The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report responds to section 1701 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111-84), which requires the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to submit a report to Congress on the Captain James A. Lovell Federal Health Care Center (JALFHCC) demonstration project. The report and appendices provide a comprehensive description and assessment of the exercise of the demonstration project authorities and a recommendation to continue the JALFHCC model at North Chicago.

The JALFHCC five-year demonstration project provided the VA and the DoD with a unique opportunity to create an integrated healthcare facility serving both Veterans and military beneficiaries. Our learning has been iterative over those five years as we sorted through duplicative and, at times, disparate processes, policies, and statutory requirements. Under current legislative authorities, we were unable to create a facility that would operate under a single line of authority. Instead, we had to create duplicative governance systems which, in turn, led to an overly complex oversight and reporting structure with multiple standards and reporting requirements.

Our report to Congress addresses many of the shortcomings of the JALFHCC, and highlights some of the more recent successes. The costs associated with this demonstration project were very high and not in keeping with our initial goal to deliver more cost-effective health care. Part of the increased costs was due to the inability to appropriately downsize facility staff. Other high operating costs were due to efforts to integrate information systems at JALFHCC. While we have made great strides in advancing data interoperability and integration between the two legacy electronic health records at JALFHCC, more needs to be done to simplify multiple networks and integrate other information technology (IT) systems that place a burden on personnel in terms of IT sustainment and care delivery. We plan to recommend legislation to resolve some of the outstanding issues.

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resource sharing between the Departments is a vital part of both our health systems. The Departments recommend continuing the JALFHCC as a unique optimally integrated facility with continued periodic reviews and implementation of identified recommended improvements. Furthermore, it is essential to continue to provide health services, including inpatient capability, for the Navy Recruit Training Command at Great Lakes, to ensure a medically ready force. However, we have more work to do to realize our vision of an integrated facility designed to improve access, quality, and the cost effectiveness of health care delivery to our Veterans and military beneficiaries.

Until we "get it right" at JALFHCC, we do not recommend similar demonstration projects at this time. Instead, we will work on expanding our other models of sharing, to include joint ventures, where it is possible and pragmatic to do so.

Thank you for your interest in the health and well-being of our Service members, Veterans, and their families. A similar letter has been sent to the Chairmen of the other appropriate congressional committees.

Sincerely,

Sloan D. Gibson
Deputy Secretary
Department of Veterans Affairs

Peter Levine
Acting Under Secretary of Defense
for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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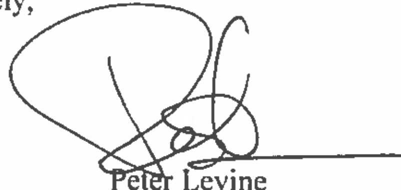

Peter Levine
Acting Under Secretary of Defense
for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

The Honorable Thad Cochran
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

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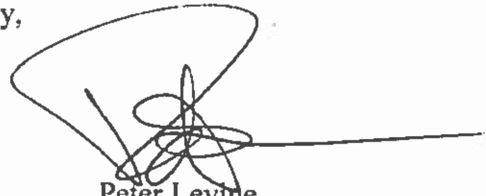

Peter Levine
Acting Under Secretary of Defense
for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Barbara A. Mikulski
Vice Chairwoman

The Honorable Harold Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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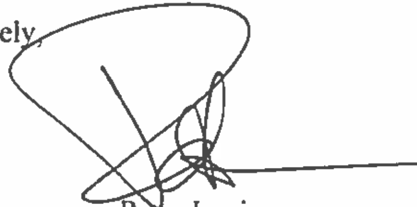

Peter Levine
Acting Under Secretary of Defense
for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

The Honorable Johnny Isakson
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

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Department of Veterans Affairs

Peter Levine
Acting Under Secretary of Defense
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Enclosure:
As stated

cc:
The Honorable Richard Blumenthal
Ranking Member

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

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Deputy Secretary
Department of Veterans Affairs

Peter Levine
Acting Under Secretary of Defense
for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Mark Takano
Acting Ranking Member

REPORT TO CONGRESSIONAL COMMITTEES ON ARMED SERVICES AND VETERANS' AFFAIRS

DEPARTMENT OF DEFENSE-DEPARTMENT OF VETERANS AFFAIRS CAPTAIN JAMES A. LOVELL FEDERAL HEALTH CARE CENTER DEMONSTRATION PROJECT

MARCH 2016

The estimated cost of this report for the Department of Defense is approximately $1,482,000. This includes $1,170,000 in expenses and $312,000 in DoD labor.

The estimated cost of this report for the Department of Veterans Affairs is approximately $1,356,400. This includes $1,235,000 in expenses and $121,000 in VA labor.

