United States Government Accountability Office

Report to Congressional Committees

February 2016

FEDERAL HEALTH CARE CENTER

VA and DOD Need to Address Ongoing Difficulties and Better Prepare for Future Integrations

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Why GAO Did This Study

The National Defense Authorization Act for Fiscal Year 2010 (NDAA 2010) authorized VA and DOD to establish a 5-year demonstration to integrate VA and Navy medical facilities into a first-of-its-kind FHCC in North Chicago, Illinois to provide health care to both VA and DOD beneficiaries. Requirements for the FHCC are outlined in an Executive Agreement.

The NDAA 2010, as amended, included a provision for GAO to review the FHCC demonstration, resulting in prior reports in 2011 and 2012. This third report assesses (1) the extent to which the FHCC governance structure and leadership processes facilitated collaboration, (2) difficulties, if any, that the FHCC faced in integrating the workforce, and (3) difficulties, if any, that the FHCC faced in integrating operations.

To conduct its work, GAO reviewed VA, DOD, and FHCC documents (such as the Executive Agreement), federal standards for internal control, and other sources of related best practices, and interviewed VA, DOD, Navy, and FHCC officials, including former and current leadership and over 100 staff.

What GAO Recommends

GAO is making 8 recommendations, including that VA and DOD collaborate to establish selection criteria for FHCC leadership and that prior to future integration efforts, VA and DOD conduct data-driven strategic workforce planning and resolve differences in IT network security standards to the extent possible. VA and DOD concurred with all of GAO's recommendations.

View GAO-16-280. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

The governance structure for the Captain James A. Lovell Federal Health Care Center (FHCC) demonstration—which includes leadership officials within the Departments of Veterans Affairs (VA) and Defense (DOD)—helped resolve collaboration problems with local leadership, but limitations with the FHCC's leadership selection and evaluation processes may impede future collaboration. For example, VA and DOD did not use—and have not yet developed—FHCC-specific criteria to select individuals for the facility's director (from VA) and deputy director (from the Navy) positions to ensure that they would be well suited for a collaborative environment. As GAO has previously reported, leaders who work successfully in a collaborative environment exhibit certain competencies, such as working well with others and communicating openly. Identifying specific selection criteria that include competencies for leading an integrated facility would help ensure that FHCC leadership have the necessary skills or experience to work well together.

Decisions regarding the integration of the FHCC's civilian and active duty workforce created difficulties with managing staffing across the facility. The FHCC did not initially conduct comprehensive, data-driven staffing analyses, which is not consistent with government best practices for workforce planning. As a result, the FHCC was unable to confirm that its workforce was appropriately aligned to maximize efficiency. According to DOD and Navy officials, this was due to a decision that the FHCC would initially maintain pre-integration staffing levels, and to the difficulty of projecting appropriate staffing levels during demonstration planning. In addition, management's ability to maximize efficiency was further impeded by a lack of data-driven staffing reviews due to data limitations, and a need to focus more intently on other integration requirements. In December 2015, FHCC officials told GAO they had developed an initiative in the interim for reviewing staffing until VA and DOD conduct a more formal, comprehensive, data-driven review of the FHCC's workforce.

The FHCC also faced difficulties integrating certain clinical and administrative operations, including information technology (IT). For example, although the Executive Agreement calls for the FHCC to utilize efficient processes, issues related to the IT infrastructure—which comprises three networks to accommodate differences in VA and DOD's network security standards—initially affected the functioning of some of the FHCC's local IT capabilities and impeded efficiency by limiting the ability of some providers and staff to consistently access VA and DOD's electronic health record systems. Although steps have been taken to improve the functioning of these capabilities, VA officials acknowledged that the FHCC's complex IT infrastructure has created difficulties with managing network connections and providing seamless access to software applications, among other issues. DOD officials said that they continue to work with VA to improve the reliability of the FHCC's IT infrastructure, such as through upgrades and expanding support for data sharing and interoperability. However, VA and DOD officials told GAO that the departments do not plan to resolve differences in network security standards to the extent that the FHCC would be able to have a single-network IT infrastructure. According to VA officials, this is due, at least in part, to the departments' different missions.

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Abbreviations

Advisory Board	Federal Health Care Center Advisory Board
AHLTA	Armed Forces Health Longitudinal Technology Application
DEERS	Defense Enrollment Eligibility Reporting System
DOD	Department of Defense
FHCC	Captain James A. Lovell Federal Health Care Center
HEC	Veterans Affairs/Department of Defense Health Executive Committee
ICU	intensive care unit
IOM	Institute of Medicine
IT	information technology
JEC	Veterans Affairs/Department of Defense Joint Executive Committee
Joint Fund	Joint Department of Defense / Veterans Affairs Medical Facility Demonstration Fund
MTF	military treatment facility
Naval Health Clinic	Naval Health Clinic Great Lakes
NDAA	National Defense Authorization Act
North Chicago VAMC	North Chicago VA Medical Center
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

February 29, 2016

Congressional Committees

In October 2010, the Departments of Veterans Affairs (VA) and Defense (DOD) expanded their efforts to share health care resources through a 5-year demonstration to more fully integrate their medical facilities in North Chicago, Illinois. As authorized by the National Defense Authorization Act (NDAA) for Fiscal Year 2010 (NDAA 2010), VA and Navy facilities in North Chicago were integrated into a first-of-its-kind facility known as the Captain James A. Lovell Federal Health Care Center (FHCC). The 5-year demonstration was intended to create a national model for the joint delivery of health care that would be more accessible and less expensive than operating two federal medical centers serving VA and DOD beneficiaries in the same area.[1] Although VA and DOD have shared resources at some level since the 1980s, the FHCC is the first health care center with a joint governance structure, a joint funding source, and an integrated workforce.[2] In fiscal year 2014, the FHCC employed a workforce of approximately 3,500 staff and provided care to about 99,000 patients at a total cost of $448 million.

The Secretaries of VA, DOD, and the Navy signed an Executive Agreement, effective October 1, 2010, which defined the departments' roles in operating and overseeing the FHCC and outlined requirements in specific "integration areas."[3] One of the integration areas established the FHCC's governance structure, specifying VA as the lead partner with a

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[1]VA beneficiaries include veterans of military service and certain dependents and survivors. DOD beneficiaries include active duty servicemembers (including Navy recruits) and their dependents, medically eligible National Guard and Reserve servicemembers and their dependents, and military retirees and their dependents and survivors. Active duty personnel also include Reserve members on active duty for at least 30 days. Military retirees are dually eligible for both VA and DOD benefits.

[2]The Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act was enacted in 1982. See 38 U.S.C. § 8111. The Department of Veterans Affairs was previously known as the Veterans Administration.

[3]The NDAA 2010 authorized the Secretaries of VA and Defense to execute an Executive Agreement to combine medical facilities. Pub. L. No. 111-84, § 1701(a), 123 Stat. 2190, 2567 (2009).

senior VA official serving as the FHCC director, and requiring that certain advisory bodies comprised of VA and DOD officials provide oversight. Other integration areas included workforce management and personnel, which addressed provisions such as staffing and the transfer of DOD civilian personnel to VA's personnel system; and various aspects of facility operations, including information technology (IT) capabilities needed to achieve interoperability between VA and DOD systems at the FHCC. According to the agreement, the FHCC was intended to meet the health care missions of both departments and DOD's operational readiness mission by integrating services previously provided by the former North Chicago VA Medical Center (North Chicago VAMC) and the Naval Health Clinic Great Lakes (Naval Health Clinic) into a single facility.[4] The agreement also specified that the FHCC was designed to improve the access, quality, and cost effectiveness of care, while providing FHCC leadership with the ability to adopt the most efficient of the clinical and administrative processes used by VA and DOD.

This unprecedented partnership to provide health care services to both VA and DOD beneficiaries at the same facility is expected to offer lessons for decision makers about whether this model of care would be effective if replicated at other VA and DOD locations. In 2012, the Institute of Medicine (IOM) issued a report on the results of the FHCC integration and concluded, among other things, that it had not been in operation long enough to determine the benefits accrued and to assess whether it had been cost effective.[5] The NDAA 2010 required the departments to submit a report to the appropriate committees of Congress no later than 180 days after 5 years of executing the Executive Agreement (or by March 2016), to include a comprehensive evaluation of the demonstration and a recommendation as to whether the FHCC should continue as a fully integrated joint facility.[6] While the comprehensive evaluation is being

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[4]DOD's operational readiness mission includes ensuring that Navy recruits are medically ready to accomplish military duties and deployments, and that active duty providers develop and maintain clinical skills necessary to serve at military treatment facilities and in combat environments.

[5]Institute of Medicine, *Evaluation of the Lovell Federal Health Care Center Merger: Findings, Conclusions, and Recommendations* (Washington, D.C.: National Academies Press, 2012).

[6]See Pub. L. No. 111-84, § 1701(d)(2), 123 Stat. 2190, 2568 (2009).

completed, Congress has approved an extension of joint funding for the FHCC through fiscal year 2017.[7]

The NDAA 2010, as amended by the NDAA for Fiscal Year 2012, included a provision for us to review and assess the progress made toward implementing the Executive Agreement and the effects of the Executive Agreement on the provision of care and operation of the facility, and to issue reports at specified times based on those assessments.[8] In 2011 and 2012, we issued two reports in response to this provision and found that the departments had made progress implementing the Executive Agreement's integration areas, but that there were delays in establishing IT capabilities (despite an investment of $122 million) that proved costly to the FHCC because of the need for workarounds to address problems.[9] We also identified other challenges encountered by the FHCC early in the demonstration, and made a number of recommendations to the departments. For example, we found that VA and DOD had not yet developed a plan to evaluate the FHCC demonstration, and recommended that the departments develop and agree to an evaluation plan, including the performance measures and standards to be used—a recommendation that VA and DOD have since implemented. (See app. I for a list of the recommendations and their status.)

In this report, we address the following questions:

1. To what extent have the FHCC governance structure and leadership processes facilitated collaboration at the integrated facility?

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[7]National Defense Authorization Act for Fiscal Year 2016, § 723, 129 Stat. 726 (2015).

[8]NDAA 2010—Pub. L. No. 111-84, § 1701(e), 123 Stat. 2190, 2568 (2009)—required GAO to report annually beginning one year after the Executive Agreement was executed; NDAA for Fiscal Year 2012—Pub. L. No. 112-81, § 1098, 125 Stat. 1298, 1609 (2011)— amended that reporting requirement to include two more reports, resulting in GAO reports in 2011, 2012, and 2015.

[9]GAO, *VA and DOD Health Care: First Federal Health Care Center Established, but Implementation Concerns Need to Be Addressed*, GAO-11-570 (Washington, D.C.: July 19, 2011); and GAO, *VA/DOD Federal Health Care Center: Costly Information Technology Delays Continue and Evaluation Plan Lacking*, GAO-12-669 (Washington, D.C.: June 26, 2012).

