May 6, 2013

The Honorable Tim Johnson
Chairman,
Subcommittee on Military Construction
Veterans Affairs, and Related Agencies
Committee on Appropriations
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The House Appropriations Committee report (H. Rept. 112-94), which accompanied the H.R. 2055, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2012, requests a report on joint Department of Veterans Affairs (VA)/Department of Defense (DoD) facilities no later than 180 days after the date of enactment. An interim report was provided in July. Our joint report is enclosed.

The Committee expressed an interest in joint medical facilities that can serve both Active Duty Service members and Veterans and could be a cost-savings strategy for both DoD and VA. The Committee requested that DoD provide a complete analysis and review of the Fort Benning facility and other joint facilities, like the former Fort Ord site.

The Departments gathered data on joint medical facility initiatives at Fort Benning, Georgia; Monterey, California; Panama City, Florida; and Honolulu, Hawaii, as well as the joint facility planning process for both Departments. The final report also includes a summary of the benefits of joint medical facilities. A similar letter is being sent to the Chairpersons of the other Congressional Defense Committees.

Thank you for your interest in the health and well-being of our Service members, Veterans, and their families.

Sincerely,

Jessica L. Wright
Acting Under Secretary of Defense
for Personnel and Readiness

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Enclosure:
As stated

The Honorable Mark Kirk
Ranking Member

May 6, 2013

The Honorable John Culberson
Chairman,
Subcommittee on Military Construction
Veterans Affairs, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20115

Dear Mr. Chairman:

The House Appropriations Committee report (H. Rept. 112-94), which accompanied the H.R. 2055, Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2012, requests a report on joint Department of Veterans Affairs (VA)/Department of Defense (DoD) facilities no later than 180 days after the date of enactment. An interim report was provided in July. Our joint report is enclosed.

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Thank you for your interest in the health and well-being of our Service members, Veterans, and their families.

Sincerely,

Jessica L. Wright
Acting Under Secretary of Defense
for Personnel and Readiness

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Enclosure:
As stated

The Honorable Sanford D. Bishop, Jr.
Ranking Member

Review and Analysis of VA/DoD Joint Medical Facilities, including Ord Military Community and Fort Benning

Pursuant to House Appropriations Committee report (H. Rept 112-94) accompanying the Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2012

Final

April 2013

Cost Estimate Total: $140,500.

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I. Executive summary

The House Appropriations Committee's report (H. Rept. 112-94) accompanying the Military Construction and Veterans Affairs, and related Agencies Appropriations Bill, 2012, requests a report on joint Department of Veterans Affairs (VA) and Department of Defense (DoD) facilities no later than 180 days after the date of enactment. VA and DoD collaborate in the delivery of medical care to beneficiaries nationwide and have done so for many years. A list of selected existing joint medical facility projects as well as projects still in various planning stages are included in Section III of this report.

VA and DoD have different planning and budget timelines, authorizations and approval processes. To overcome some of these hurdles, VA and DoD have proposed legislative language changes to alter the authorization, budget and appropriation process and make it more conducive for collaboration. The Office of Management and Budget (OMB) has approved VA's proposed legislative language changes in the fiscal year (FY) 2014 Budget to change the definition of a medical facility in 38 U.S.C. §8101(3) to include projects not specifically under the jurisdiction of the Secretary, and to obtain the authority to plan, design, construct, and/or lease shared facilities. DoD received OMB approval for similar provisions in their FY 2014 Budget submission that would allow DoD to enter into agreements with VA for planning, design, construction, and/or leasing of shared facilities.

The report provides a review and analysis of the potential benefits and cost savings opportunities associated with VA/DoD joint medical facilities. Increased VA/DoD sharing has the potential to enhance access to and quality of health care for both VA and DoD beneficiaries alike. The report contains a detailed description of four sample collaborative

efforts at Ord Military Community (California), Ft. Benning (Georgia), Panama City (Florida), and Honolulu, Ewa Plain (Hawaii).

This final report follows an interim report previously submitted in July 2012. Delays occurred in gathering data, which prevented submittal of the final report by the requested June 20, 2012 deadline. Additional delays were encountered to coordinate with the legislative proposal review process.

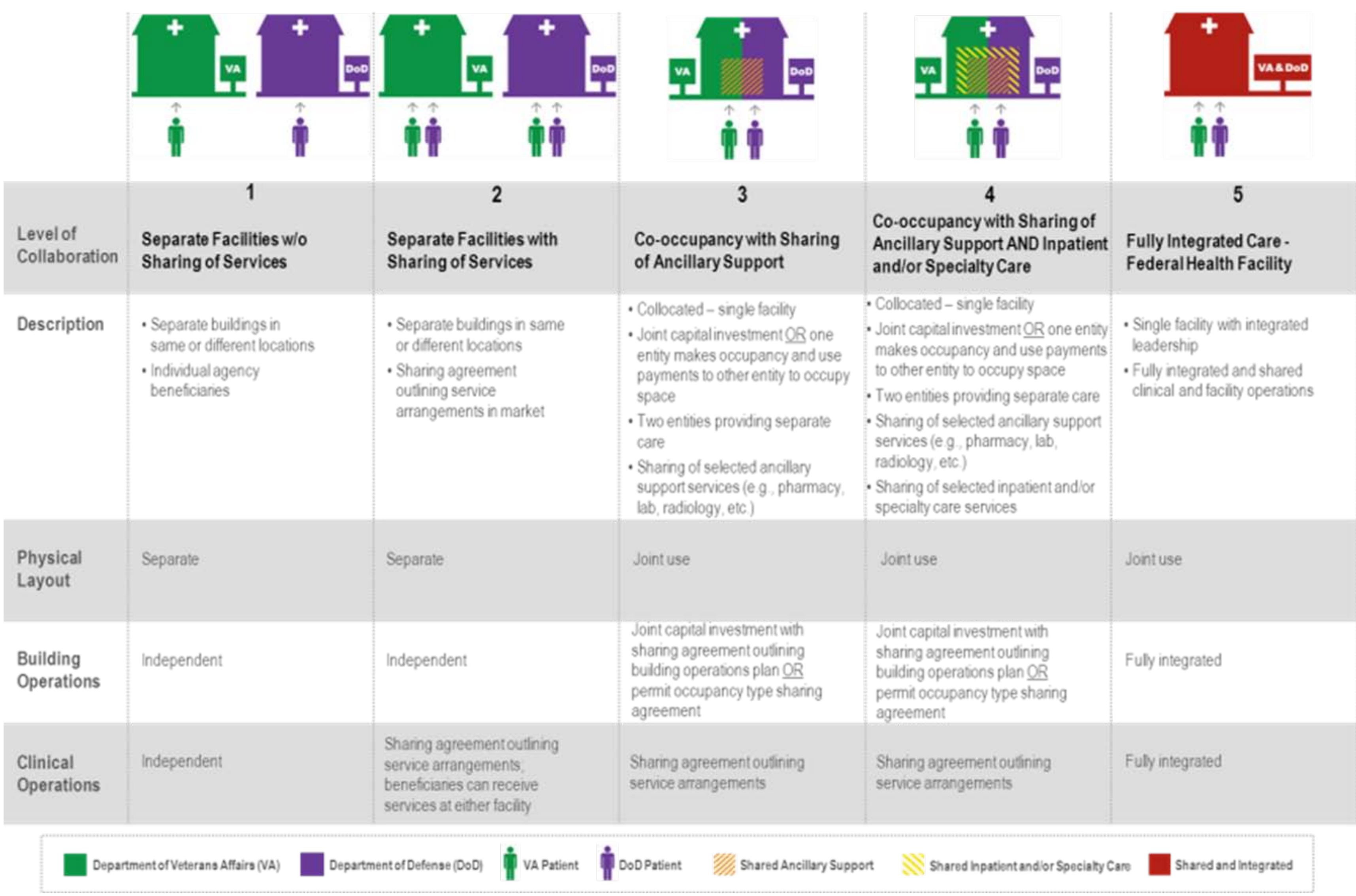
A. OVERVIEW

DoD and VA are pleased to present this report in response to the U.S. House Appropriations Committee's (HAC) request. The purpose of this report is to provide a review and analysis of joint VA and DoD medical facilities. This report contains the following parts:

- An overview of the VA and DoD joint medical facility planning process;
- A list of existing VA/DoD joint medical facilities;
- A list of future possible joint VA/DoD medical facility projects; and,
- A review and analysis of sample VA/DoD joint medical facility initiatives at Ord Military Community (California), Ft. Benning (Georgia), Panama City (Florida), and Honolulu, Ewa Plain (Hawaii), including descriptions of the degree to which collaboration will occur in each initiative, assessments of the potential cost savings to be achieved, and lists of key considerations associated with the projects.

B. Overview of VA/DoD Joint Medical Facility Planning Process

VA and DoD have a long history of collaborating in the provision of medical care to their respective beneficiaries. In some cases, this sharing of services occurs in separate buildings or facilities and, in other cases, it occurs in a building occupied by both agencies. For the purposes of this report, a "joint medical facility" is defined as a facility where both VA and DoD occupy shared space (see Levels 3-5 in the following diagram). The diagram depicts different levels of VA and DoD collaboration.



VA / DoD Levels of Collaboration

	1	2	3	4	5
Level of Collaboration	**Separate Facilities w/o Sharing of Services**	**Separate Facilities with Sharing of Services**	**Co-occupancy with Sharing of Ancillary Support**	**Co-occupancy with Sharing of Ancillary Support AND Inpatient and/or Specialty Care**	**Fully Integrated Care - Federal Health Facility**
Description	• Separate buildings in same or different locations • Individual agency beneficiaries	• Separate buildings in same or different locations • Sharing agreement outlining service arrangements in market	• Collocated – single facility • Joint capital investment OR one entity makes occupancy and use payments to other entity to occupy space • Two entities providing separate care • Sharing of selected ancillary support services (e.g., pharmacy, lab, radiology, etc.)	• Collocated – single facility • Joint capital investment OR one entity makes occupancy and use payments to other entity to occupy space • Two entities providing separate care • Sharing of selected ancillary support services (e.g., pharmacy, lab, radiology, etc.) • Sharing of selected inpatient and/or specialty care services	• Single facility with integrated leadership • Fully integrated and shared clinical and facility operations
Physical Layout	Separate	Separate	Joint use	Joint use	Joint use
Building Operations	Independent	Independent	Joint capital investment with sharing agreement outlining building operations plan OR permit occupancy type sharing agreement	Joint capital investment with sharing agreement outlining building operations plan OR permit occupancy type sharing agreement	Fully integrated
Clinical Operations	Independent	Sharing agreement outlining service arrangements, beneficiaries can receive services at either facility	Sharing agreement outlining service arrangements	Sharing agreement outlining service arrangements	Fully integrated

Early joint facilities emerged from planning based on the perceived and actual economies of scale of joint construction and reduced infrastructure. To streamline planning and facilitate collaboration opportunities, VA and DoD each have a designated VA/DoD collaboration office. However, up until recently there was no formal agreement or mechanism for sharing workload data, requirements, gaps, etc. between the two Departments to systematically identify dual presence and possible joint opportunities.

The VA and DoD Construction Planning Committee (CPC), a workgroup that reports to the Joint Executive Council (which is chaired by the VA Deputy Secretary and the DoD Under Secretary for Personnel and Readiness), for the first time ever in 2012 provided capital planning data to VA and DoD planners to utilize in their capital investment processes to assist in identifying additional collaborative opportunities. The data elements provided include population, utilization and purchased care, and key points of contact at both Departments. This enhanced, formalized joint facility planning process, described in greater detail in Section II of this report, emphasizes the importance of these planning efforts being initiated at the local level.

