**DOD/VA JOINT INCENTIVE FUND GUIDE**

**April 2019**

VERSION 3.0

|  |  |  |  |
| --- | --- | --- | --- |
| **Version** | **Name** | **Update** | **Date** |
| 2.0 | Jimmy Costello | Format and Content Updates | 7/15/16 |
| 3.0 | Cathy Simpson | Content Updates | 4/5/19 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Version History**

# Introduction

The DoD/VA Joint Incentive Fund (JIF) Guide provides information and direction to the Department of Defense (DoD) and Department of Veterans Affairs (VA) on the JIF program, how to draft and submit a successful proposal, and what is required once an initiative has been selected for funding. This document also contains project management tips and considerations to assist with the implementation of funded projects.

## Background of the Joint Incentive Fund

The National Defense Authorization Act 2003, Section 721, amended Section 8111 of title 38, United States Code to authorize the DoD-VA Health Care Sharing Incentive Fund, which became known as the Joint Incentive Fund (JIF). The purpose of JIF is to provide “seed” money for creative sharing initiatives at DoD/VA facility, regional and national levels to facilitate the mutually beneficial coordination, use, or exchange of health care resources, with the goal of improving the access to, and quality and cost effectiveness of, the health care provided to beneficiaries of both Departments.

Minimum VA and DoD contributions to the fund are $15 million from both Departments ($30 million per year) beginning fiscal year (FY) 2004. Since FY 2004, over 170 initiatives have been funded.

The Veterans Health Administration (VHA) administers the fund under the policy guidance and direction of the Health Executive Committee (HEC). The VHA Chief Financial Officer (CFO) will provide periodic status reports of the financial balance of the fund to the Defense Health Agency (DHA) CFO and to the HEC. The VHA CFO along with the DHA CFO provides oversight of the JIF as co-Chairs of the HEC Financial Management Work Group (FMWG). The FMWG membership consists of representatives from DHA, VHA and the Services and is responsible for all JIF activities to include review, approval and funds management.

## Approved Uses of the Joint Incentive Fund

|  |  |  |
| --- | --- | --- |
| **Potential Uses** | **Authorized** | **Not Authorized** |
| *Major Capital Equipment* | X |  |
| *Minor Capital Equipment* | X |  |
| *Salary & Benefits – Civilian Personnel* | X |  |
| *Salary & Benefits – Military Personnel* |  | X |
| *Major Construction Projects* |  | X |
| *Minor Construction Projects* | X |  |
| *Major Information Technology Systems* |  | X |
| *Joint VA/DoD Major Construction Planning* | X |  |
| *Capital Leases* | X |  |
| *Operating Leases* | X |  |
| *One-time Investment Costs (other than above)* | X |  |
| *Recurring Operating Costs* | X |  |

## Limitation on the Use of the Incentive Funds

There are no limitations other than the broad categories listed in the chart above. For example, allocated Incentive Funds can be used for one-time investments and/or limited operations. To ensure continuity of operations of projects involving recurring operations, the Incentive Fund allocations can be used for more than the first year, but not more than two years, of operation unless approved by the HEC (limited by business case pay back analysis described in the Financial Analysis Section). The reason for limiting the use of the Incentive Fund for recurring requirements is to ensure that the Fund resources are available to achieve the purposes envisioned by the authorizing legislation.

# Understanding the Rules of the Program

## How is My Proposal Evaluated?

Each proposal is evaluated based off of the same general criteria. These are areas you will want to focus on and highlight in your proposal. The following criteria may be considered in scoring proposals:

### Improves Quality of Care

• **Direct** - An improvement that can clearly be tied back to the beneficiaries

• **Indirect** - A secondary positive outcome such as upgraded infrastructure or enhanced working environment for staff

### Corporate Priority/Supports Joint Strategic Plan

• Make sure this isn’t just a local fix that is already being addressed with an enterprise wide solution

### Improves Access of Care

* Enhances or provides a service that meets projected long term demand

### Return on Investment

• The long term financial benefit of the project; see Financial Analysis section

### Measurable Performance Data

• Includes data to prove success of the project, for example cost savings/avoidance, access to care percentages, improved outcome statistics, customer satisfaction metrics

### Size and Scope of Impact (local, regional, or national)

• For example; does it only apply to one MTF/VA medical facility (local) or does it impact an entire TRICARE Region and/or VISN (Regional)?

### Approved Projects for this Site

• First-time submitters get added points to encourage broader use of the fund

### Other Intangible Benefits (not measurable)

• All other benefits that don’t fit into the above categories

## How the Funding Works

Funding for JIF projects is unique. In accordance with the authorizing legislation, allocations from the Incentive Fund shall remain available until expended. This means that the funds contributed by each Department are not subject to the same time limitations or restrictions as their donor appropriations, e.g., one-year or two-year funds become no- year funds when placed in the Incentive Fund.

Typically, funds are split among the participating organizations. It is very important to determine the most effective distribution. This component is largely dependent on how the joint initiative and compensation agreement is structured. Some considerations include:

• Is one organization particularly skilled at the acquisition of the personnel and/or equipment required?

• Will one organization be providing the bulk of the manpower and infrastructure required?

• Is the funding distribution consistent with the implementation plan?

• Is the funding distribution consistent with the sustainment plan?

• In our proposal, have we clearly delineated how funding is to be broken down between the participating organizations?

### Things to Consider

The JIF was set up as a transfer allocation. We have found that the JIF line of accounting will not process correctly within the VA’s civilian personnel pay system, nor in DoD’s Defense Travel System for personnel assigned to DHA. Keep these limitations in mind as you put proposals together.

# Submission Process for Local Proposals

Formal calls for Incentive Fund initiatives are released at least annually. Departments and facilities are required to adhere to the suspense dates and follow the process below, or as directed by your Service/VA POC when submitting local mutually agreed upon proposals. Enterprise level proposals will route through the appropriate HEC Work Group and/or DHA/VHA office/organization rather than following the process below.