Report to Congressional Committees on Armed Services and Veterans' Affairs: Department of Defense-Department of Veterans Affairs Captain James A. Lovell Federal Health Care Center Demonstration Project

Section 706 of the Duncan Hunter National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2009, Public Law 110-417, and Section 1701 of NDAA FY 2010, Public Law 111-84, provided demonstration project authority for a combined federal medical facility of the Department of Defense (DoD) and Department of Veterans Affairs (VA). Naval Hospital Great Lakes (NHGL) and the VA Medical Center (VAMC) in North Chicago were combined as the new Captain James A. Lovell Federal Health Care Center (JALFHCC) on October 1, 2010. NDAA FY 2010 requires that not later than March 2016 the Secretary of Defense and the Secretary of Veterans Affairs jointly submit to the appropriate committees of Congress a report on the exercise of the authorities granted in NDAA FY 2010. The report is required to include the following:

(A) A comprehensive description and assessment of the exercise of the authorities in the title.
(B) The recommendation of the Secretaries as to whether the exercise of the authorities in this title should continue.

This report includes a brief summary of DoD and VA sharing, a brief description of the JALFHCC demonstration project, findings and conclusions of the evaluation efforts, and the Secretaries' recommendation concerning the continuation of the demonstration. This report was prepared by DoD and VA staff using findings from the JALFHCC evaluation report prepared by an independent contractor[1], found at Appendix A; and the JALFHCC Information Management/Information Technology (IM/IT) evaluation report prepared by the Veterans Health Administration (VHA) Office of Quality, Safety and Value, Product Effectiveness (PE)[2], found at Appendix B.

DoD/VA Health Care Resource Sharing Background

DoD and VA have a more than 30-year history of health care resource sharing resulting in agreements between military medical treatment facilities (MTFs) and VAMCs across the country, including ten joint ventures (JVs) encompassing a wide range of services. Resource sharing minimizes duplication and underuse of health care resources, promoting cost-effective use of federal health care resources and benefiting both DoD and VA beneficiaries. Sharing agreements include agreements where health care resources are acquired or exchanged between the Departments. Joint ventures are characterized by specific resource sharing agreements encompassing multiple services resulting in joint operations. These arrangements are long term commitments of more than five years to facilitate comprehensive cooperation, shared risk, and mutual benefit. Joint ventures may or may not involve joint capital planning and coordinated use of existing or planned facilities.

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[1] Knowesis. *Evaluation and Assessment of Joint Veterans Affairs and Department of Defense Medical Facility Demonstration Project.* September 2015.
[2] Veterans Health Administration Office of Quality, Safety and Value Product Effectiveness. *Captain James A. Lovell Federal Health Care Center (JAL JALFHCC) Information Management, Information Technology Evaluation.* July 2015.

VA and DoD Healthcare Needs in North Chicago

A comprehensive market survey and analysis was not performed to determine if establishment of an FHCC in the North Chicago market was necessary or the best site for a demonstration project. Several external reports had previously questioned the requirement for a VA bedded facility in North Chicago. A 1978 Government Accountability Office (GAO) report[3] recommended that VA suspend its plan to expand medical and surgical beds in North Chicago given the existence of sufficient capacity at nearby VA facilities. In 1999, an internal VA study proposed closing all inpatient care at the North Chicago VAMC (NCVAMC) and converting it into an outpatient clinic, to which local Veterans' groups and the Illinois congressional delegation objected. In 2001, the VA Capital Asset Realignment for Enhanced Services (CARES) process (similar in objectives to DoD's Base Realignment and Closure (BRAC) Commission) slated a number of VA facilities, including the VAMC in North Chicago, for closure.

The NHGL, located approximately 1.5 miles from NCVAMC, was built in 1960. The 12-story building was a tertiary facility with 850 beds, 11 operating rooms, and space for 16 clinics. However, by 2000, the Navy was staffing only 50 medical-surgical beds, which were about 50 percent occupied, and most of the building had been converted to outpatient clinic space. The 1993 BRAC Commission decided to consolidate Navy recruit training, then in three locations, to Naval Station Great Lakes, located near the city of North Chicago. This decision gave more urgency to the need to replace the old and obsolete Navy hospital with a new ambulatory care facility. The Navy planned to purchase inpatient care from the VA or nearby area hospitals. DoD's military construction program planned to replace the facility in FY 2007 at a cost estimated in 2001 to be $170 million.

In 2001, with release of the CARES recommendation to close NCVAMC, local Veterans' groups and the Illinois congressional delegation began to push vigorously the possibility of combining care for both DoD and VA beneficiaries at the NCVAMC to justify keeping it open. DoD and VA agreed to have the Navy use the VA hospital for inpatient and emergency services and used the funding for military construction to expand NCVAMC rather than build a standalone facility on the Navy base.