The CPC's efforts to both improve data sharing and reform existing legislation effectively position VA and DoD to increase the quantity and scope of future collaborative medical facilities.

C. Existing and Future VA/DoD Joint Medical Facilities

VA and DoD collaborate in the delivery of medical care to beneficiaries nationwide and have been doing so for many years. A list of selected existing joint medical facility projects is included in Section III of this report. In addition to existing projects, as published in VA's FY 2013 Budget Submission, VA and DoD have numerous joint projects in various planning stages. A list of these projects is also included in Section III of this report.

D. Sample VA/DoD Joint Medical Facilities

This report provides a review and analysis of the potential benefits and cost savings opportunities associated with VA/DoD joint medical facilities. Increased VA/DoD sharing has the potential to enhance access to and quality of health care for both VA and DoD beneficiaries alike. This report contains a detailed description of four sample collaborative efforts planned for the Ord Military Community (California), Ft. Benning (Georgia), Panama City (Florida), and Honolulu, Ewa Plain (Hawaii). Summaries of these projects and their anticipated levels of collaboration are provided in the following table.

Table 1: Sample VA/DoD Joint Projects' Key Features

	Ord Military Community Outpatient Clinic	Ft. Benning Collaboration	Panama City Outpatient Clinics	Honolulu Ewa Plain Outpatient Clinic
Level of Collaboration	▪ Co-occupancy with Sharing of Ancillary Support AND Inpatient and/or Specialty Care with some aspects of a Fully Integrated Federal Health Facility.	▪ Separate Facilities with Sharing of Services.	▪ Separate Facilities with Sharing of Services.	▪ Co-occupancy with Sharing of Ancillary Support.
Brief Description	▪ VA plans to lease a build-to-suit facility in the Monterey Bay Area for DoD-VA use. VA is responsible for building operations and will enter into a sharing agreement with DoD that outlines the terms of DoD's "lease" of space from VA.	▪ DoD is building a new Army Community Hospital on Ft. Benning and temporarily leasing approx. 10,000 net usable square feet (NUSF) in Columbus, GA until the new hospital is completed. ▪ VA will lease approx. 55,000 NUSF of outpatient clinic space in Columbus, GA.	▪ VA and DoD to build separate, adjacent outpatient clinics on Navy-owned site, which is separated from Naval Support Activity (NSA) installation by a fence line. ▪ Shared ancillary support and specialty care services.	▪ VA plans to lease a facility in Honolulu and will provide use of space in this facility to DoD. ▪ DoD will pay occupancy and use fees to VA to occupy space. ▪ The two agencies will share ancillary support services provided by VA.
Project Status	▪ Project site has been identified. ▪ Local VA/DoD planning teams are currently updating design to prepare build-to-lease solicitation.	▪ No joint medical facility planned at this time. ▪ Local planners are collaborating on additional sharing agreements.	▪ Joint design has been completed. ▪ Construction is estimated to be completed in December 2013.	▪ Local VA/DoD planning teams are currently structuring sharing agreement(s) and preparing the build-to-lease solicitation.
Physical Layout	▪ Single building with approx. 115,000 NUSF) of clinical space. ▪ Based on the initial Concept of Operations (CONOPS), DoD and VA would have required approx. 16,000 NUSF and 99,000 NUSF of clinical space, respectively. However, this break-out may change based on further exploration of integration (e.g., a single electronic health record).	▪ Separate buildings. ▪ Different sites (not co-located) but in close proximity to one another.	▪ Two separate buildings connected by covered walkway. ▪ VA clinic will be 30,000 gross square feet (GSF). ▪ DoD clinic will be 5,300 GSF.	▪ Single building, approx. 119,000 NUSF. ▪ DoD will occupy approx. 29,000 NUSF of clinical space. ▪ Remainder of the space will be common elements or various VA functions. ▪ Administrative space in Tripler Army Medical Center (TAMC) East Wing will be made available for DoD clinic space.
Building Operations	▪ VA is responsible for building operations and will enter into a sharing agreement with DoD that outlines the terms of DoD's occupancy of VA space.	▪ Each agency is responsible for its own building operations.	▪ Independent – each agency will be responsible for its own building operations.	▪ VA is responsible for building operations.
Clinical Operations	▪ Clinical operations will be shared and integrated for a limited scope of specialty operations and services that both DoD and VA beneficiaries require.	▪ Clinical operations will only be shared through existing and future sharing agreements in the market.	▪ Shared ancillary support services include radiology, pharmacy, and lab. ▪ Shared specialty care services to include dentistry.	▪ VA and DoD will share ancillary support services, including radiology, pharmacy and lab. ▪ Specialty care services will not be shared.

E. Summary of Benefits of Joint Medical Facilities / Conclusions

The expected quantity of cost savings associated with the planned projects depends on each project's unique characteristics and the nature of the sharing agreements that the two Departments establish. Many of these anticipated sharing agreements have not yet been finalized so it is difficult to provide any quantitative assessment of the cost savings associated with these projects. The following table summarizes each sample project's qualitative potential for cost savings using a rating of High, Medium, Low, or No potential for cost savings over three primary categories: Capital Investment, Building Operations, and Clinical Operations.

Table 2: Summary – Qualitative Assessment of Cost Savings Potential

Category	Quantitative Potential for Cost Savings by Sample Project Site			
	VA/DoD Ord Military Community Outpatient Clinic	VA/DoD Ft. Benning Collaboration	VA/DoD Panama City Outpatient Clinics	VA/DoD Honolulu Ewa Plain Outpatient Clinic
Capital Investment				
1. Land	Medium	No potential	High	Low
2. Facility Design and Construction	Medium	No potential	Medium	Low
3. Road and Utility Infrastructure	Medium	No potential	Medium	Low
4. Medical Equipment and Build Out	Low	No potential	Low	Low
Building Operations				
1. Facility Management/Site Maintenance	Low	No potential	Low	Low
2. Utilities	Low	No potential	Low	Low
3. Security	Low	No potential	Low	Low
4. Administration/Governance	Low	No potential	Low	Low
Clinical Operations				
1. Shared ancillary services	Medium	Low	Low	Low
2. Shared specialty care services	Medium	Low	Medium	Low
3. Shared clinical staff	Low	Low	Low	Low
4. Shared/Integrated Electronic Health Record System	High	High	High	High

Extensive joint planning efforts have been conducted on the local and VA Central Office/DoD Headquarters levels to enable medical facility collaboration as exemplified in these four sample projects. This analysis also revealed several hurdles that could hinder efforts to achieve higher levels

of collaboration and integration. The primary ones as identified by local planners and other key VA and DoD stakeholders include the following.

1. **Differences in Capital Investment Planning Processes and Timing** make it difficult to align planning for the delivery of healthcare services with availability of clinical space that is dependent on budgetary approval processes.

2. **Structuring of Occupancy and Use Payments Between DoD and VA under Existing Regulations** can present a funding challenge for lease projects, since there are no specific regulations permitting one Department to issue occupancy and use payments for facility space to the other in a joint medical facility.

3. **Different Electronic Health Records (EHR) Systems** exist between VA and DoD. EHR systems and the ability to share records between clinical departments are the backbone of efficient clinical operations. The Integrated Electronic Health Record (iEHR) system is an enterprise level solution currently under development by VA and DoD.

4. **Security/Access to Military Installations** can impact the ability of VA beneficiaries to access care. Most DoD clinics are located on DoD installations with secured perimeters. This can present an access challenge to VA beneficiaries whose cars often do not have the appropriate registrations / decals to get on an installation, or who are driven by others to receive services. Furthermore, the security procedures and requirements often differ from installation to installation and are more intense during periods of elevated threat levels. This can often hinder the efficient collaboration and sharing of medical services.

Being able to overcome some of the hurdles outlined above may streamline the joint medical facility planning process. However, despite these challenges that joint medical facilities projects sometimes face, there are numerous benefits associated with these projects. Some of these benefits include, but may not be limited to:

1. Increased facility operational efficiencies by occupying one facility or co-locating facilities

2. Reduced capital infrastructure redundancies by occupying one facility or co-locating facilities

3. Improved access to services for VA and DoD beneficiaries through sharing of ancillary support services

4. Increased clinical operational efficiencies through sharing of one or more clinical services which allows for more effective staff utilization

5. Reduction in “contracted out” services to private providers and use of Federal partner capacities instead (government to government reimbursement versus government to private sector)

VA and DoD intend to improve the planning and execution of future joint projects, thereby enhancing the overall quality of care for VA and DoD beneficiaries alike.

II. Introduction

The Departments of Defense (DoD) and Veterans Affairs (VA) are pleased to present this report as requested by the U.S. House Appropriations Committee (HAC).

A. Project Purpose

The purpose of this report is to provide a review and analysis of joint VA and DoD medical facilities. This report contains an overview of the VA and DoD joint medical facility planning process, a list of future possible joint VA/DoD medical facility projects, and a review and analysis of sample VA/DoD joint medical facility initiatives at Ord Military Community (California), Ft. Benning (Georgia), Panama City (Florida), and Honolulu, Ewa Plain (Hawaii). The report describes the status of each of the four collaborative efforts and the degree to which collaboration will occur. In addition, the report contains a description of the potential cost savings to be achieved along with a list of key considerations associated with each project.

B. Project Background

This report is in response to the following request from the House Appropriations Committee, included in House Report 112-94:

> ***Joint Veterans Affairs/Department of Defense facilities*** *— The Committee has long expressed an interest in the construction of joint Veterans/Army medical facilities. With the construction of new medical facilities such as the Martin Army Hospital at Ft. Benning, joint medical facilities that can serve both active duty service members and veterans could be a cost-savings strategy, for both the Department of Defense (DoD) and the VA. Therefore, the Committee requests the VA and DoD to provide to the Committee a complete analysis and review of the Ft. Benning facility and other joint facilities, like the former Ft. Ord site, and report its findings no later than 180 days after the date of enactment of this Act. Further, the Committee requests the GAO to conduct a review of effectiveness and cost-efficiency of joint VA/military medical facilities currently in operation and identify other facilities where a joint VA/DoD project could be successful. The GAO report also should be submitted.*

