EXECUTIVE AGREEMENT
FOR THE DEPARTMENT OF DEFENSE–DEPARTMENT OF VETERANS AFFAIRS
MEDICAL FACILITY DEMONSTRATION PROJECT
FEDERAL HEALTH CARE CENTER

I. INTRODUCTION: In accordance with § 8111 of Title 38, United States Code (hereafter "§ 8111"), § 1104 of Title 10 (hereafter "§ 1104"), § 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year (FY) 2009 Public Law (P.L.) 110-417 (hereafter "NDAA 2009"), and §§ 1701-1706 of the National Defense Authorization Act for FY 2010 P.L. 111-84 (hereafter "NDAA 2010"), this document is the agreement between the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to integrate Naval Health Clinic Great Lakes (hereafter "NHCGL") and North Chicago VA Medical Center (hereafter "NCVAMC") and operate a system of healthcare known as the DoD/VA Medical Facility Demonstration Project, Federal Health Care Center (hereafter "FHCC"). This Executive Agreement (EA) authorizes the FHCC to provide health care services to VA and DoD beneficiaries, consistent with applicable policies of both Departments. To meet the requirement of Title 38 to ensure mission accomplishment for both departments in this VA DoD integration, the FHCC will support both VA/DoD Healthcare and DoD Operational readiness missions.

Participant Departments:

Department of Defense
The Pentagon
Washington, DC 20001

Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Department of Navy (DON)
The Pentagon
Washington, DC 20350

Participant Organizations:

Naval Health Clinic Great Lakes and the North Chicago VA Medical Center.

II. EXECUTIVE SUMMARY: This document is the formal agreement between the DoD and the VA regarding the standup and operation of the FHCC located in North Chicago, Illinois, and Great Lakes, Illinois.

A. **Overview**. This unique VA/DoD effort will operate under a single line of authority to manage VA and DoD medical and dental care provided by the FHCC in North Chicago and Great Lakes while meeting the unique missions of DoD and VA. The FHCC is designed to improve access, quality, and cost effectiveness of health care delivery for the

beneficiaries of the NHCGL and NCVAMC and to promote continued beneficiary access to care, operational readiness, continued employee benefits, continued education of health care professional trainees, and approved research projects, and to provide the FHCC leadership with the ability to access the most efficient clinical and administrative processes.

B. **Integrated System.** The FHCC will integrate management of the services currently provided by NCVAMC and its community based outpatient clinics, the newly constructed Naval Ambulatory Care Center located on the NCVAMC campus, and the Navy Fleet Medicine clinics associated with Naval Station Great Lakes (i.e., Recruit Training Command (RTC) and Training Support Center (TSC)) into a single health care delivery system. The Navy Fleet Medicine clinics will continue as military treatment facilities, serving military personnel, and its real and personal property will remain under the governance of US Navy. Extensive sharing of resources within the FHCC will continue in accordance with § 8111 and § 1104.

C. **Transfer of Functions.** The FHCC will combine the missions of both the NHCGL and NCVAMC into a single organizational structure incorporating a unified line of supervision, single medical and dental staff, and single clinical (e.g. Medicine, Surgery, Psychiatry), and, to the extent feasible, administrative support departments (e.g. Fiscal, HR, Patient Administration). Through an intended transfer of function (ToF) from the Navy to the VA of health care delivery at the Naval Ambulatory Care Center, the FHCC will feature an integrated staff. The NHCGL Commanding Officer has determined that the effective operation of the Naval Ambulatory Care Center includes the ability to move staff between all locations of the FHCC in order to:

- Accommodate fluctuating workload driven by recruit and student volume.
- Accommodate training opportunities for both staffs, in particular Navy staff, who will be able to maintain current competencies in all aspects of the continuum of care from recruit processing to primary care, specialty care, acute care including surgery, ER, inpatient and ICU.
- Provide coverage in the event of deployment and other staff shortages.
- Provide seamless continuity of care from the recruit and student clinics, to the ER, subspecialty care, inpatient care, etc. through one integrated health care facility with one clinical and administrative staff reporting through a single chain of command.
- Support the FHCC training and education mission.

III. PROPERTY TRANSFER AND REVERSION PROCEDURES: If with respect to the Naval Ambulatory Care Center it is determined a property transfer or reversion is warranted, the transfer or reversion process as authorized in NDAA 2010, § 1702 will apply.

IV. MISSION: The mission of the FHCC is to provide comprehensive, compassionate, patient-centered care to VA and DoD beneficiaries while supporting the highest level of operational readiness. Subsidiary missions include education and research in support of beneficiary health care.

V. BACKGROUND: This EA is the culmination of a comprehensive VA/DoD planning process that required legislative and policy solutions to allow the NCVAMC and the NHCGL to integrate as the FHCC. Attachment A details sections of the EA.

VI. PURPOSE: This EA serves to define the relationship between DoD and VA in the operation of the FHCC. The agreement provides for, but is not limited to, nine specific areas authorized by NDAA 2009, § 706 (Governance, Patient Priority Categories, Budgeting, Staffing & Training, Construction, Physical Plant Management, Contingency Planning, Quality Assurance, and Information Technology) and specific areas authorized by NDAA 2010, §§ 1701 to 1705 (§ 1701 Demonstration Project Authority, § 1702 Transfer of Property, § 1703 Transfer of Civilian Personnel of the Department of Defense, § 1704 Joint Funding Authority, § 1705 Eligibility of members of the Uniformed Services for Care and Services).

A. **Governance**: The authorities for establishing the FHCC are NDAA 2010, § 8111, and § 1104 with the requirement to meet the missions of VA and DoD. The VA is identified as the lead partner. Lead partner is defined as the Department with the ultimate responsibility for fulfillment of the FHCC mission and accountability for the operation of the FHCC. A VA Senior Executive Service (SES) appointee will serve as Director with line authority and responsibility for executive level management of the FHCC. The DoD is identified as the other partner. Other partner is defined as the Department accountable for supporting the fulfillment of the FHCC mission and daily operations of the FHCC. This agreement recognizes that a DON Captain (O6) will serve as the Deputy Director who is accountable to the Director for the day-to-day operation of all components of the FHCC. Additionally, the Deputy will be the senior military officer and will maintain authority for Uniform Code of Military Justice (UCMJ) administration.

   The FHCC Director and Deputy Director are accountable to their respective agencies for the fulfillment of the FHCC mission.

   The FHCC Advisory Board, operating under a charter from the VA/DoD Health Executive Council (HEC) and co-chaired by VA and DoD representatives, will serve as a forum for discussing issues related to this EA. Issues that are unable to be resolved through the Advisory Board will be referred up the Navy Medicine and VA chains of command for resolution at the appropriate level with final resolution at the HEC.

   For the purpose of the Inspector General (IG) Act of 1978, as amended, the FHCC will be considered a VA program and operation and all records will be considered VA records. The VA Office of Inspector General (OIG) is designated as the primary OIG for oversight of the FHCC including IG investigations, audits, inspections, and/or reviews, including those involving quality of care issues. The VA OIG will consult with the DoD OIG on matters of mutual interest and will refer matters to DoD OIG (including Naval

Criminal Investigative Service (NCIS)) that are outside jurisdiction of VA OIG. Nothing in the paragraph shall be construed as limiting the authority of the DoD IG.

Additional information: Attachment A, Section 1.

B. **Eligibility for Health Care at the FHCC:** For purposes of eligibility for health care under Chapter 55 of title 10 U.S.C., access to health care services at the integrated NCVAMC/NHCGL by DoD beneficiaries will be subject to any resource limitations established by DoD. Under Chapter 55, with the exception of active duty members, eligibility of other DoD beneficiaries is on a space-available basis, which, in turn, is a function of available resources. DoD/DON will annually project space-availability for DoD beneficiaries based on available DoD resources, including funding and non-monetary (i.e., staffing) resources to be contributed to FHCC operations. All necessary active duty care will be resourced by DoD/DON. Projections will reflect that services for dually eligible beneficiaries (those eligible under both 38 U.S.C., and Chapter 55 of 10 U.S.C.) will be resourced by DoD and VA in accordance with the agreed upon Reconciliation model. Active Duty members and Active Duty dependents enrolled in TRICARE Prime pay no co-payments for inpatient or outpatient health care services. DoD may establish special co-pay rules for the FHCC under demonstration project authority of 10 U.S.C. § 1092 for other beneficiaries.

The medical services and benefits available to Veterans and non-Veteran VA beneficiaries are as authorized by Chapters 17, 18, and 31 of 38 U.S.C.

Dual-eligible beneficiaries will be able to choose their VA or DoD benefit at each episode of care in accordance with existing Laws and Departmental Regulations. The Reconciliation Methodology will allocate cost to the respective Department based on the authority of care for each episode of care to the extent possible.