2. What difficulties, if any, has the FHCC faced in integrating the workforce?

3. What difficulties, if any, has the FHCC faced in integrating operations?

To determine the extent to which the FHCC's governance structure and leadership processes facilitated collaboration at the facility, we reviewed relevant documentation, including FHCC organizational charts, memoranda, and reports issued by FHCC leadership; e-mails and meeting minutes documenting discussions among FHCC leaders and VA, DOD, and Navy officials, including officials at the department level or within departmental components; the IOM's evaluation of the FHCC; and our prior reports about the FHCC.[10] We reviewed the requirements related to the FHCC governance structure and leadership, including those contained in the Executive Agreement and a related executive decision memorandum, position descriptions and performance agreements for FHCC leadership, and related governance and leadership best practices described in our prior reports.[11] We interviewed the current FHCC director and deputy director, as well as the other civilian and active duty leadership officials at the facility. We also interviewed the prior FHCC director and deputy directors. We interviewed 10 VA, DOD, and Navy officials responsible for monitoring and overseeing FHCC leadership, some of whom also served as the past and current co-chairs of the FHCC Advisory Board (Advisory Board).[12] These officials included the executive

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[10]In this report, we use the term "VA officials" to refer to officials who work at the department level or within a VA component, such as the Veterans Health Administration or the Veterans Integrated Service Network (VISN) for the Great Lakes region (VISN 12). In addition, we use the term "DOD officials" to refer to officials who work at the Defense Health Agency. Navy officials include officials who work within the Department of Navy, including the Navy Bureau of Medicine and Surgery and Navy Medicine East.

For our prior reports about the FHCC, see GAO-11-570 and GAO-12-669.

[11]GAO, *VA and DOD Health Care: Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities*, GAO-12-992 (Washington, D.C.: Sept. 28, 2012); and GAO, *Managing for Results: Implementation Approaches Used to Enhance Collaboration in Interagency Groups*, GAO-14-220 (Washington, D.C.: Feb. 14, 2014).

[12]The Advisory Board is charged with fostering collaboration between VA and DOD at the FHCC. It also addresses issues unable to be resolved within the local governance structure and monitors operations of the FHCC to ensure the mission of both departments are met. The VISN 12 director serves as the VA co-chair on the Advisory Board. The commander for DOD's Navy Medicine East serves as the DOD co-chair.

director of the Office of Interagency Health Affairs within the Veterans Health Administration (VHA); the prior and current network directors for the relevant Veterans Integrated Service Network (VISN), which is VISN 12; the Assistant Secretary of Defense for Health Affairs; the Navy Surgeon General, who commands the Navy Bureau of Medicine and Surgery; and the prior and current commanders for Navy Medicine East.[13]

To identify any difficulties faced in integrating the workforce, we reviewed relevant documentation pertaining to FHCC workforce management and personnel planning, including FHCC business rules for making staffing decisions, relevant meeting minutes, prior third-party and departmental evaluations, and our prior reports about the FHCC.[14] We also reviewed requirements and guidance related to workforce alignment and staffing flexibilities, including the Executive Agreement integration area on workforce management and personnel, a related executive decision memorandum, the FHCC's Total Workforce Management and Personnel plan, and the Office of Personnel Management's Human Capital Assessment and Accountability Framework, as well as other related best practices described in our prior reports.[15] We also reviewed our prior reports related to duplication and health care collaboration between VA and DOD, and documentation of VA and DOD joint strategic planning efforts.[16] We obtained and analyzed data related to FHCC staffing levels and the mix of civilian, military, and contract personnel. In addition, we

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[13]VA's health system is divided into regional areas called VISNs, each responsible for managing and overseeing medical facilities within a defined geographic area. VISNs oversee the day-to-day functions of VA facilities that are within their network. Each VA facility is assigned to a single VISN. The Navy Bureau of Medicine and Surgery is the headquarters command for Navy Medicine. Navy Medicine East is the Navy regional medical command for the North Chicago area.

[14]See GAO-11-570 and GAO-12-669.

[15]GAO, *Human Capital: Key Principles for Effective Strategic Workforce Planning,* GAO-04-39 (Washington, D.C.: Dec. 11, 2003), GAO, *A Model of Strategic Human Capital Management,* GAO-02-373SP (Washington, D.C: March 15, 2002), GAO, *Human Capital: Effective Use of Flexibilities Can Assist Agencies in Managing Their Workforces,* GAO-03-2 (Washington, D.C.: Dec. 6, 2002), and Office of Personnel Management, *Human Resources Management in Agencies, Human Capital Assessment and Accountability Framework and Human Capital Assessment and Accountability Framework Systems, Standards, and Metrics*, 73 Fed. Reg. 23012 (Apr. 28, 2008) (codified at 5 C.F.R. § 250).

[16]GAO, *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue,* GAO-11-318SP (Washington, D.C.: Mar. 1, 2011) and GAO-12-992.

conducted interviews with VA, Navy, and FHCC officials knowledgeable about FHCC workforce management processes, staffing practices, and strategic workforce reviews over the course of the demonstration. We also conducted 15 in-person, semi-structured small-group interviews at the FHCC with 59 civilian and active duty staff from a variety of clinical and administrative areas of the facility, to obtain their perspective on the effects of workforce integration, including the aspects that had positive and negative impacts on their daily work.[17] (See app. II for more information on our small-group interview methodology.)

To identify any difficulties faced in integrating FHCC operations, we reviewed relevant documentation, including FHCC policies and guidance, relevant meeting minutes, prior and ongoing third-party and departmental evaluations, and our prior reports about the FHCC.[18] We also reviewed requirements related to facility operations, including those contained in the Executive Agreement and executive decision memoranda, as well as relevant standards for internal control in the federal government related to information and communications, establishing and maintaining a control environment, and control activities.[19] We obtained and analyzed data on FHCC patient utilization (encounters), referrals to network providers, and costs associated with IT workarounds. In addition, we conducted interviews with VA, DOD, Navy, and FHCC officials knowledgeable about the FHCC's IT, clinical, and administrative operations. We also conducted 12 in-person, semi-structured, small-group interviews with 47 FHCC managers and staff from various clinical and administrative areas of the facility to obtain their perspectives on different aspects of integrating operations that had positive and negative impacts on their daily work.

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[17]We identified key aspects related to workforce integration from sources such as previous interviews with FHCC officials, a prior GAO report, Advisory Board meeting minutes, and the Executive Agreement.

[18]Ongoing departmental evaluations include VA and DOD's evaluations of FHCC IT systems (which is being conducted by VHA's Office of Quality, Safety and Value, Product Effectiveness) and other FHCC operations (which is being conducted through a contract with Knowesis, Inc.).

See GAO-11-570 and GAO-12-669.

[19]GAO, *Standards for Internal Control in the Federal Government,* GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

As part of our work to identify difficulties faced in integrating the FHCC's workforce and operations, we assessed the reliability of the FHCC data we received on patient encounters, staffing levels, patient referrals to network providers, and costs associated with IT workarounds by reviewing related documentation, performing data reliability checks (such as examining the data for missing values), and interviewing FHCC officials. After taking these steps, we determined that the data were sufficiently reliable for the purposes of our audit. Finally, data from our small-group workforce and operations interviews are not generalizable to all FHCC staff, nor to FHCC staff in the specific clinical and administrative areas from which we selected our interview participants.

We conducted this performance audit from January 2015 to February 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The FHCC is the first integrated medical center operated and managed by both VA and DOD that serves both departments' beneficiaries. The 5-year demonstration was intended to create a national model for the joint delivery of health care that would be more accessible and less expensive than operating two federal medical centers serving VA and DOD beneficiaries in the same area. Although the FHCC was launched in October 2010, VA and DOD have shared resources in and around North Chicago since the 1980s. In 2006, the Naval hospital's inpatient services were transferred to the North Chicago VAMC, at which point the Naval hospital became the Naval Health Clinic. The creation of the FHCC allowed VA to continue and expand its inpatient services in North Chicago.

Overview of FHCC Integration

The FHCC consists of all the buildings and locations formerly operated by either the North Chicago VAMC or the Naval Health Clinic (including various outpatient and recruit clinics), as well as an ambulatory care center, and provides the services previously offered by these facilities.[20]

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[20]As of December 2015, three VA community-based outpatient clinics were linked to the FHCC, providing off-site services, including primary care, to VA beneficiaries.

The FHCC has an East Campus and a West Campus. The East Campus is comprised of health clinics that had been part of the former Naval Health Clinic, which provide health care primarily to the Navy recruits who train at the Naval Station Great Lakes for several months each year.[21] The West Campus includes the former North Chicago VAMC and the ambulatory care center, where both VA and DOD beneficiaries receive health care services. West Campus care includes inpatient care and various outpatient services, such as primary care, dermatology, and women's health services, as well as on-site laboratory, radiology, and pharmacy services, enabling patients to access these ancillary services in the same location as their outpatient services. The West Campus also includes the Community Living Center, which provides long-term care services and support exclusively to VA beneficiaries. (See fig. 1 for the proportions of care provided at each FHCC campus and by beneficiary type.)

[21]Medical and dental services are provided to Navy recruits on the East Campus in support of the Recruit Training Command and Training Support Center. The FHCC is responsible for ensuring that each recruit is medically ready for service, and the Recruit Training Center runs the Navy's boot camp for all newly enlisted recruits. In fiscal year 2014, the FHCC provided medical care to approximately 45,000 Navy recruits. The Training Support Center runs the "A" schools, which are advanced training programs for enlisted sailors.

Figure 1: Number of Inpatient and Outpatient Encounters for the Captain James A. Lovell Federal Health Care Center (FHCC) in Fiscal Year 2014, by Campus and Beneficiary Type

Total FHCC encounters: 1,070,825

43%

57%

East Campus encounters: 605,213[a]

<1%
Veterans[c]

1%
Other (TRICARE)[d]

18%
Active duty (TRICARE)[d]

81%
Navy recruits (TRICARE)[d]

West Campus encounters: 465,612[b]

5%
Navy recruits (TRICARE)[d]

7%
Active duty (TRICARE)[d]

20%
Other (TRICARE)[d]

68%
Veterans[c]

Source: GAO analysis of FHCC data. | GAO-16-280

Note: Data provided by the FHCC are for fiscal year 2014, the most recent fiscal year for which complete data were available. Data include total outpatient and dental encounters—which FHCC officials defined as "face-to-face interactions with a patient"—and inpatient discharges, as recorded in the electronic health record systems maintained by the Department of Veteran Affairs (VA) and Department of Defense (DOD). Radiology, pharmacy, and laboratory encounters were excluded due to data limitations.