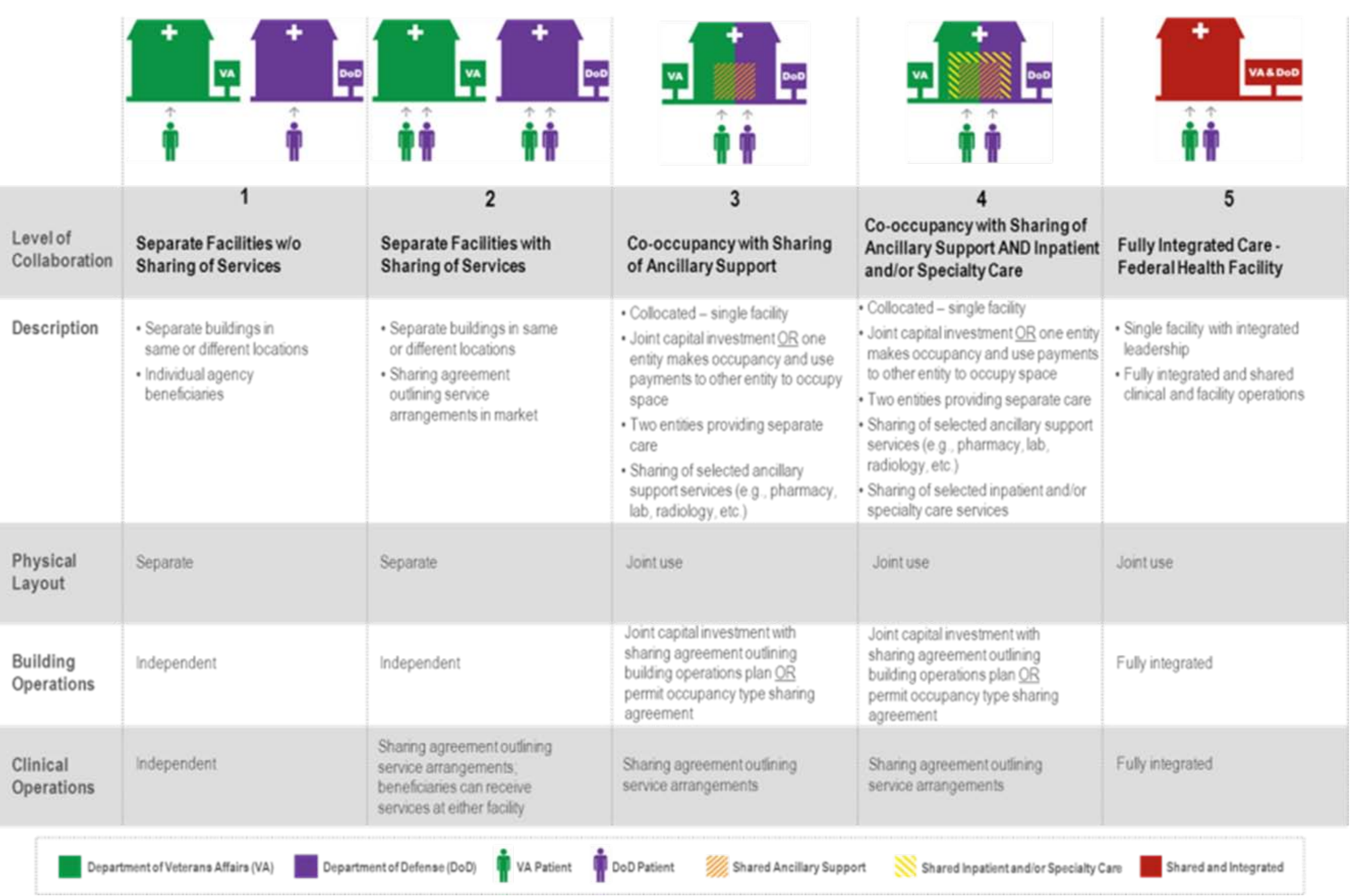
This report reflects input from both VA and DoD at the Central Office / Headquarters and field levels. To develop this report, VA and DoD held bi-weekly calls with key agency and project leads. Staff members from both agencies had the opportunity to review and comment on all parts of the report.

III. Overview of VA/DoD Joint Medical Facility Planning Process

A. Definition of Joint Medical Facility

VA and DoD have a long history of collaborating in the provision of medical care to their respective beneficiaries. In some cases, this sharing of services occurs in separate buildings or facilities and, in other cases, it occurs in a building occupied by both agencies. For the purposes of this report, a "joint medical facility" is defined as a facility where both VA and DoD occupy shared space.

The following diagram depicts different levels of VA and DoD collaboration. In Level 1, VA and DoD are operating separate, independent facilities and do not share any services. In Level 2, VA and DoD continue to operate separate, independent facilities, but one or more sharing agreements exist, which outline the services that each agency provides to the other's beneficiaries. In Level 3, VA and DoD operate in a single facility and share one or more ancillary support services. This facility may result from a joint capital investment or an arrangement where one entity occupies space in another's facility. Sharing agreements outline how building operations work and how ancillary support services are shared. In Level 4, similar to Level 3, VA and DoD operate in a single facility and share ancillary support services, in addition to inpatient and/or specialty care services. Sharing agreements outline how building operations work, as well as which ancillary support, inpatient and/or specialty care services are shared. In Level 5, where the greatest degree of collaboration occurs, VA and DoD operate in a single facility with shared leadership and fully integrated, shared clinical and facility operations.



VA / DoD Levels of Collaboration

Level of Collaboration	1 Separate Facilities w/o Sharing of Services	2 Separate Facilities with Sharing of Services	3 Co-occupancy with Sharing of Ancillary Support	4 Co-occupancy with Sharing of Ancillary Support AND Inpatient and/or Specialty Care	5 Fully Integrated Care - Federal Health Facility
Description	• Separate buildings in same or different locations • Individual agency beneficiaries	• Separate buildings in same or different locations • Sharing agreement outlining service arrangements in market	• Collocated – single facility • Joint capital investment OR one entity makes occupancy and use payments to other entity to occupy space • Two entities providing separate care • Sharing of selected ancillary support services (e.g., pharmacy, lab, radiology, etc.)	• Collocated – single facility • Joint capital investment OR one entity makes occupancy and use payments to other entity to occupy space • Two entities providing separate care • Sharing of selected ancillary support services (e.g., pharmacy, lab, radiology, etc.) • Sharing of selected inpatient and/or specialty care services	• Single facility with integrated leadership • Fully integrated and shared clinical and facility operations
Physical Layout	Separate	Separate	Joint use	Joint use	Joint use
Building Operations	Independent	Independent	Joint capital investment with sharing agreement outlining building operations plan OR permit occupancy type sharing agreement	Joint capital investment with sharing agreement outlining building operations plan OR permit occupancy type sharing agreement	Fully integrated
Clinical Operations	Independent	Sharing agreement outlining service arrangements, beneficiaries can receive services at either facility	Sharing agreement outlining service arrangements	Sharing agreement outlining service arrangements	Fully integrated

VA and DoD define the broader term "joint venture" as a health care operations model negotiated between two or more components of the VA and DoD health care systems and approved by each agency at the national level. This strategic alliance is designed to share agencies' strengths, minimize risks, improve the management of resources, increase healthcare infrastructure utilization and efficiencies and improve quality and access to care for beneficiaries of both agencies. The joint venture agreement addresses the responsibility, duties, and rights of each member. Joint ventures may apply to the mutually beneficial coordination, use or exchange of use of the health care resources of VA and DoD, and may extend to the full range of facility services or be limited to specific product lines. Value is determined by measuring improvements in health care quality, access, and cost effectiveness from the product/service/outcome of the partnering initiative.

B. Decision Factors for How Medical Facilities Are Selected for Collaboration

Early joint facilities emerged from planning based on the perceived and actual economies of scale of joint construction and reduced infrastructure. However, up until recently, there was no formal agreement or mechanism for sharing workload data, requirements, gaps, etc. between the two Departments to systematically identify dual presence and possible joint opportunities. The VA and DoD Construction Planning Committee (CPC), a subcommittee that reports to the VA/DoD Joint Executive Council (which is chaired by the VA Deputy Secretary and the Under Secretary of Defense for Personnel and Readiness), for the first time ever recently provided capital planning data to VA and DoD planners to utilize in their capital investment planning processes to assist in identifying additional collaborative opportunities. This enhanced, formalized joint facility planning initiative is further described below.

Additional CPC efforts have focused on addressing different VA and DoD planning and budget timelines, authorizations and approval processes. Significant differences in VA and DoD's capital investment planning and programming processes currently impede joint construction collaboration. The two Departments are organized differently and employ their own unique business processes. One of the biggest challenges is that funding thresholds and timelines do not align. The CPC's recent proposed legislative changes are described later in this section.

To streamline planning and facilitate collaboration opportunities, VA and DoD each have a designated VA/DoD coordination office. In addition, the CPC's joint facility planning process emphasizes the importance of these planning efforts being initiated at the local level. Factors that typically impact the decision to pursue a joint facility include:

1. Successful current relationship between two Federal health care sites, as exhibited by joint committees or other forums which hold regular meetings to discuss current and potential sharing initiatives.

2. Shared governance/policies, i.e., policies established by each Department that mirror those of the Federal partner for issues related to joint efforts.

3. Degree of risk sharing, e.g., success of the partnership is vital to the continued mission success of each of the partners – examples include specialized care/surgery, Graduate Medical Education and staff augmentation.

4. Proximity of the partners, such that patient travel times are within the maximum standards for each Department.
5. Opportunity exists for joint construction.

The CPC recently aggregated and analyzed population and utilization data for both agencies for all VA hospitals and DoD medical facilities (clinics, hospitals, etc.) within 40 miles of one another. This analysis resulted in common data points and criteria designed to assist both Departments in identifying potential joint construction and collaborative lease opportunities. Based on this analysis, VA established a communication protocol for collaboration on potential VA/DoD joint projects. The enhanced process includes the following key steps:

- **Initial Planning Phase:** VA local planners and Capital Asset Managers (CAMs) begin by reviewing VA/DoD data. The VA/DoD data are sorted by local hospital and/or clinic site staff and consists of corresponding population and proximity, in-house utilization/workload, and purchased care utilization/workload. Planners and CAMs may also develop potential collaborative initiatives based on their knowledge and familiarity of their own facilities' needs, service capacity or other areas that are outside of the data elements provided.
- **Potential Interest in Collaboration:** If after review of the data provided (or other self-identified elements), it is determined a joint project should be explored further, the local planners and CAMs may initiate contact with their local DoD counterpart.
- **Development of Project Selected:** VA local planners, CAMs, and Integrated Project Team will develop project for consideration in VA's Strategic Capital Investment Planning (SCIP) and/or DoD's Capital Investment Decision Model process. The project may be standalone (major, minor, lease project) or be incorporated into an existing capital investment initiative.
- **Project Entered into SCIP Automation Tool and Business Case Developed:** The VA project is entered into the SCIP Automation Tool so that it is included as part of the current year's Action Plan. To request funding in the current fiscal year, a Business Case must be prepared. Both the Action Plans and Business Case should clearly identify that the project is a joint VA/DoD collaborative effort. The justification for each project should reference the VA/DoD data provided whenever possible. Similarly, DoD's preparation of a Capital Investment Plan would also reference a joint VA/DoD effort.

VA has disseminated this protocol and associated guidance to the field, and pursuant thereto, local VA staff are encouraged to coordinate with their DoD counterparts to discuss potential joint facility or other collaborative opportunities. Ultimately, projects that demonstrate a collaborative VA/DoD component increase their priority score in VA's capital planning process. DoD has taken a similar approach that relies on its web-based World Class Toolkit, which is accessible to all the services. Shared data available on this site will enable local DoD facility planners to identify new collaborative projects.

The CPC's efforts to improve data sharing effectively position VA and DoD to increase the quantity and scope of future collaborative medical facilities.