## Submission Process – Local



\* The FMWG will review proposals, as well as other appropriate staff from each Department, to ensure compliance with established Incentive Fund proposal requirements. Other program offices will also review these, depending on the nature of the submission.

# Developing a Successful Proposal

## Before you Start

There are several keys to drafting a successful proposal. The most important is to **BEGIN EARLY and DESIGNATE a CLEAR LEAD PARTNER.** Gathering accurate information, consulting with all involved parties, and condensing it all into a clear/concise message is very time intensive. JIF proposals have been submitted annually since FY 2004. Don’t re-invent the wheel! If someone has already drafted a successful proposal that you could use as guidance, use it.

Before diving into the draft of your proposal, it is suggested that you break the project down into individual, digestible components. This will allow you to build a solid outline and identify critical factors to be fully addressed in your project plan. In developing the structure of your proposal, it is important to think through potential pitfalls/roadblocks. You don’t want to get too far into the project (and worse yet, have it approved and funded) and realize that there is a critical “show stopper” that you didn’t consider (further discussed in Risk Assessment).

## Explain Why Your Initiative Should be Funded

As you draft your proposal, make it clear up front why this is an important initiative to be funded. Just like any written piece, you want to peak your audiences’ interest from the start. Write about the specific opportunity your organization has. Tell the reader the nature of the opportunity at the local level, the number of persons or organizations impacted and how this initiative improves upon business as usual. The reader should have answers to the following questions:

1. How and when did you identify the opportunity?

2. What is the problem you are proposing to solve (statement of need)?

3. Do you have a thorough understanding of the scope and impact?

4. Do you cite recent statistics and research conducted?

5. Are you seeking funds for an initiative that is sustainable after two years?

The more information you have on the initiative, the easier it is to write a winning statement of need. You won’t be grasping for straws or generalizing; instead, you’ll be able to be able to give the panel some true and hard facts.

## Measurable and Achievable Goals

Along with making your purpose clear up front, you will have to set specific and measurable goals. Ensure that these goals are easily quantifiable and you know exactly how you are going to capture the performance data. Many people fall into the pitfall of setting goals that they will not be able to effectively track. Not being able to objectively show the progress of your initiative will decrease the chances for long term sustainability. Detailing accurate cost estimates and funding requirements is a critical component that is discussed further in the Business Case Analysis portion of this guide.

## Timeline Summary

A timeline is critical in managing any project and a summarized version should be included in your proposal. There are a lot of variables to consider, so consult closely with key agencies (i.e. certification of funds, contracting, facility management, training staff, etc). Any project is the sum of several tasks. At the task level, make sure to determine time to complete and the responsible party.

## Risk Assessment

Assessing risk is a critical task before undertaking any initiative. When developing your proposal, clearly identify major potential risk areas that may temporarily or permanently derail the project. Common areas of risk are cost, schedule, acquisitions, technical, etc. We recommend developing a best, worst, and most likely case scenario. This will help you to think through and plan on the most appropriate course of action as the project develops.

## Sustainment Plan

JIF funding is considered “seed” money that allows the participating organizations to get the project off the ground. Once the project is operational, it is the responsibility of the organizations to sustain the funding stream to allow operations to continue. There is a lot of effort that goes into developing proposals and implementing projects, so it is absolutely imperative that a realistic and executable sustainment plan is developed.

Common methods used to fund ongoing operations include savings or cost avoidance, reimbursement from either department, increased third party collections, increased recapture of private sector care expenditures, and increased operational budgets.

Regardless of how the project will be sustained, the plan must be certified by the Service SG/CFO and VHA/VISN Director or, in the case of Enterprise-level proposals, the DHA/VHA Program Office that has agreed to sustainment funding.

The following are specific issues that should be addressed in the details of your sustainment plan:

1. What will you do if the plan turns out not to be financially self-sustaining (i.e. cancel or continue)?

2. Do you have a contingency plan in the case that you require additional JIF funds?

3. If you plan to continue the initiative even though it is not self-sustaining, have you identified the necessary program offsets?

4. Have you effectively communicated to your chain of command the future budgetary requirements to sustain this initiative?

5. Does your plan include an exit strategy in the case that it doesn’t succeed?

## Lessons Learned

• Proposals that involve recruitment of professional staff have experienced difficulty hiring part-time personnel. Sites should anticipate and look for alternatives.

• Sites attempting to hire radiologists should anticipate much higher costs and should consider contracting readings and methods for transmitting radiological studies and images as an alternative to hiring radiology staff.

• MRI technicians are difficult to hire as civil servants due to more attractive salary levels in the private sector. Sites should be aware of this and consider contracting.

• Take the time to obtain realistic cost estimates before submission of a proposal.

• Do not combine several initiatives into one proposal. Simple, verifiable projects with good supporting data have a better chance of being selected.

• Take the time in the beginning to develop a solid proposal and think through operational level details in close coordination with your sharing partner. Projects which transform into something different between scoring rounds have less chance of being selected.

• Ensure that projects have been submitted up both chains of command. Projects which do not have support by both a DoD and VA partner, including support of headquarters Service, VISN or Program Office, will not be scored.

• Do not attempt to justify proposals based on workload outside the DoD or VA.

• Projects involving information management/information technology (IM/IT) solutions should ensure that they are congruent with corporate direction and do not duplicate work being developed.

• If your project includes hiring civilian personnel, consider the effect of pay banding which has been implemented in DoD. Adjust grades and steps within the financial analysis tool to account for this.

• For DoD, some proposals which transfer care from the private sector to VA will require a transfer of funding from Budget Activity Group (BAG) 2 (private sector care) to BAG 1 (in-house care). Work through your appropriate chain of command to request movement of funds between BAGs.

• It is important to determine at what point the JIF funding will end and when billing should begin. This will depend upon the point at which operating costs are no longer paid by the JIF, and is not the same for every project.

## Power of Partnership

Joint Incentive Fund proposals by nature require coordination. To put it simply, the more coordination with your VA or DoD partner, the better. The most successful JIF projects always boast a strong relationship between the participating organizations. It is common sense, but cannot be stressed enough.