[a]The FHCC's East Campus includes health clinics that had been part of the former Naval Health Clinic, which provide health care primarily to Navy recruits.

[b]The FHCC's West Campus includes the former North Chicago VA Medical Center and the ambulatory care center, which provide health care to both VA and DOD beneficiaries. The encounters for the West Campus include care provided at VA's three offsite community-based outpatient clinics associated with the FHCC.

The services available to FHCC patients and the priority for accessing them vary depending on whether patients are eligible for VA or TRICARE health care programs, which offer different benefit packages, pharmacy formularies, and civilian provider networks.[22] Dual-eligible beneficiaries can choose to use either their VA or TRICARE benefits at the onset of each episode of care.[23] The FHCC may serve all eligible VA and DOD beneficiaries, subject to resource and space availability limitations. To ensure beneficiaries' access to care and the medical readiness of enlisted Navy recruits, a patient priority system was defined in the Executive Agreement. The system gives highest priority to active duty servicemembers, including Navy recruits, and subsequently prioritizes VA beneficiaries and other DOD beneficiary categories. If clinical capacity at the FHCC is reached, lower-priority beneficiaries may be referred outside of the FHCC to a civilian provider through either VA or DOD depending on their beneficiary status.

Unlike other sites where VA and DOD share resources, the FHCC has a joint funding source, to which VA and DOD contribute. The NDAA 2010 established the Joint DOD-VA Medical Facility Demonstration Fund (Joint Fund) as the funding mechanism for the FHCC, with VA and DOD both

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[22]Through TRICARE, DOD offers three basic options for its beneficiaries: (1) a managed care option called TRICARE Prime, (2) a preferred-provider option called TRICARE Extra, and (3) a fee-for-service option called TRICARE Standard. Beneficiaries must enroll in order to receive health care services through TRICARE Prime but do not need to enroll in order to receive services through TRICARE Standard and Extra. An additional option, TRICARE for Life, supplements Medicare coverage for beneficiaries enrolled in Medicare Part B.

[23]Veterans receiving treatment for a service-connected condition must use their VA benefits.

making transfers to the Joint Fund from their respective appropriations.[24] As authorized in the NDAA 2010, the Executive Agreement required a financial reconciliation process that permits VA and DOD to identify their contributions to the Joint Fund each year. These contribution proportions are determined based on the proportion of shared care provided by each department, as well as the amount each department spent for mission-specific services provided to its beneficiaries. Each year since 2012, VA's share of total FHCC obligations has been about two-thirds, while DOD's has been about one-third.[25]

Executive Agreement

The Executive Agreement, signed by the Secretaries of VA, DOD, and the Navy, defines the departments' sharing relationship at the FHCC by establishing an integrated governance structure, combining VA and DOD staff into a single workforce, and integrating various aspects of operations. It contains key provisions to be met in 12 integration areas. As of August 2015, the FHCC had implemented 9 of the integration areas, maintained or made progress toward meeting the provisions of 2 additional areas, and determined that it would not fully implement the IT integration area because the departments abandoned plans to develop a single, integrated system in 2013. (See table 1 for the key provisions and status of the 12 integration areas.)

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[24]The NDAA 2010, which established the Joint Fund, was enacted on October 28, 2009. The Executive Agreement was signed in April 2010. The Joint Fund did not receive any earmarked appropriations in fiscal year 2010 so the FHCC was funded using the allowable alternative funding mechanism outlined in the Executive Agreement. For fiscal year 2011, both DOD and VA were under a continuing resolution for the first three quarters and generally subject to prior-year funding until April 15, 2011. The first three quarters of fiscal year 2011 were also funded using the allowable alternative funding mechanisms until the full year appropriations act was enacted on April 15, 2011. See Pub. L. No. 112-10, §§ 8107, 2017, 2018, 125 Stat. 38, 81, 175 (2011). For fiscal year 2012 – 2015, DOD and VA received specific appropriations to be transferred to the Joint Fund. See Pub. L. No. 112-74, §§ 8107, 224, 225, 125 Stat. 786, 830-31, 1158 (2011); Pub. L. No. 113-6, §§ 8099, 223, 224, 127 Stat. 198, 320-21, 406 (2013); Pub. L. No. 113-76, §§ 8098, 223, 224, 128 Stat. 5, 128, 459 (2014); Pub. L. No. 113-235, §§ 8102, 222, 223, 128 Stat. 2130, 2278, 2564-2565 (2014).

[25]The reconciliation process did not begin until fiscal year 2012.

Table 1: Implementation Status of the 12 Executive Agreement Integration Areas for the Captain James A. Lovell Federal Health Care Center (FHCC), as of August 2015

Executive Agreement integration area	Key provisions	Status		
		Implemented	In progress	Will not be fully implemented
Governance structure	FHCC leadership structure and advisory bodies	X		
Access to health care at the FHCC	Patient priority system and eligibility of members of the uniformed services for care	X		
Research	Institutional Review Board approval and policy for the protection of human subjects	X		
Contracting	Departments of Veteran Affairs (VA) and Defense (DOD) responsibility for contracting support	X		
Quality assurance	Accreditation and oversight from external entities and credentialing and privileging of health care providers	X		
Contingency planning	Emergency and disaster management and security	X		
Integration benchmarks	Completion of 15 integration benchmarks may occur before 2015	X[a]		
Workforce management and personnel	Staffing, training, and the transfer of DOD civilian personnel to VA	X[a]		
Property	Construction, transfer of property, and physical plant management	X[b]		
Reporting requirements	VA and DOD reports to congressional committees and Comptroller General reviews		X	
Fiscal authority	Budgeting, joint funding authority, and reconciliation		X	
Information technology	Administrative and clinical IT, including efforts to achieve interoperability between VA and DOD systems			X[c]

Source: GAO analysis of FHCC and DOD information. | GAO-16-280

Note: Integration areas that are categorized as "implemented" are areas in which all the identified provisions in the Executive Agreement have been completed, those categorized as "in progress" are areas in which at least one provision has not been completed, and those categorized as "will not be fully implemented" are areas in which at least one provision is not expected to be completed before the end of this demonstration.

[a]In 2012, we reported that this integration area was in progress. See GAO, *VA/DOD Federal Health Care Center: Costly Information Technology Delays Continue and Evaluation Plan Lacking*, GAO-12-669 (Washington, D.C.: June 26, 2012).

[b]In 2012, we reported that this integration area was in progress, as the FHCC was permitted to address the property integration area prior to the end of the demonstration in 2015, but was not required to do so. See GAO, *VA/DOD Federal Health Care Center: Costly Information Technology Delays Continue and Evaluation Plan Lacking*, GAO-12-669 (Washington, D.C.: June 26, 2012). Since that time, VA and DOD have agreed that the Navy will maintain ownership of the FHCC's ambulatory care center and will not transfer the property to VA.

[c]In 2012, we reported that this integration area was delayed because the FHCC had not met the deadline for at least one provision in the Executive Agreement, and because the FHCC no longer planned to develop its own capability for one of the provisions, pharmacy orders portability, until a more long-term effort to merge VA and DOD's electronic health record systems into a single system was complete. See GAO-12-669. The departments abandoned their effort to develop a single

integrated system in 2013. According to VA and DOD officials, as of October 2015, there were no plans to implement the provision of pharmacy orders portability at the FHCC.

FHCC Governance Structure

According to the governance structure established in the Executive Agreement, the FHCC is to be accountable to both VA and DOD, with VA serving as the lead department. (See fig. 2.)

- The FHCC director, a VA executive, is to be accountable to VA for the fulfillment of the FHCC mission, while the deputy director, a Navy Captain who rotates approximately every 2 years, is to be accountable to the Navy and, ultimately, DOD.

- The Advisory Board is responsible for ensuring that the VA and DOD missions are met by monitoring the FHCC and handling issues that are not resolved at the local level. It is to be co-chaired by representatives of both departments—the network director for VISN 12 within VHA and the commander for Navy Medicine East within the Navy's Bureau of Medicine and Surgery. The board is to meet on no less than a quarterly basis to discuss the FHCC's progress and recommendations, and it is to make decisions through a consensus of its voting members.[26]

- FHCC issues that are not able to be resolved by the Advisory Board are to be elevated to the joint VA/DOD Health Executive Committee (HEC) for resolution, as specified in the Executive Agreement.[27] However, if the HEC is unable to resolve an issue, it may be elevated to the VA/DOD Joint Executive Committee (JEC).[28]

[26]There are eight Advisory Board members, with four members representing VA (two are voting members) and four representing DOD (three are voting members).

[27]The HEC, which is a sub-committee of the JEC, provides oversight for the specific cooperative efforts of each department's health care organizations. The HEC is organized into a number of work groups that focus on specific high-priority areas of national interest.

[28]The JEC is made up of senior VA and DOD officials and provides broad strategic direction for collaboration and resource sharing between the two departments.

Figure 2: Governance Structure for the Captain James A. Lovell Federal Health Care Center (FHCC), as of September 2015

Source: GAO analysis of VA, DOD, and FHCC information. | GAO-16-280

[a]The JEC is made up of senior VA and DOD officials and provides broad strategic direction for collaboration and resource sharing between the two departments.

[b]The HEC is a sub-committee of the JEC and is co-chaired by senior VA and DOD officials. The HEC provides oversight for the specific cooperative efforts of each department's health care organizations, and is organized into several work groups that focus on specific high-priority areas of national interest.