1. **Patient Priority:** The FHCC may serve all eligible beneficiaries, subject to resource and space availability limitations. Based on availability of resources, DoD may establish limits by beneficiary categories consistent with the DoD priority system. Medical emergencies will be given treatment preference. The priority of care for DoD eligible and sponsored beneficiaries is defined in 32 Code of Federal Regulations (CFR) 199.17(d)(1)(a)-(e). Access to care standards for DoD TRICARE Prime beneficiaries are defined by 32 CFR 199.17(p)(5)(ii).

   In the case of resource constraints, patient priority for treatment will be as follows:
   (1) members of the Armed Forces on Active Duty (consistent with NDAA 2010, § 1705(b)(1)),
   (2) all Veterans and non-Veteran VA beneficiaries subject to applicable enrollment and eligibility requirements and TRICARE Prime enrolled Active Duty dependents,
   (3) TRICARE Prime enrolled retirees, their dependents and survivors,
   (4) TRICARE Standard Active Duty dependents,

(5) TRICARE Standard retirees, their dependents, and survivors (including TRICARE for Life beneficiaries).

2. **Additional Elements:** Due to the unique mission of the Naval Training Center Great Lakes, routine monitoring and reporting is required to ensure that healthcare management programs and strategies at the FHCC maintain the enlisted "pipeline to the Fleet."

   In the event of a reduction of a significant number of civilian or uniformed personnel, the FHCC will continue to follow both Navy and VA access standards. If resources at the FHCC cannot accommodate the demand, the FHCC will employ all available options to ensure the operational readiness and healthcare missions are not compromised. This may include redirection of VA and/or DoD patients to their respective networks applying the patient priority for care as provided above.

C. **Fiscal Authority:**

1. **Funding:** As authorized in NDAA 2010, § 1704, a Joint Medical Facility Demonstration Fund (JMFDF) will be established on the books of the Treasury under VA. The Secretary of Defense, in consultation with the Secretary of the Navy, and the Secretary of Veterans Affairs shall jointly provide for an annual independent review of the JMFDF for at least three years of FHCC operations. Such review shall include detailed statements of the uses of amounts of the JMFDF and an evaluation of the adequacy of the proportional share contributed to the JMFDF by each of the Secretary of Defense and the Secretary of Veterans Affairs. This review will include detailed statements of the uses of the accounts of the JMFDF and an evaluation of the adequacy of the proportional share contributed to the JMFDF by each Secretary. This funding authority shall terminate on September 30, 2015.

2. **Budgeting:** A JMFDF, as defined in NDAA 2010, § 1704, will be the funding mechanism for the FHCC, to the extent allowed by law. The JMFDF will allow both VA and DoD to contribute funds to manage the FHCC and will include amounts from DoD's Defense Health Programs, Operations and Maintenance and Procurement when authorized and appropriated for that purpose and VA's three health care appropriations (Medical Services, Medical Support and Compliance, and Medical Facilities), the Information Technology (IT) Systems appropriation and the Construction, minor projects appropriation. DoD appropriations for military personnel, research and development, and military construction are not available fund sources for contributions to the JMFDF. It will not contain contributions from the VA Construction, major projects appropriation.

   Generally funds transferred to the JMFDF shall be available to fund FHCC operations including capital equipment, real property maintenance, and minor construction projects that are not required to be specifically authorized by law under 10 U.S.C. § 2805, or 38 U.S.C. § 8104. The FHCC will use agreed upon historical execution data as a baseline for VA's and DoD's/Bureau of Medicine and Surgery (BUMED)'s

funding contribution for the first three years of operation (FY 2011-2013). The transfers to the JMFDF, regardless of the source of contributing appropriation, will be available for obligation for the remainder of the fiscal year of the transfer with not more than two percent of the transfer being available for obligation during the next fiscal year.

As the JMFDF will be an account in the Treasury under the VA, the VA shall establish funds control mechanisms that conform to the statutory fund availability requirements of NDAA 2010, § 1704(b), and the DoD and VA agree to endeavor to schedule contributions to minimize staggered legal periods of availability of amounts within the fund that will result from multiple transfer contributions into the JMFDF within a single fiscal year.

3. **Reconciliation:** As authorized in NDAA 2010, § 1704, an integrated financial reconciliation process shall be developed and implemented that meets the fiscal reconciliation requirements of the DoD, DON, and VA, and that permits each to identify their fiscal contributions to the JMFDF, taking into consideration their respective accounting, workload, and financial management differences. The integrated financial reconciliation process established as provided in section 2.b of attachment A will reflect accepted health care industry standards, such as Centers for Medicare & Medicare Services standards.

   It is understood that any major changes to funding which impact daily clinical operations will be reconciled on an expedited basis to prevent anti-deficiency violations and/or decrement of care.

4. **Other Health Insurance:** Consistent with NDAA 2010, § 1704, amounts collected from medical care collections under the authority of 10 U.S.C. § 1095, 38 U.S.C. § 1729, and P.L. 87-693, popularly known as the "Federal Medical Care Recovery Act," (42 U.S.C. § 2651 et seq.) will be transferred to the JMFDF.

5. **Alternative Funding Mechanism:** In the event that Congress does not authorize and appropriate funds specifically for the purpose of transfer to the JMFDF as provided in NDAA 2010, § 1704(a)(2), or if the JMFDF is otherwise unavailable to support the FHCC in any year, FHCC shall be supported by an alternative funding mechanism, consistent with 38 U.S.C. 8111 and other applicable law. Under such alternative mechanism, DON will transfer on a quarterly basis to VA amounts calculated and subject to reconciliation and other terms comparable to the extent practicable with the JMFDF.

Additional information: Attachment A, Section 2.

D. Workforce Management and Personnel Issues:

1. **Staffing:** A combination of civilian, military and contract personnel will staff the FHCC. The VA personnel systems will be the primary systems used for General Schedule (GS) and Title 38 civilians within the FHCC including the appropriate VA pay and performance evaluation systems under title 5 and title 38/Hybrid 38. A title 38 and Hybrid 38 Professional Standards Board process will occur for DoD personnel transferring into title 38/Hybrid 38 positions. To meet mission requirements as described in NDAA 2010, § 1703, DoD will employ civilian personnel at the FHCC; examples will include but are not limited to legal officers and Information Management (IM) IT personnel. For these GS civilian personnel, DoD personnel systems (subject to adjustments as otherwise authorized by law) will be used.

   Decisions made regarding the manpower allocation for the total force (i.e., active duty, reserve, federal civilian and contractor personnel) will be aligned and allocated based on mission, function, task, work center and other factors as appropriate. The VA and DoD will work together to define mechanisms that will provide necessary information to comply with military manpower requirements and other required reporting systems. Specifics of these reports and other identified needs for sharing information will be defined in an appropriate Executive Decision Memorandum (EDM).

2. **Transfer of Civilian Personnel:** As authorized by NDAA 2010, § 1703, and in accordance with the Office of Personnel Management (OPM) ToF regulations derived from 5 U.S.C. § 3503, the Secretary of Defense may transfer to the VA functions and the associated civilian employees necessary for the effective operation of the facility, as defined in NDAA 2010 § 1702(a)(1), and the Secretary of Veterans Affairs may accept this ToF and incumbent employees. Pursuant to § 1703(b)(2)(A), the DoD civilian employee positions eligible for transfer are identified at Attachment B. In order to facilitate integrated health care operations at the FHCC, it is the intent of DoD and VA to execute a transfer of eligible civilian personnel on or about October 10, 2010, contingent upon completion of all necessary conditions of the ToF. Additionally, transfer will be contingent upon establishment of a BUMED/Veterans Health Administration (VHA)/DON Workforce Management and Personnel Plan completed by May 15, 2010 that will be the basis of an EDM sufficient for building, validating, tracking and reporting of total work force requirements and execution for Uniformed military, Federal civilian, and contractor personnel.

   The Workforce Management and Personnel EDM will contain, at a minimum, assurances that the administrative processes and integrated data systems/exchanges are established and in place to support joint DoD and VA workforce management reporting and justification requirements. The Workforce Management and Personnel EDM will be completed and approved by July 31, 2010.

   The transition of transferred employees to VA's personnel systems of pay and benefits will not result in any reduction in regular rate of compensation or creditable

service. Employees converted to title 38/Hybrid title 38 under the ToF who have successfully completed a one year probationary period under title 5 will be considered to have completed the required probation period. Employees who are converted to title 38 under the ToF who are in the process of completing a title 5 probation period will receive credit for their service toward completion of their probationary period. Their probationary period will be the one year required under 5 U.S.C. Completion of this one-year probationary period will satisfy the probationary period requirement under 38 U.S.C. §7403(b)(1). Employees reassigned under the ToF from a DoD title 5 position to a VA title 5 position, who have already completed a probation period, will not incur another probation period. Employees in this category who are in the process of completing a one-year probation will be given credit toward the completion of a one year probation period.

In accordance with NDAA 2010, § 1702(b)(2)(C), if it is determined a reversion is warranted, VA and DoD agencies will develop a plan to revert (i.e., transfer back from VA to DoD) associated functions including appropriate resources, civilian positions, and personnel, in a manner that will not result in adverse impact to the missions of either DoD or VA.