C. Key Considerations Associated with Joint Facilities

VA/DoD sharing of health care resources has been advocated at multiple levels of the Federal government and embraced by the leadership of both organizations. Appropriate sharing of resources promotes efficiencies that can be devoted to improved health care across both agencies. However, there are a number of considerations associated with pursuit of joint facilities. Some of these considerations include:

- **Information Management/Information Technology:** VA and DoD currently have different electronic health records (EHR) systems for the recording, encryption, storage, and transmission of patient medical information. Maintaining certifiable levels of security and access on parallel systems may increase costs. Integrating both systems and making them compatible may be a key area of opportunity to facilitate collaboration. This Integrated Electronic Health Record (iEHR) is an enterprise level solution currently under development at VA Central Office and DoD Headquarters.
- **Security and Access:** Joint facilities located on DoD installations may face security restrictions that impact the ability of Veterans and their families to easily access health care. Most DoD clinics are located on DoD installations with secured perimeters. The security procedures and requirements often differ from installation to installation, and are more difficult during periods of elevated threat levels. To mitigate this issue, arrangements can be made in which access to the clinic/hospital is achieved without granting access to the rest of the installation.
- **Identity:** VA and DoD have traditionally maintained distinct identities as organizations – VA dedicated to the care of Veterans and DoD dedicated to the care of active duty military and their families. Both agencies' patients have a strong sense of ownership with regard to clinics and medical centers/hospitals. Partnerships and contracting arrangements that place beneficiaries of one agency in another's facility may be met with resistance from stakeholders. Because of the two different missions, there is risk of identity dilution for both DoD and VA. This may be mitigated in part by having separate VA and DoD wards, or separate outpatient clinic areas in a joint outpatient facility. However, these types of arrangements may compromise operational efficiency.
- **Governance:** There are important governance issues that must be examined before VA or DoD enters into a facility sharing arrangement with another entity. Both parties must be clear on the management structure and decide who is to be the lead partner responsible for the operation, maintenance, and provision of health care services at the proposed facility. Detailed sharing agreements that address facility operations and maintenance, staffing, and patient care are needed and specific legislation may be required for certain types of sharing. The agreements must assure all parties have appropriate access to and prioritization for care. Patients' health care needs must not suffer from the lack of independent provision of services. The agreements would address differing processes and priorities for funding construction, maintenance, and operation of facilities. Different review processes and corresponding timeframes related to these issues could impact the delivery of care.

D. Recent Proposed Legislation

Current statutes constrain or preclude VA and DoD from capital investment in shared medical facilities for joint planning and design, major construction, minor construction and leasing. To

overcome this issue, VA described language to Congress for consideration as part of the FY 2014 Budget would change the definition of a medical facility in 38 U.S.C. §8101(3) to include projects not specifically under the jurisdiction of the Secretary and to obtain the authority to plan, design, construct, and/or lease shared facilities in 38 U.S.C. §8111B. DoD is considering submitting similar provisions that would allow DoD to enter into agreements with VA for planning, design, construction, and/or leasing of shared facilities. OMB has approved the proposed legislative languages changes which will enable VA and DoD to transfer funds to one another for the purposes of planning, designing and/or constructing a shared medical facility provided the applicable agency's estimated share of project costs meets all regulatory project cost thresholds. Funds transferred for the purposes of leasing space in a shared medical facility would be credited to the applicable agency's appropriation and would be available without fiscal year limitation. More specifically, VA is pursuing the following through these legislative proposals:

- **Minor Construction Projects**: VA seeks authority to transfer/receive funds and construct joint minor projects within each of their respective dollar thresholds ($10M for VA and $2M for DoD).
- **Major Construction Projects:** VA seeks authority to transfer/receive funds with the specific project authorization and appropriation language.
- **Leasing Projects**: VA seeks authority to transfer/receive funds and lease a shared medical facility.
- **Planning and Design**: VA seeks authority to transfer/receive planning and design funds.

This legislation is important because it would improve the access, continuity, quality and cost effectiveness of direct health care provided to Veterans, Service Members, and their beneficiaries.

VA is submitting its FY 2014 legislative proposals to the 113th Congress along with the President's budget. Among these proposals is legislation that will allow VA and DoD to coordinate efforts in assisting both Veterans and active military personnel. VA staff will be happy to discuss with House and Senate Committees after the proposals have been transmitted.

IV. Existing and Future VA/DoD Joint Medical Facilities

VA and DoD collaborate in the delivery of medical care to beneficiaries nationwide and have been doing so for many years. The below list highlights selected existing VA/DoD collaborative initiatives, listed alphabetically by state.

Table 3: List of Selected Existing VA/DoD Collaborative Facilities

Location	Name	Brief Description of Project
1. Anchorage, AK	Elmendorf AFB and Alaska VA Health Care System	▪ In the late 1990s, the integrated DoD/VA jointly staffed Elmendorf Hospital opened with 75 acute care and 17 substance abuse rehabilitation beds for the Air Force, and 18 acute care beds for VA, for a total of 110 beds, plus clinical and ancillary services. ▪ The Air Force manages the Elmendorf "federal" hospital while the VA manages the 10-bed Intensive Care Unit. ▪ In 2009, VA opened a clinic built on DoD-owned land next to the hospital and are "linked" via an enclosed corridor. ▪ Sharing agreements provide the following services to VA and DoD beneficiaries: inpatient care to include inpatient surgeries and procedures; all specialty clinics and same day surgery; emergency room; ancillary services; central sterile supply; and logistics.
2. Fairfield, CA	Travis AFB, David Grant USAF Medical Center (DGMC) and Northern California VA Health Care System	▪ VA and DoD operate adjacent facilities on DoD-owned land in Fairfield, CA. ▪ DoD provides Veterans with the following services: 24-hour emergency department, outpatient and inpatient hospitalization, inpatient mental health, neurosurgery, cardiovascular and endovascular surgery services, dialysis and radiation therapy. ▪ VA provides space for DGMC to operate a satellite primary care clinic and ancillary services within VA in Northern Sacramento at the McClellan VA Outpatient Clinic (OPC); and a Chiropractor Clinic and a Neurosurgery Clinic located at the VA Fairfield OPC, which is adjacent to DGMC. ▪ VA and DoD beneficiaries receive neurosurgery, hemodialysis and peritoneal dialysis services staffed by both VA and DoD providers.
3. Key West, FL	Naval Branch Health Clinic (NBHC) Key West and Miami VA Health Care System CBOC	▪ In February 2000, the NBHC/VA Outpatient Clinic, Key West was opened. The Navy and VA co-occupy an approximately 60,000 gross square foot outpatient care facility. ▪ The Navy provides family practice services, dental services and ancillary support services such as laboratory, pharmacy and radiology. ▪ VA provides internal medicine, physical therapy and mental health services.
4. Honolulu, HI	Tripler Army Medical Center (TAMC) and VA Pacific Islands Health Care System (VAPIHCS) – VA Clinic and Center for Aging on DoD-owned land	▪ Sharing agreements exist for the following inpatient services: Medicine, Orthopedics, General Surgery, Urology and Psychiatry. ▪ VA houses administrative services in the Tripler's East wing and operates a 20-bed inpatient Mental Health Unit on TAMC Ward 3B2, and a Post-Traumatic Stress Disorder (PTSD) Residential Treatment Program that supports VA and DoD beneficiaries. ▪ Currently, ambulatory services provided by VAPIHCS to TAMC beneficiaries include chronic and acute Dialysis, PTSD Rehabilitation and augmentation of providers in Ophthalmology, Orthopedics, Hematology and Pain Management services.

Location	Name	Brief Description of Project
5. North Chicago, IL	James A Lovell Federal Health Care Center (FHCC)	▪ DoD and VA operate the FHCC as a Demonstration Project for the first fully integrated VA/DoD medical facility. ▪ FHCC operates as an integrated single Chain of Command facility that encompasses all medical and dental care in Great Lakes and North Chicago. ▪ A Senior Advisory Board made up of Navy Line, Navy Medical, and VA leadership ensures both Navy and VA missions are met.
6. Fort Detrick, MD	Ft. Detrick VA Community-Based Outpatient Clinic	▪ Opened in September 2011, VA expanded a CBOC at the Army's Ft. Detrick.
7. Biloxi, MS	Keesler AFB and VA Gulf Coast Veterans Health Care System	▪ DoD (Air Force) and VA share services at Centers of Excellence (COE) situated on two medical campuses located within minutes of each other. ▪ DoD provides cardiovascular care, MRI and radiation oncology, while VA provides a sleep laboratory.
8. Albuquerque, NM	Kirtland AFB and New Mexico VA Health Care System	▪ VA and DoD operate the New Mexico Regional Federal Medical Center (NMRFMC) on DoD-owned land in Albuquerque, NM. ▪ VA provides inpatient, outpatient specialty care and emergency, ancillary, and tenant services for DoD and its beneficiaries. ▪ DoD provides primary/preventive health care, flight medicine, general ambulatory surgery, and dental services to VA beneficiaries.
9. Las Vegas, NV	Nellis AFB and VA Southern NV Health Care System – Mike O'Callaghan Federal Hospital (MOFH)	▪ Currently, VA and DoD share a medical facility on DoD property ▪ All ancillary support services and commonly used areas to include the emergency rooms, operating rooms, and intensive care units consist of integrated staff providing services to both VA and DoD/AF patients. ▪ The inpatient wards (medical/surgical, psychiatric, and obstetrics) are staffed separately by each agency supporting its own beds (118-beds for the AF and 52-beds for the VA). When one ward fills to capacity, additional patients are admitted to the adjacent or contiguous ward in order to fully utilize available resources.
10. Charleston, SC	Naval Health Clinic Charleston and Ralph H. Johnson Medical Center - VA/ DoD Joint Ambulatory Care Clinic at Joint Base Charleston-Weapon Station	▪ The Joint Ambulatory Care Clinic at Goose Creek opened in September 2010 and provides VA and DoD beneficiaries with access to MRI and non-invasive cardiology services. ▪ The VA Ralph Johnson VAMC occupies a portion of the Naval Hospital Beaufort. ▪ VA and DoD share the following services at the facility: radiology, optometry, audiology and podiatry.
11. El Paso, TX	William Beaumont Army Medical Center (WBAMC) and El Paso VA Health Care System (EPVAHCS)	▪ VA and DoD operate co-located facilities on DoD-owned land in El Paso, TX. ▪ VA provides primary, behavioral health and specialized ambulatory care services to VA beneficiaries and funds eight Internal Medicine residents, provides Operating Room space, and staffing for the Joint Central Material Services (Sterilization) department. ▪ DoD provides DoD and VA beneficiary's inpatient services for 24-hour Emergency Care, medical, surgical hospitalization, and specialty care not available at EPVAHCS services. ▪ DoD is currently constructing at a new site about eight miles from the current WBAMC; VA is remaining at the current site.

Location	Name	Brief Description of Project
12. Fort Belvoir, VA	VA Community-Based Outpatient Clinic	▪ Fort Belvoir Community Hospital (FBCH). ▪ VA operates CBOC in the new FBCH.

VA and DoD have numerous joint projects in various planning stages. The following table contains a list of those collaborative projects in alphabetical order by state.