There are entire books dedicated to the subject of writing successful business proposals and the above are just a few major things to consider. The bottom line is to be realistic and think long term. If you’re submitting a proposal to meet a short term challenge or one that doesn’t demonstrate clear benefit, you should consider seeking alternative solutions and other sources of funding.

# Keys to Financial Analysis

Rule #1 of any good financial analysis is to perform due diligence. It is very important that you have accurate cost estimates and funding requirements. Those numbers can only be based on solid data captured from all involved parties. The following are the key components.

## Cost Categories

Any new project/initiative is comprised of two types of costs; start-up and sustainment. Start-up costs are one-time expenditures associated with setting up a new service or operation. These costs are the initial capital outlay that builds the foundation of any ongoing operation. Examples include new equipment, facility renovations, hiring bonuses, initial advertisement of new service/program, permits, etc.

Once the foundation is built, you begin incurring sustainment costs. Sustainment costs represent the cost of doing business. They can be broken down further into fixed and variable costs. Fixed costs are your overhead costs that remain the same irrespective of output level. They include costs such as rent, salaries/wages, and scheduled maintenance. Variable costs are expenses that change in proportion to the activity of the service/operation. A common variable cost item is supplies.

## Identifying Costs

There are two critical reasons why it is important to accurately capture all costs associated with your project. The first is to ensure you request the appropriate amount of funding. If there is cost overrun in your project, there is no guarantee that the shortfall will be funded with JIF dollars. The second is for sustainment planning purposes. After the JIF funding stream has run dry, you must have a clear plan on how you will financially sustain the project. This requires projecting the costs associated with ongoing operations.

The following are some suggested sources for pricing information (not an exhaustive list):

|  |  |
| --- | --- |
| **Department** | **Type of Costs** |
| Medical Logistics/Acquisitions | * Equipment, supplies, services |
| Finance/Resource Management | * Personnel, private sector care expenditures |
| Managed Care Support Contractor | * Private sector care expenditures |
| Contracting | * Personnel, service |
| Facility Management | * Lease, construction, renovation |
| Medical Equipment Maintenance | * Equipment maintenance, equipment repair |
| Practice Administrators | * Operation costs |
| Human Resources (Civilian Personnel Office) | * Personnel |
| Information Management and Technology | * Software, hardware |
| Education and Training | * Training |

Due diligence and accurateness of cost estimates cannot be stressed enough. Being overly optimistic and underestimating costs in an attempt to boost your return on investment can come back to bite you if there is a significant cost overrun (not uncommon in facility projects). Not to mention that it does not accurately reflect the value of your project. Being too conservative can result in under execution of funds that could have been allocated to another valuable project.

## Benefit Categories

There are two basic categories of financial benefit, direct and indirect. Indirect benefits (soft) are those things on the periphery that are positively impacted by the new or enhanced service your project offers. These benefits typically come in the form of cost reduction or avoidance. Some examples include reduced cost of errors, decrease in training costs, and decrease in patient travel costs. Direct benefits (hard) are those benefits directly attributable to your new or enhanced service. Examples include purchased care savings, increased 3rd party collections and increased sharing reimbursement.

## Identifying and Projecting Benefit

Just as when identifying costs, gathering data from the appropriate source is the key to demonstrating an accurate benefit to your project. The list of cost sources above also applies in the search for calculating benefit. Again, it is not an exhaustive list, but those departments can assist in determining what your savings and reimbursement will be.

Determining how to project benefits can often be difficult, with many variables to consider. A key point to remember is that projects take time to get off the ground. It is very (stress very) rare that a project will see benefit from day 1. From a benefits perspective, projects typically go through three general stages:

1. Start-Up- It is unlikely that you will reap any financial benefit during this stage. This is the foundation building prior to start of new service/operation.

2. Learning curve stage- At this stage, you have built the foundation (i.e. purchased equipment/supplies, hired staff) and are in the initial stages of operations. Operational processes/issues are being refined and it will take time before the service reaches its full capability. Benefit during this phase is limited and should be projected such (i.e. 50% of fully operational unit).

3. Fully Operational- At this stage, your project is running to full capacity and achieving maximum benefit.

The benefit calculation must be based on solid logic. Avoid falling into the trap of “just go with the high number”. In addition, future benefit projections should be in current year dollars (no inflation added) since the Real Interest Rates are used for discounting. This is further explained in the next section. Financial analysis is not a marketing exercise; it is to be fact based.

## The Analysis

After inputting your cost and benefit data into the financial analysis tool, your project’s net present value (NPV), payback period, and return on investment (ROI) will be automatically calculated.

• **Net Present Value**: the total present value of a time series of cash flows. It is a standard method for using the time value of money to appraise long-term projects.

* + The “Discount Rate” is the interest rate used to discount or calculate future costs and benefits so as to arrive at their present values. This term is also known as the opportunity cost of capital involved. The rate is set by the Office of Management and Budget (OMB) and SHOULD NOT BE CHANGED.

• **Return on Investment:** the ratio of money gained or lost on an investment relative to the amount of money invested. It is used to evaluate the efficiency of an investment or to compare the efficiency to a number of different investments (i.e. JIF initiatives).

• **Payback Period**: the period of time required for the return on investment to “repay” the sum of the original investment. For example, a $1000 investment which returned $500 per year would have a two year payback period.

There are limited funds to distribute each year and your proposal’s financial benefit will be compared to others. Although demonstrating a strong position financially (i.e. high ROI, short payback period) will reflect positively on your proposal, it is not the only component considered. The review panel is looking for a comprehensive business plan, which addresses the full range of benefits your initiative offers.

## Link to Financial Analysis Tool

Please contact your DoD or VA JIF point of contact for the most recent financial analysis tool.