3. **Active Duty:** A continued, robust active duty staff is critical to the long-term success of the FHCC. Active duty staff stationed at the FHCC will be held to the same standards of Sailorization as the fleet. Uniformed members will be deployable as directed by higher authority. All members will be subject to UCMJ and any other military policies and directives.

4. **Staff Training:** All VA and DoD required training and staff orientations including emergency preparedness will be conducted. Operational military readiness training will be maintained for all military personnel. Advance notice of operational readiness training and arrangements for appropriate coverage of clinical units will be made to ensure that patient care is not adversely impacted by this training. Information Security (IS) (including Privacy Act Training) & Information Assurance (IA) required training (as prescribed by current policy) will be provided to all individuals working at the FHCC before they are granted access. Such training must be completed on an annual basis.

5. **Deployment**: In the event of deployment of a significant number of uniformed personnel, the FHCC will continue to follow both Navy and VA access standards. If resources at the FHCC cannot accommodate the demand, the FHCC will employ all available options to ensure the operational readiness and healthcare missions are not compromised. This may include redirection of VA and/or DoD patients to their respective networks applying the patient priority for care as provided above.

Additional information: Attachment A, Section 3.

E. **Property Issues:**

1. **Construction:** The DON may retain ownership of the newly constructed Naval Ambulatory Care Center and parking structures and related personal property purchased with DoD MILCON funds on VA property. Dollar thresholds contained within OPNAVINST 11010.20G and normal Commanding Officer authority limits for BUMED facilities for Defense Health Program (DHP) Operations and Maintenance (O&M) projects will be maintained. If the DON transfers to VA ownership of the Naval Ambulatory Care Center and parking structures and related property purchased, VA project planning process and authority limits will be followed. MILCON-funded alteration projects constructed in VA space are considered VA property. For this purpose, construction at the FHCC is defined as altering, extending, or improving the facility.

2. **Transfer of Property:** In accordance with NDAA 2010, § 1702, the Secretary of Defense may transfer, without reimbursement, to the Secretary of Veterans Affairs jurisdiction, custody, and control over the new Navy ambulatory care center, and parking structures to include real and related property and equipment. The DoD may, to the extent allowed by applicable regulations (or authorized exceptions to such regulations), transfer NHCGL DON-owned and purchased related personal property for use at the FHCC out of the DoD tracking system into the VA equipment tracking system. Transfer of ownership of real and personal property may not occur prior to the date specified in § 1702(a)(2) of NDAA 2010. The specific benchmarks referred to in that section (completion of these benchmarks, as agreed upon by the DON and VA, would allow transfer of property before five years after the date of this agreement) are set forth at Attachment A. If it is determined a reversion is warranted, VA and DoD agencies will develop a plan to revert associated functions including appropriate resources in a manner that will not result in adverse impact to the missions of either DoD or VA and will occur without reimbursement to the Secretary of Veterans Affairs.

   Dollar thresholds contained within OPNAVINST 11010.20G and normal Commanding Officer authority limits for BUMED facilities for Defense Health Program (DHP) O&M projects will be maintained for all DON-owned property. Should the DON transfer jurisdiction, custody, control and accountability of real property improvements constructed with DoD MILCON funds to VA, funding limits will adhere to VA's Non-Recurring Maintenance and Minor Construction programmatic guidelines.

   In future planning projects if DON retains jurisdiction, custody, control and accountability of real property improvements constructed with DoD MILCON funding, the established DON BUMED project planning process must be followed. If DON transfers jurisdiction, custody, control and accountability of real property improvements constructed with DoD MILCON funds to the Department of VA, VA project planning process must be followed.

Recapitalization costs of buildings owned by DON will be paid by the DHP. The FHCC Leadership will work with BUMED to program and budget for such costs. If DON transfers building ownership to VA, VA will assume recapitalization costs. Recapitalization costs of buildings owned by VA will be paid by VA.

When planning future major construction on the FHCC, the funding source (DoD or VA) will determine which process is followed. For agreed upon wide-based infrastructure upgrades VA, through the financial reconciliation process, will be the host and will receive DoD funding to the extent authorized by law. In the event there are differences in construction criteria, the more stringent requirement will govern.

3. **Physical Plant Management:** The Department owning the real property retains overall recapitalization responsibility for that property. Physical Plant Management at the FHCC is the recurring, day-to-day, periodic or scheduled maintenance or repair required to preserve or return a facility to such a condition that it may be used for its designated purpose. The FHCC will be responsible for this maintenance.

F. **Contingency Planning**: The FHCC will follow VA and DoD guidelines for all emergency and disaster planning including but not limited to IT Contingency Planning.

Additional information: Attachment A, Section 4.

G. **Quality Assurance**: The FHCC will have one integrated quality-assurance plan that will follow designated Quality Assurance (QA), patient safety, and risk management requirements of VA and Navy while also recognizing the unique requirements of both Departments. The FHCC Director will acknowledge and allow duly authorized investigative teams and personnel access to the FHCC in order to conduct required reviews. Both Departments will work together to minimize duplicative inspections. The FHCC will maintain accreditation by all external accrediting bodies required by either Department, including but not limited to The Joint Commission, Nuclear Regulatory Commission, College of American Pathologists (CAP), and Commission on Accreditation of Rehabilitation Facilities. Additionally the FHCC is subject to oversight inspections by BUMED Medical Inspector General (MEDIG), VA OIG, VHA Medical Inspector, DON Inspector General (IG) and DoD IG.

The VA OIG will have primary responsibility under the IG Act for conducting oversight, monitoring, and evaluation of FHCC's quality-assurance programs and operations, including quality of care delivered to FHCC's patients. In order to ensure that reviews are conducted according to the appropriate standard, VA OIG will be informed regarding areas of review where the FHCC has pre-elected (with concurrence of the VHA Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs) to follow DoD/DON standards.

All quality-assurance records will be considered VA records for the purposes of the IG Act. Copies of all reports, recommendations, and findings will be provided to BUMED Risk Management or MEDIG upon request.

The FHCC will allow VA Office of Information and Technology (OI&T) Oversight and Compliance Team, Defense Information Systems Agency, and DON Naval Network Warfare Command, to perform regular assessments of IT Operations, Information Security, Privacy, Records Management and Research Security.

FHCC credentialing and privileging of all healthcare providers assigned to the FHCC will be approved by the FHCC Director as the sole designated privileging authority. All active duty health care professionals will maintain Navy clinical privileges, as approved by the Deputy Director at the FHCC, for operational and readiness purposes only.

Additional information: Attachment A, Section 5.

H. Information Issues:

1. **Information Management/Information Technology:** Information systems at the FHCC will exchange information to the greatest extent permitted by VA and DoD. The Electronic Medical Record (EMR) and financial/personnel computer systems include but are not limited to: Veterans Health Information System and Technology Architecture (VistA)/ Computerized Patient Record System (CPRS) and Composite Health Care System (CHCS)/Armed Forces Health Longitudinal Technology Application (AHLTA), Defense Medical Human Resources System, Internet (DMHRSi) Financial Management System (FMS), and Decision Support System (DSS), or subsequent systems, will be used at the FHCC. The responsibility to deliver capabilities and provide on-going IM/IT oversight and problem resolution for the FHCC will be overseen by the HEC with support from the VA-DoD Interagency Program Office, Military Health System (MHS) IM/IT, VA OI&T, and VHA Office of Finance. Acquisitions, upgrades or modifications to enterprise systems will maintain the interoperability and functionality at the FHCC. All applications, systems, and associated networks will be maintained and funded by the respective Department.

2. **Privacy, Confidentiality:** The FHCC will comply with all applicable privacy and confidentiality statutes, regulations, and guidance, including but not limited to the Privacy Act, 5 U.S.C. § 552a; 38 U.S.C. §§ 5701, 5705, and 7332; the Health Insurance Portability and Accountability Act Privacy Rule, 45 C.F.R. Parts 160 and 164; Executive Orders; National Security Directives; and Office of Management and Budget Circulars. Information protected by statute or regulations will be disclosed only if specifically authorized under all applicable legal authorities.

3. **Information Security/Information Assurance:** The FHCC will comply with all applicable provisions of the Federal Information Security Management Act, P. L. 107-347, 116 Stat. 2946 (2002); 38 U.S.C. §§ 5721-5728; the HIPAA Security Rule, 45 C.F.R. Parts 160, 162, and 164; Executive Orders; National Security Directives; Office of Management and Budget Circulars; and other information security and

privacy standards and requirements as established by the National Institute of Standards and Technology, DON, DoD, and VA.

Additional information: Attachment A, Section 6.

I. **Research:** The FHCC will comply with VA policy, including approval by the National Independent Review Board (IRB), as required for research projects. When DoD researchers or patients are involved in a study, Navy protection of human subjects regulations and policy will be followed in addition to VA regulations.