Table 4: List of Planned/Proposed VA/DoD Collaborative Facilities

Location	Name	Brief Description of Project
1. Monterey, CA	VA/DoD (Army) Health Care Center	▪ Approved in 2010 VA major lease project of approximately 115,000 NUSF. ▪ Integrated VA/DoD facility envisioned.
2. Denver, CO	New Medical Facility	▪ Approved VA major construction project. ▪ New 114-bed inpatient medical center, a 52 bed Spinal Cord Injury/Community Living Center, a central utility plant, a research building, and parking facilities on the same campus as the University of Colorado Hospital complex in Aurora. ▪ Collaboration with Buckley Air Base. ▪ Buckley Clinic occupies space in an existing VA building on the future VA Medical Center campus as of April 2012.
3. Ft. Walton Beach, FL	Eglin AFB and VA Community-Based Outpatient Clinic	▪ Proposed VA Minor Construction project to expand Eglin AFB CBOC. In addition, there is a proposed plan to relocate the Eglin AFB perimeter fence to place the Eglin hospital outside of the fence line. This would improve access for VA beneficiaries between the CBOC and the adjacent DoD hospital.
4. Panama City, FL	VA/DoD Community-Based Outpatient Clinic	▪ VA minor construction project. ▪ DoD unspecified minor construction project. ▪ Projected completion in 2013.
5. Honolulu, HI	VA Ambulatory Surgery / Endoscopy Programs	▪ VA minor construction projects. ▪ Projects are nearing design completion and construction is anticipated to begin in spring 2013. ▪ Joint VA and DoD use of programs anticipated.
6. Honolulu, HI	Advance Leeward Outpatient Healthcare Access (Ewa Plain)	▪ Proposed VA major lease of approximately 119,000 NUSF in the Ewa Plain of Oahu. ▪ DoD (Army, Navy, Coast Guard) will pay occupancy and use fees to VA to occupy space in the same building. ▪ VA and DoD healthcare programs will operate under the same roof. ▪ Plans for sharing of common support functions to improve efficiency and reduce and eliminate duplication of services are underway. ▪ The facility will also be conducive to and important to the goal of seamless transition from DoD to VA and the communication, process, and relationships that this entails.
7. Ft. Leavenworth, KS	VA Ambulatory Surgical Center	▪ Potential future VA major construction project that will incorporate acute inpatient care (24 Medical/Surgical/Intensive Care Unit beds, 14 Psych/Substance Abuse beds), emergency care (10 treatment spaces), inpatient and outpatient surgery and other appropriate support services. ▪ VA/DoD joint sharing opportunity. ▪ A feasibility study has been conducted on the construction of an approximately 80,000 NUSF Joint VA/DoD Medical Center.

Location	Name	Brief Description of Project
		▪ Facility will treat both VA and active duty military personnel. ▪ The sharing of medical staff will be a benefit to both agencies and their respective beneficiaries. ▪ Facility will put special emphasis on Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND), women's health services, Integrated Disability Evaluation System (IDES), mental health, tele-health, and employee recruitment.
8. Wichita, KS	VA Medical Facility on McConnell Air Force Base	▪ Proposed VA major construction project on McConnell Air Force Base – to consist of the new construction of approximately 164,000 GSF of new space. ▪ Air Force property (land) will be made available to VA at no cost. ▪ A feasibility study has been conducted to determine healthcare need and the potential for VA/DoD collaboration. ▪ VA/DoD sharing opportunity. ▪ One of the core drivers for this project is VA collaboration with the 22d Air Refueling Wing (22d Medical Group) at McConnell Air Force Base. ▪ Discussions with Dole VAMC and 22d Air Refueling Wing leadership about the need to replace the VA inpatient facilities led to a proposal to instead build the proposed new bed tower near McConnell Air Force Base. ▪ Air Force leadership recognized the value of having a training platform where inpatient and critical care skills can be maintained, thereby maximizing mission capability. ▪ VA will benefit from the donated land, staff augmentation from the Air Force, seamless transition for IDES examinations and inpatient coordination of care, and a collocated medical facility to support the shared National Disaster Medical System and emergency preparedness roles.
9. Louisville (Ft. Knox), KY	VA Community-Based Outpatient Clinic at the Army's Ft. Knox Hospital	▪ VA currently operates a CBOC in the existing Ireland Army Community Hospital (IACH) at Ft. Knox. ▪ Army is building a new hospital at Ft. Knox, and VA and DoD are exploring options to relocate the CBOC to the new Army facility. ▪ Multiple VA/DoD sharing agreements are currently in place for diagnostic services and Full Time Equivalent Employee sharing. ▪ Potential VA minor construction project that consists of development of a 16,000 SF CBOC at Ft. Knox to replace the existing facility. ▪ CBOC will be used to provide primary care and mental health services and will cost approximately $6.3 million to build. ▪ Construction of the IACH has been placed on hold pending further DoD budget considerations. ▪ Timelines for solicitation, design, and construction will be based on what DoD decides. ▪ VA intends to solicit for design services immediately after a final decision is made concerning the Army's plans for its facility, and a construction contract would be awarded the following fiscal year.
10. Fort Meade, MD	VA Community-Based Outpatient Clinic	▪ VA and DoD have existing sharing agreements in place at this facility.
11. Providence / Newport, RI	VA Community-Based Outpatient Clinic at	▪ Proposed VA minor construction project to develop replacement CBOC on Navy-owned land.

Location	Name	Brief Description of Project
	Newport Naval Hospital	▪ This project will provide the opportunity for collaboration between DoD and VA through sharing of medical specialists and access by VA to laboratory and diagnostic facilities for Veterans. ▪ The current VA CBOC located nearby has a significant space deficit. ▪ This project would deliver a timely replacement of the current facility. ▪ This project will result in increased opportunities for VA/DoD collaboration and will be achieved through formal agreement with appropriate staff at the Newport Naval Base to utilize land at this location for the construction of a VA clinic.
12. Beaufort, SC	VA Community-Based Outpatient Clinic at Navy's Beaufort Hospital	▪ Navy is planning to build a replacement hospital at Beaufort, SC. ▪ VA has a CBOC in current hospital and is exploring potential options to relocate the CBOC to the new Navy facility when it is built. ▪ This Minor Construction project was initially approved in SCIP for FY2013, but VA's pursuit of this project is dependent upon DoD approval of its own replacement hospital. Medical Military Construction (MILCON) Program Objective Memorandum (POM) generated by TMA has a Hospital Replacement for Beaufort in FY2017.
13. El Paso, TX	VA Integrated Inpatient Services Adjoined to New William Beaumont Army Medical Center (WBAMC)	▪ VA-proposed Major Construction project that consists of approx. 55,000 SF of inpatient bed space. Initial VA funding year is anticipated to be FY2016 to begin design phase. The bed space is a combination of Medical, Surgical, and Mental Health that will be added to current bed space of the new WBAMC. This project would share staffing of Acute Inpatient Care. ▪ WBAMC is constructing a new medical campus approximately 8 miles from its current location. WBAMC is currently at 95% design so adding this VA space to the new building will not be possible before FY2017. ▪ The new WBAMC campus is located on the far east side of El Paso within the boundary of Ft. Bliss. ▪ El Paso VA Healthcare System (EPVAHCS) cannot establish inpatient care requirements on its own – this decision was made in conjunction with VA's Office of Policy and Planning, who reviewed VA inpatient requirements and found that EPVACHS's Average Daily Census was below the required amount needed to maintain competencies for staff.
14. Hampton, VA	New Clinical Building	▪ New clinical building will support VA/DoD Joint Incentive Fund (JIF) mental health initiative that provides DoD/VA cooperative Family Assistance. ▪ This minor construction of a 20,000 SF building will include approximately 2,000 SF to support this JIF program. ▪ Project expands the existing VA/DoD resource sharing agreement between Naval Medical Center of Portsmouth and Hampton VA Medical Center. ▪ Initial funding year for the grant is FY 2012, and services for VA and DoD beneficiaries are currently provided in Building 115 on the Hampton VAMC campus, which is slated for demolition as part of this new proposed Minor Construction project. ▪ Both DoD and VA Chaplains will provide services at the site.
15. Richmond, VA	Expanded Women's Health/ Primary Care Addition	▪ Currently, VA and DoD receive Joint Incentive Funds for a gynecologist who provides services to VA and DoD beneficiaries

Location	Name	Brief Description of Project
		▪ This 12,000 NUSF Minor Construction project will build additional space for Women's Health and Primary Care on the VA Medical Center campus in Richmond.
16. Puget Sound, WA	VA/DoD (Navy) Community-Based Outpatient Clinic	▪ VA Puget Sound HCS (VAPSHCS) and Navy are working to submit a JIF proposal for a joint leased CBOC on the Kitsap Peninsula. ▪ VA currently leases a CBOC several miles from the Naval Hospital Bremerton (NHB), WA. ▪ This potential project would consist of a Major Lease for 35,000 NUSF of space in Kitsap County, WA, to replace the existing Bremerton VA CBOC. ▪ VAPSHCS will take responsibility for the lease acquisition process expected to commence in FY 2014. ▪ The Joint VA/Navy Clinic would: o Include all VA staff and services from the existing Bremerton leased CBOC whose lease will expire in December 2014 o Add new VA-staffed basic radiology and laboratory diagnostic services and specialty care services for audiology, optometry, mental health and physical therapy o Allow two Navy Medical Home Port Teams from NHB to assist in decompressing NHB's limited clinical and parking space o Add a Navy-staffed full pharmacy ▪ VA will provide space to the Navy and purchase pharmacy services. ▪ Navy will purchase laboratory, radiology and specialty services from VA. ▪ Under the sharing agreement, Veterans will have access to NHB's emergency, specialty and inpatient services. ▪ Final draft of new VA/DoD sharing agreement is at the Navy Bureau of Medicine and Surgery and VA Central Office for final approval. ▪ This VA/DoD initiative meets the long-term needs of both departments as defined in the Healthcare Requirements Analysis. ▪ Simultaneously, VAPSHCS and NHB are submitting an FY 2013 JIF proposal to fund two years of lease costs, lump-sum tenant improvements, lump sum activation costs, and two years of staffing costs for new services at the Joint VA/Navy Clinic. ▪ If the JIF funds all start-up costs for this Joint VA/Navy Clinic, the lease process will be moved to FY 2013 as an out-of-cycle SCIP project.
17. Ft. Hood/CTVAHCS Joint Sleep Lab	Killeen, TX	▪ CR Darnall Army Medical Center and Central TX VA Health Care System will lease space and operate a 16-bed Sleep Lab between Ft. Hood and Temple, TX. Each partner will operate eight beds with common equipment set and business processes.

V. Sample VA/DoD Joint Projects Analysis

A. *SAMPLE PROJECT #1: VA/DoD Ord Military Community Outpatient Clinic*

The Army and VA are currently operating separate facilities in the Monterey Bay Region of California. Under the Base Realignment and Closure Act (BRAC) of 1991, Ft. Ord and its hospital were closed in 1994 and the Ord Military Community (OMC) was established. Since the hospital was closed, active duty personnel from the OMC receive care at the Presidio of Monterey's Troop Medical Clinic. For most specialty care services, active duty military personnel are potentially required to travel out of the local area to another military treatment facility or utilize the TRICARE network. Beneficiaries of active duty military and retirees have access to limited care within the Troop Medical Clinic and rely on the TRICARE network for most services. Currently, the VA clinic in Monterey is land constrained and requires additional space in order to expand services to properly serve the surrounding Veteran population. The Army Western Regional Medical Command Regional Leadership and the VA Veterans Integrated Service Network (VISN) 21 Director have formally agreed to collaborate in a new integrated clinic in the Monterey Bay Region.

1. Description of Planned Collaborative Effort and Degree to Which Collaboration Will Occur

The new Monterey VA/DoD clinic will be acquired through a build-to-suit lease with a private sector lessor/developer procured by VA. In the initial planning stages, there was discussion of siting this project on land identified by the Army on the Ord Military Community site. However, given the selected lease acquisition model for the joint clinic, use of Federal land was deemed infeasible. Instead, VA will procure a build-to-suit lease on private land in the Monterey Bay Region for the planned Monterey VA/DoD facility. Having completed the site selection phase of the procurement, VA and DoD have selected an approximately 14-acre site adjacent to Route 1 in Marina, CA. The planned project includes 99,000 NUSF of space for VA and 16,000 NUSF of space for the Army. VA and DoD executed a Concept of Operations (CONOPS) for the collaborative operation and sharing of services in January 2012. Once 30 percent design is achieved, VA and DoD will start the developer solicitation process.