[c]The FHCC Advisory Board is a HEC workgroup comprising senior officials from VA and DOD. The director of the Veterans Integrated Service Network 12 and commander of Navy Medicine East serve as co-chairs. It was created specifically to provide guidance and support to FHCC leaders and to resolve issues that arise at the FHCC.
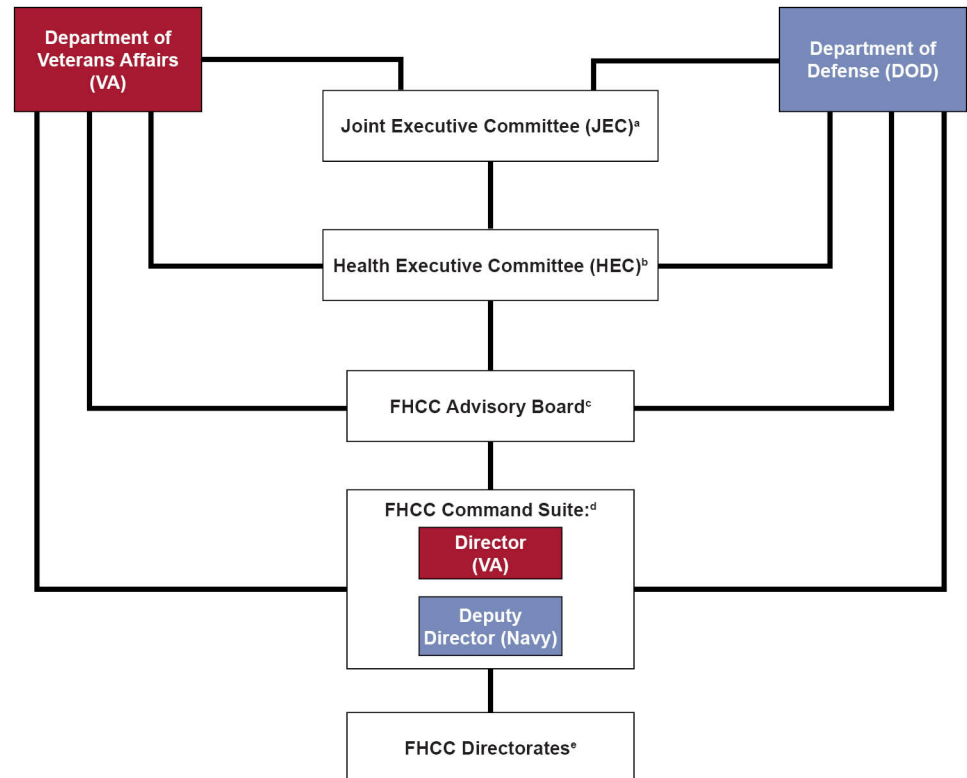
[d]The FHCC director, a VA executive, is accountable to VA for the fulfillment of the FHCC mission, while the deputy director, a Navy Captain who rotates approximately every 2 years, is accountable to the Navy and, ultimately, DOD.

[e]The FHCC's organizational structure groups its workforce and operations under directorates that are led by an associate director representing one department (VA or DOD) and an assistant director representing the other department.

FHCC Organizational Structure

The FHCC's initial organizational structure included six directorates that reported to the FHCC command suite, which included the director (from VA) and the deputy director (from the Navy). In April 2014, the FHCC implemented a new organizational structure as directed by its Advisory Board. The reorganization regrouped and elevated certain clinical areas to create new directorates.[29] Each directorate is led by an associate director either from VA or the Navy, with an assistant director (subordinate to the associate director) representing the other department. The new structure was intended to facilitate communication between leaders and staff, and increase leadership opportunities for Navy staff, according to FHCC leadership officials. (See fig. 3 for organizational charts of the FHCC directorates at the start of the demonstration and after the 2014 reorganization.)

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[29]For example, geriatric and mental health clinical areas were initially grouped with other clinical areas in directorates led by the VA Chief Medical Executive and VA Nurse Executive, respectively. The reorganization grouped geriatric and mental health services together and elevated them to become a single directorate.

Figure 3: Reorganization of the Directorate Structure at the Captain James A. Lovell Federal Health Care Center (FHCC), as of September 2015

Initial FHCC Directorate Structure

FHCC Command Suite:[a]
- Director (VA)
- Deputy Director (Navy)

- Patient Services – Nurse Executive
- Dental Services
- Facility Support
- Fleet Medicine
- Patient Care – Chief Medical Executive
- Resources

Reorganized FHCC Directorate Structure

FHCC Command Suite:[a]
- Director (VA)
- Deputy Director (Navy)

- Geriatrics and Mental Health
- Fleet Medicine
- Medical Practice – Chief Medical Executive
- Inpatient Services – Navy Nurse Executive
- Nursing Practice/ VA Nurse Executive
- Dental Services
- Clinical Support Services
- Primary Care
- Specialty Care
- Resources
- Facility Support

VA leadership   Navy leadership

Source: GAO analysis of FHCC information. | GAO-16-280

Notes: In April 2014, 10 of the 11 directorates shown in the chart of the reorganized structure were implemented at the FHCC, and the final directorate (Nursing Practice/VA Nurse Executive) was implemented in May 2014. In both structures, the directorates are led by either a VA or Navy associate director, with an assistant director (who is subordinate to the associate director) representing the other department. The directorates are divided further into departments, divisions, and sections.
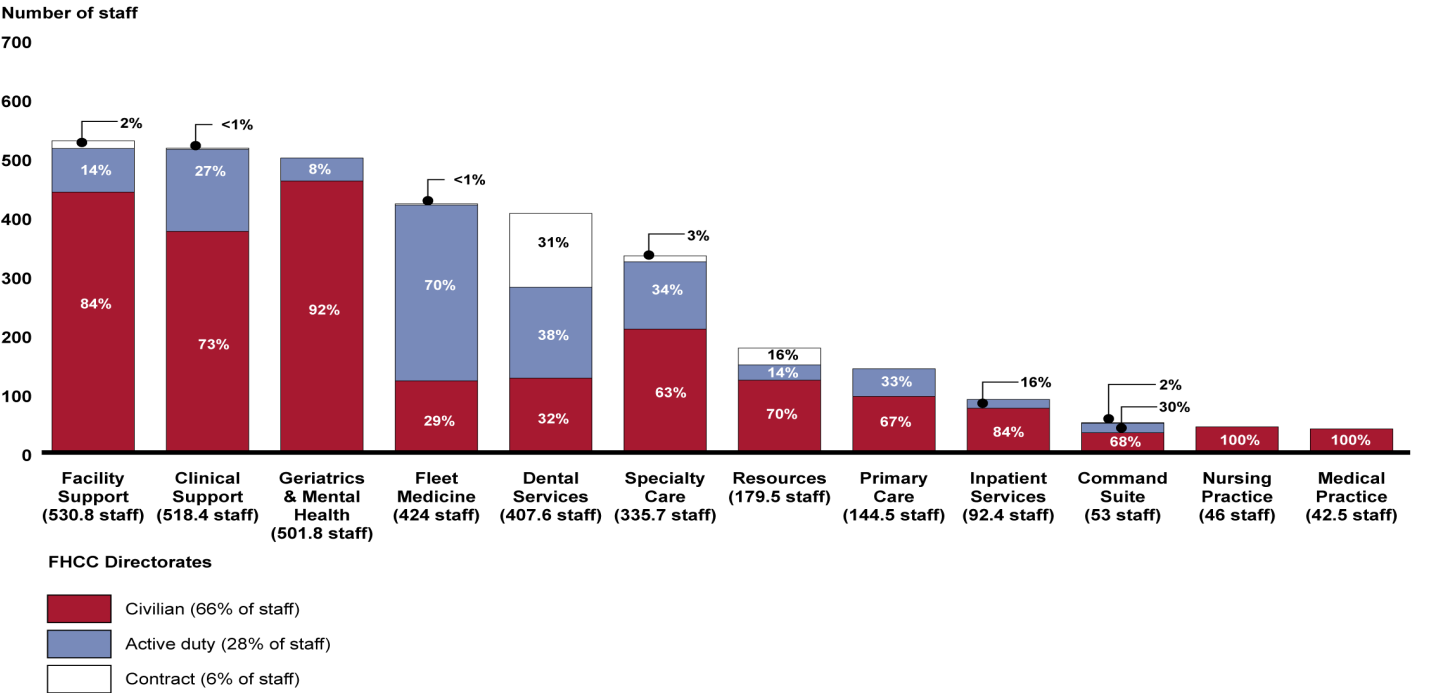
[a]The command suite includes the FHCC director and deputy director, the Office of Performance Improvement, and additional staff such as special military assistants.

FHCC Workforce

In accordance with the Executive Agreement, staff from the Naval Health Clinic and the North Chicago VAMC merged to create a single, joint workforce. This included the transfer of DOD civilian staff employed by

the Naval Health Clinic into VA's personnel system as authorized in the NDAA 2010.[30] As of June 2015, the FHCC's workforce included approximately 3,300 civilian, active duty, and contract staff. Civilians comprised 66 percent (about 2,200) of the facility's overall workforce, while 28 percent (about 900) were active duty servicemembers, and 6 percent (about 200) were contract staff. However, the proportions of civilian and active duty staff varied by directorate. (See fig. 4 for the number and proportion of staff at the FHCC overall and within each directorate, and app. III for an example of clinic-level staffing within the Specialty Care directorate.)

Figure 4: Number and Proportion of Civilian, Active Duty, and Contract Staff by Directorate at the Captain James A. Lovell Federal Health Care Center (FHCC), as of June 2015

Source: GAO analysis of FHCC information. | GAO-16-280

[30]Pub. L. No. 111-84, § 1703, 123 Stat. 2570, 2571 (2009). The VA and DOD personnel systems for civilians have some different statutory bases. The NDAA 2010 authorized the DOD and Navy secretaries to move DOD civilians into the VA's personnel system, and the departments used this authority for the 533 civilians who were employed at the Naval Health Clinic prior to integration. Nineteen DOD civilian personnel remained under DOD's personnel authorities because of access restrictions to certain DOD IT networks.

The FHCC's civilian staff are governed by VA personnel statutes and regulations, collective bargaining agreements (including a nursing union and government employee union), and VA's human resources and payroll management systems. The FHCC's active duty staff include enlisted sailors (such as hospital corpsmen) and officers (such as administrative and clinical managers, physicians, and surgeons) who rotate and deploy in accordance with Navy workforce regulations.[31] Active duty staff are subject to the Uniform Code of Military Justice and other military policies and directives. For example, military personnel working at the FHCC must maintain physical training requirements, carry out performance evaluations using Navy fitness reports, and conduct other collateral duties as assigned through their military chain of command. Contract staff are employed at the FHCC to supplement the civilian and active duty workforce. Per the Executive Agreement, all VA and DOD required training and staff orientations are to be completed by FHCC staff.[32]

FHCC IT Systems and Capabilities

In the absence of a single integrated electronic health record system, FHCC health care providers must use either VA's system—the Veterans Health Information Systems and Technology Architecture (VistA)—or DOD's system—the Armed Forces Health Longitudinal Technology Application (AHLTA)—to record information related to patient care. The system that providers use depends on where the care is being provided and on the type of beneficiary (VA or DOD). FHCC providers use VistA for primary care visits and prescriptions for VA beneficiaries, and for most West Campus specialty care visits for both VA and DOD beneficiaries. FHCC providers also use VistA's Computerized Patient Record System to capture information on all West Campus emergency room visits, inpatient stays, and surgical care.[33] FHCC providers use AHLTA for nearly all care

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[31]Hospital corpsmen perform duties as assistants in the prevention and treatment of disease and injury and assist health care professionals in providing medical care to Naval personnel and their families. They also serve as battlefield corpsmen, rendering emergency medical treatment to include initial treatment in a combat environment. Navy personnel rotate after 2 or 3 years and can be deployed up to two times during their rotation at the FHCC.

[32]The FHCC established a Department of Education and Training to manage all of the training requirements.