J. **Integration Benchmarks**: As authorized in NDAA 2010, § 1702, BUMED, Navy Medicine East (NME), and VA have agreed to Benchmarks to define the degree of integration success. Completion of these benchmarks, as agreed upon by the DON and VA are the determinants for possible property transfer from the Secretary of Defense (in consultation with the Secretary of the Navy) to the Secretary of Veterans Affairs in fewer than five years after the date of this agreement.

Additional information: Attachment A, Section 7.

K. **Reporting Requirements**: As authorized in NDAA 2010, § 1701(d):

1. **Notice on Agreement**: Not later than seven days before executing this executive agreement, the Secretary of Defense and the Secretary of VA shall jointly submit to the appropriate committees of Congress (as defined in NDAA 2010, § 1701(f): the Committees on Armed Services and Veterans' Affairs of the Senate; and Committees on Armed Services and Veterans' Affairs of the House of Representatives), a report setting forth a copy of this executive agreement.

2. **Final Report**: Not later than 180 days after the fifth anniversary of the date of the execution of this executive agreement, the Secretary of Defense and the Secretary of VA shall jointly submit to the appropriate committees of Congress a report on the exercise of the authorities in NDAA 2010. The report shall include the following:
   a. A comprehensive description and assessment of the exercise of the authorities in NDAA 2010.
   b. The recommendation of the Secretaries as to whether the exercise of the authorities of NDAA 2010 should continue.

3. **Comptroller General Reviews**: Not later than one year after the execution of this executive agreement and annually thereafter, the Comptroller General is required by law to conduct a review and assessment of:
   a. The progress made in implementing this agreement.
   b. The effects of the agreement on the provision of care and operation of the facility.

   Reports: Not later than 90 days after the commencement of each review and assessment, the Comptroller General is required to submit to the appropriate

committees of Congress a report on such review and assessment. Each review shall set forth:

i. The results of such review and assessment.
ii. Such recommendations for modifications of this executive agreement, or the authorities in NDAA 2010, as the Comptroller General considers appropriate in light of the results of such review and assessment.

4. **Modified Policies, Practices and Procedures**: Any agreement to significantly modify pre-existing VA and DoD policies or to change major practices and procedures will be made in the form of an EDM. Such EDMs will be reviewed by the FHCC Advisory Board. EDMs will be submitted to the HEC for review and approval.

L. Contracting: VA is responsible for contracting support for the FHCC. Subject to the availability of authority under 10 U.S.C. § 1091, DoD retains responsibility for any personal services contracts that it determines are necessary to staff the facility.

VII. AUTHORITY: NDAA 2010 (P.L. 111-84), §§ 1701 – 1705; NDAA 2009 (P.L. 110-417), § 706; 38 U.S.C. § 8111; 10 U.S.C. § 1104.

VIII. EXEMPTIONS: The FHCC is exempt from 38 U.S.C. § 8111(e)(2) and (3) to the extent required by this agreement.

IX. EFFECTIVE DATE, TERMS OF MODIFICATION AND TERMINATION: In accordance with NDAA 2010, § 1701, this Executive Agreement becomes effective October 1, 2010 unless the parties specify earlier dates for specific portions of the agreement. In accordance with NDAA 2010, § 1701, the Secretary of Defense, in consultation with the Secretary of the Navy and the Secretary of Veterans Affairs shall execute this signed EA for the joint use by DoD and VA not later than 180 days after the date of the enactment of NDAA 2010, §§ 1701-1705. The signed EA will continue unless terminated, modified, or extended. The Agreement is a binding operational agreement on matters specified in NDAA 2009, § 706 and NDAA 2010, §§ 1701-1705. This Agreement may be modified or terminated if VA and/or DoD Secretaries deem it necessary for mission fulfillment. The Parties note that the Comptroller General is required by NDAA 2010, § 1701(e) to conduct a review and assessment of the progress made in implementing the agreement and the effects of the agreement on the provision of care and the operation of the facility not later than one year after the execution of this agreement and on an annual basis thereafter. The results of such review and assessment may provide recommendations for modifications of this EA.

Modifications to this agreement must be in writing. Authority for this, as well as additional agreements to implement this agreement, is delegated: for VA to the Under Secretary for Health; and for DoD to the Assistant Secretary of Defense (Health Affairs), in coordination with the Secretary of the Navy (or designee) and subject to the direction of the Under Secretary of Defense (Personnel and Readiness).

APPROVE / DISAPPROVE

Ray Mabus APR -9 2010 DATE
Secretary of the Navy

APPROVE / DISAPPROVE

Robert Gates DATE
Secretary of Defense APR 23 2010

APPROVE / DISAPPROVE

Eric K. Shinseki DATE
Secretary of Veterans Affairs APR 23 2010

ATTACHMENT A

1. GOVERNANCE

OVERSIGHT AND MANAGEMENT: An Advisory Board comprised of DoD and VA senior members, operating under a charter from the Health Executive Council (HEC) and co-chaired by VA and DoD representatives, will monitor the operations of the FHCC to ensure the missions of both agencies (health care and operational readiness) are met. A local Stakeholders Advisory Council (SAC) will operate under a charter from the FHCC Director, and meet at least quarterly. This SAC will consist of members from various local organizations representing FHCC customers and will provide local feedback on how the FHCC is meeting the needs of the customers served.

The performance evaluation of the SES Director will be signed by Veterans Integrated Service Network (VISN) 12 Director with input from Commander NME and the FHCC Advisory Board. The fitness report of the Navy O6 Deputy Director will be signed by Commander NME with input from the SES Director and the FHCC Advisory Board.

RULES AND REGULATIONS FOR THE FHCC: The daily operations of the FHCC will be addressed in facility directives approved by the FHCC Director.

LIABILITY: As DoD, DON and VA are instrumentalities of the United States, all claims alleging negligence, wrongful acts, or omissions, will be handled in accordance with the Federal Tort Claims Act (FTCA) (28 U.S.C. §§ 1346(b), 2671-2680), including its defenses and immunities.

All FHCC employees and health care providers performing duties within the course and scope of their federal employment will be covered by the Gonzales Act (10 U.S.C. § 1089) and or the Federal Employees Liability Reform and Tort Compensation Act (28 U.S.C. § 2679). Both parties will cooperate in the investigation of any FTCA claims.

All other liabilities normally paid out of monies appropriated for the operations and maintenance of the Participant Facilities will be paid out of the JMFDF which will be administered at the FHCC (see Section VI (C) above).

2. FISCAL AUTHORITY

a. BUDGETING

The FHCC budget process will be described in an approved Budget EDM.

The FHCC will use a single unified budget to operate the integrated facility and will execute funding using VA's current and future Financial Reporting System. Additional Fund Control Points, Cost Centers, a VA to DoD financial data crosswalk, and a 7000 series of accounts are being developed to ensure that VA's current and future Financial Reporting System provides the budget details and reporting capability that VA and DoD require. Specific budget requirements are included in the Budget EDM. The minimum data structure for budgeting will require:

1. A combination of station codes, program codes, fund control points, cost centers and budget object codes for each functional aspect of the FHCC organization. This information can be made available from VA's current and future Financial Reporting System.
2. Budgeting will be based upon obligation data, and supported by cost data where required (i.e., cost data will used to determine the Department share of costs according to the most recent annual analysis in the reconciliation model).

The VA will manage the JMFDF and request appropriate apportionment. The VA and DoD will transfer funding into the JMFDF at the first available date upon passage of an appropriations bill or continuing resolution. The funds transferred to the JMFDF will be available to fund the operations of the facility, including capital equipment, real property maintenance, and minor construction projects.

The JMFDF will be composed of funds appropriate for and contributed by DoD and VA and Medical Collections and reimbursements earned by the FHCC:

1. Appropriated 1-Year. Funds transferred to the JMFDF from the appropriated amounts of DoD and VA are available for 1 fiscal year after the transfer except as described in number two below. Should any excess of the one year funds exist it will be returned to the contributing Departments before it expires.
2. Appropriated 2-Year. Of the amount transferred to the JMFDF from the appropriated amounts of DoD and VA, an amount not to exceed 2 percent of such amount shall be available for 2 fiscal years after the transfer.

The FHCC will use agreed upon historical execution data as a baseline for VA and DoD's funding contributions for the first three years of operation (FY 2011-2013). Beginning with the budget preparation cycle for FY 2014, the Reconciliation Model proposed by the Chief Financial Officers (CFOs) BUMED, Office of Assistant Secretary of Defense (Health Affairs) (OASD(HA)), and VHA, in an approved Reconciliation EDM, will become the basis for developing FHCC budgets.

The FHCC will prepare and submit budget requests, by 1 April for the Budget Year, to each Department (VA and DoD) to be submitted for the President's Budget. This will include exhibits and back-up material identifying the amounts to be transferred to the JMFDF. Both agencies will develop future year requirements under their own Department's data requirements as identified in their Department President's Budget submission for contribution to the FHCC. OASD(HA) and VA appropriations contribution will be reflected separately and by the appropriation contributing the funding. These new requirements should be factored into the subsequent Budget Call process. New initiatives or special programs will need to be considered, as well as major capital expenditures and projects.