JALFHCC Demonstration Project Description

The five-year demonstration project began on October 1, 2010. As outlined in the Executive Agreement (EA), the JALFHCC demonstration was expected to:

- Improve access, quality and cost
- Meet military readiness standards
- Maintain high patient and provider satisfaction
- Increase research and training opportunities

The JALFHCC operates under an integrated governance structure and a single line of authority to manage DoD and VA medical and dental care while continuing to meet the unique missions of both Departments. VA is the lead partner and assumes the role of the Director, responsible for executive-level management of the JALFHCC. Navy assumes the role of Deputy Director,

[3] GAO, *Inappropriate Number of Hospital Beds Planned by Veterans Administration for Chicago Area,* HRD 78-127, http://www.gao.gov/products/106270

responsible for supporting the fulfillment of the JALFHCC mission and daily operations. The JALFHCC is the only facility with a single budget that is applied to both DoD and VA functions. The JALFHCC relies on the Joint Treasury Fund as authorized in the NDAA, currently set to expire on September 30, 2017.

The Departments contracted with an independent federal contractor to conduct a comprehensive evaluation and assessment of the JALFHCC and to report their findings and conclusions. As part of their evaluation, the contractor was tasked to also evaluate three established JV sites to determine whether the JALFHCC is more or less successful as an integrated facility than facilities that remain separate, but collaborative. The three JV sites included in the report are located in Northern California, Anchorage, and El Paso. Additionally, the Departments chartered the VHA PE office to conduct an in-depth IM/IT evaluation, coordinating their efforts with the contractor.

Findings of the Independent Contractor Evaluation

The contractor reported findings with respect to the anticipated improvements outlined in the EA (access, quality, cost effectiveness, military readiness, patient satisfaction, and staff satisfaction and development) for each JALFHCC operating domain (governance and management, business processes, clinical processes, logistics and contracting, education and training, staffing and human resources, IT, capital facilities and equipment, and research). The contractor evaluated data from FY 2008 – 2014; therefore, the report does not reflect changes that occurred in 2015. The contractor's findings are as follows:

- "**Access**: There is no evidence that integration either improved or worsened overall access to care. Insofar as integration enabled JALFHCC to hire and maintain a robust and fairly consistent specialty staff, and to add a few additional services, the effect was positive. However, there is evidence of markedly declining primary care enrollment per clinic provider over the course of the demonstration."
- "**Quality**: There is evidence of a small improvement in quality of care as demonstrated by national quality metrics and performance relative to Veterans Integrated Services Network (VISN) 12 as a whole is slightly better in Joint Commission (JC) surveys. Overall, however, there is no evidence of substantial improvement or deterioration in quality."
- "**Cost Effectiveness**: The start-up and ongoing costs of this demonstration are very high, substantially higher than a stand-alone JV might have been. Output per full time employee equivalent (FTEE), measured in a standard fashion among the systems evaluated, is remarkably low."
- "**Readiness**: Performance in maintaining "medically ready sailors" has improved with integration. Provision of an adequate volume and acuity of cases to support "ready medics" has been disappointing to date."
- "**Patient Satisfaction**: The JALFHCC had the same level of inpatient patient satisfaction compared to the VA national average in FY 2014, but outpatient satisfaction has dropped below VA and parent VISN averages."
- "**Staff Satisfaction and Development**: JALFHCC employees' level of satisfaction with job and supervision are similar to the rest of the VA and to the other VA sites surveyed. They all are on a negative trend. Of note, the JALFHCC's trend has gone from being the best of the comparison facilities in FY 2008 to the poorest in FY 2014. Cultural

dissatisfaction is frequently articulated in interviews at all sites where VA and DoD personnel work together, and it is unclear whether JALFHCC is better or worse in this regard. Some aspects of staff development have been significantly augmented by the integration, although most could be achieved in a JV. Integration has facilitated a modest increase in research involvement by staff, and the increase in size and inpatient volume has permitted broader engagement in post-graduate medical education programs."

The contractor's evaluation concluded that "overall, the benefits resulting from the FHCC demonstration project are not inherently superior to those that could be achieved by a JV, while actually costing more."