# Post-Selection

## Interim Progress Reports (Quarterly)

Required quarterly progress reports are conducted using a specific interim progress report (IPR) format that will be sent to you from the DoD and/or VHA sharing office. This format was created with input from the Services, DHA, and VA. The focus of the IPRs is to demonstrate progress in implementing your project and showing the success of the project once it is up and running. Of particular interest is the status of financial obligations and the timeliness of implementation along with the return on investment (ROI) and cash flow. JIF projects are funded for two years with the expectation that once funds are received, the project will be up and running before or close to that two year timeframe. The IPR is the reporting mechanism to show that the project is on track or to report on issues delaying the project’s implementation. Failure to properly update your schedules and obligations and/or issues can result in funds being pulled back for lack of progress. The IPR includes updates, performance measures, financial updates, metrics, issues, and other key items. These progress reports follow the same routing process as your JIF proposal and are reviewed by the Financial Management Working Group (FMWG).

## Project Changes and Funds Transfers

Throughout the years that the JIF program has been in effect there have been several instances where the scope of a project needs to change for one reason or another. Often it is due to the inability to contract for a particular specialist so the decision will be made to contract another type employee. Regardless of the reason for the change in scope of the project, it must be approved before any action can take place by the project managers. If the scope needs to change, document it thoroughly in your IPR and provide a detailed summary of the changes with sufficient justification for the FMWG to make a decision.

If the change affects the financial requirements of the project, an updated BCA is required along with the IPR and summary. This information will be reviewed and discussed at the FMWG and a decision provided regarding the requested change made and sent out to the project managers listed on the IPR.

In the event funding needs to be transferred between DoD and VA or between one Service to another, this request must also come up from the site to the FMWG for consideration and appropriate action. Since this does not impact the ROI or the overall financial requirements, an updated BCA is not required. Funding transfer requests can be requested in the quarterly IPR or be done with an email through the Service and VA appropriate chain of authority. Make sure the funding information is exact and includes all pertinent information to facilitate the transfer.

## Sharing Agreement & Final Report

Once your project is fully obligated, you will be required to draft a final report (see Appendix D: Final Report Template). At this point, your initiative has been implemented, become fully operational, and, from the FMWG’s perspective, is set for sustainment. In the event you have excess funds, these funds will need to be returned to the JIF Treasury Account. Excess funds cannot be used for other JIF projects or used for sustainment.

As your project goes into the sustainment phase, you will also be required to draft a formal sharing agreement that encompasses the newly created joint services. The sharing agreement can be a stand-alone agreement or be added to a larger sharing agreement already in existence. Many sites heavily involved in resource sharing employ a master sharing agreement that is updated as circumstances change. Contact your organization’s DoD/VA Resource Sharing POC for further direction.

## Project Failure

While most projects are successful, there are some over the years that simply did not work out as planned. There are many reasons this can occur, but generally, with careful planning and good preliminary data gathering, the projects are successful. However, if after every attempt to save the project is exhausted, and the project is determined to be unsuccessful, termination may be the only option remaining. This can be accomplished by following the following actions:

1. All parties involved with the project must be in agreement that the project cannot be saved and be willing to inform their chain of authority of the same.

2. A request, signed by the Commanders/Directors of each applicable party to terminate the project must be submitted through their chains of authority to the HEC FMWG that outlines what actions were taken and why the project cannot continue.

3. A complete accounting of all financial actions along with the exact amount of remaining dollars must be included with the termination request.

4. All activities need to cease on the project until a response from the HEC FMWG POCs is received.

5. Once permission is granted to terminate the project, the remaining JIF dollars will need to be returned to the HEC Treasury Account in accordance with financial guidance from each parties respective finance managers.

6. As the dollars are being returned, a final report on the project must be submitted through all parties’ respective chains of authority to the HEC FMWG that discusses all actions taken and provides detailed lessons learned for the HEC FMWGs future planning/decisions.

Once all paperwork is completed and all remaining monies returned, the project will be terminated and no future reporting will be required.

# Project Management Tips

## Project Scope

The long-term success of your initiative is largely dependent on effective project management, from implementation to sustainment. The following are some tips to consider as you get started.

First and foremost, you must fully understand the project scope. The scope is the definition of what the project is supposed to accomplish and the budget (time and money) that has been created to achieve these objectives. It is absolutely imperative that any change to the scope of the project have a matching change in budget, either time or resources. If a piece of equipment you originally planned to purchase is outdated and you must purchase an upgraded version, it is likely that time and budget will be affected. An adjustment to your plan should be made immediately.

Usually, scope changes occur in the form of “scope creep”. Scope creep is the piling up of small changes that by themselves are manageable, but in aggregate are significant.

You cannot effectively manage the resources, time and money in a project unless you actively manage the project scope. When you have the project scope clearly identified and associated to the timeline and budget, you can begin to manage project resources.

## Managing Your Resources

As the project lead, your primary resources to manage are people and money. It is critical that each major component of the project have a clear responsible individual with the right skills. It is your job to ensure they know what needs to be done, when and how. You must motivate them to take ownership of the project too. Managing direct employees normally means managing the senior person in each group of employees assigned to your project. Remember that these employees also have a line manager to whom they report and from whom they usually take technical direction. It is your job to provide project direction to them.

There is nothing that can bring a project to a screeching halt faster than running out of money. In the review process for JIF projects, money execution is the primary focus item. Execution of funds ties in closely with effectively managing the project timeline. Any project can be broken down into a number of tasks that have to be performed.

## Schedule Management

To prepare the project schedule, the project manager has to figure out what the tasks are, how long it will take, what resources they require, and in what order they should be done. If you omit a task, the project won’t be completed. If you underestimate the length of time or the amount of resources required for the task, you may miss your schedule. The schedule can also be blown if you make a mistake in the sequencing of the tasks.

Build the project schedule by listing, in order, all tasks that need to be completed. Assign duration to each task and allocate the required resources. Determine predecessors (what tasks must be completed before) and successors (tasks that can’t start until after) each task. It’s a pretty simple straightforward process.

The difficulty in managing a project schedule is that there are seldom enough resources and enough time to complete the tasks sequentially. Therefore, tasks have to be overlapped so several happen at the same time. There are many excellent software programs that greatly simplify the tasks of creating and managing the project schedule by handling the iterations in the schedule logic for you.