The FHCC will submit a six year life cycle capital equipment request to VHA and DON (BUMED) budget officials during the budget formulation process. VA and BUMED budget officials will include capital equipment requirements for the appropriate budget years in their

budget submissions, and will make appropriate contributions to the JMFDF at the beginning of each year to fund these requests, subject to availability of appropriated funds.

Mission Specific Pass Through (MSPT) capital equipment will be the funding responsibility of the sponsoring Department. For non-MSPT areas, funding responsibility between VA and DoD for capital equipment items will be developed based on the relative usage as determined by workload metrics. Budgeted amounts for replacement of these items will be handled through the JMFDF and outside the reconciliation process.

Both Departments agree that unplanned, additional requirements that emerge will be requested through appropriate channels by the FHCC and, if approved, will be funded by additional contributions to the JMFDF in the year of execution The share of contributions will be consistent with the most current agreement on financial responsibility.

The FHCC will develop an Operating Plan (OP) by month, to include industry standard workload and Full Time Equivalents (FTEs), and compare this Plan to the current year budget. The FHCC OP will be based upon approved funding levels from the Departments, including collections. In order to develop an OP that reflects total obligations, the OP should include collections, reimbursements and anticipated carryover (if any) of prior year balances.

The FHCC will be required to complete an annual independent review in accordance with NDAA 2010 § 1704.

b. RECONCILIATION

The FHCC reconciliation process will be based upon the methodology outlined in an EDM proposed by BUMED, OASD(HA), and VHA CFOs and approved by the HEC. This reconciliation process allocates the defined total costs attributable to each Department through the application of industry standard weighted workload measures and/or agreed to metrics to each beneficiary type (VA or DoD). Patient eligibility required for reconciliation is an issue that requires appropriate business rules implemented in the information technology and financial processes.

An annual reconciliation report will be prepared identifying workload and resource consumption of both DoD and VA beneficiaries who have been provided healthcare services at the FHCC.

The source systems that will be used for the reconciliation model will be: DSS, VA's managerial cost accounting system, financial data from VA's current and future Financial Reporting System, and DMHRSi, along with the agreed upon industry standard data from VistA and AHLTA.

To the extent possible, automated source systems will feed reconciliation reports and will be used as the main tool in determining contributions from DoD OASD(HA) and VA, to the JMFDF.

The annual reconciliation report will be provided not later than 31 January following the close of the prior fiscal year.

Reconciliations will lag at least one-year for actual contribution purposes to the JMFDF and will lag one-to-three years for budget presentation purposes.

The Reconciliation Model is based upon patient care and MSPT categories, including:

1. Non-Mental Health Inpatient measured with relative weighted products (RWPs)
2. Mental Health Inpatient measured with Bed Days of Care
3. Outpatient workload measured with relative value units (RVUs)
4. Same Day Surgery measured with RVUs and Ambulatory Procedure Classes (APCs)
5. Emergency Room Workload measured with RVUs and APCs
6. Outpatient Laboratory based on actual DSS cost
7. Outpatient Radiology measured with RVUs
8. Outpatient Pharmacy based on actual DSS cost
9. Prosthetics based on actual DSS cost
10. Dental based on actual DSS cost
11. DoD MSPTs based on actual DSS cost
12. VA MSPTs based on actual DSS cost

MSPTs are unique activities that apply to either VA or DoD missions only. These mutually agreed upon MSPTs are excluded from the reconciliation model, and the sponsoring Department assumes their full burden of expense.

There are three phases to reconciliation. These phases are necessary to ensure appropriate cost and workload data is available for decision making purposes. The three phases are the Discovery Phase, Initial State Phase, and the End State Phase.

Discovery Phase: This phase began October 1, 2009 and ends September 30, 2010, and uses FY 2008 and FY 2009 cost accounting data from DSS and Medical Expense and Performance Reporting System/Expense Assignment System, workload data from VistA and AHLTA/CHCS, and the application of industry standard workload weights provided by OASD(HA). Reports are manually calculated to provide refinement and methodology validation of the reconciliation process. There will be no actual transfer of funding based on the reconciliation reports during the Discovery Phase.

Initial State Phase: Data from FMS, DSS, DMHRSi, AHLTA/CHCS, VistA, and industry standard metrics from OASD(HA) will be utilized to meet high level detail (i.e., inpatient, outpatient, ancillary, etc.) for the Initial State Phase. The cost categories will be allocated to VA and DoD by agreed upon industry standard metrics for each Department's beneficiaries utilizing the data sources listed above. Monthly cost and workload reports will be provided in this phase for the total FHCC and Department/clinic level. It is expected that the Initial State Phase will last from October 1, 2010, through September 30, 2013, with review and implementation of findings and appropriate adjustments to be made throughout that period. There will be no actual transfer of funding based on the reconciliation reports during the

Initial State Phase unless agreed upon by the BUMED, OASD(HA) and VHA CFOs and all requirements are in place to start the End State Phase early.

End State Phase: The End State Phase is expected to begin October 1, 2013, and, for reconciliation, will:

- use VA current and future Financial Reporting System and DSS to capture and calculate cost data,
- interface DMHRSi, DSS, AHLTA, and VistA workload data, and
- use systems generated industry-standard workload weights to calculate the relative contribution of VA and DoD to the FHCC budget.

IM/IT support is required by the FHCC in FY 2011 to develop an automated process for integrating these data sets to automatically generate the annual reconciliation report. The first automated reconciliation report should be generated no later than December 31, 2013 using FY 2013 FHCC data. The reports produced in the End State Phase must be auditable and transparent. To the extent possible these agreed annual reconciliation reports will also be used to determine each Department's next planned contribution based on their prior year resource consumption at the FHCC. FY 2013 data is the first time the reconciliation methodology will be used to determine both Departments' next actual contribution.

The Finance and Budgeting Task Group (TG), with assistance from the IM/IT TG, must document all clinical and financial systems (VA/DoD) requirements at the FHCC so they are configured to allow the accurate assignment of associated expenses including, Budget Object Code, Account Classification Code, Account Level Budgeter Cost Center, and Cost Center. Beneficiary type will be assigned at the clinic level. Additionally, the OASD(HA) will require data feeds from clinical systems to produce outputs such as RVUs and RWPs necessary for accomplishing the agreed upon reconciliation processes.

Applicable military labor costs are a free receipt to the FHCC and will be considered a credit to the Navy's expenses in the reconciliations.

Collections and reimbursements received at the FHCC will be credited as part of their contribution in the fiscal year they are realized.

The development of reconciliation business rules will be accomplished throughout the Discovery and Initial State Phases and agreed to by the Department CFOs.

The FHCC will comply with current Departmental internal management control policy and procedures.

Certain indirect costs will be excluded from the reconciliation model, specified in the Reconciliation EDM as proposed by BUMED, OASD(HA), and VHA CFOs.

3. PERSONNEL ISSUES

a. WORKFORCE MANAGEMENT:

The FHCC workforce management and personnel requirements will be described in a comprehensive Workforce Management and Personnel EDM, created in collaboration with the Finance and Budgeting TG. The FHCC, in meeting the mission of both DoD and VA, will evaluate existing data systems, and if necessary, work toward additional systems that will successfully design an integrated financial, workload and personnel approach to report and justify total workforce requirements in accordance with both DoD and VA governing statutes, regulations and policy.

The management of personnel assigned to the FHCC will be achieved through a total workforce perspective. Especially critical is the tracking and monitoring of military members and, if any, federal civilian and contractors positions comprising DoD expeditionary workforce. Data available through integrated personnel and workforce management systems such as DSS, DMHRSi and other financial records systems will be examined and leveraged to identify the most appropriate means of capturing and analyzing the data needed to build and maintain the FHCC workforce in accordance with DoD and VA policy.

b. TRANSFER OF CIVILIAN PERSONNEL

The Secretary of Defense may transfer to the VA up to approximately 540 incumbent civilian employees to the pay, benefits, and personnel systems that apply to employees of VA. The transition of employees so transferred to the pay systems of VA will not result in any reduction in an employee's regular rate of compensation (including base pay, locality pay, any physician comparability allowance, and any other fixed and recurring pay supplement) at the time of transition. The ToF is being accomplished in consultation with the Unions and in accordance with OPM Regulations derived from 5 U.S.C. § 3503.

The transferred employees who will be converted to positions covered by 38 U.S.C. § 7421(b), will continue to have collective bargaining rights under title 5 U.S.C., notwithstanding the provisions of 38 U.S.C. § 7422, for a two-year period beginning on the effective date of the ToF. At the end of this two-year period, the Secretary of Veterans Affairs will evaluate the extension of collective bargaining rights, using the following criteria:

- Consideration of the impact of the extension of such rights.
- Consultation with exclusive employee representatives of the transferred employees about such impact.
- Determination, after consultation with the Secretary of Defense and the Secretary of the Navy, whether the extension of such rights should be terminated, modified or kept in effect.
- Submittal to Congress of a notice regarding the determination made above.