[33]In our report, the term "VistA" includes VistA's Computerized Patient Record System.

provided on the East Campus, primary care visits and some specialty care visits for DOD beneficiaries on the West Campus, and for prescriptions ordered for DOD beneficiaries on both campuses.[34] Some FHCC providers must use both VistA and AHLTA in order to view complete patient information; for example, DOD primary care providers must use VistA to view results of DOD beneficiaries' emergency room visits.[35]

The Executive Agreement required specific IT capabilities to be based on local needs to support clinical services provided to the integrated patient population, including the following:

1. single patient registration, which would allow staff to register patients in both systems simultaneously;

2. medical single sign-on with context management, which would allow staff to log in one time to access both VistA and AHLTA and ensure that staff are looking at the same patient's record in both systems; and

3. orders portability, which would allow VA and DOD clinicians to place, manage, and update clinical orders from either VistA or AHLTA for radiology, laboratory, consults (specialty referrals), and pharmacy services.

Two of these local capabilities (medical single sign-on and single patient registration) became operational in December 2010. Orders portability for radiology, laboratory, and consults became operational later (in June 2011, March 2012, and August 2012, respectively). According to VA and DOD officials, the departments spent approximately $130 million on the development of these and other IT capabilities at the FHCC through fiscal year 2015, as well as an additional estimated $25-26 million in IT workaround costs. DOD officials estimated that their total sustainment costs for these IT capabilities would be $12.5 million in fiscal year 2015

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[34]In our report, the term "AHLTA" includes DOD's Composite Health Care System, which is used for appointment scheduling and for orders processing by ancillary services staff, and which providers generally use for entering orders, including prescriptions, when AHLTA is not available.

[35]FHCC officials also told us that providers can view complete patient records on one screen through the Joint Legacy Viewer, a capability that was recently extended to 1,750 VA providers at the FHCC in August 2015. In order to make changes to a patient record, however, providers need to use either VistA or AHLTA.

and around $8-10 million in future years.[36] VA officials estimated that VA's sustainment costs going forward would be substantially less, likely around $1.5 million per year.

One of the required local capabilities—orders portability for pharmacy—was never achieved and a workaround was maintained throughout much of the demonstration. If implemented, this capability would have enabled providers to enter prescriptions for VA and DOD beneficiaries in whichever electronic health record system they used to record care for their patients—AHLTA or VistA. However, currently, providers can only enter prescriptions for VA beneficiaries in VistA and for DOD beneficiaries in AHLTA. In 2012, at the time of our last report on the FHCC, we reported that the FHCC no longer planned to develop its own capability for pharmacy orders portability until a more long-term effort to integrate VA and DOD's electronic health record systems into a single system was complete.[37]

In 2012, we also reported that VA and DOD were pursuing an effort to develop a single integrated system, for which they reported spending $564 million. However, they abandoned this effort in February 2013, citing challenges with the cost and schedule.[38] Each department announced that it would focus instead on either building or acquiring similar core sets of electronic health record capabilities and would ensure interoperability between them. DOD plans to develop a new electronic health record system as part of its Defense Healthcare Management Systems Modernization program—for which it awarded a contract in July 2015—whereas VA plans to evolve and modernize its existing system as part of its VistA Evolution program.[39] DOD officials told us that they plan to implement DOD's new electronic health record system at the FHCC in the first quarter of fiscal year 2021. VA officials told us that updates to VistA as part of VA's VistA Evolution program will be implemented at the FHCC beginning in fiscal year 2016, with completion by the second quarter of fiscal year 2019.

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[36]VA and DOD officials clarified that their estimated sustainment costs do not include any estimated costs for future IT workarounds.

[37]See GAO-12-669.

[38]See GAO-14-302.

[39]See GAO-15-530.

FHCC Governance Structure Helped Resolve Initial Collaboration Problems with Local Leadership, but Limitations with Leadership Selection and Evaluation Processes May Impede Future Collaboration

Initial problems with collaboration among the FHCC's local leadership led to issues being elevated within the FHCC's governance structure for successful resolution. VA and DOD did not use—and have not yet developed—FHCC-specific criteria to select individuals for the facility's director (from VA) and deputy director (from the Navy) positions to ensure that they would be well suited for a collaborative environment. In addition, VA and DOD do not have a process to exchange information when evaluating director and deputy director performance, despite acknowledging the need to do so to ensure accountability for both departments' missions. These limitations in selection and evaluation processes could hamper collaboration in the future.

Problems with Local Collaboration Resulted in Issues Being Elevated within the Governance Structure for Resolution

Collaboration problems among FHCC local leadership throughout much of the 5-year demonstration made the resolution of issues difficult. In July 2011—within the first year of the demonstration—the Navy's Inspector General reported concerns about leadership cohesion and trust. Additional concerns were identified in May 2012, when VA's National Center for Organization Development visited the FHCC and subsequently reported that there were power struggles, a lack of collaboration, and other problems with unity among local leaders.[40] Some former VA and FHCC officials and current Navy officials told us that the initial FHCC director's decision-making process largely reflected input from the three VA-led directorates with limited input from the remaining three directorates, which were led by Navy officials.[41] Some Navy officials noted that the lack of Navy input precluded the FHCC's ability to function as an integrated facility and negatively affected staff morale. The initial FHCC director told us that any perceived imbalance was due to functional

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[40]VA's National Center for Organization Development works with VA worksites to promote organizational health through, for example, workplace or facility assessments, executive coaching, and leadership development.

[41]The three VA-led directorates were Patient Care, Patient Services, and Facility Support. The three Navy-led directorates were Fleet Medicine, Dental Services, and Resources.

reasons such as the need to collaborate with directorate leaders responsible for the majority of medical activities, which happened to be VA-led directorates.

Specifically, problems with collaboration among local leadership resulted in difficulties with resolving concerns identified in the wake of a 2012 death of an active duty patient in the FHCC's intensive care unit (ICU). In response to the death, both departments sent subject matter experts to conduct a review in late July 2012. In addition to reviewing the incident, these experts reviewed a wide range of issues at the FHCC, including those related to local leadership, the scope of services at the facility, and the extent of workforce integration in some of the FHCC's clinical areas. Key issues they identified were concerns about the workforce and oversight of the FHCC's ICU and other clinical areas, and the Navy's leadership role at the FHCC. (See fig. 5 for a timeline of key events impacting leadership at the FHCC.)

- **Workforce and oversight of the FHCC's ICU and other clinical areas.** The subject matter experts recommended a number of corrective actions related to the FHCC's workforce, which included increasing Navy clinical staff in the ICU, operating room, and other inpatient areas to better distribute workload and improve integration in these areas. They also recommended corrective actions for oversight, which included developing a robust tracking system for issues previously identified during the peer review process to better ensure good quality of care across the facility.[42]

- **Navy's leadership role at the FHCC.** The subject matter experts also reported that there were perceptions that the Navy maintained a secondary position throughout the entire organization.[43] This perception was evidenced by the initial directorate structure, which had placed the FHCC's clinical activities largely under two VA-led

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[42]The FHCC's peer review process is intended to improve quality of care through reviews of individual provider decisions and actions by health care professionals who are qualified to make fair and credible assessments. This process can result in the identification of issues at the organization system level that need to be addressed to improve overall quality of care at the facility.

[43]Prior to the visit by subject matter experts, FHCC staff reported a similar concern to officials with VA's National Center for Organization Development. According to these officials, they noted that having VA officials occupy the top leadership positions was leading to a perceived inequity in power, with Navy staff feeling "second class" as a result.

directorates: Patient Care, led by the VA Chief Medical Executive; and Patient Services, led by the VA Nurse Executive.[44] The experts found that the lack of leadership opportunities for Navy staff made the FHCC less likely to be selected by Navy personnel for assignment. They noted, too, that the Navy promotion system requires increasing levels of responsibility to achieve the next rank, but that the directorate structure did not enable active duty staff to compete for key leadership positions at the FHCC. The subject matter experts recommended reevaluating the local organizational structure to accelerate the integration process and develop career paths for Navy staff to allow for longevity and promotion opportunities. Similar concerns had been raised earlier by the Advisory Board, although the FHCC director and the deputy director assigned at the onset of the demonstration were not in support of reorganization.

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[44]The Patient Care directorate included the ICU, emergency department, ambulatory care, surgery, and mental health services; and the Patient Services directorate included ancillary services, education and training, diagnostic services, geriatrics, and rehabilitation services.

Figure 5: Timeline of Key Events Impacting Leadership at the Captain James A. Lovell Federal Health Care Center (FHCC) during the Demonstration

October 2010
Implementation of the FHCC. Existing Department of Veterans Affairs (VA) medical center director established as FHCC director. Navy Captain assigned as FHCC deputy director.

February 2012
Active duty patient dies in the FHCC's Intensive Care Unit (ICU).

August 2012
New deputy director (Navy) begins assignment at the FHCC.

July 2012
VA and Navy send subject matter experts to conduct a review at the FHCC.

April 2013
Active duty patient treated in the FHCC's ICU dies after being transferred to another facility for care.

July 2013
Co-chairs of the Health Executive Committee (HEC) direct FHCC director and deputy director to improve communication.[b]

May 2013
FHCC Advisory Board approves exclusion criteria for ICU care for all FHCC patients, following a memo issued by the deputy director.[a]

March 2014
Initial director retires. Second deputy director becomes acting director.[c]

April–May 2014
Under the Advisory Board's direction, FHCC reorganized from 6 to 11 directorates

September 2014
Third deputy director begins assignment at the FHCC.

November 2014
FHCC reports to Advisory Board that all issues from the July 2012 review have been addressed.

October 2014
Second director begins assignment at the FHCC.

2010
2011
2012
2013
2014
2015

Source: GAO analysis of VA, DOD, and FHCC information. | GAO-16-280

[a]The Advisory Board was created specifically to provide guidance and support to FHCC leaders and to resolve issues that arise at the FHCC. The Board is co-chaired by the network director of the Veteran Integrated Service Network (VISN) to which the FHCC is assigned (VISN 12) and the commander of Navy Medicine East, which is the regional medical command that oversees the region where the FHCC is located.

[b]The HEC is co-chaired by the VA's Under Secretary for Health and DOD's Assistant Secretary of Defense for Health Affairs. The HEC provides oversight for the specific cooperative efforts of each department's health care organizations, and it is organized into a number of work groups to carry out its work and focus on specific high-priority areas of national interest.

[c]The FHCC's organizational structure groups its workforce and operations under directorates that are led by an associate director representing one department (VA or DOD) and an assistant director representing the other department.