When all tasks have been listed, resourced, and sequenced, you will see that some tasks have a little flexibility in their required start and finish date. This is called float. Other tasks have no flexibility, zero float. A line through all the tasks with zero float is called the critical path. All tasks on this path, and there can be multiple, parallel paths, must be completed on time if the project is to be completed on time. The Project Manager’s key time management task is to manage the critical path.

Successful project management is an art and a science that requires strong organization and people skills. The ideas presented above help give you a basic framework, but consider it only a beginning. Good luck!

# Helpful Links

1. DoD/VA Joint Strategic Plan FY 2019-2021: https://prhome.defense.gov/Portals/52/Documents/VA-DoD%20FY%202019-2021%20JSP%20(signed%20March%2018%202019).pdf
2. DoD/VA Program Coordination Office: <http://www.tricare.mil/DVPCO/default.cfm>
3. AF/VA Resource Sharing Program (must register for use of this site): <https://kx2.afms.mil/kj/kx3/DoDVASharing/Pages/home.aspx>
4. AMEDD/VA Healthcare Resource Sharing Program: <http://vadodrs.amedd.army.mil/>
5. Bureau of Medicine and Surgery (BUMED): <http://www.med.navy.mil/BUMED/Pages/default.aspx>
6. VA/DoD Interagency Program Office (site currently off-line): <http://www.tricare.mil/tma/ipo/>
7. UBO: <http://www.tricare.mil/ocfo/mcfs/ubo/billing.cfm>
8. Veterans Health Administration: <http://www.va.gov/health/>

# Appendix A: Proposal Template, Tips, and Examples

|  |  |
| --- | --- |
| **JIF Proposal Business Case Template** |  |

## Example of Successful Local Proposal

### Descriptive Information

**Initiative**:

DoD/VA Joint Dialysis Center

**Host**:

60th Medical Group

David Grant USAF Medical Center 101 Bodin Circle

Travis AFB, CA 94535

**DoD**: Region 10

**VA**: VISN 21

### Initiative Description

The Dialysis Clinic at the 60th Medical Group, David Grant USAF Medical Center (DGMC) currently has five dialysis machines and treats DoD beneficiaries. Four patients may be dialyzed at once, with one machine being reserved for emergent/acute care. The clinic currently runs one 12-hour shift, three days a week. With the current staffing/equipment, the clinic offers two dialysis sessions per day, providing dialysis for eight patients a day.

The project includes renovation of existing space and expands to eight chairs for chronic dialysis care with a ninth machine located in the inpatient unit for acute/emergent needs, and one machine for backup during routine maintenance. Routine maintenance currently occurs on days the clinic is not performing dialysis. A backup machine will be necessary when the unit expands to 6 days a week so that routine maintenance does not affect patient treatment. The unit would be jointly staffed, with the DoD Nephrology Clinic providing physician oversight.

TRICARE patients with End Stage Renal Disease are eligible for Medicare after 3 months. At this time, TRICARE becomes a secondary payer to Medicare for off-base dialysis care. TRICARE paid approximately $148,000 in FY03 to purchase dialysis care for 28 DGMC Prime enrollees. Of this amount, approximately $45,000 was for patients residing within 30 minutes of David Grant Medical Center. Estimated referral costs that VA Northern California Health Care System (VANCHCS) spent in FY03 are in excess of

$2,800,000 for 59 dialysis patients. This represents a cost per patient of $47,457 each year. The reason for the disparate cost is due to VA’s requirement to pay all dialysis costs for enrolled patients. The Veterans Millennium Health Care and Benefits Act of 1999 states that once a veteran is enrolled and receiving dialysis treatments, the VA cannot shift those costs and responsibility to Medicare at any time. Both VANCHCS and DGMC see escalating referral costs associated with our chronic dialysis patients.

### Goals and Objectives

Approval of this initiative creates a DoD-VA Joint Dialysis Center that:

1. Recoups over $800,000 per year in purchased dialysis care costs. Because of the lower capital costs with the joint initiative, an ROI of $10 for every capital dollar invested are realized, leading to a payback in less than 1 year of $10 for every dollar spent (see Attachment 3, Proposal Summary)
2. Increases patient volume and complexity for residency education and training
3. Allows for expansion of the current 4-station Dialysis Center at the David Grant Medical Center (DGMC) into an 8-station unit
4. Upgrades the current dialysis stations with five new dialysis machines, eight new chairs, as well as other improvements
5. Helps to achieve VA/DoD Performance Measures through activation of new sharing opportunities

### Outcomes

An eight-chair hemodialysis unit would dialyze up to 48 VA and DoD chronic dialysis patients each week. All five current chairs, purchased in 1999, are in poor condition and need replacement. Renovation to this unit would expand capacity from four to eight stations. Space constraints limit the clinic to a maximum of eight stations. By purchasing five new dialysis machines (to complement the existing five machines) and eight new chairs, the unit would have a total of 10 machines: eight for treatment, one for inpatient/acute needs, and one for backup during routine maintenance. New equipment and joint staffing will allow the unit to operate three sessions per station each day on

12-hour shifts.

### Waivers, Deviations, or Certifications Necessary

Specialized training certification is not required, however specialized training is. A

6-week program is provided at DGMC while employees are on the job. A standardized curriculum is used which enables staff to be certified by the State of California in six months, with national certification once the staff member has completed one year of on the job training of full time employment.

### What Approvals or Authorizations are Required?

Leadership at both agencies was required to review the proposal during the initial incentive fund request to ensure that after incentive funding, the program would remain viable. Air Mobility Command (AMC) and the VISN 21 Director were also apprised of the joint venture proposal prior to submission.

### Exportable for Other Joint Venture or DoD/VA Sharing Sites?

Yes. The existing sharing agreement between VANCHCS and DGMC has been in effect since the early nineties. The ease of a venture such as this one is as a result of good communication, mutual benefit in terms of cost or training, and cost savings to the Government. This joint venture could and should be a benchmark service, which has long term gain in sharing.