Findings of the VHA PE IM/IT Evaluation

VHA PE reported on IM/IT investments made to enable JALFHCC integrated operations including: Joint Patient Registration (JPRS); Medical Single Sign-On with Context Management (MSSO/CM); financial reconciliation; orders portability capabilities; and network infrastructure and communication. PE's findings are summarized as follows:

- With the JALFHCC demonstration project, DoD and VA have made great strides in advancing data interoperability and integration initiatives. The demonstration, however, has also shown that an integrated health care center that utilizes multiple networks and multiple electronic health records (EHRs) will place greater burden on facility-level personnel in terms of IM/IT sustainment and care delivery.
- Because DoD and VA have ceased efforts to jointly develop an integrated EHR (iEHR), JALFHCC serves as a critical achievement in the pursuit of agency-wide interoperability.
- JALFHCC clinical operations are not as efficient as compared to independent DoD and VA facility operations.
- The use of separate networks and separate EHRs with different reporting and data standards has made it difficult for the single leadership group to manage JALFHCC operations.

PE concluded that "while considerable IM/IT achievements have been realized at JALFHCC, until interoperability solutions are in place that can effectively transport all information from one EHR to the other in a computable format, the two Departments should focus on improving existing interoperability solutions and making access to legacy EHRs faster and more seamless."

Exercise of Congressional Authorities

The following integration actions were the result of the legislative authorities granted in NDAA FY 2010:

<u>Demonstration Project Authority</u>

DoD, in consultation with Navy, and VA were authorized to execute a signed EA for the joint use of the facility and new ambulatory care center (ACC). The EA was developed collaboratively between the two Departments and signed on April 23, 2010. The EA is the formal operational agreement between DoD and VA. The EA includes terms and conditions as required by NDAA FY 2010, as well as provides greater detail on the mechanics of the operations of the joint use facility and the contributions that both DoD and VA make toward the demonstration project.

Transfer of Property

DoD is authorized to transfer the facility to the VA without reimbursement. As part of the demonstration project, the Navy funded and built a new ACC by expanding the existing NCVAMC, renovated existing NCVAMC space, and built a new parking garage and surface parking area. The Navy has elected to retain title to the ACC and parking structure. A 50-year land-use permit was issued by VA to Navy from 2007 until 2057. This is consistent with the authority granted by Congress.

Transfer of Civilian Personnel of the Department of Defense

DoD was authorized to transfer functions necessary for the effective operation of the facility to VA. DoD civilian employees were transferred to the VA under the VA pay, benefits, and personnel systems. As part of the demonstration project, Navy transferred approximately 470 civilian positions to the VA personnel system in 2010. Navy retained 14 civilians because access to certain computer systems is restricted to DoD employees.

Joint Funding Authority

A "Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund (JMFDF)" was established in 2010. This Treasury Fund is the operating account for the JALFHCC, with contributions from both DoD, in consultation with Navy, and VA. Currently, the JMFDF authority will expire on September 30, 2017.

Eligibility of Members of the Uniformed Services for Care and Services

JALFHCC is authorized to be treated as a facility of the uniformed services to the extent provided in the EA, which shall provide an integrated priority list for access to health care at the facility. The JALFHCC operates under the integrated priority list as established in the EA.

Additionally, the EA states that Active Duty members and Active Duty family members enrolled in TRICARE Prime will not be required to pay co-payments for inpatient or outpatient health care services. However, this rule could not be extended to other DoD beneficiary categories. This necessitated that DoD establish a TRICARE co-pay waiver demonstration project in order to eliminate co-pays for all other DoD beneficiaries, and a report on this TRICARE co-pay waiver demonstration project is attached at Appendix C.

Findings and Recommendations of the DoD/VA Team for the Future State

A joint DoD/VA team performed an in-depth review of the previously mentioned evaluation reports and studied the implications of different future scenarios for key functional areas at JALFHCC. The DoD/VA team found that reverting the JALFHCC to a JV model is neither advisable nor likely achievable for two reasons. First, the former NHGL structure was torn down and funding for that replacement facility was used to expand the former NCVAMC. Second, returning all or some of the approximately 470 former DoD employees would require complex negotiations to return staff to DoD positions. Civilians who move from VA back to DoD might have to be reclassified, resulting in potential job or salary changes. For example, at the time of the merger, DoD nursing staff received significant pay raises during their transition into VA positions with a generally higher pay scale. All of this will be laborious and lengthy, taking focus away from providing care to the beneficiaries. The DoD/VA team instead focused

on developing a list of modifications that could help improve the processes and operations at JALFHCC and move JALFHCC closer to achieving its original goals. These findings and modifications are listed below by functional area.

Performance Reporting and Metrics

For the first five years of the demonstration, JALFHCC leadership tracked 38 metrics to evaluate the 15 areas of integration outlined in the EA. In 2012, the Institute of Medicine (IOM) wrote an exhaustive report[4] that stated that "….these 38 metrics provide limited information or conclusions regarding performance with regard to cost, quality and access." Other studies have also cited challenges in obtaining relevant data and lack of meaningful performance benchmarks or measures.