In August 2012, at the end of the first deputy director's 2-year assignment, the Navy assigned a new deputy director who began taking steps to address some of the key issues that had been identified. However, according to some former VA and FHCC officials and current Navy officials, progress was difficult because the initial director and the second deputy director did not effectively collaborate to resolve these issues locally. The following spring—late April 2013—another active duty patient who was treated in the FHCC's ICU died. In light of this occurrence and the lack of resolution on previously identified ICU concerns, the deputy director determined that all DOD beneficiaries requiring ICU services would be diverted to other providers within the TRICARE network until exclusion criteria (medical conditions for which patients should not be admitted to the FHCC's ICU) could be better defined. When the initial director disagreed, they elevated the issue to the Advisory Board co-chairs. This resulted in a May 1, 2013, memo that reflected the director's eventual concurrence with the deputy director's position about diverting DOD beneficiaries needing ICU care to the TRICARE network.[45] The deputy director then proposed a detailed list of exclusion criteria to the Advisory Board, and on May 7, 2013, the board's co-chairs decided to apply the criteria to all FHCC patients (including both VA and DOD beneficiaries) seeking ICU care.

In addition, the initial director and second deputy director had difficulty collaborating on increasing the Navy's leadership role. According to some former VA and FHCC officials and current Navy officials, the deputy director held weekly meetings to work towards a reorganization plan, but the director did not fully engage in these efforts, which slowed the resolution process. When we shared these concerns with former FHCC leadership officials, both said they collaborated effectively to resolve some issues, such as by preparing the FHCC budget, making improvements to local IT solutions, and preparing for Joint Commission reviews. However, the initial director told us that the frequency and quality of his communication with the second deputy director was generally less than that of the first deputy director, and both the initial director and second deputy director said that there was a lack of trust between them. Our prior work on approaches for enhancing collaboration among federal

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[45]At that time, the director also agreed that certain VA beneficiaries considered for ICU admission should instead be stabilized and transferred to another facility with adequate capability.

agencies found personal interactions, such as in-person meetings, helped build trust, which is an essential element to collaborative relationships.[46]

Ultimately, both the concerns about the ICU and other clinical areas, and the Navy's leadership role at the FHCC had to be elevated within the FHCC's governance structure for resolution. In July 2013, the HEC co-chairs (VA's Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs) visited the FHCC to meet in person with the initial director, deputy director, and Advisory Board co-chairs. During this visit, the HEC co-chairs instructed the initial director and deputy director to improve their communication and to move forward with resolving the key issues outlined in the 2012 review by subject matter experts. Soon thereafter, the initial director and deputy director submitted a memo to the HEC co-chairs about their collaboration and progress in addressing the key issues. They enclosed a communication plan, which included a pledge to meet weekly to seek consensus or compromise and to not make decisions without concurrence or input from one another. The memo also indicated that they were in the process of resolving all of the concerns raised in the 2012 review and were working closely with the Advisory Board co-chairs to address concerns regarding the directorate structure. The specific concerns cited by the subject matter experts about the workforce and oversight of the FHCC's ICU and other clinical areas and the Navy's leadership role at the FHCC were resolved in the following ways:

- **Resolution of concerns about the workforce and oversight of FHCC's ICU and other clinical areas.** In a November 2013 Advisory Board meeting, the deputy director presented a status update on the diversion of certain patients to the network and actions taken to implement the corrective actions identified in the 2012 review. He noted that patients with certain conditions who were seeking care in the ICU were still being diverted to the network but that the FHCC had begun implementing the recommended corrective actions for the ICU and other clinical areas. This initiated a series of updates to the Advisory Board based on an ICU Action Tracker, which was a spreadsheet used by the FHCC to monitor progress on executing the corrective actions. By June 2014, only 4 actions remained, and in

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[46]See GAO, *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies,* GAO-06-15 (Washington, D.C.: Oct 21, 2005) and GAO-14-220.

November 2014 (a couple of months after the deputy director had completed his 2-year cycle and moved on to another facility), the FHCC executed the remaining actions. In addition, the FHCC reported that it had revised and finalized a list of exclusion criteria for its ICU based on its existing capabilities.[47]

- **Resolution of concerns about Navy's leadership role at the FHCC.** In late November 2013, a unanimous decision was made by the Advisory Board to move forward with their reorganization proposal, although the initial director recommended that the directorates not be reorganized.[48] After the initial director retired in March 2014, the deputy director became the acting director, and the reorganization of the directorates was implemented soon afterwards.

Some VA and Navy officials and several FHCC officials told us that the current director and deputy director, who took over in fall 2014, have brought an enhanced level of interdepartmental collaboration to the FHCC. Current FHCC officials told us that, for example, the director and deputy meet with each other daily, generally participate in other meetings together, and communicate well. FHCC officials noted the positive benefits of this collaborative leadership including increased transparency and improved staff morale.

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[47]Examples include cardiogenic shock, gastrointestinal bleeding requiring after hours emergent endoscopy, and acute surgical emergency without availability of surgical capabilities.

[48]In the November Advisory Board meeting, the director recommended that the FHCC continue with the current structure for the rest of the demonstration. The rationale behind the director's recommendation was that evaluations from IOM and others used the existing structure as a baseline and therefore it should be tested for the duration for the demonstration.

VA and DOD Have Not Yet Established Specific FHCC Leadership Selection Criteria or Appropriate Accountability Mechanisms

Our prior work has shown that leaders who work successfully in a collaborative environment exhibit certain competencies, such as working well with others and communicating openly.[49] Our prior work on VA and DOD's collaboration also found that effective collaboration was dependent on local leaders' interest and commitment in working together.[50] In comparison, VA did not select the initial director for the FHCC based on an assessment of the traits and skills required to implement the demonstration. Instead, VA retained the existing director of the North Chicago VAMC as the FHCC director. According to a VA official, the decision not to select a new director was in keeping with the departments' decision that no individuals would lose their jobs as a result of the integration. In addition, the director's position description at the onset of the demonstration was the same one that had been used prior to the integration. It had not been updated since 1997 and was the same position description that was generally used for directors of other VAMCs. As a result, it did not include responsibilities that explicitly required collaborative competencies for leading an integrated facility and for supporting both departments' missions.

In contrast, because the commanding officer of the Naval Health Clinic was ending his scheduled rotation period, the Navy selected another Captain to begin serving as the deputy director for the FHCC. Navy officials told us that the selection process did not involve VA officials, but included discussions about the unique characteristics and needs of the FHCC, as well as the desired skill sets and personality traits for this command, including strong communication skills, previous exposure to the VA, and the ability to collaborate with VA at all levels. Unlike VA, there is no formal position description for the FHCC's deputy director, which falls under the Navy's personnel system.

In May 2012, VA updated the director position description to include explicit criteria for leading the integrated FHCC. For example, the position description now requires that the director: ensure that the health care missions of both VA and DOD are accomplished; establish bidirectional internal lines of communication that flows freely throughout the organization; and deliver quality health care, operational readiness, and meet industry standard performance measures through maintaining

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[49]See GAO-14-220.

[50]See GAO-12-992.

relationships with the deputy director and local leaders. In 2014, VA published an announcement for a new FHCC director that included the updated position description, and both VA and Navy officials were involved in the selection process to fill the position. VA officials told us the department is exploring whether specific selection criteria can be identified for future selection of FHCC directors, as well as deputy directors, and Navy officials told us they expect to participate in this effort. According to Advisory Board minutes, all board members (including both VA and Navy officials) agreed that it would be beneficial to identify FHCC-specific criteria when selecting local leadership to help ensure that the leaders complement and support each other's strengths.

Our prior work has also shown that reinforcing individual accountability for collaborative efforts through performance management systems can help enhance and sustain collaboration among federal agencies.[51] A VA official told us that the updated position description for the FHCC director allows VA to seek formal input from DOD in the evaluation process for a director's performance. They noted, however, that VA would need to specify this in the director's performance plan, and this was not done for the evaluations for the initial FHCC director or his successor. Navy officials told us that while there is no inherent barrier for DOD to seek formal input from VA for the evaluation of the deputy director's performance, there has not been a formal mechanism established for DOD to do so. Navy officials noted that informal input was received from VA when considering the performance of a past deputy director. VA officials told us that the Advisory Board is exploring the formal exchange of information across departments to evaluate the performance of local leadership moving forward. VA and Navy officials told us that this exchange of information would be beneficial because it would help ensure accountability for both VA and DOD missions.

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[51]See GAO-14-220.

FHCC Workforce Integration Created Difficulties with Managing Staffing Levels across the Facility, and Had Mixed Effects on Staff Efficiency, Work Quality, and Job Satisfaction

Workforce integration at the FHCC posed difficulties for management in determining appropriate staffing levels across the facility and in addressing fluctuations in staffing needs. The FHCC staff we interviewed expressed mixed perceptions about the effects of workforce integration on their efficiency, the quality of their work, and their job satisfaction. Some staff also highlighted concerns about the departments' overlapping training requirements and the underutilization of Navy hospital corpsmen.

FHCC Faced Difficulties Determining Appropriate Staffing Levels and Addressing Fluctuations in Staffing Needs

Staffing Levels

Initial staffing decisions for the facility were not data-driven. Instead, an executive decision memorandum stipulated that the FHCC maintain the staffing levels for the Naval Health Clinic and North Chicago VAMC by incorporating existing staff from both facilities in the same (or similar) positions and pay levels that existed prior to the integration. However this approach is not consistent with government best practices, which recommend employing a data-driven workforce planning approach to determine appropriate workforce size and alignment for organizations attempting to restructure, redeploy, or reorganize.[52] Federal internal control standards also state that management decisions should be based

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[52]See GAO-02-373SP and GAO-04-39. In addition, see 5 C.F.R. Part 250, which describes the Office of Personnel Management's requirements for agencies to enhance and improve the strategic management of their civilian workforce.

on relevant, reliable, and timely information.[53] A Navy official involved with planning the demonstration told us that the decision to maintain prior staffing levels was due in part to the unprecedented nature of the integration, which made it difficult for them to project appropriate staffing levels prior to the integration. DOD officials also noted that the departments decided to maintain prior staffing levels to ensure that the FHCC's creation did not result in job loss for existing employees. As a result, at the start of the demonstration, the FHCC could not confirm that its workforce was aligned to achieve efficiency gains that would have been associated with a consolidation of health care facilities.

Beyond the initial staffing decisions, the FHCC also did not conduct comprehensive data-driven staffing reviews of the FHCC throughout the demonstration as planned. Workforce plans developed by VA and Navy officials required FHCC officials to conduct staffing reviews within the first year of the demonstration and periodically thereafter. These reviews were intended to determine appropriate staffing levels by evaluating the FHCC's patient workload and health-care needs in order to support the combined FHCC mission and achieve workforce efficiencies. However, according to a Navy official involved in the planning of the FHCC and officials at the FHCC, these reviews were not conducted as planned for reasons including limitations with integrated workload data. In addition, the Navy official explained that these reviews were not conducted because of a need to focus on ongoing implementation of other integration requirements during the early years of the demonstration. As a result, FHCC management was unable to confirm appropriate staffing levels across the facility, continuing the risk for potential staffing inefficiencies. For example, staffing reviews would have helped the FHCC identify and make arrangements for active duty staff to obtain additional development in certain clinical areas. Prior to the integration, the Naval hospital had transitioned to a Naval Health Clinic, and as a result, it had stopped providing emergency and inpatient services. Consequently, the FHCC did not initially have any active duty staff in the emergency department and inpatient care areas in keeping with the decision to maintain staff in their current positions prior to the integration. Advisory Board officials identified this issue as potentially problematic for maintaining the clinical proficiencies of active duty staff to support DOD's

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[53]GAO, GAO/AIMD-00-21.3.1.

readiness mission.[54] According to the Advisory Board, reviews of the FHCC's staffing requirements could have identified and addressed this concern.