Based on the newly proposed level of collaboration, this project could be classified as "Co-occupancy with Sharing of Ancillary Support AND Inpatient and/or Specialty Care" with aspects of a "Fully Integrated Care – Federal Health Facility. Once a modified CONOPS has been negotiated, it will be easier to more clearly delineate the level of collaboration anticipated. Both VA and DoD are striving to make this project a Fully Integrated Care – Federal Health Facility.

Table 5: Ord Military Community/Monterey Bay Area Outpatient Clinic Key Features

Ord Military Community Military Community/Monterey Bay Area Outpatient Clinic	
Level of Collaboration	▪ Co-occupancy with Sharing of Ancillary Support AND Inpatient and/or Specialty Care with some aspects of a Fully Integrated Federal Health Facility.
Brief Description	▪ VA plans to lease a build-to-suit facility in the Monterey Bay area for DoD-VA use. VA is responsible for building operations and will enter into a sharing agreement with DoD that outlines the terms of DoD's "lease" of space from VA.
Project Status	▪ Project site has been identified.

Ord Military Community Military Community/Monterey Bay Area Outpatient Clinic	
	▪ Local VA/DoD planning teams are currently updating design to prepare build-to-lease solicitation.
Physical Layout	▪ Single building with approx. 115,000 NUSF of clinical space. ▪ Based on the initial CONOPS, DoD and VA would have required approximately 16,000 NUSF and 99,000 NUSF of clinical space, respectively. However, this break-out may change based upon further exploration of integration (e.g., a single electronic health record).
Building Operations	▪ VA is responsible for building operations and will enter into a sharing agreement with DoD that outlines the terms of DoD's occupancy of VA space.
Clinical Operations	▪ Clinical operations will be shared and integrated for a limited scope of specialty services that both DoD and VA beneficiaries require.

2. Assessment of Potential Cost Savings to be Achieved

Potential cost savings are discussed for three categories: Capital Investment, Building Operations, and Clinical Operations. Each category includes four main areas to identify potential savings by reducing redundancies. Depending on the proposed project, each category is rated as having high, medium, low, or no potential for cost savings. The assessment for potential cost savings in the table below is based on the assumption that a fully integrated facility will be built. Since a new CONOPS (or sharing agreement) had not been established as of the writing of this report, assumptions were made based on conversations with the local stakeholders and their vision for collaboration.

Table 6: Ord Military Community/Monterey Bay Area – Qualitative Assessment of Cost Savings Potential

Category	Description of Potential Cost Savings Opportunities	Potential for Cost Savings
Capital Investment		
1. Land	▪ New VA/DoD facility in Marina reduces need for separate land purchases. DoD's fair share of land cost is proportionally included as part of occupancy and use rate to VA.	Medium
2. Facility Design and Construction	▪ VA will conduct solicitation and work with selected developer to ensure facility is built to VA standards. ▪ Initial capital investment savings are achieved by DoD not having to build a separate facility. However, DoD will incur long-term operating expense in the form of occupancy and use payments to VA.	Medium
3. Road and Utility Infrastructure	▪ Initial capital investment savings are achieved by DoD not having to build separate road and utility infrastructure. However, a portion of this capital investment will be reflected in DoD's occupancy and use payments to VA.	Medium
4. Medical Equipment and Build Out	▪ Sharing ancillary services may reduce medical equipment redundancies and save costs. However, depending on how the new equipment is purchased, there may be a proportional reimbursement sharing arrangement between the Departments. ▪ Marginal savings may be achieved for space build-out, depending on how new sharing agreement is structured.	Low
Building Operations		
1. Facility	▪ VA/DoD facility management staff will likely provide facility management and	Low

Category	Description of Potential Cost Savings Opportunities	Potential for Cost Savings
Management/ Site Maintenance	site maintenance and costs will be shared on a "fair share" basis.	
2. Utilities	▪ Building utilities will likely be paid on a "fair share" basis.	Low
3. Security	▪ Building security will likely be paid on a "fair share" basis.	Low
4. Administration / Governance	▪ Administrative staff will likely be shared. ▪ VA may hold clinic leadership position due to its larger presence and being the prime tenant. DoD will likely have a designated senior representative to participate in clinic governance decisions.	Low
Clinical Operations		
1. Shared ancillary services	▪ Ancillary services will be provided in one facility by VA and DoD staff to both VA and DoD beneficiaries. There may be a "fair share" cost sharing or staffing ratio to reflect DoD's smaller overall workload requirements.	Medium
2. Shared specialty care services	▪ VA and DoD are committed to maximizing shared specialty care services based on workload requirements.	Medium
3. Shared clinical staff	▪ Clinical staff will likely be shared across joint clinical services. ▪ Staff levels may be adjusted based on specialties and to reflect DoD's smaller overall workload requirements.	Low
4. Shared / Integrated Electronic Health Record System	▪ At the enterprise level, significant cost savings may be achieved. However, at the level of a small clinic, the savings may be negligible or zero.	High

3. Key Considerations Associated with the Joint Facility at Ord Military Community/Monterey Bay Area

Collaboration near the Ord Military Community provides VA and DoD with a great opportunity to expand services and the provision of care to beneficiaries in the Monterey Bay Region. VA and DoD are actively reassessing and revising the projected space needs facility design parameters and existing CONOPS with the goal of sharing as many clinical services as possible. This will take additional time and planning efforts before a solicitation can be published. In addition, increased integration will require additional planning and adjustments in areas such as facility governance, staffing, building security and integration of EHR sharing systems. For example, VA and DoD do not currently have compatible IT systems that allow sharing of medical records, but are collaborating to develop solutions to this challenge.

B. SAMPLE PROJECT #2: VA/DoD Ft. Benning Collaboration

The Army and VA currently operate separate facilities in Columbus, GA. DoD and VA have conducted planning meetings since May 2005 to evaluate opportunities for further collaboration in the Columbus area. DoD is currently planning to build a new Martin Army Community Hospital (MACH) on Ft. Benning with the intent to deliver the facility and commence the provision of medical services in summer 2013. Due to project delays, DoD signed a lease in 2009 for a small (approximately 10,000 NUSF) primary care clinic in North Columbus to address wartime expansion of the soldier and family member population. VA obtained approval in FY 2012 for an approximately 55,000 NUSF clinic lease in Columbus, GA, to replace the space-constrained existing clinic (approximately 17,000 NUSF) to respond to growing Veteran demand. The Congressional authorization for clinical space in Columbus, GA, is specifically designated for lease funding and, as such, cannot be used for construction. Erecting a CBOC at Ft. Benning will require Congressional authorization, first, to build a CBOC at Ft. Benning and, second, to modify the current funding authorization. Changing the existing Congressional authorization will delay expansion of CBOC operations. The solution is that VA will select land in close proximity to Ft. Benning.

1. Description of Planned Collaborative Effort and Degree to Which Collaboration Will Occur

DoD and VA collaboratively explored various sharing options throughout the years for the development of a joint facility in Columbus, GA, but various constraints, such as timing and funding and approval processes, prevented the options considered from coming to fruition. Although a joint facility was not possible in the Columbus area, VA and DoD intend to continue sharing services through existing and new sharing agreements. Currently three established sharing agreements enable a mutually beneficial relationship between VA and DoD at Ft. Benning. The sharing agreements identify the coordination, use, and exchange of health care resources that will occur at the site, with the intent of improving access, quality, and cost effectiveness of the health care provided by VA and the Army to their beneficiaries. Currently, VA and DoD have established sharing agreements for cataract surgery, inpatient care services, and the Integrated Disability Evaluation System. Another sharing agreement for inpatient psychiatric services is currently being finalized. Under the sharing agreements, DoD will provide services to VA beneficiaries at the MACH on an as-available basis, and VA will compensate DoD following the national agreement for reimbursement rates as established by the Health Executive Council's Financial Management Work Group.

Based on the proposed level of collaboration, this project could be classified as "Separate Facilities with Sharing of Services" as explained in the following summary table. While the separate, non-adjacent facilities will share the specific services mentioned above, VA is sensitive in that distance affects the ability of the facilities to share more services, which is why the new lease will be in close proximity to Ft. Benning.

Table 7: Ft. Benning/Columbus, GA Collaboration Key Features

Ft. Benning/Columbus, GA Collaboration	
Level of Collaboration	▪ Separate Facilities with Sharing of Services.
Brief Description	▪ DoD is building a new Army Community Hospital on Ft. Benning and temporarily leasing approx. 10,000 NUSF in Columbus, GA, until the new hospital is completed. ▪ VA will lease approx. 55,000 NUSF of outpatient clinic space in Columbus, GA.

Ft. Benning/Columbus, GA Collaboration	
Project Status	▪ No joint medical facility planned at this time. ▪ Local planners are collaborating on additional sharing agreements.
Physical Layout	▪ Separate buildings. ▪ Different sites (not co-located) but in close proximity to one another.
Building Operations	▪ Each agency is responsible for its own building operations.
Clinical Operations	▪ Clinical operations will only be shared through existing and future sharing agreements in the market.

2. Assessment of Potential Cost Savings to Be Achieved

Potential cost savings are discussed for three categories: Capital Investment, Building Operations, and Clinical Operations. Each category includes four main areas to identify potential savings by reducing redundancies. Depending on the proposed project, each category is rated as having High, medium, low or no potential for cost savings.

Table 8: Ft. Benning/Columbus, GA – Qualitative Assessment of Cost Savings Potential

Category	Description of Potential Cost Savings Opportunities	Potential for Cost Savings
Capital Investment		
1. Land	▪ VA and DoD have separate facilities.	No potential
2. Facility Design and Construction	▪ VA and DoD have separate facilities.	No potential
3. Road and Utility Infrastructure	▪ VA and DoD have separate facilities.	No Potential
4. Medical Equipment and Build Out	▪ VA and DoD have separate facilities.	No potential
Building Operations		
1. Facility Management/ Site Maintenance	▪ VA and DoD have separate facilities.	No Potential
2. Utilities	▪ VA and DoD have separate facilities.	No Potential
3. Security	▪ VA and DoD have separate facilities.	No Potential
4. Administration / Governance	▪ VA and DoD have separate facilities.	No Potential
Clinical Operations		
1. Shared ancillary services	▪ There are currently no sharing agreements in place for ancillary services due to the distance between sites.	Low
2. Shared medical services	▪ MACH has MOUs to provide Inpatient Care and Psychiatric Inpatient Care on an as-needed basis.	Low
3. Shared clinical staff	▪ The VAMC has begun sending ophthalmology physicians to work in Same Day Surgery Operating Room space at MACH.	High

Category	Description of Potential Cost Savings Opportunities	Potential for Cost Savings
4. Shared / Integrated Electronic Health Record System	▪ There will not be an integrated electronic health records system to share patient information until an enterprise solution is available.	Low

3. Key Considerations Associated with Ft. Benning/Columbus, GA Collaboration

VA and DoD will share services in Columbus, GA, as part of a collaborative effort between the two Departments in the local market. While collaboration in a joint facility is not planned, existing and new sharing agreements are realizing efficiencies and reducing redundancies. The local collaborative relationship between the two Departments is conducive to the implementation of additional sharing agreements in the future that enhance the potential for future sharing of capital infrastructure and clinical resources.

C. SAMPLE PROJECT #3: VA/DoD Panama City Outpatient Clinics

The Navy and VA currently operate separate outpatient clinics at the Naval Support Activity (NSA) in Panama City, Florida. The Navy clinic is on-base, the VA primary care and dental clinics are on-base, and the VA mental health clinic is off-base. Both agencies' existing facilities are too small to adequately accommodate the current workload and are physically and functionally obsolete. VA and DoD have several sharing agreements in place in Panama City that reduce duplicate operations for dental and ancillary services. The two agencies recently completed an approximately $1.23M JIF project to consolidate pharmacy and laboratory space and renovate the dental clinic space for joint use. To improve access and efficiency and expand the already existing close collaboration, VA and the Navy are planning to develop two new larger facilities.