VA will recognize after transfer of each transferred physician's and dentist's total number of years of civilian service as a physician or dentist in the DoD for purposes of calculating such employee's rate of base pay, notwithstanding the provisions of 38 U.S.C. § 7431(b)(3).

VA will assure the preservation of the applicable service credit of the employees so transferred for the purposes of all pay and associated benefit decisions.

With the Transfer of Civilian Personnel, the FHCC Director will have authority to implement certain Title 5 and Title 38 work scheduling flexibilities such as: flexible work hours, alternative work weeks with regular days off, credit hours, Baylor Plan scheduling and allowed time for physical activity programs.

c. HEALTH PROFESSIONS TRAINEES AND ACADEMIC AFFILIATIONS

The NCVAMC is affiliated with various medical health care facilities and training institutions. These relationships are documented within specific affiliation agreements. With the change of the name of the NCVAMC to the FHCC, all affiliation agreements will be re-signed and re-authorized. The relationship of the FHCC to all academic affiliates will evolve to accommodate the inclusion of the DoD partner, the changed mix of patients, and the change in staffing of the merged medical center. Appropriate FHCC staff will participate in the education and training of trainees, upon approval by the appropriate academic institution and/or sponsoring institution. The new FHCC will have its own Affiliation Partnership council (as specified in VA policy).

The FHCC will allocate appropriate resources to meet the training mission, including access to applicable learning resources, such as training space, information technology and support for educational leaders such as Facility Education Officers, Program Directors and Site Directors. The FHCC will meet all accrediting body requirements to keep programs in good standing to the extent authorized by law and DoD and VA policy.

In addition, the FHCC will allow appropriate time for FHCC supervising staff to engage in academic activities, including teaching, clinical supervision, didactics, mentoring and research. An appropriately qualified designated education officer (DEO) or Associate Chief of Staff for Education will be appointed to manage affiliations and oversee policy implementation with respect to health professional trainees in affiliated programs, and those sponsored by either VA or DoD. Training program will function under VA policies for trainee supervision and appropriate handbooks and directives for trainee appointments, affiliation and disbursement agreements and educational relationships including VHA Handbook 1400.1 and 1400.05.

d. ASSESSMENT

As a demonstration project and consistent with anticipated IG and Comptroller General Reviews, it is critical that any assessment go beyond mere staff satisfaction criteria. Comparisons of current VA and DON personnel prior and subsequent to integration should

include data consistent with commonly accepted human resources and other applicable programs. The Naval Postgraduate School and VA National Center for Organizational Development along with appropriate DoD and VA medical and human resources organizations will assist in the development of criteria and assessment methods. Additional details will be provided in a separate agreement.

4. Contingency Planning

The FHCC will maintain:

a) A Full-Time Emergency Manager.
b) A Public Health Emergency Officer (collateral duty) to support Navy Region Mid-West (BUMEDINST 6200.17)
c) Training standards to meet "joint" VA/DoD programs.

Operational Health Service Support: The FHCC must ensure awareness of ongoing operational requirements. Planning is necessary to mitigate the impact to FHCC services when DON/VA operational requirements are assigned to the FHCC for sourcing. This may require the movement of certain aspects of health care to respective VA and DoD networks.

VA police would have jurisdiction to enforce federal law, regulations and policy on VA owned FHCC real property at the main campus with the support and assistance of the Master-at-Arms to the extent allowed by law, regulation, and policy and will be outlined in a VA/DON Memorandum of Understanding. Masters-at-Arms are under the direction of VA police for law enforcement purposes, not including UCMJ issues.

VA owned real property at FHCC will be under Department of Homeland Security guidelines in coordination and consultation with Naval Station Great Lakes. FHCC property located on DoD owned property will be under guidelines of DoD Anti-Terrorism Force Protection (ATFP).

A FHCC security program may incorporate elements of DoD instruction 2000.16, DoD Anti-Terrorism standards, and VA Law Enforcement and Security Handbook 0730: this will enable the establishment of minimum requirements for security plans and protective measures for the FHCC.

5. Quality Assurance

Credentialing and Privileging: Credentialing will be completed in accordance with the FHCC Credentialing EDM, which will assure compliance with DON and VA requirements. All health care professionals, to include civilians, contractors, and active duty, assigned to the FHCC will be privileged in accordance with VA policy. Those health care professionals who are permitted by law and the FHCC to provide patient care services independently will be granted FHCC privileges.

Those active duty health care professionals that do not meet the requirements for FHCC privileges will practice at the FHCC in accordance with the clinical proficiencies required by BUMED Instruction 6320.66E for active duty health care professionals to maintain DON clinical privileges.

Maintaining clinical proficiency is essential to ensure that active duty health care professionals are able to perform military duties upon deployment or reassignment to a military treatment facility. Using CCQAS these professionals will be privileged by FHCC Deputy Director for DON privileges. However, while practicing at FHCC, those health professionals whose licenses do not allow independent practice will function under a scope of practice signed by the FHCC Director. This scope of practice will mirror DON privileges. The FHCC will support these clinical proficiencies for which there are available resources. The prescribing of controlled substances will be in accordance with federal law, which requires authorization by the jurisdiction in which the health care professional is licensed.

All active duty DON health care professionals, with or without FHCC privileges, will undergo the process for requesting navy privileges in accordance with BUMED Instruction 6320.66E. The granting of Navy privileges is required to maintain readiness for deployment and meet the DON mission requirements. The granting of DON clinical privileges will be approved by the FHCC Deputy Director. DON privileges will not be exercised in the FHCC.

Once the credentialing process is completed, clinical practice requests for both FHCC practice and DON privileges will be forwarded through the appropriate leadership to the Executive Committee of the Medical Staff (ECMS). ECMS will review and make recommendations to the FHCC Director via the Deputy Director for approval of FHCC practice requests and to the Deputy Director for approval of DON privileges for active duty health care professionals. Competency information collected for all health care practitioners will support clinical practice requests for the FHCC as well as Navy privileges.

Active duty enlisted personnel at the FHCC will function as they would in any Military Treatment Facility within Navy Medicine as stated in OPNAVINST 6400.1C (Training, Certification, Supervision Program, and Employment of Independent Duty Corpsmen) and NAVPERS 18068F (Navy Enlisted Occupational Standards). Their scope of function will link to an active duty professional provider and/or senior enlisted technical leader for their stated discipline. Clinical areas with basic and specialty trained Corps Staff will maintain training programs to ensure that personnel meet and maintain clinical core competencies and operational preparedness to deploy.

Independent Duty Corpsman at the FHCC will be limited to clinical areas in which an active duty credentialed and privileged provider practices.

This policy on professional practice will be incorporated into the FHCC Bylaws, Rules, and Regulations and shall be reviewed one year after the FHCC has become operational to determine whether it meets the DON's and the FHCC mission requirements.

ADVERSE PRIVILEGING ACTIONS: The FHCC Director has the authority to initiate adverse privileging actions to remove a healthcare provider assigned to the FHCC from patient care or to restrict or prohibit performance of selected specific procedures. These actions will be in accordance with VA regulations and policy including facility bylaws. For active duty providers, panel membership for any formal hearing shall include Active Duty representation. The FHCC

Director will make the decision on any adverse privileging action and will report adverse privileging actions to the National Practitioner Data Bank (NPDB). The service specific Surgeon General shall be notified of the initiation and final determinations of any adverse privileging action involving an active duty provider.

SHARING OF QUALITY ASSURANCE INVESTIGATIONS AND REPORTS: In order to demonstrate transparency, respond to higher authority on questions of quality and support the readiness mission, the DON will have a need to access both QA and other patient and administrative records of the FHCC in order to address quality questions and investigations. QA data are investigations and reports that include, but are not limited to: Sentinel Events; Root Cause Analyses; Failure Effect and Mode Analyses; Event (incident) reports; reports to the Food and Drug Administration (FDA) for devices or blood products defects or injuries; recalls or look backs; Infection Control data for recruits; National Healthcare Safety Network-Centers for Disease Control data; VA and National Surgical Quality Improvement Programs (NSQIP) and related ORYX and Healthcare Effectiveness Data and Information Set performance measures; and other inquiries involving QA information including Armed Forces Institute of Pathology (AFIP) autopsy results in recruit related deaths, BUMED and MEDIG inquires, Congressional inquiries concerning standard of care, and DoD OIG investigations or audit findings related to the Quality Programs or quality oversight processes at the FHCC.

VA quality assurance activities are made confidential and privileged by 38 U.S.C. § 5705. Records created as part of a VA medical quality assurance program are confidential and may not be disclosed to any person or entity except as provided in § 5705. VA is authorized to disclose quality assurance records to DoD in accordance with 38 U.S.C. §§ 5705(b)(1)(B) and 38 C.F.R. § 17.509(b). Section 5705(b)(4) prohibits a person or entity to whom VA quality assurance records have been disclosed from making further disclosure of the records except for a purpose provided in § 5705(b).