Reporting of performance metrics is complicated by the disparate ways that JALFHCC data is collected and the multiple DoD and VA data systems and sources where JALFHCC data is stored. Unlike any other MTF or VAMC, JALFHCC workload and cost data is produced in two different agency systems, differently. Both DoD and VA headquarters leaders need to be able to view JALFHCC through the same lens that they view their other facilities. Lack of comparative performance information at JALFHCC has hindered decision making and improvement both within the facility and at higher headquarters.

JALFHCC held a Data Summit in August 2014 with the goal of bringing together subject matter experts from each Department in a collaborative environment to facilitate mechanisms to allow sharing and reporting of JALFHCC data across DoD and VA systems. The Data Summit initiated greater interagency collaboration, enhanced information exchange, and promoted further understanding between the Departments. In 2014, a contractor with specialized knowledge of data and operations at JALFHCC as well as DoD and VA healthcare data, worked to integrate/normalize DoD and VA data and develop meaningful metrics for use by JALFHCC leaders and managers so that they can target areas for improvement and drive success. The JALFHCC Advisory Board receives quarterly updates on this project. This project will also provide invaluable data to support development of a performance based budget described in the following section.

Budget/Funding

The JALFHCC is currently funded through the JMFDF with annual contributions from both DoD and VA. The JMFDF is currently set to expire on September 30, 2017. The annual budgets for JALFHCC are currently based on prior year costs plus an agreed upon inflation rate to determine the topline for the next budgeting period. The inflation rate has historically been a DoD blended rate. Each Department's contribution to the JMFDF is then based on the percentage of that Department's costs and workload as determined through the financial reconciliation process. The current budget process of prior year cost plus inflation does not account for performance. The Departments will explore options to **develop a performance-based budget --** leveraging the above work to integrate and normalize data on JALFHCC to develop performance metrics**--** to optimize cost efficiency and productivity. Additionally, the

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[4] Institute of Medicine of the National Academies (IOM), 2012. *Evaluation of the Lovell Federal Health Care Center merger: Findings, conclusions, and recommendations.* Washington, DC: The National Academies Press.

Departments will continue efforts to **develop an automated budget reconciliation tool** and will **explore options for the best future funding mechanism**.

Governance

The original vision for the JALFHCC was to establish a DoD and VA jointly owned and operated facility. However, in 2007, both DoD and VA Offices of General Counsel determined that joint ownership was not legally possible. Consequently, the JALFHCC is an expanded JV with very unique congressional authorities as described above. The common governance model with a single line of authority sets it apart from all other JVs, otherwise many of the JALFHCC's positive resource sharing features are replicated in other JVs. However, when JALFHCC integrated in 2010, both DoD and VA retained their unique systems, missions, leadership, and operating models. This resulted in JALFHCC leadership being held accountable to separate/unique Departmental priorities, goals, and associated business processes and systems with a complex oversight and reporting structure.

Currently, the JALFHCC reports to the VISN as a VA facility, to the Navy as a "pseudo" MTF, as well as to the JALFHCC Advisory Board, and the DoD/VA Health Executive Committee/Joint Executive Committee. Dual sets of standards and multiple reporting requirements add additional burden and complexity. See Figure 1 below. JALFHCC has a unique one-of-a-kind status that may not be fully understood across programs and offices of either Department nor how their specific programs and policies apply to the JALFHCC.