1. Description of Planned Collaborative Effort and Degree to Which Collaboration Will Occur

VA and the Navy jointly planned and submitted funding requests (VA Minor Construction and Navy Unspecified Minor Construction Request) for an approximately 30,000 GSF VA clinic and an approximately 5,300 GSF Navy clinic to be built directly adjacent to each other and connected through a covered walkway. The two facilities will be built on a 10 acre Navy-owned site, which is an enclave separated from the NSA installation by a fence line. VA will occupy this site at no cost under a 25-year use agreement with two 25-year option periods. The ideal solution would have been to construct a single shared facility. However, VA and the Navy have different timelines for project approval, and a mechanism does not exist that allows either agency to contribute to the other's construction fund. The facilities were designed by the same architect/engineering (A/E) firm to facilitate coordination and realize efficiencies in functional and aesthetic design. VA and DoD are currently preparing separate construction solicitations. Ideally, one contractor will construct both projects to achieve further efficiencies, but this will depend on the outcome of the solicitation processes. The facilities will share one access road, parking and utilities. Site and infrastructure maintenance will be provided by VA and utilities will be metered individually for each facility. Both clinics are anticipated to open in late 2013 and will be governed by VA and Navy leadership, respectively.

Clinical services to be shared through sharing agreements include ancillary support services (radiology, pharmacy, and lab) and specialty care services such as dentistry. Under the sharing agreement(s), VA will supply the necessary staff, facility space, equipment and supplies to provide the ancillary services in the VA clinic following the national agreement for reimbursement rates as established by the Health Executive Council's Financial Management Work Group. VA will provide the facility space, equipment, and supplies for dental services, but staffing will be provided jointly. The Navy will provide dental technicians and VA will provide a dentist.

Based on the proposed level of collaboration, this project could be classified as "Separate Facilities with Sharing of Services" as explained in the following summary table.

Table 9: Panama City Outpatient Clinics Key Features

Panama City Outpatient Clinics	
Level of Collaboration	▪ Separate Facilities with Sharing of Services
Brief Description	▪ VA and DoD to build separate, adjacent outpatient clinics on Navy-owned site, which is

Panama City Outpatient Clinics	
	separated from NSA installation by a fence line. ▪ Shared ancillary support and specialty care services.
Project Status	▪ Joint design has been completed. ▪ Construction is estimated to start in July 2012 and complete in December 2013.
Physical Layout	▪ Two separate buildings connected by covered walkway. ▪ VA clinic will be 30,000 GSF. ▪ DoD clinic will be 5,300 GSF.
Building Operations	▪ Independent – each agency will be responsible for its own building operations.
Clinical Operations	▪ Shared ancillary support services include radiology, pharmacy and lab. ▪ Shared specialty care services to include dentistry.

2. Assessment of Potential Cost Savings to be Achieved

Potential cost savings are discussed for three categories: Capital Investment, Building Operations, and Clinical Operations. Each category includes four main areas to identify potential savings by reducing redundancies. Depending on the proposed project, each category is rated as having high, medium, low or no potential for cost savings.

Table 10: Panama City – Qualitative Assessment of Cost Savings Potential

Category	Description of Potential Cost Savings Opportunities	Potential for Cost Savings
Capital Investment		
1. Land	▪ VA has a no-cost use agreement with the Navy. ▪ New Navy clinic is built on Navy-owned land.	High
2. Facility Design and Construction	▪ VA and Navy achieved efficiencies by using the same A/E firm to design both facilities. ▪ VA and Navy will conduct independent solicitation processes to identify a general contractor. The outcome of the solicitations will determine whether one or two Contractors will be used for the project. If only one contractor is secured, this would produce further efficiencies and cost savings. ▪ If the space could be shared and only one facility built, additional savings would have been realized.	Medium
3. Road and Utility Infrastructure	▪ Cost savings will be achieved by sharing several infrastructure elements, such as a joint access road, parking, utility connections from the public domain to the facilities.	Medium
4. Medical Equipment and Build Out	▪ By sharing ancillary services with VA, the Navy will be able to reduce its medical equipment costs. However, these savings are offset by having to reimburse VA for the use of ancillary services.	Low
Building Operations		
1. Facility Management/Site Maintenance	▪ A formal concept of operations has not been executed yet, but VA may provide the facilities management and site maintenance services to the Navy, who would reimburse VA on a "fair share" basis.	Low
2. Utilities	▪ A formal concept of operations has not been executed yet, but the buildings	Low

Category	Description of Potential Cost Savings Opportunities	Potential for Cost Savings
	will likely be metered separately.	
3. Security	▪ A formal concept of operations has not been executed yet, but building security will likely be provided separately due to the two agencies' different facility security/Anti-Terrorism/Force Protection requirements. ▪ Cost savings could have been gained here if the two agencies were allowed to build a joint use facility.	Low
4. Administration / Governance	▪ Each facility will have its own facility administrative staff. ▪ Each facility will have its own facility governance.	Low
Clinical Operations		
1. Shared ancillary services	▪ Ancillary services will be provided in the VA facility and by VA staff to both VA and DoD beneficiaries. DoD will reimburse VA on a per encounter / per service provided basis. This allows DoD to purchase these services from VA instead of the private sector.	Medium
2. Shared medical services	▪ A formal concept of operations has not been executed yet, but the only medical service currently anticipated to be shared is dental. Services will be provided in the VA clinic by a VA dentist and DoD technicians.	Low
3. Shared clinical staff	▪ Except for dental services, there will be no sharing of clinical staff.	Low
4. Shared / Integrated Electronic Health Record System	▪ There will not be an integrated electronic health records system to share patient information until an enterprise solution is available. ▪ VA providers will need training and access to Navy systems, specifically the Dental Common Access System for Dental and Armed Forces Health Longitudinal Technology Application (AHLTA) for medical, to document treatment provided to active duty Navy beneficiaries.	High

3. Key Considerations Associated with the Joint Facilities in Panama City

The collaborative development of these new clinics represents a great opportunity for VA and DoD to expand and enhance care provided to beneficiaries in this market. However, as described by local field staff from both agencies, the expected sharing that will occur in these two clinics presents challenges for both agencies. One of the biggest issues is the sharing of medical records between the two agencies. VA and DoD's information management/information technology systems are not currently compatible. For example, when the DoD physician orders an MRI test for a DoD patient from VA's radiology department, it is unknown how the test will be ordered by DoD and then the EHR transferred from VA back to DoD. Similar challenges are expected with lab tests and prescriptions. VA and DoD are exploring different ways of addressing these hurdles. Site access is another issue that had to be addressed during the facility planning processes. To allow Veterans and their families' sufficient facility access, the site selected for the future clinics had to be off-base or separated from the rest of the NSA by a fence.

D. SAMPLE PROJECT #4: VA/DoD Honolulu Ewa Plain Outpatient Clinic

VA and DoD have a long history of sharing services in Hawaii at the TAMC and the Spark M. Matsunaga VA Medical Center. To form a coordinated approach to long-term capital investment planning in the Hawaii Multi-Service Market, VA and DoD commissioned a joint market-wide requirements analysis to identify the current and future healthcare needs for all Federal beneficiaries and identify potential locations and opportunities for collaboration to better serve VA and DoD beneficiaries in Hawaii.

1. Description of Planned Collaborative Effort and Degree to Which Collaboration Will Occur

Based on the findings of the approved Market-Study, VA submitted a funding request in the FY 2013 budget for an approximately 119,000 NUSF major build-to-suit lease project. VA will occupy approximately 90,000 NUSF and DoD (Army, Navy and Coast Guard) will occupy approximately 29,000 NUSF of clinical space. The remaining space will be used to house the VA National Teleradiology Program and to co-locate several VA functions, such as the Veterans Benefits Administration (VBA) Honolulu Regional Office and the Kapolei VA Vet Center. A private developer will build the clinic to VA criteria under a 20-year lease agreement. VA will assume responsibility for the initial planning and solicitation costs necessary to run the competitive procurement process. Once the facility is delivered, VA will be responsible for building operations and maintenance, and providing space to DoD under terms to be defined in comprehensive sharing agreements and one or more permits.

VA and DoD have not executed sharing agreements for this facility yet. Their current vision for collaboration is that clinical services will be performed separately by each agency, but ancillary and support services (radiology, lab and pathology, and pharmacy) will be shared. VA would operate the ancillary and support services and get reimbursed by DoD for each encounter / service performed following the national agreement for reimbursement rates as established by the Health Executive Council's Financial Management Work Group. Based on the proposed level of collaboration, this project could be classified as "Co-occupancy with Sharing of Ancillary Support," as explained in the following summary table.

Table 11: Honolulu, Ewa Plain Outpatient Clinic Key Features

Honolulu, Ewa Plain Outpatient Clinic	
Level of Collaboration	▪ Co-occupancy with Sharing of Ancillary Support
Brief Description	▪ VA plans to lease a facility in Honolulu and will provide use of space in this facility to DoD. ▪ DoD will pay occupancy and use fees to VA to occupy space. ▪ The two agencies will share ancillary support services provided by VA.
Project Status	▪ Local VA/DoD planning teams are currently structuring sharing agreement(s) and preparing the build-to-suit solicitation.
Physical Layout	▪ Single building, approx. 119,000 NUSF ▪ DoD will occupy approx. 29,000 NUSF of clinical space. ▪ Remainder of the space will be common elements or various VA functions. ▪ Administrative space in TAMC's E Wing will be made available for DoD clinic space.
Building Operations	▪ VA is responsible for building operations.

Honolulu, Ewa Plain Outpatient Clinic	
Clinical Operations	▪ VA and DoD will share ancillary support services, including radiology, pharmacy and lab. ▪ Specialty care services will not be shared.

2. Assessment of Potential Cost Savings to be Achieved

Potential cost savings are discussed for three categories: Capital Investment, Building Operations, and Clinical Operations. Each category includes four main areas to identify potential savings by reducing redundancies. Depending on the proposed project, each category is rated as having high, medium, low or no potential for cost savings.