RISK MANAGEMENT AND TORT CLAIMS: All tort claims arising under the FTCA will be accepted for investigation by VA Chicago Office of Regional Counsel (RC). Upon receipt of a claim in which DON/DoD employees are believed to be involved or if a claim is filed by an active duty service member, VA RC will provide a copy of the tort claim to the FHCC Deputy Director. Where initial RC review shows only limited or peripheral VA involvement, the claim will be transferred to DON for investigation in accordance with its procedures. DON will be the lead Department in all pediatric and obstetrical malpractice cases unless both VA and DON agree otherwise. Each Department will promptly notify its involved employees and instruct their cooperation with the lead Department's investigation. In the event VA leads a pediatric or obstetrical malpractice case, BUMED will identify a specialty reviewer to provide an independent medical evaluation and written opinion responding to questions posed by the RC attorney regarding medical aspects of the claim; any resultant opinion will be protected as attorney work product.

The decision to deny claims arising in the FHCC rests with the lead Department; where the lead Department determines the claim should be denied, the denial letter will be courtesy copied to the non-lead Department when previous notice of such claim has been provided. If such a claim goes into litigation, the RC, Professional Staff Group I and Navy Office of Judge Advocate

General Code 15 will collaborate to determine which Department should be the lead Department and the litigation support each respective Department will provide to the Department of Justice (DOJ) or local Office of the United States Attorney (USA).

The decision to settle claims rests with the lead Department, USA or DOJ where applicable. If a medical malpractice claim is settled or a judgment is entered against the government, the lead Department will forward notice of payment and sufficient information to the non-lead Department for consideration of reporting to the NPDB. Such information includes, but is not limited to, complete medical records, any diagnostic films, and where VA is the lead Department, post-payment provider statements and any medical reviews developed in consideration of the case by VA Office of Medical-Legal Affairs after notification of payment. Each Department will follow its own procedures regarding reporting of their respective practitioners to the NPDB. Collateral QA actions arising from the allegations will be handled in accordance with the terms of the existing sharing agreement between NCVAMC and NHCGL.

Each Department will be responsible for reporting its own employees, including trainees, to the NPDB. A VA trainee such as a resident can only be reported through VA reporting process and standards (see below), and a DON trainee can only be reported according to the DON reporting standards (see below).

The FHCC has a responsibility, as a part of its monitoring procedures for resident supervision, to review any incident reports and tort claims involving resident trainees. [See VHA Handbook 1400.1, Resident Supervision.] The DEO and the training program director of any trainee listed in a tort claim must be notified. Resident trainees (in VA or affiliate-sponsored programs) function at all times in a supervised capacity. VA residents will only be reported to the NPDB if a panel convened to review a paid tort claim determines that an individual resident was grossly negligent (i.e., disregarded the instructions of the supervising practitioner) or acted with willful professional misconduct (38 CFR Part 46; Policy Regarding Participation in NPDB.

For DON trainees the Surgeon General will make a determination regarding NPDB reporting. If the Surgeon General determines that the attending practitioner clearly met all reasonable standards of supervision and the trainee's act or omission was not reasonably foreseeable by the attending practitioner, the trainee (not the attending practitioner) shall be reported to the NPDB for failure to meet the standard of care.

DON is required by regulations to convene a health care investigation involving the disability or death of an active duty service member where the adequacy of health care is reasonably at issue. The FHCC Deputy Director is responsible for convening these investigations and for notifying the FHCC Director. All involved providers assigned to the FHCC will cooperate in these investigations.

OVERSIGHT INSPECTIONS AND INVESTIGATIONS: The FHCC Director will acknowledge and allow duly authorized investigative teams and personnel access to the FHCC in order to conduct required reviews. Each Department will allow authorized observers to participate in those reviews. This includes but is not limited to: BUMED MEDIG, VA OIG, VHA Medical Inspector and DON IG, NCIS investigators, Office of Security and Law Enforcement

investigators, AFIP pathologists, The Joint Commission, CAP, FDA, VA OI&T Oversight and Compliance, American Red Cross and the American Association of Blood Banks, Congressional oversight visitors and other VA/DoD approved special project teams. All providers and staff assigned to the FHCC will participate fully in the investigation, inspection, and/or review as requested and in accordance with DoD and VA regulations and policy. The Department specific Surgeon General and VISN shall be notified of the initiation of the investigations, inspections, reviews, and/or visits so that information can be documented and tracked for further quality oversight review. The FHCC Director will forward a copy of the final investigation, inspection, and/or review report from any of the above referenced organizations to the VISN and service specific Surgeon General for review and further action if needed. The FHCC Director will involve and consult with the AFIP Medical Examiner in any cases involving an active duty death, and report the findings to service specific Surgeon General and the member's chain of command.

CONGRESSIONAL OR MEDIA DISCLOSURE PROCESS (RELATED TO HEALTH CARE ISSUES): The FHCC Director will promptly advise the appropriate VA offices and the Navy Medicine chain of command (through the FHCC Deputy Director) on congressional and media inquiries and coordinate appropriate responses. The VA Office of Congressional and Legislative Affairs (OCLA) and the BUMED Office of Communications (OC) agree to coordinate with higher echelons on congressional, public affairs, and presidential inquiries when appropriate. VA OCLA and BUMED OC will promptly notify the FHCC Director of the same.

CLINICAL DISCLOSURE PROCESS: Institutional Disclosure of Adverse Events and Large Scale Disclosures of Adverse Events will follow the policy of the VA per VHA DIRECTIVE 2008-002 (January 18, 2008). The VHA Principal Deputy Under Secretary for Health will be notified of adverse events that rise to the level of large scale or institutional disclosures as required in VHA Directive 2008-002. The Navy Surgeon General's Risk Manager will be advised of adverse events involving active duty members or recruits that rise to the level of institutional and large scale disclosure.

6. INFORMATION ISSUES

a. INFORMATION MANAGEMENT/INFORMATION TECHNOLOGY

The IM/IT Executives from MHS and VA Office of Health Information have developed and documented the clinical business requirements, validated by the subject matter experts (SME), to meet the initial operating capabilities for opening day in 2010.

1. Working with the SMEs from both the local and central levels at each Department, the technical teams will develop the technical solutions, based upon approved business requirements, to be delivered by the responsible parties in the areas of software development and infrastructure and will meet the initial operating capabilities for opening day in 2010 and continue to deliver additional capabilities in the outgoing years. The responsibility to deliver clinical capabilities is overseen by the HEC and approved by the VA/DoD Joint Executive Council.

2. The use of AHLTA/CHCS, VistA/CPRS, or subsequent systems will be based on the functional need for documentation that meets the needs of the clinicians and the specific patient populations in a given clinic. AHLTA/CHCS, VistA/CPRS, or subsequent systems will be used for the purposes of maintaining the recruit processing mission of the Naval RTC and the operational readiness of the active duty population.

    i. Both agencies have committed to the use of the enterprise service bus for the exchange of clinical data.
    ii. Acquisitions, upgrades, or modifications to enterprise systems will maintain the interoperability and functionality at the FHCC. All applications will be maintained in an operational state once successfully tested, accepted, and deployed.
    iii. All enterprise solutions developed will be exportable to other VA/DoD joint ventures and medical sharing locations.
    iv. Initial capabilities will include solutions funded for content areas listed below:

        a. Single Patient Registration.
        b. Clinical Single-Sign-On with Patient Context Management.
            - Initial Release for Clinical users (10/2010).
            - Follow up work on administrative users (post 2010).
        c. Orders Portability for Pharmacy, Laboratory, Radiology and Consults/Referrals
        d. Documentation of patient care will support Medical and Dental Operational Readiness.
        e. Financial Management solutions will be evaluated and software changes will be developed after October 1, 2010.
        f. Outpatient appointing enhancements will continue to be explored.

3. The design of the secure network (infrastructure) will support all applications approved for use by both DoD and VA to provide patient care and be in keeping with all IS, IA and privacy standards that are required by the DON, DoD, and VA for access to their networks.

    The initial FHCC Infrastructure is a Demilitarized Zone (DMZ) architecture which maintains clear separation of networks as required by the current policy environment.

    All interdepartmental communications will occur via DoD/VA Regional Gateways, the Local DoD/VA Fiber Gateway at the FHCC, approved Remote Access Solutions, or by future architectures approved by Defense Information Systems Network Security Accreditation WG and VA Enterprise Security Change Control Board.

    The Facilities Operational Infrastructure Strategic Working Group (FOISWG) will support implementation and integration issues for the FHCC through deployment of the Final Operating Capability of the infrastructure and initial developed services (see section 6.a.2.iv. above). It is anticipated that standard architectures will be managed

by the Enterprise components of VA and MHS to include:

Implementation, sustainment, and change management of DoD/VA Facility IT Logical Infrastructure, Gateways, Common Network Services, Public Key Infrastructure, and Directory Solutions.

b. INFORMATION SECURITY/INFORMATION ASSURANCE

1. Per Section VI.H. above, IS/IA methods, procedures and protocols will be strictly adhered to and will address the most stringent requirements per defined DMZ architecture boundaries.