### Beneficiaries Impacted

Nationally, the demand for dialysis is growing at a rate of 8 percent a year based on information from the American Society of Nephrology. By the year 2010, the number of dialysis patients is expected to jump to 650,000, from more than 300,000 in 2001. The demand for dialysis is growing as people are living longer and kidneys fail with age, and the number of cases of diabetes, which may lead to kidney failure, continues to rise.

**DGMC**: Current capacity limits chronic treatments to eight per day. In the previous quarter there have been seven new patients started which required movement and placement to outside facilities.

**VANCHCS**: Of the 103 VANCHCS veterans who are receiving dialysis on FEE, 19 veterans reside in Solano County. As noted above, dialysis cases are projected to grow at 8% per year. This project will allow for up to 24 patients over the next several years. However, with this growth rate, demand for dialysis will double current levels in 9 years.

### Interoperability Requirements

Staffing will be totally integrated within 6 months of startup. Maintenance of equipment will be provided by DGMC with the VA sharing in the cost of maintenance. VANCHCS will also pay for supplies consumed by VANCHCS beneficiaries. The joint dialysis center will be located at DGMC, therefore DGMC will be the host and the scope of care and other JCAHO requirements will fall under DGMC. Lastly, DoD will reimburse nephrologists and any associated ancillary support and space to DGMC at the established sharing agreement rate. Outpatient pharmaceutical requirements will be provided by VANCHCS. Inpatient Pharmacy support will be provided by DGMC under the pre- existing sharing agreement.

### Alternative Solutions

In addition to the proposed joint initiative, two alternatives were addressed:

**Alternative 1**, the Status Quo, assumes that DGMC would continue to provide dialysis care for its beneficiaries and VA would continue to fee workload into the community. A market survey in Solano County was conducted for waiting lists in a roughly 50-mile radius from DGMC. Of the clinics contacted, there were 10 openings spread sporadically through the community with many facilities reporting waiting lists. The facilities contacted within a 25-mile radius of DGMC, there were only three openings. In January of 2004, there were waiting lists for patients needing chronic dialysis in the Fairfield and Vallejo areas. In addition to the waiting times, is the risk of poor continuity of care between the contract and VANCHCS.

**Alternative 2** calls for each agency to pursue their growth needs independently through in-house projects. VA would build a dialysis annex adjacent to the existing Fairfield OPC. DGMC would increase use of existing chairs to accommodate greater need.

### Unique Characteristics

Because the dialysis center is located on base, we will work with the 60th Security Forces to ensure access for VA patients who are receiving care. In the past, our veterans have experienced few delays unless the base was on lockdown, which prevents anyone from entering or leaving the base for a short period of time.

### Program Management

The joint DoD and VA personnel will staff 12-hour shifts Monday through Friday. The VA would staff the Saturday shift in exchange for the DoD staff pulling after hours call. The VA would hire two RNS and three LVNs to support the increase in shifts. DGMC billets remain unchanged (one vacant medical technician position will be filled when the patient load increases). Care of all patients would fall under the supervision of the DGMC Nephrology Staff. VA hires will be oriented to DGMC. Annual performance reviews for VANCHCS will be initiated by the senior VA RN and signed off by the nurse manager of the center. After the 2-year incentive fund support is withdrawn, VANCHCS will assume the salary cost for assigned VA staffing support. This joint staffing arrangement can be utilized to support vacancies when DoD personnel deploy.

### Oversight by Decision Authorities

Dialysis staff will participate in regularly scheduled meetings currently in place within DGMC. The joint clinic will be a recurring agenda item briefed on a monthly basis at the Joint Initiatives Working Group co-chaired by DGMC and VANCHCS. Additionally, metrics will be briefed at the quarterly Executive Management Team meeting co-chaired by the DGMC commander and VANCHCS Director.

It is assumed that the GAO will play a role in oversight of incentive fund sites to ensure best use of Government dollars.

### What type of management Information Systems will be used?

Dialysis patients will be entered into CHCS. Patients receiving inpatient care, or other consultative services not available in VANCHCS will also be entered into CHCS. VANCHCS staff located in the VA Outpatient Clinic next to DGMC have access to CHCS to view ancillary testing and other results. DGMC nephrology and dialysis staff will be trained in the use of CPRS to view the full electronic record of dialysis patients for consultations that were provided by VANCHCS as well as enter consultation requests to VANCHCS. Referrals/pharmacy prescriptions to be conducted/filled by VANCHCS will be entered into CPRS. VA and DGMC have separate pharmacies located at Travis AFB.

### Show Stoppers

There is a proposal being considered by the Air Force to end the Internal Medicine residency program at DGMC and double the size of the Family Practice Residency program. Since the Family Practice program would remain, there is still a need for certain sub-specialties to support their Internal Medicine rotations that are part of their training. Initial guidance indicates DGMC would retain the two Nephrologist authorizations. However, if DGMC lost all Nephrologist authorizations, both the VA and Air Force would develop a plan to hire this support either through the VA or contracted staff in order to maintain the dialysis center.

### Address any concerns included in the comments column in Attachment

Medical Maintenance will be provided by DGMC with VANCHCS sharing in the cost of repair and maintenance of IT and medical equipment located in dialysis center.

### Stakeholder Comments and Concerns

Stakeholders were not contacted during Round Two. It is assumed that veterans residing in the outlying areas of Solano County will not embrace this proposal, as this patient population has already pre-established relationships with their current caregivers. Given the growth in dialysis need, new veterans will be offered dialysis at DGMC where the veteran can enjoy on site consultation for all ancillary and specialty requirements he or she may need.

### Support of VA/DoD Counterparts?

Yes. This joint proposal was discussed and approved by the Executive Management Committee (EMT), co-chaired by the DGMC Commander/Office of the Lead Agent and VANCHCS Director in December 2003.

### Does this Initiative support the Joint Strategic Plan?

Yes. In July 2003, the Joint Initiatives Working Group (co-chaired by DGMC Administrator and VANCHCS Planning) requested an analysis to determine whether the EMT should consider dialysis as a joint strategic initiative. Found to be viable, this initiative is part of the DGMC/VANCHCS Joint Strategic Planning Grid.