Table 12: Honolulu, Ewa Plain – Qualitative Assessment of Cost Savings Potential

Category	Description of Potential Cost Savings Opportunities	Potential for Cost Savings
Capital Investment		
1. Land	▪ DoD pays VA for its fair share of the land costs. ▪ DoD collocation with VA represents replacement of an existing lease with a new lease for DoD.	Low
2. Facility Design and Construction	▪ VA will conduct solicitation and work with selected developer to ensure facility is built to VA standards. ▪ Incremental efficiencies and cost savings to the government may be realized by DoD co-locating with VA. However, DoD will still incur long-term operating expenses in the form of occupancy and use payments to VA.	Low
3. Road and Utility Infrastructure	▪ Economies of scale may be achieved in the initial capital investment for road and utility infrastructure by consolidating services in one facility. However, a portion of this capital investment will be reflected in DoD's occupancy and use payment s to VA.	Low
4. Medical Equipment and Build Out	▪ By sharing ancillary services with VA, DoD will have reduced medical equipment costs. However, these savings may be offset by having to reimburse VA for services provided to DoD beneficiaries. ▪ Marginal savings may be achieved since DoD will only be responsible for build-out of its space.	Low
Building Operations		
1. Facility Management / Site Maintenance	▪ VA will provide facility management and site maintenance as prime tenant. DoD will pay for these services on a pro-rata basis through its full service occupancy and use rate.	Low
2. Utilities	▪ VA will pay for utilities and pass through DoD's share as part of its full service occupancy and use rate.	Low
3. Security	▪ VA will pay for building security and pass through DoD's share as part of its full service occupancy and use rate.	Low
4. Administration / Governance	▪ VA will pay for general building administration costs and pass through DoD's share as part of its full service occupancy and use rate. ▪ DoD may have additional administrative staff to support its clinical operations.	Low

Category	Description of Potential Cost Savings Opportunities	Potential for Cost Savings
	▪ VA may hold clinic leadership position due to its larger presence and being the prime tenant. DoD will likely have a designated senior representative to participate in clinic governance decisions.	
Clinical Operations		
1. Shared ancillary services	▪ Sharing of ancillary services is anticipated, but exact details for how this will occur are still being developed at this time.	Low
2. Shared specialty care services	▪ A formal concept of operations has not been executed yet, but VA and DoD are further exploring sharing of specialty care services.	Low
3. Shared clinical staff	▪ A formal concept of operations has not been executed yet, but VA and DoD are not exploring shared clinical staff.	Low
4. Shared / Integrated Electronic Health Record System	▪ At the enterprise level, significant cost savings may be achieved. However, at the level of a small clinic, the savings may be negligible or zero.	High

3. Key Considerations Associated with the Joint Facility in Honolulu

A potential challenge is the structuring of occupancy and use payments from DoD to VA under existing laws and regulations. VA expressed interest in creating sharing agreements synchronized with the duration of VA's 20-year lease term. VA is interested in structuring sharing agreements for this facility under 38 U.S.C. §8111, which addresses sharing of health care resources including use of space between VA and DoD health care facilities and can allow for a continuous agreement over the 20-year term of VA's lease.

VI. Summary of Benefits of Joint Medical Facilities/Conclusions

This report provides a review and analysis of the potential benefits and cost savings opportunities associated with VA/DoD joint medical facilities. Increased VA/DoD sharing has the potential to enhance access to and quality of health care for both VA and DoD beneficiaries alike. This report contains a detailed description of four sample collaborative efforts at Ord Military Community (California), Ft. Benning (Georgia), Panama City (Florida), and Honolulu, Ewa Plain (Hawaii). Summaries of these projects and their anticipated levels of collaboration are provided in the following table.

Table 13: Sample VA/DoD Joint Projects' Key Features

	Ord Military Community Outpatient Clinic	Ft. Benning Collaboration	Panama City Outpatient Clinics	Honolulu Ewa Plain Outpatient Clinic
Level of Collaboration	▪ Co-occupancy with Sharing of Ancillary Support AND Inpatient and/or Specialty Care with some aspects of a Fully Integrated Federal Health Facility.	▪ Separate Facilities with Sharing of Services.	▪ Separate Facilities with Sharing of Services.	▪ Co-occupancy with Sharing of Ancillary Support.
Brief Description	▪ VA plans to lease a build-to-suit facility in the Monterey Bay Area for DoD-VA use. VA is responsible for building operations and will enter into a sharing agreement with DoD that outlines the terms of DoD's "lease" of space from VA.	▪ DoD is building a new Army Community Hospital on Ft. Benning and temporarily leasing approx. 10,000 NUSF in Columbus, GA, until the new hospital is completed. ▪ VA will lease approx. 55,000 NUSF of outpatient clinic space in Columbus, GA.	▪ VA and DoD to build separate, adjacent outpatient clinics on Navy-owned site, which is separated from NSA installation by a fence line. ▪ Shared ancillary support and specialty care services.	▪ VA plans to lease a facility in Honolulu and will provide use of space in this facility to DoD. ▪ DoD will pay occupancy and use fees to VA to occupy space. ▪ The two agencies will share ancillary support services provided by VA.
Project Status	▪ Project site has been identified. ▪ Local VA/DoD planning teams are currently updating design to prepare build-to-lease solicitation.	▪ No joint medical facility planned at this time. ▪ Local planners are collaborating on additional sharing agreements.	▪ Joint design has been completed. ▪ Construction is estimated to be completed in December 2013.	▪ Local VA/DoD planning teams are currently structuring sharing agreement(s) and preparing the build-to-lease solicitation.
Physical Layout	▪ Single building with approx. 115,000 NUSF of clinical space. ▪ Based on the initial CONOPS, DoD and VA would have required approx. 16,000 NUSF and 99,000 NUSF of clinical space, respectively. However, this break-out may change based on further exploration of integration (e.g., a single electronic health record).	▪ Separate buildings ▪ Different sites (not co-located) but in close proximity to one another.	▪ Two separate buildings connected by covered walkway. ▪ VA clinic will be 30,000 GSF. ▪ DoD clinic will be 5,300 GSF.	▪ Single building, approx. 119,000 NUSF ▪ DoD will occupy approx. 29,000 NUSF of clinical space. ▪ Remainder of the space will be common elements or various VA functions. ▪ Administrative space in TAMC's E Wing will be made available for DoD clinic space.
Building Operations	▪ VA is responsible for building operations and will enter into a sharing agreement with DoD that outlines the terms of DoD's occupancy of VA space.	▪ Each agency is responsible for its own building operations.	▪ Independent – each agency will be responsible for its own building operations.	▪ VA is responsible for building operations.
Clinical Operations	▪ Clinical operations will be shared and integrated for a limited scope of specialty services that both DoD and VA beneficiaries require.	▪ Clinical operations will only be shared through existing and future sharing agreements in the market.	▪ Shared ancillary support services include radiology, pharmacy, and lab. ▪ Shared specialty care services to include dentistry.	▪ VA and DoD will share ancillary support services, including radiology, pharmacy and lab.

The expected amount of cost savings associated with the planned projects reviewed in this study depends on each project's unique characteristics and the nature of the sharing agreements that the two Departments establish. Many of these anticipated sharing agreements have not yet been finalized so it is difficult to provide any quantitative assessment of the cost savings at this time. The following table summarizes each sample project's qualitative potential for cost savings using a rating of high, medium, low or no potential for cost savings over three primary categories: Capital Investment, Building Operations, and Clinical Operations.

Table 14: Summary – Qualitative Assessment of Cost Savings Potential

Category	Quantitative Potential for Cost Savings by Sample Project Site			
	VA/DoD Ord Military Community Military Community Outpatient Clinic	VA/DoD Ft. Benning Collaboration	VA/DoD Panama City Outpatient Clinics	VA/DoD Honolulu Ewa Plain Outpatient Clinic
Capital Investment				
1. Land	Medium	No potential	High	No potential
2. Facility Design and Construction	Medium	No potential	Medium	No potential
3. Road and Utility Infrastructure	Medium	No potential	Medium	No potential
4. Medical Equipment and Build Out	Low	No potential	Low	No potential
Building Operations				
1. Facility Management / Site Maintenance	Low	No potential	Low	Low
2. Utilities	Low	No potential	Low	Low
3. Security	Low	No potential	Low	No potential
4. Administration / Governance	Low	No potential	Low	Low
Clinical Operations				
1. Shared ancillary services	Medium	Low	Low	Low
2. Shared specialty care services	Medium	Low	Medium	Low
3. Shared clinical staff	Low	Low	Low	Low
4. Shared / Integrated Electronic Health Record System	High	High	High	High

Extensive joint planning efforts have been conducted on the local and Central Office/Headquarters levels to enable medical facility collaboration as exemplified in these four sample projects.

Collaborative efforts are often based on existing sharing agreements for one or more services or comprehensive joint market studies, such as the multi-service market study performed in Hawaii. Understanding each other's workload projections and future facility infrastructure needs based on respective beneficiary demographics offers a sound foundation for joint medical facility planning efforts.

This analysis also revealed several hurdles that could hinder efforts to achieve higher levels of collaboration and integration. The primary ones as identified by local planners and other key VA and DoD stakeholders include the following:

1. **Differences in Capital Investment Planning Processes and Timing** makes it difficult to align planning for the delivery of healthcare services with availability of clinical space, which is dependent on budgetary approval processes.

   Example: In Panama City, the collaborative effort includes two separate clinics (one VA and one DoD clinic) that will be built adjacent to each other. In order to facilitate the funding of this effort, one clinic proceeded as a VA-funded Minor Construction project and the other as a DoD-funded Unspecified Minor Construction project. Joint planning and funding authority and appropriation would have allowed the design and construction of a single facility, which would have further eliminated redundancies and increased economies of scale.

2. **Structuring of Occupancy and Use Payments Between DoD and VA under Existing Regulations** can present a funding challenge for lease projects since there are no specific laws or regulations permitting one Department to issue occupancy and use payments for facility space to the other in a joint medical facility.

   Example: The planned joint Ewa Plain clinic in Honolulu will be a private build-to-suit lease facility under a 20-year lease term. One agency can pay the lessor agency through occupancy and use fees in a sharing arrangement under 38 U.S.C. §8111 consistent with the term of the lease. However, if the sharing partner desired to discontinue the use of the space sharing agreement, this agreement would have to include recompense for the lessor agency for the space it leased on behalf of the sharing partner for the remainder of the term of the lease.

3. **Different EHR Systems** exist between VA and DoD. EHR systems and the ability to share records between clinical departments are the backbone of efficient clinical operations. The iEHR system is an enterprise level solution currently under development at VA Central Office and DoD Headquarters.

   Example: One of the primary challenges for taking the Ord Military Community Military Community project to more integration will be the development of an enterprise level iEHR system. VA currently uses the Veterans Information Systems and Technology Architecture (VistA), while DoD uses the AHLTA.

4. **Security/Access to Military Installations** can impact the ability of VA beneficiaries to access care. Most DoD clinics are located on DoD installations with secured perimeters. This can present an access challenge to VA beneficiaries whose cars often do not have the appropriate registrations / decals to get on an installation, or who are driven by others to receive services. Furthermore, the security procedures and requirements often differ from

installation to installation. This can often hinder the efficient collaboration and sharing of medical services.

Example: At Panama City, the existing Navy clinic and VA primary care and dental clinics are on-base, and the VA mental health clinic is off-base. VA beneficiaries are often driven to their appointments by caregivers, or others they depend on for mobility, who do not have access to military installations. Providing temporary access onto military installations is cumbersome to VA beneficiaries and their caregivers and presents a potential security concern for DoD installations. This issue is exemplified, for example, by the local VA and DoD planners for the Panama City project redrawing/moving the Naval Support Activity base's fence line to keep the new DoD and VA clinics outside of the secured perimeter, thereby providing direct facility access for VA beneficiaries.

Being able to overcome some of the hurdles outlined above may streamline the joint medical facility planning process. However, despite these challenges that joint medical facilities projects sometimes face, there are numerous benefits associated with these projects. Some of these benefits include, but may not be limited to:

1. Increased facility operational efficiencies by occupying one facility or co-locating facilities.
2. Reduced capital infrastructure redundancies by occupying one facility or co-locating facilities.
3. Improved access to services for VA and DoD beneficiaries through sharing of ancillary support services.
4. Increased clinical operational efficiencies through sharing of one or more clinical service(s), which allow a higher staff utilization rate.
5. Reduction in "contracted out" services to private providers and use of Federal partner capacities instead (government to government reimbursement versus government to private sector).

VA and DoD intend to improve the planning and execution of future joint projects, thereby enhancing the overall quality of care for VA and DoD beneficiaries alike.