In the absence of comprehensive data-driven reviews, FHCC officials have developed a process to manage the integrated workforce on a case-by-case basis. At the outset of the demonstration, the FHCC established the Total Force Management Committee to oversee the facility's overall workforce structure and individual positions to help ensure appropriate levels of clinical and administrative personnel within the FHCC. Each month, the committee evaluates routine staffing requests from FHCC directorates by considering analyses related to workload demands, as well as fiscal constraints. According to FHCC officials, the committee's process has been instrumental in expanding the presence of active duty providers in clinical areas such as inpatient care. However, staffing decisions made by the committee have not been based on comprehensive, data-driven reviews. In December 2015, FHCC officials told us they had developed an initiative in the interim for reviewing cost, productivity, and staffing in the FHCC's clinical departments, which they plan to complete by the end of 2016. They told us that this initiative is intended to improve clinical and administrative efficiency and support the Total Force Management Committee's staffing decisions. According to FHCC officials, this initiative will be temporary until VA and DOD conduct a more formal, comprehensive, data-driven review of the FHCC's workforce.

Fluctuations in Staffing Needs

The FHCC has faced difficulties addressing fluctuating staffing needs because it lacks the authority to use personal services contracts on its West Campus.[55] FHCC officials told us that personal services contracts would help alleviate recent staffing concerns related to issues such as turnover, particularly the hiring of nursing, primary care, and facility services (e.g., housekeeping) staff. DOD uses personal services contracts to accommodate fluctuations in military treatment facilities' (MTF) staffing demands due to surges in active duty patients as well as

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[54]DOD's operational readiness mission includes ensuring that active duty providers develop and maintain clinical skills necessary to serve at military treatment facilities and in combat environments.

[55]A personal services contract is defined as a "contract that, by its express terms or as administered, makes the contractor personnel appear to be, in effect, government employees." FAR §§ 2.101, 37.104(a)

deployments of active duty staff—characteristics shared by the FHCC. Specifically, these contracts provide MTFs with the flexibility to temporarily increase its workforce when demands surge and temporarily reduce the workforce when demand decreases due to, for example, changes in the number of recruits needing care at any given time. Government best practices for human capital management suggest that agencies have the capability to make flexible use of their internal workforce and appropriately use contractors to accomplish their mission.[56] However, the FHCC's West Campus facilities do not have an MTF designation, and according to FHCC officials, the other contracting options available for the West Campus are, for the most part, limited to VA-specific usage and do not offer the duration, flexibility, or ease of award that personal services contracts offer.

To award personal services contracts, agencies must have specific authority.[57] However, the FHCC was not granted this authority through the Executive Agreement, and according to FHCC leadership officials, VA currently lacks such authority for the FHCC to use these contracts on its West Campus. We previously recommended that DOD seek legislative authority to obtain MTF designation for the FHCC, as DOD is authorized to award personal services contracts at MTFs. However, DOD disagreed, stating that as the FHCC stabilized and matured, the confusion due to the lack of an MTF designation would diminish.[58] Additionally, according to DOD officials, an MTF designation would introduce additional operational requirements and challenges to the FHCC, including financial management and quality assurance requirements, which would outweigh the benefits associated with such a designation. During the demonstration, DOD and FHCC officials proposed that VA should pursue a solution to use personal services contracts because the FHCC's West Campus is considered a VA facility. As of September 2015, a solution that would allow the FHCC to use personal services contracts had not been identified. Absent the use of personal services contracts on its West Campus, the FHCC's ability to respond to fluctuations in staffing needs may continue to be hindered.
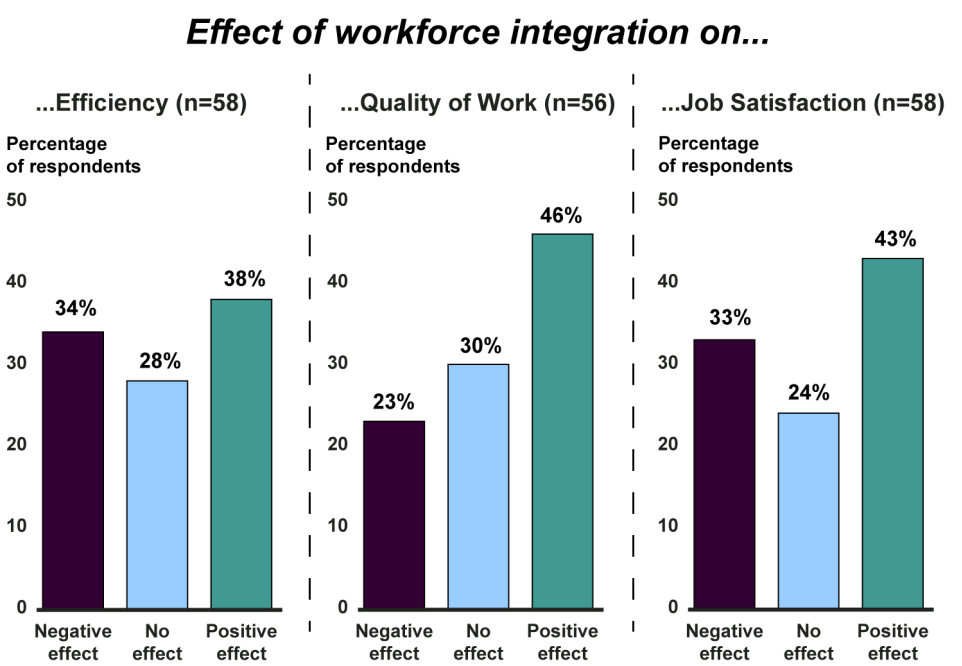
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[56]See GAO-02-373SP.

[57]Agencies must have specific statutory authority to award personal services contracts. 5 U.S.C. § 3109. DOD has specific authority in 10 U.S.C. § 1091 for using personal services contracts at MTFs, which allows the FHCC to use contracts on its East Campus.

[58]See GAO-11-570.

FHCC Staff Had Mixed Views about the Effects of Workforce Integration on Their Efficiency, Quality of Work, and Job Satisfaction

According to the FHCC staff who participated in our small-group interviews, the workforce integration of VA civilian staff with active duty Navy staff had both positive and negative effects on their efficiency, the quality of their work, and on their job satisfaction. (See fig. 6.)

Figure 6: Effects of Workforce Integration on Staff Efficiency, Quality of Work, and Job Satisfaction, Based on Small-Group Interviews with Captain James A. Lovell Federal Health Care Center (FHCC) Staff, April–May 2015

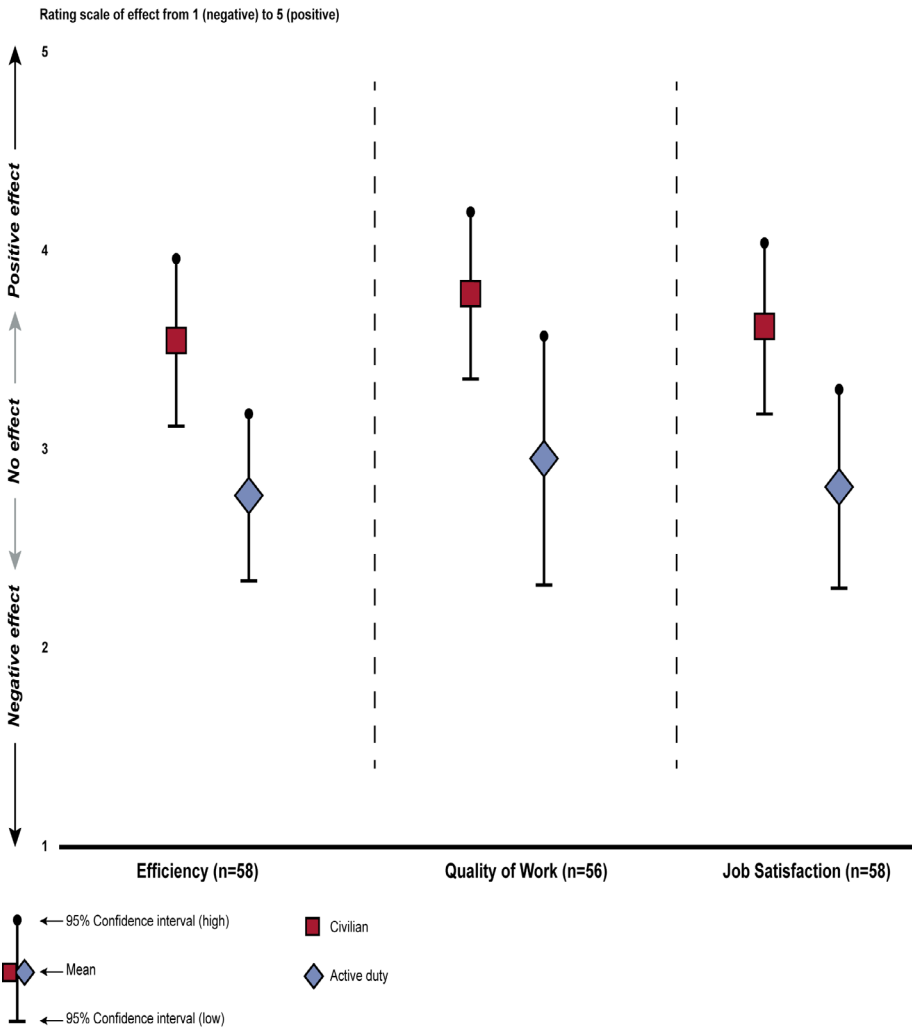*Effect of workforce integration on...*

Source: GAO analysis of small-group interview data. | GAO-16-280

Note: Data are from small-group interviews with FHCC clinical and administrative staff during a site visit in April-May 2015 and are not generalizable. During an in-person site visit in April-May 2015, FHCC staff were given a written questionnaire prior to a structured discussion on the effects of workforce integration at the FHCC. The questionnaire asked them to indicate the overall effect of workforce integration on their daily work with respect to efficiency, quality of work, and job satisfaction. Percentage totals may not add to 100 percent due to rounding.

