufficient flexibility to allow monies from the fund to be expended on requirements analysis and planning in relation to construction projects and to outline the CAPC role in evaluating JIF proposals with a significant capital component.

The HEC has established Work Groups to focus on coordination in specific areas to improve efficiency. Highlights of HEC activities and accomplishments for FY 2004 include:

Joint Acquisition: VA and DoD established an agreement to eliminate duplication in specific contracting efforts, to leverage buying power, and obtain best value contract solutions. Appendices have been developed to cover acquisitions in medical-surgical, pharmaceuticals, and high tech medical equipment. Through these agreements, both VA and DoD save substantial taxpayer dollars through cost avoidance and lower prices. Collaboration in pharmaceuticals contracting has been notably successful.

There are currently 81 joint contracts, 13 blanket purchasing agreements, 12 pending joint contracts, and 17 proposed joint contracts In FY 2002, cost avoidance through joint pharmaceutical procurement contracts totaled over $139 million; in FY 2003 cost avoidance was $148 million; and in FY 2004 cost avoidance was $185 million.

VA and DoD began the migration to a single Federal pricing instrument, the Federal Supply schedule, for medical surgical products in January 2002. The Materiel Management Work Group is continuing to define requirements for a joint on-line single Federal pricing catalog, which will provide "real time" visibility of contract items.

Financial Management: The Departments established a standardized reimbursement methodology between VA and DoD medical facilities through a Memorandum of Agreement implementing standardized outpatient billing rates based on discounted CHAMPUS Maximum Allowable Charges schedule Guidelines and procedures were also developed for waiver request applications.

Joint Incentive Fund: As mandated by Section 721 of the FY 2003 National Defense Authorization Act, the HEC established a Joint Incentive Fund to provide incentives for creating innovative sharing initiatives at the facility, regional and national levels. Each Department contributed $15 million to the fund in FY 2004 A similar amount will be deposited to the fund at the beginning of each fiscal year. A charter was approved and implementation guidelines developed for administration of the JIF in July 2004. The VA/DoD Financial Management Work Group (FMWG) received 58 proposals in response to the initial call for proposals. The Work Group approved 29 of these proposals to proceed to the second round. In the second round, 19 projects were scored and 12 recommended for funding at a total cost of $29.9 million. Funding will be allocated to the selected projects upon certification that they are self sustaining. Proposals recommended for funding involve a wide range of services including various tele-health projects, women's health services, a joint cardiac catheterization lab, a joint dialysis unit and the opening of a joint clinic.

Demonstration Projects: Section 722 of the FY 2003 National Defense Authorization Act mandates the establishment of health care coordination projects between VA and DoD. Seven demonstration projects were selected in FY 2004 and implementation is scheduled for the first quarter of 2005. The program will evaluate the success of demonstration projects designed to improve the coordination of health care resources between VA and DoD for application elsewhere. Each Department made available $6 million in FY 2004. From FY 2005 through FY 2007 each Department will make available $9 million for each year. All sites are expected to begin their projects by October 2004. The seven demonstration sites approved by the HEC are:

Budget and financial management systems:

- VA Pacific Islands Health Care System and Tripler Army Medical Center, Hawaii
- Alaska VA Health Care System and the 3rd Medical Group, Elmendorf Air Force Base, Alaska

Coordinated staffing and assignment systems:

- Augusta VA Medical Center and Eisenhower Army Medical Center, Georgia
- Hampton VA Medical Center and the 1st Medical Group, Langley Air Force Base, Virginia

Medical information and information technology management systems:

- Puget Sound VA Health Care System and Madigan Army Medical Center, Washington
- El Paso VA Health Care System and William Beaumont Army Medical Center, Texas
- South Texas VA Health Care System, Wilford Hall Medical Center and Brooke Army Medical Center, Texas

GOAL 6: Joint Contingency/Readiness Capabilities: Ensure the active participation of both agencies in support of the VA/DoD Contingency Plan and National Response Plan.

The VA/DoD HEC established the Contingency Planning Work Group in FY 2004 to enhance collaborative efforts in support of the VA/DoD Contingency Plan and the National Disaster Medical System. Through the Work Group, VA and DoD are jointly updating the MOU regarding VA furnishing health care services to members of the armed forces during a war or national emergency. Additionally, hundreds of joint mass casualty training exercises occur between local VA and DoD medical facilities on an annual basis. Each Department dedicates staff, equipment, supplies and logistical support to these exercises, which focus on incident and consequence management as well as VA/DoD contingency operations. To enhance medical readiness, VA and DoD participate in an alliance with other federal agencies, FEDS-Heal, to ensure that Army reservists are ready for deployment to any global military mission Through this initiative VA helps the reserve component meet the requirements of retention physicals and prepare for mobilization.

B. Summary of Update of Joint Strategic Plan for FY 2005

In FY 2004 the JEC reviewed and updated the JSP. During the planning process, the JEC clarified roles and responsibilities of the entities under the Executive Council structure, included specific performance metrics, introduced a more strategic planning horizon, and committed to linking VA/DoD JSP goals and objectives to Departmental strategic plans The FY 2005 Joint Strategic Plan is located at Appendix B of the Annual Report.

V. RECOMMENDATIONS TO PROMOTE SHARING BETWEEN THE DEPARTMENTS

No formal recommendations for legislation are made at this time. Work Groups under the Executive Council Structure developed recommendations to promote sharing between VA and DoD. Highlights of those recommended actions approved through the Executive Council structure and implemented in FY 2004 are outlined above. Ongoing and future initiatives to enhance VA/DoD collaboration are included in the revised JSP.

VI. THE PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS (PTF)

In May 2001, President George W. Bush signed Executive Order 13214 creating the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). The charge to the PTF was to identify ways to improve health care delivery to Department of Veterans Affairs (VA) and Department of Defense (DoD) beneficiaries through better coordination and improved business practices. The PTF published its final report in May 2003. The Final Report contained recommendations organized around the principles of Leadership; Providing a Seamless Transition to Veteran Status, Removing Barriers to Collaboration; and Timely Access to Services and Funding. The JEC incorporated the majority of the Task Force's final recommendations into the VA/DoD Joint Strategic Plan. The formal response to the PTF's recommendations can be found in Appendix C

MAR 1 4 2005

The Honorable John W. Warner
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

As required by Public Law 108-136, Section 583, we are pleased to submit the enclosed report for Fiscal Year 2004 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Committee. This report, which includes an updated version of the Joint Strategic Plan, was also provided to the Secretaries of each Department.

Sincerely yours,

Gordon H. Mansfield
Deputy Secretary of Veterans Affairs

David S. C. Chu
Under Secretary of Defense
Personnel and Readiness

Enclosure

cc: Senator Carl Levin