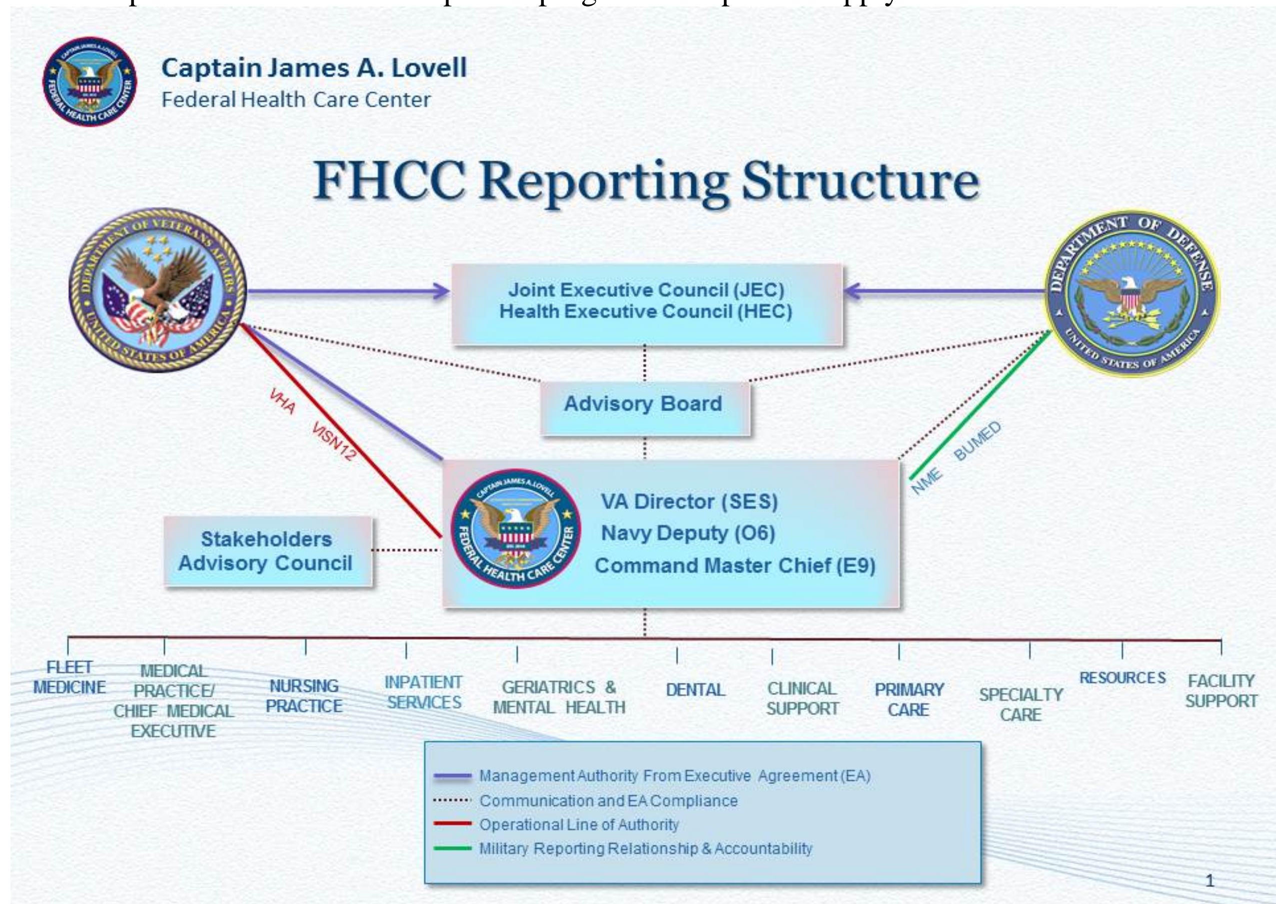

Figure 1

The Departments are **exploring changes to the reporting structure** to make it less burdensome for the site leadership, beginning with an **extensive review and revision of the EA and associated executive decision memoranda** (EDMs). This review should be conducted with the goal of reducing redundancies and clarifying interagency governance roles, responsibilities, and activities, as well as conflict resolution procedures. The revised EA should include language to strengthen and coordinate the selection and evaluation processes for the JALFHCC Director and Deputy Director by documenting how both Departments would be formally involved in these processes. Similarly, the Departments should conduct a review to **minimize or eliminate duplicate reporting policies and procedures** at JALFHCC. This will require the Departments to compromise in order to establish a standard process for JALFHCC and may involve revisions, waivers, or carve-outs of national policies.

The JALFHCC Advisory Board's role has evolved from in-depth tracking of operations, integration, and conflict resolution during the initial stages of the facility to more general oversight of an established and mature integrated facility. Consequently, **the Advisory Board charter should be revised** to re-define their evolved role of a more high level, monitoring, and decision-focused body.

Manpower

In 2010, approximately 470 civilian positions employed by NHCGL were transferred from the Navy into the VA's personnel system without the benefit of determinations of the total staffing requirements of the JALFHCC. Each organization merged existing staffs to form one team resulting in excessive labor costs and inefficiencies. The Departments plan to jointly conduct a **total force review** to validate the JALFHCC manpower requirements and adjust the military Activity Manpower Document and VA civilian organization staffing tables accordingly.

Military Readiness

In addition to providing care to military beneficiaries, DoD MTFs serve an essential role in maintaining the deployability of the Active Duty personnel they care for as well as ensuring the readiness of military medical personnel providing that care. The ability to deliver ready medical capabilities in time of conflict is highly dependent on the training and clinical currency of military medical personnel. MTFs are critical to providing these skills and competencies.

Like DoD MTFs, JALFHCC is committed to maintaining the health and deployability of the Active Duty personnel assigned to their care, with the additional, highly-expanded charge related to the approximately 40,000 Navy enlisted recruits. Additionally, JALFHCC must ensure that the Active Duty clinical staff assigned to JALFHCC remains current in their required clinical competencies. The contractor found that clinical experiences, particularly for physicians, appeared to have declined with integration. The Departments will implement a plan to **optimize the use of military staff** by establishing and monitoring military clinical currency measures, increasing clinical opportunities both internally and through external partnerships, establishing specific guidelines for enhanced utilization of corpsmen, and eliminating duplicate training requirements.