### Financial Information

### Required Investment

$ 1,343,780

### Year One and Year Two Incentive Fund Requests

**Year 1:** $803,300

**Year 2:** $540,480

### Provide an Approximate Breakout of Benefit to VA and DoD

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Proposed Initiative: Joint 8 Bed Unit DGMC** | **Alternative f1: Status Quo** | **Alternative 2: VA 8 Bed Unit Fairfield OPC** |
| Net Present Value of Investment | $2,965,125 | $4,390,094 | $8,919,679 |
| ROI of Investment | $10 | $0 | ($1) |
| IRR of Investment |  | $0 | $0 |
| Payback Period of Investment | 0.1 | Does not breakeven | Does not breakeven |
| Estimated Cost Savings/Avoidance between Proposed Initiative and Alternatives | n/a | ($1,424,970) | ($5,954,554) |

The above table provides financial summary data for the proposed joint venture and for addressing dialysis program needs. As can be seen, the proposed Joint 8-bed Dialysis Unit at DGMC has the lowest cost or most favorable NPV of the three options considered. With an NPV of $2.9 Million over the five years analyzed, the proposed initiative has an advantage of $1.4 Million over the Status Quo (Alternative 1- Fee Workload) and $5.9 Million over Alternative 2, which builds a new VA dialysis unit at Fairfield OPC. Because of the lower capital costs with the joint initiative, an ROI of $10 for every capital dollar invested are realized, leading to a payback in less than 1 year.

Because of the template design, it is difficult to breakout individual savings between both agencies. In terms of dollars, VA realizes significantly greater savings due to VA’s requirement to pay all dialysis costs for enrolled patients. DGMC will realize approximately $166,000 annually in sharing revenue alone and approximately $45,000 in TRICARE recapture per year based on private sector care costs for patients living within 30 minutes of DGMC.

### How will recurring costs be supported after Incentive Funding is no longer available?

Both agencies are committed to continuing to carry the program once funding has expired and willing to showcase the venture of its successes and lessons learned.

### Tangible/Economic Benefits

This proposal allows both agencies to combine resources to recoup referral health care dollars for chronic dialysis patients. It is projected that both agencies will save over $800K annually in future referral costs. Although these savings will be predominantly for the VA, the DoD would see some reduced costs in purchased care for dialysis patients.

### Intangible Benefits

Increasing dialysis patients seen at DGMC will have a positive impact on the AF’s Graduate Medical Education Program. VA patients may receive all associated consultation on site from either VA or DoD.

### Other Supporting Information

### Impact of Waiting Times or Access

Currently, access is limited to 8 dialysis patients a week (excluding acute visits) in the DGMC Dialysis Clinic. Approximately 10 DGMC-enrolled (TRICARE Prime) patients are disengaged each year to the local community for hemodialysis due to limited access. Additionally, DoD patients not enrolled in TRICARE Prime can only be treated at DGMC on a very limited basis. Expanding the unit would allow these patients to be treated at DGMC reducing overall healthcare costs. All VA patients currently must be seen in the community for dialysis.

### Impact on Quality Care

Continuity appears to be the greatest driver in quality. Patients simply don’t receive dialysis treatment. Their disease results in numerous consultations. Part of their disease includes consultations for nutrition, social services, interventional radiology, vascular surgery and cardiology to name a few. The VA outpatient clinic at Fairfield is located at Travis Air Force Base and is adjacent to DGMC where the patients can receive much of their consultative support. Other support not available will be provided by DGMC under the existing sharing agreement.

### Capital Asset Realignment for Enhanced Services (CARES) Impact

The North Valley Market submitted a plan to close the gap for increased demand in Specialty Care Services. The Market Plan included continued and greater sharing between DGMC and VANCHCS and more specifically included identifying opportunities to expand access to Specialty Services for Veterans at David Grant Medical Center. Joint dialysis care was among the specifics addressed in the VISN 21 Network Market Plan. Both agencies have enjoyed a trusting relationship and continue to find ways to address needs that benefit both organizations.

### Metrics

1. Reduction in purchased care costs for VA and TRICARE Prime beneficiaries
2. Increase in number of VA and DoD patients dialyzed at DGMC
3. Customer Satisfaction Surveys
4. VA/DoD Sharing Performance Goals

### Milestones

**May 2004**

* Submit Round 2 Proposal
* Await Go-No Go Decision

**July 2004 (if approved)**

* Prepare paperwork necessary for new VA FTEE positions
* Confirm requirements needed for renovation
* Announce VA FTEE positions

**August 2004**

* Letters to VA beneficiaries indicating new dialysis center
* DoD and VA staff briefed on joint service and process for referral and contacts
* Order equipment/supplies
* Select new FTEE
* Begin renovation

**September 2004**

* Complete renovation
* Complete hiring requirements and begin orientation
* Test medical equipment
* Contact patients
* Notify Travis Security Police

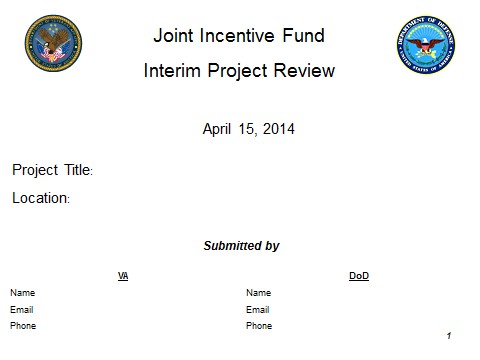
**October 2004**

* Install and test new equipment
* Complete orientation
* Build metrics
* Market grand opening

**November 2004**

* Activate Joint Dialysis Center

# Appendix B – Interim Progress Report Template (This Template is being replaced by an online tool in MAX.GOV)



Project Goals/ Objectives

* + Goals and Objectives:

– .

– .

– .

– .

* + Desired Outcomes:

– .

– .

– .

– .