2. Separation of Duties: This requirement which is found in National Institute Standards and Technology (NIST) SP 800-53 will be enforced at all times as it relates to IT, IS/IA and all employees.

   All individuals requiring access to FHCC information and information systems must submit to background screening, complete information security awareness and privacy training annually, read and sign the appropriate rules of behavior annually, and fulfill and comply with other applicable policies and procedures.

   Initially, IS/IA issues and conflicts will be addressed by the Department rules governing that Department's information systems as defined by the DMZ architecture boundaries.

   It is anticipated that continuous alignment of IA Governance processes and standards will occur at the Enterprise and that incremental improvements will be incorporated into the FHCC IA Governance Processes.

3. Incident Management: All Information Security Incidents will be reported by the Incident Response Officer within the FHCC Information Security Office.

   Data breaches, security incidents, and other events that may indicate such breach or incident must be reported to appropriate department entities, including VA Network Security Operations Center and DoD Navy Cyber Defense Operations Center within timelines as required by Department policy. Data breach investigative teams will consist of both VA and DoD personnel.

   IS Surveillance Rounds will be conducted on all areas of the FHCC to assess and recommend remediation of all IS related issues.

4. Certification and Accreditation (C&A) Process: Initially, VA will certify and accredit all information systems as required using its current methodology which follows NIST 800-53 standards for 2010. Navy will certify and accredit its network enclave and programs of record (POR) using DoD IA Certification and Accreditation Process (DIACAP) standards. The MHS will certify and accredit its network and POR using

DIACAP standards.

It is anticipated that continuous alignment of C&A processes and standards will occur at the Enterprise and that incremental improvements will be incorporated into the FHCC C&A processes as they are approved by the appropriate Designated Approving Authorities (DAA).

7. INTEGRATION BENCHMARKS

1. Patient satisfaction measures meet VA and DoD benchmarks.
2. Maintenance of Medical Individual Accounts for Recruits at less than five percent; maintain Training Center Support Students Not Under Instruction for medical reasons at less than two percent; Individual Medical Readiness – indeterminate status for active duty less than five percent.
3. SAC determination that the FHCC meets both DoD and VA missions.
4. Successful annual Comptroller General review.
5. Validation of fiscal reconciliation report by annual independent audit.
6. VA clinical and administrative performance measures exceed mean for all VAMCs.
7. Meet all access to care standards.
8. Evidenced Based Health Care measures meet or exceed VA and DoD mean.
9. Satisfactory clinical and facility inspection outcomes from external oversight/accreditation groups, including but not limited to:
    a. Joint Commission
    b. VA OIG
    c. DoD OIG
    d. VA Office of the Medical Inspector
    e. BUMED MEDIG
    f. American Association of Blood Banks
    g. FDA
    h. CAP
    i. Occupational Safety and Health Administration.
10. Officer promotion/retention and enlisted advancement/retention meet or exceed DON means.
11. IM/IT implementation timeline met and no negative impact on patient safety.
12. Staff satisfaction and other appropriate measures identified VA and DoD as benchmarks.
13. RVU/RWP/Dental Weighted Value production meets Business Plan targets.
14. Maintain pre FHCC academic and clinical research missions.
15. Trainee Satisfaction as measured by the Learner Perception Survey.

END ATTACHMENT A

ATTACHMENT B

DoD CIVILIAN EMPLOYEE POSITIONS ELIGIBLE FOR TRANSFER

CIVILIAN JOB SERIES		POSITIONS
0018	Safety & Occupational Health Management	3
0180	Psychologist	15
0181	Psychology Technician	5
0185	Social Worker	8
0189	Recreation Assistant	2
0301	Miscellaneous Administration & Program	8
0303	Miscellaneous Clerk & Assistant	5
0304	Information Receptionist	1
0305	Mail & File	3
0318	Secretary	15
0322	Clerk Typist	1
0326	Office Automation	7
0343	Management & Program Analysis	11
0344	Management Assistant	5
0501	Financial Administration & Program	5
0503	Financial Clerical & Technician	3
0505	Financial Management	1
0525	Accounting Technician	1
0601	General Health Science	1
0602	Medical Officer	33
0603	Physician Assistant	4
0610	Nurse	30
0620	Practical Nurse	2
0621	Nursing Assistant	6
0622	Medical Supply Technician	2
0630	Dietitian & Nutritionist	2
0633	Physical Therapist	3
0636	Rehabilitation Therapy Assistant	3
0640	Health Aid & Technician	46
0642	Nuclear Medicine Technical	1
0644	Medical Technologist	10
0645	Medical Technician	37
0646	Pathology Technician	2
0647	Diagnostic Radiologic Technologist	12
0660	Pharmacist	8
0661	Pharmacy Technician	20
0665	Speech Pathology & Audiology	3
0668	Podiatrist	2
0669	Medical Records Administration	1
0671	Health System Specialist	8
0675	Medical Record Technician	8

0679	Medical Support Assistance	7
0680	Dental Officer	36
0681	Dental Assistant	81
0683	Dental Laboratory Technician	3
0690	Industrial Hygiene	7
0800	Interdisciplinary Engineer	2
0802	Biomedical Engineering Technician	3
0808	Architecture	1
0856	Electronics Technician	1
0962	Contact Representative	11
0998	Claims Assistance & Examining	1
1035	Public Affairs	1
1101	General Business and Industry	1
1105	Purchasing	4
1106	Procurement Clerical & Assistance	2
1306	Health Physicist	1
1311	Physical Science	1
1411	Library	2
1640	Facilities Operations	1
1670	Equipment Specialist	1
1712	Training Instruction	4
1725	Public Health Educator	1
2003	Supply Program Management	1
2005	Supply Technician	9
2010	Inventory Management	1
2102	Transportation Assistant	1
2150	Transportation Operations	1
2210	Information Technology	1
5703	Motor Vehicle Operating	1
6907	Materials Handling	3
TOTAL		533

NOTE: This list represents Federal civilian positions associated with the transfer of function from Naval Health Clinic Great Lakes to the Captain James A Lovell Federal Health Care Center. Some minor variations may result prior to execution of the transfer of function in October 2010 pending final Base Realignment and Closure and other DoD budgetary and workforce adjustments.

END ATTACHMENT B

APPENDIX A

Acronym List for
FHCC Executive Agreement and Attachment A

AFIP – Armed Forces Institute of Pathology
AHLTA – Armed Forces Health Longitudinal Technology Application
BUMED – Bureau of Medicine and Surgery
C&A – Certification and Accreditation
CAP – College of American Pathologists
CFR – Code of Federal Regulations
CHCS – Composite Health Care System
CPRS – Computerized Patient Record System
DAA – Designated Approving Authorities
DEO – designated education officer
DHP - Defense Health Program
DIACAP – DoD IA Certification and Accreditation Process
DMHRSi – Defense Medical Human Resources System, Internet
DMZ – Demilitarized Zone
DoD – Department of Defense
DOJ – Department of Justice
DON – Department of the Navy
DSS – Decision Support System
EA – Executive Agreement
ECMS – Executive Committee of the Medical Staff
EDM – Executive Decision Memorandum
ER – emergency room
ERM – Electronic Medical Record
FDA – Food and Drug Administration
FHCC – Federal Health Care Center
FTCA – Federal Tort Claims Act
FY – Fiscal Year
GS – General Schedule
HEC – VA/DoD Health Executive Council
IA – Information Assurance
IG – Inspector General
IM – Information Management
IRB – Independent Review Board
IS – Information Security
IT – Information Technology
JMFDF – Joint Medical Facility Demonstration Fund
MEDIG – Medical Inspector General
MHS – Military Health System
MILCON – Military Construction
MSPT – Mission Specific Pass Through
NCIS – Naval Criminal Investigative Service

NCVAMC – North Chicago VA Medical Center
NDAA – National Defense Authorization Act
NHCGL – Naval Health Clinic Great Lakes
NIST – National Institute Standards and Technology
NME – Navy Medicine East
NPDB – National Practitioner Data Bank
NSQIP – National Surgical Quality Improvement Programs
O&M – Operations and Maintenance
OASD(HA) – Office of the Assistant Secretary of Defense (Health Affairs)
OC – BUMED Office of Communications
OCLA – VA Office of Congressional and Legislative Affairs
OI&T – Office of Information and Technology
OIG – Office of Inspector General
OP – Operating Plan
OPM – U.S. Office of Personnel Management
PL – Public Law
POR – programs of record
QA – Quality Assurance
RC – Regional Counsel
RTC – Recruit Training Command
RVUs – relative value units
RWP – relative weighted products
SAC – Stakeholders Advisory Council
SES – Senior Executive Service
SMEs – subject matter experts
TG – Task Group
ToF – Transfer of Function
U.S.C. – United States Code
UCMJ – Uniform Code of Military Justice
USA – United States Attorney
VA – Department of Veterans Affairs
VAMC – VA Medical Center
VHA – Veterans Health Administration
VISN – Veterans Integrated Service Network
VistA – Veterans Health Information System and Technology Architecture

END APPENDIX A