Quality Assurance

The quality oversight functions as documented in the EA state that the JALFHCC would follow VA quality guidelines and rules; however it did not delineate reporting timelines, requirements, or sharing of quality assurance (QA) data between the Departments to meet DoD-specific QA regulations. The Departments plan to **develop a detailed QA EDM** that outlines a timely QA inquiry review and response process between DoD and VA.

Acquisition & Logistics

Contracting, facilities management, and acquisition support is provided by the VA Great Lakes Acquisition Center, Naval Facilities Engineering Command, and VA Office of Construction & Facilities Management. JALFHCC is currently the pilot site for a Defense Medical Logistics Standard Support (DMLSS) project funded through an enterprise Joint Incentive Fund (JIF) award.[5] Both Departments will continue to **identify ways to make logistics and facilities management operations more efficient and effective**.

Pharmacy

JALFHCC reviews drug classes to make their DoD and VA formularies as similar as possible, but national DoD and VA formulary requirements prohibit a single formulary. JALFHCC has been added to all joint VA/DoD manufacturer contracts and therefore pays the same price as any DoD or VA facility would for these products. VA has also added JALFHCC to the VA-specific contracts and the JALFCC uses the VA prime vendor and VA procurement systems for purchasing pharmaceuticals; therefore, they also have access to VA-specific contracts. DoD has not added JALFHCC to its customer list, nor does the JALFHCC have access to the DoD procurement system; therefore they do not have access to DoD-specific contracts. However, the facility has been able to obtain DoD pricing for certain high-cost/high-use medications for patients seen on the East Campus through direct agreements with the manufacturer. Both Departments remain committed to **continued improvement of pharmacy formulary and drug pricing processes**.

Facilities

In conjunction with P.L. 111-84, VA issued Navy a 50-year land-use permit from 2007 until 2057. The Navy subsequently funded and built a new ACC contiguous to the NCVAMC, renovated existing NCVAMC space, and built a new parking garage and surface parking area on the existing NCVAMC property. **Navy has elected to retain jurisdiction, custody, control over, and continued use of these improvements.**

IM/IT

DoD and VA JALFHCC planners selected a common IM/IT services model for JALFHCC that utilizes both the legacy DoD and VA EHRs. The JIF program provided over $130 million to design and develop seven unique functionalities in place of a single EHR: Medical Single Sign-On with Context Management, Single Patient Registration, and Orders Portability for Radiology, Laboratory, Pharmacy and Consults as well as an automated reconciliation tool. Five of these

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[5] In January 2013, based upon a joint VA-DoD business case and JIF request, DoD/VA Health Executive Committee (HEC) approved a $23M enterprise JIF (eJIF) initiative to pilot DMLSS as a proof of concept for potential expansion to all VA.

seven functionalities were implemented. The two remaining functionalities are pharmacy orders portability and an automated financial reconciliation tool.

Pharmacy orders portability could not be completed due to numerous reasons to include patient safety concerns, legal issues, policy constraints, differing formularies and allergy and condition codes, as well as unforeseen pharmacy systems complexities that could not be resolved by developers. JALFHCC faced difficulties in implementing the EA's provision for an automated financial reconciliation tool, which would automate the manual processes used to produce financial reconciliation reports.

Both Departments agree that IM/IT at JALFHCC requires improvement. The current IM/IT model should remain in place at JALFHCC and **a POA&M has been developed** by the Departments to perform a gap analysis and make recommendations to improve the IM/IT model in its current state and future state, which will include a determination on pharmacy orders portability and an automated reconciliation tool. Efforts to improve the systems will continue, however the transition to a new EHR will limit financial investments in the long term.

Education & Training

Staff education and training was one of the first areas at JALFHCC to integrate; they operate from a single office and share all resources. While provider and support staff case volume, acuity, and opportunity has improved in some areas (specifically for enlisted staff), there has been markedly low surgical case volume, limited advanced clinical practice opportunity, and a decline in FTEE case workload. The Departments will conduct a **staffing study** to optimize the JALFHCC workforce and address the low surgical case volume and FTEE workload issues.

