MEMORANDUM FOR SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE
DIRECTOR, DEFENSE HEALTH AGENCY
NETWORK DIRECTORS (10N1-23)
VETERANS HEALTH ADMINISTRATION CHIEF OFFICERS

SUBJECT: Fiscal Year (FY) 2015 Department of Defense and Department of Veterans Affairs (DoD-VA) Joint Incentive Fund (JIF) Projects

The Health Executive Council (HEC) has approved the DoD-VA Health Care Sharing Incentive Fund proposals for FY 2015. Selected projects with approved funding are consolidated on the attached list in attachment (1). Projects that were not selected are shown at attachment (2).

Approved projects demonstrated a clear and convincing value proposition that was clearly aligned with the Joint Strategic Plan (JSP). Equally important, they showed great potential value in improving access, quality or safety measures; generating time or cost savings; creating productivity increases; and/or streamlining workflows.

Projects not accepted were also of high quality but did not communicate the same compelling value proposition. Although the project was not selected at this time, the proposal sponsors are encouraged to continue to provide innovative ideas for consideration by the JIF program in future submission cycle(s).

Funding for approved projects will be dispersed after the VA and DoD Project Managers have attended mandatory JIF project management training. Funds must only be used for the authorized scope of work associated with the approved JIF project. Excess JIF funds cannot be used for sustainment, and all excess funds should be promptly returned.

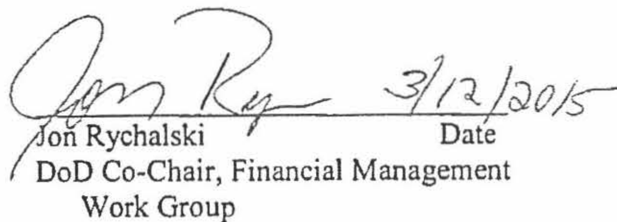
The HEC is responsible for ensuring the effectiveness and efficiency of the funded projects, including progress towards achieving the stated aims and results. To that end, Interim Project Reviews (IPRs) will be used for reporting this data. IPRs will be conducted for all FY 2015 approved projects. IPRs should be jointly prepared by each site and should reflect a brief but accurate assessment of the projects' accomplishments and limitations during the funding period. The initial IPR is due in the first quarter after JIF funding has been received, and quarterly thereafter throughout the funding period on the 15th of January, April, July and October using the template in attachment (3). The designated lead coordinator should forward the IPR electronically to Mr. Michael Gardner at michael.gardner2@va.gov and Ms. Mary Wessendorf at maritess.wessendorf.ctr@mail.mil via the appropriate Service Surgeons General representative and

VISN Sharing Coordinator. A final report must be completed within 30 days of the completion of the project using a template which will be provided at that time.

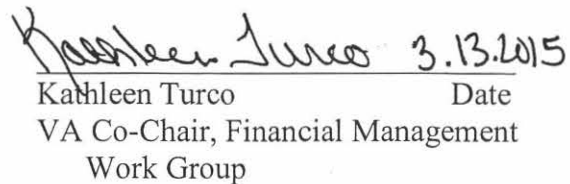
If a scope change is required (e.g., project will extend beyond two years from date funded or the project is decreasing or expanding), Project Managers must submit a change request package in attachment (4), including an impact assessment, to the Financial Management Work Group (FMWG).

If the approved project is not demonstrating successful implementation in terms of ROI, not implementing the original scope of work a timely fashion, or not meeting performance objectives to improve access, quality, or safety, the FMWG co-chairs may end the JIF initiative. The program managers may be advised to close their project and return unobligated and undispersed funds within 90 days.

For further information and questions, Ms. Mary Wessendorf may be reached at (703) 681-8812.