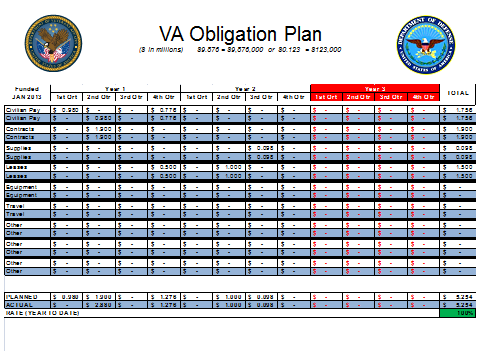
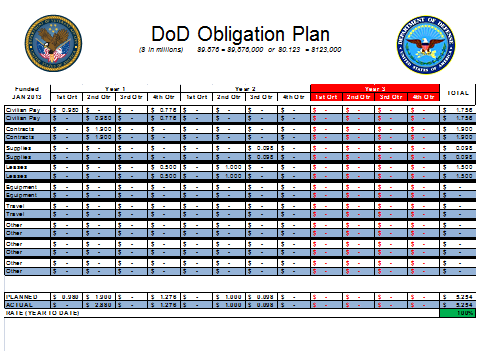
– .

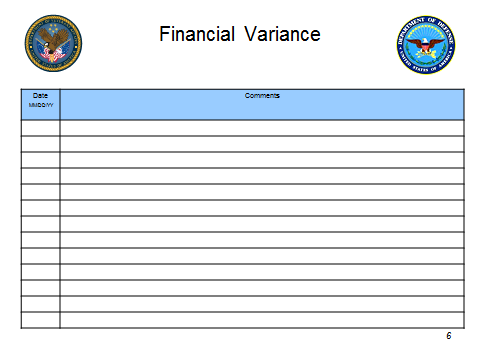
*2*

Schedule of Activities

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Owner  *(DoD, VA*  *or Both)* | Activity Name  *(Sub Activity/ Task Description)* | Projected Start  MM/DD/YY | Projected Completion  MM/DD/YY | Completion  MM/DD/YY | Comments |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

*1*





 Cost/Benefit Progress 



**500,000**

**400,000**

**300,000**

**200,000**

**100,000**

**0**

**1st Qtr**

**Obligations Total 300,000 Cumulative Benefit 0**

**Positive Cash Flow 0**

**2nd Qtr**

**350,000**

**25,000**

**0**

**3rd Qtr**

**350,000**

**150,000**

**0**

**4th Qtr**

**350,000**

**400,000**

**50,000**

*5*

## þÿPerformance Measures

* + List performance measures from the proposal and demonstrate progress toward meeting the goals.

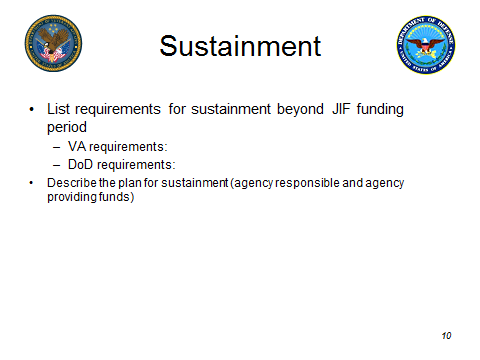
*6*

## þÿProject Status Report

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Critical** | **Caution** | **Controlled** | **Complete** |
| **On Schedule** |  |  |  |  |
| **Within Budget** |  |  |  |  |
| **Personnel Hiring** |  |  |  |  |
| **Contract Awards** |  |  |  |  |
| **Return on Investment Progress** |  |  |  |  |
| **Meeting Goals**  **& Objectives** |  |  |  |  |

Place “X” in block that applies to this project. See note pages for definitions.

*7*



## þÿLessons Learned

* (Date) Provide noteworthy Lessons Learned

*(See example in notes section)*

*8*

## þÿSummary Comments

* Include summary remarks regarding the status of the project
* Provide points of emphasis where needed
* State if assistance and/or approvals are needed

*9*

# Appendix C – Final Report Template

**Joint Incentive Fund Project Final Report**

**Project Name (Site Name)**

1. **Project Overview**: Provide background on the project based on concept proposal – what was the project established to accomplish; what was the hypothesis (i.e., implementation of this sharing capability should produce these benefits); what were the project goals and objectives; etc.
2. **Project Implementation**
   1. Activities: *Describe the steps taken to accomplish the project goals and objectives. Identify accomplishments, products, deliverables, and/or processes associated with each activity****.***
   2. Resources: *Provide high level budget information (the obligation slide from the IPR). Using the table below state the Return on Investment (ROI) identified in the business case analysis, the actual/achieved ROI to date, the projected ROI, and provide explanations/justifications for any deviation from the projected ROI.*

|  |  |
| --- | --- |
| *ROI identified in BCA* | *$* |
| *ROI actual/achieved to date* | *$* |
| *Projected ROI* | *$* |
| *Date ROI is projected to be achieved* | *DD/MMM/YYYY* |
| ***Explain deviation if applicable:*** | |

1. **Metrics**: *Discuss the metrics used to evaluate how well the project met the objectives stated in the concept proposal. Describe the metrics collection and analysis methodology and assumptions. Present the metrics in graphical form (from IPR). Discuss the conclusions drawn from the metrics.*
2. **Lessons Learned**: *Describe the major lessons learned (best practices/positive experiences or problems/ failures and associated corrective actions) that may be beneficial to others. Discuss risks, constraints and/or barriers you encountered, the impact they had, and how they were overcome.*
3. **Conclusions**: *Provide a summary of the overall conclusions of the demonstration project (overall, were project goals and objectives achieved).*
   1. Sustainability: *Provide an assessment of why and how the sharing capability (or portions of the project products or processes) will be continued at this site after the JIF period ends. What are the advantages and disadvantages of sustaining the capability?*
   2. Exportability: *Provide an assessment of whether or not this sharing capability (or portions of the project products or processes) would be useful at other locations. What are the advantages and disadvantages of using the capability elsewhere?*
4. **Sharing Agreement**: *Provide the status of the sharing agreement associated with this project, e.g., completed, in development with projected completion date, added to master sharing agreement.*