JALFHCC has an affiliation with the Rosalind Franklin University School of Medicine & Science/The Chicago Medical School and the University of Illinois at Chicago. There are 56 medical residents and over 300 medical students trained at JALFHCC each year. Residency/Fellowship training is in internal medicine, psychiatry, endocrinology, infectious disease, pulmonary medicine, cardiology, ophthalmology and dermatology. JALFHCC currently has 140 affiliation agreements with 95 different institutions across the country and 14 new agreements in various processing stages. Additionally, BUMED and JALFHCC have arranged a trauma program since 2014 at Cook County Hospital for Naval medical personnel to maintain some aspects of skills maintenance and training. The Departments will **improve involvement with the resident and student programs** to provide a richer learning environment.

Conclusions

Many of the challenges described in the findings section of this report show that the integrated model implemented at JALFHCC was an overreach as numerous systemic and infrastructure support issues were much harder and significantly more expensive than originally envisioned or estimated.

Reverting the JALFHCC to a JV model is neither advisable nor likely achievable. Instead, the Departments are committed to improving the processes and operations at JALFHCC and moving JALFHCC closer toward achieving its original goals of improving access to care; meeting military readiness standards; maintaining high patient and provider satisfaction; and increasing research and training opportunities.

The JALFHCC is currently maintaining 95% access to all clinics while satisfying fluctuating patient demands of the Navy's Recruit Training Command to support Navy mission of sending medically ready sailors to the fleet. The JALFHCC currently exceeds patient satisfaction monitoring standards by using DoD's Integrated Customer Evaluation, VA's Strategic Analytics for Improvement and Learning, Press Ganey, VA's Survey of Healthcare Experience of Patient, and the EA-mandated Stakeholder Advisory Council. Stakeholder and patient comments note high satisfaction with the care environment at the JALFHCC. The JALFHCC leadership and staff are committed to creating a long-lasting mutually beneficial partnership between the two Departments in North Chicago.

While JALFHCC's success in exercising congressionally-legislated authorities is the essential issue in this report, the contractor's report's comparison of JALFHCC against three mature JVs yielded invaluable information and insights into three areas:

1. Whether the JALFHCC model was more or less advantageous than non-integrated JVs.
2. Whether integration could or should be extended to other places.
3. What options are available to capitalize on lessons learned from the JALFHCC demonstration project and other JVs.

Further development and evaluation of the demonstration project is required in order to fully evaluate the overall effectiveness and efficiencies that may potentially be gained by implementing this model to other JVs. The Departments have concluded that future sites for integration should only be considered when, at a minimum, the following factors are fully addressed:

1. A viable IM/IT model for a FHCC model is developed and established.
2. Sufficient progress has been made to normalize DoD/VA healthcare data and development of appropriate measurable criteria for assessing performance of JALFHCC.
3. Criteria for selection of candidates in senior leadership positions for future sites have been carefully developed and implemented.
4. Sufficient Departmental policies have been reconciled and modified to reduce confusion and redundancies at or about the JALFHCC.
5. Criteria for selection of future sites and requirements for comprehensive market study and analysis has been established.
6. Data-driven strategic workforce planning is performed.

Recommendation

The Departments recommend continuation of the JALFHCC demonstration as an integrated facility with implementation of improvements as outlined in the "Findings of the DoD/VA Team Review" section of this report. The Departments will continue to monitor and oversee operations at JALFHCC via the JALFHCC Advisory Board and the HEC, performing periodic reviews and assessments to ensure that JALFHCC continues to make progress in achieving the EA goals.

ACRONYMS

ACC	Ambulatory Care Center
BRAC	Base Realignment and Closure
BUMED	Bureau of Medicine and Surgery
CARES	Capital Asset Realignment for Enhanced Services
DMLSS	Defense Medical Logistics Standard Support
DPMB	Demonstrable Positive Mutual Benefits
DoD	Department of Defense
DoN	Department of the Navy
EA	Executive Agreement
EDM	Executive Decision Memoranda
EHR	Electronic Health Record
FHCC	Federal Health Care Center (*generic*)
FTEE	Full Time Employee Equivalent
FY	Fiscal Year
GAO	Government Accountability Office
HEC	Health Executive Committee
iEHR	Integrated Electronic Health Record
IM/IT	Information Management/Information Technology
JALFHCC	Captain James A. Lovell Federal Health Care Center
JC	Joint Commission
JEC	Joint Executive Committee
JIF	Joint Incentive Fund
JMFDF	Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund
JPRS	Joint Patient Registration
JV	Joint Ventures
MSSO/CM	Medical Single Sign-On with Context Management
MTF	Military Treatment Facility
NCVAMC	North Chicago VA Medical Center
NDAA	National Defense Authorization Act
NME	Navy Medicine East
OMB	Office of Management and Budget
PE	Product Effectiveness
POA&M	Plan of Actions & Milestones
QA	Quality Assurance
VA	Department of Veterans Affairs
VAMC	VA Medical Centers
VHA	Veterans Health Administration
VISN	Veterans Integrated Services Network