Jon Rychalski Date
DoD Co-Chair, Financial Management Work Group



Kathleen Turco Date
VA Co-Chair, Financial Management Work Group

Attachments:
As stated

FY 2015 JIF Projects Selected for Funding

Location/ Title	JIF Code	Service	VISN	Cost
Air Force Medical Support Agency/VISN 23 Tele-ICU Center, Minneapolis, MN (VA Midwest Healthcare Network) *(Tele-Intensive Care Unit)*	15175	Air Force	23	$4,955,000
60th Medical Group Travis/Northern California Veterans Affairs Health Care System *(Medical Surgical Bed Expansion)*	15173	Air Force	20	$2,096,000
96th Medical Group Eglin/Gulf Coast Health Care System *(Orthopedic Spine Care)*	15174	Air Force	16	$1,117,000
Walter Reed National Medical Military Center/Martinsburg VAMC *(Tele-Neurosurgery)*	15182	CAPMED	5	$2,488,000
Naval Medical Center Portsmouth/Hampton VA Medical Center *(Continuity of Psychiatric Care)*	15180	Navy	6	$2,682,000
Naval Hospital Beaufort/ Ralph H. Johnson Charleston VA Medical Center *(Physical Therapy)*	15179	Navy	7	$918,000
Naval Medical Center San Diego/San Diego Veterans Affairs Health Care System (SDVAHCS) *(Physical Therapy)*	15181	Navy	22	$8,421,000
DoD/VA National *(Joint Centralized Credentials Quality Assurance System 2)*	15177	N/A	N/A	$9,200,000
DoD/VA National *(Safety Event Reporting System)*	15178	N/A	N/A	$7,300,000
DoD/VA National *(Interagency Care Coordination Committee Training)*	15176	N/A	N/A	$3,150,000
Total				**$42,327,0000**

Attachment 1

FY 2015 JIF Projects Not Selected for Funding

Location/ Title	Service	VISN	Cost
DoD/VA National *(E-Clinic) This project did not achieve the minimum score for selection based on established scoring criteria.* <u>Feedback:</u> There is no parametric method to bound the cost to completion of this proposal. The proposal presumes a non-trivial amount of clinical staff and beneficiary time spent in the market research, training development and implementation activities; which may lead to productivity losses in clinic during the duration of the project.	N/A	N/A	$3,632,000
DoD/VA National *(Insomnia Tele-Health) This project did not achieve the minimum score for selection based on established scoring criteria.* <u>Feedback:</u> Insomnia Tele-health appears to be another potential mental health training initiative that needs to be piloted and assessment should first be completed as this is a nation-wide project. Such projects should not be theoretical/literature based.	N/A	N/A	$2,216,000
DoD/VA National *(Joint Use Market Planning Portal) This project did not achieve the minimum score for selection based on established scoring criteria.* <u>Feedback:</u> The risks and uncertainties faced by this proposal include the frequency of utilizing this tool instead of developing a strong periodic report(s) using available data for geospatial, quadrant analysis, etc. to provide to the work groups that conduct facility planning and research/establish sharing opportunities. This tool needs to be de-conflicted with other data tools used by DHA HIT/Analytics.	N/A	N/A	$1,811,000
Walter Reed National Military Medical Center/Martinsburg VAMC *(Tele-Vascular) This project did not achieve the minimum score for selection based on established scoring criteria.* <u>Feedback:</u> Data is measureable but more refined metrics are needed, e.g., what % of VA PC costs are expected to be recovered? What is the projected workload increase?	CAPMED	5	$1,982,000
Walter Reed National Military Medical Center/Martinsburg VAMC *(Tele-Pain) This project did not achieve the minimum score for selection based on established scoring criteria.* <u>Feedback:</u> Additional ROI could not be quantified (like decrease opioid dependency, less patient visit to ER, patient decompensation decreasing, decreasing number of visits, savings from successful transition of patients from DoD to VA). ROI did not forecast the increase in DoD and VA intervention pain procedures that are likely to increase once DoD and VA Tele-Pain expands. DoD will continue supporting their assets and most of the VA costs are most equipment supply costs.	CAPMED	5	$1,947,000
Walter Reed National Military Medical Center/Martinsburg VAMC *(Women's Health) This project did not achieve the minimum score for selection based on established scoring criteria.* <u>Feedback:</u> Benefits may be overstated; more clarity would need to be provided on the DC VAMC workload projection. 49% percent of the ambulatory care estimate of projected recapture accrues from both Non-Active Duty (AD) and Other beneficiary categories. However, unless significant programs are implemented to redirect their utilization behavior, those two categories of beneficiaries would exhibit the least propensity to be recaptured as compared to AD and AD Dependents. Similarly, the inpatient care recapture estimate projects 47.5% of the recapture from those same beneficiary categories. This benefit appears to be overstated by: 1) not limiting to PSC performed within catchment area, 2) not considering enrollment status of the consumers of PSC, and 3) not considering what additional costs might be necessary to stimulate the recapture of the Non-AD and Other beneficiaries.	CAPMED	5	$1,748,000
Total			**$13,336,000**

Attachment 2