We identified some variations between the responses of civilian staff and active duty staff for these outcomes. For example, civilian staff we interviewed reported a more positive overall view of the effects of

workforce integration in all three areas compared to the active duty staff we interviewed.[59] (See fig. 7.)

Figure 7: Comparison of Effects of Workforce Integration on Staff Efficiency, Quality of Work, and Job Satisfaction between Civilian and Active Duty Staff, Based on Small-Group Interviews at the Captain James A. Lovell Federal Health Care Center (FHCC), April–May 2015
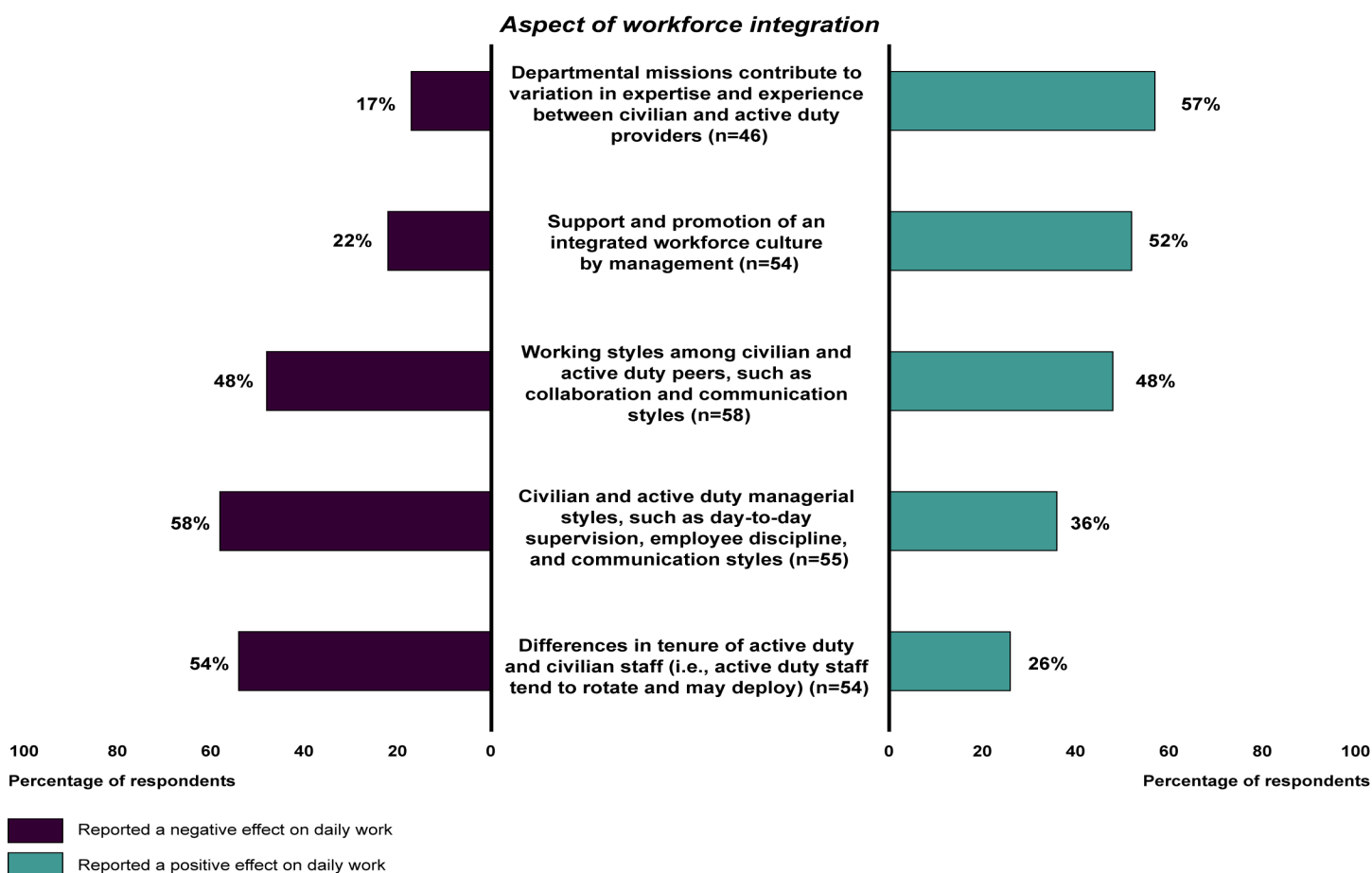

Source: GAO analysis of small-group interview data. | GAO-16-280

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[59]Differences in the average responses for civilian and active duty staff we interviewed were statistically significant at the 95 percent confidence level.

Note: Data are from small-group interviews with FHCC clinical and administrative staff during a site visit in April-May 2015 and are not generalizable. During an in-person site visit in May 2015, FHCC staff were given a written questionnaire prior to a structured discussion on the effects of workforce integration at the FHCC. The questionnaire asked them to indicate the overall effect of workforce integration on their daily work with respect to efficiency, quality of work, and job satisfaction. Responses were selected along the following scale: (1) Very negative effect, (2) Somewhat negative effect, (3) No effect, (4) Somewhat positive effect, (5) Very positive effect. Included here are the plotted measures of central tendency (mean) of those responses for civilian and active duty staff we interviewed as well as the range of the 95 percent confidence interval for the mean.

Certain key aspects of workforce integration—such as variation in experience and expertise, working styles, and staff tenure—had positive and negative effects on the daily work of staff, according to our small-group interviews. (See fig. 8.) Concerns related to these key aspects were also identified in the Navy's Inspector General report in July 2011 and were again reported by staff when VA's National Center for Organization Development visited the FHCC in May 2012. For example, the Navy Inspector General reported in 2011 that active duty staff expressed concerns about their civilian counterparts' working styles.

Figure 8: Effects of Key Aspects of Workforce Integration on Daily Work Based on Small-Group Interviews with Captain James A. Lovell Federal Health Care Center (FHCC) Staff, April-May 2015

Aspect of workforce integration

Aspect	Negative	Positive
Departmental missions contribute to variation in expertise and experience between civilian and active duty providers (n=46)	17%	57%
Support and promotion of an integrated workforce culture by management (n=54)	22%	52%
Working styles among civilian and active duty peers, such as collaboration and communication styles (n=58)	48%	48%
Civilian and active duty managerial styles, such as day-to-day supervision, employee discipline, and communication styles (n=55)	58%	36%
Differences in tenure of active duty and civilian staff (i.e., active duty staff tend to rotate and may deploy) (n=54)	54%	26%

Percentage of respondents

■ Reported a negative effect on daily work
■ Reported a positive effect on daily work

Source: GAO analysis of small-group interview data. | GAO-16-280

Note: Data are from small-group interviews with FHCC clinical and administrative staff during a site visit in April-May 2015 and are not generalizable. Respondents were first asked to review a list of items relevant to workforce integration and to indicate whether each item had positive, negative, both positive and negative, or no effects on their daily work. This figure includes the percentages of respondents who reported positive effects, negative effects, or both. It does not include the percentage of respondents who reported no effects. As a result, percentages for each aspect do not add to 100.

In particular, the FHCC staff in our small-group interviews provided the following information about the positive and negative effects of the key aspects of workforce integration that we listed:

- **Variation in expertise and experience.** Overall, 57 percent of staff in our small-group interviews indicated that variation in the expertise and experience of civilian and active duty staff had positive effects on their

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daily work. Some civilian staff we interviewed noted an appreciation for the new clinical approaches proposed by their active duty counterparts, such as the trauma protocols shared by Navy doctors, nurses, and corpsmen who had previously been deployed to combat areas. Similarly, some active duty staff reported an appreciation for civilian staffs' ability to provide guidance based on different experience acquired from treating the veteran patient population.

- **Support and promotion of integrated culture.** More than half of the FHCC staff in our small-group interviews (52 percent) also gave favorable ratings to the current FHCC management's support and promotion of an integrated workforce culture. An administrative staff member commented that FHCC's leadership has supported collaboration in order to develop joint solutions when VA and Navy processes differ at the service level of the facility, which has led to a more efficient work environment. In contrast, however, another staff member told us that FHCC management is constrained in its ability to promote an integrated workforce culture because of the distinct and somewhat divergent missions of VA and DOD.

- **Working styles.** Responses from staff in our small-group interviews were mostly split with respect to whether the working styles of civilian and active duty peers had positive or negative effects on their work. In a positive example, one civilian staff member noted that patient-level staff communicated well with each other to accomplish clinical tasks, particularly those tasks involving direct patient care. However, active duty staff we interviewed more frequently reported that differences in working styles between civilian and active duty peers negatively affected their work.[60] For example, some active duty staff characterized civilian working styles as less accountable and more resistant to change, which they said resulted in lower morale and reduced efficiency. Other active duty staff told us that they were often held to a higher standard than their civilian counterparts and were expected to be more flexible in work settings.

- **Managerial styles.** More than half of the staff in our small-group interviews (58 percent) reported that differences between civilian and active duty managerial styles had negative effects on their daily work. For example, one active duty staff member expressed frustration with

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[60]The differences between civilian and active duty staff responses were statistically significant at a 95 percent confidence level.

civilian supervisors, stating that their bureaucratic approach interfered with immediate patient needs and responsiveness. In contrast, one civilian staff member perceived active duty managerial styles to be commanding and absolute. One civilian staff member expressed a concern with active duty supervisors' unfamiliarity with civilian personnel rules, especially as they related to union agreements, employee discipline, and recruitment.[61]

- **Tenure and military rotation.** More than half of the staff in our small-group interviews (54 percent) reported that differences in the tenure of civilian and active duty staff at the FHCC had negative effects on daily work. Some civilian staff we interviewed expressed frustration with the frequent rotations of active duty staff, especially regarding what they described as the inefficiency of having to constantly train replacement staff. One active duty staff member also expressed frustration that civilian staff—who typically have a longer tenure at the facility—were able to avoid process changes proposed by active duty staff simply by waiting until the staff member deployed or rotated. Nonetheless, some staff told us that the longer tenure of civilian employees also provided stability to the facility, and rotations of active duty staff, at times, cultivated an environment that is open to change.

In the course of discussing these key aspects of workforce integration during our small-group interviews, as well as other interviews, FHCC staff raised the following additional concerns:

- **Training overlap.** Some active duty staff in our small-group interviews indicated that some training courses overlap and negatively affect the efficiency of their work. Throughout the demonstration, all FHCC staff were required to complete mandatory VA training; active duty staff were also required to complete required DOD training, and, at times, according to FHCC officials, the content of VA and DOD trainings overlapped. Officials from the FHCC Department of Education and Training told us that they look for overlap in training requirements when they compile an annual training plan for FHCC staff, and that concerns they raised to the relevant VISN (VISN 12) were not resolved. For fiscal year 2016, FHCC officials identified potential overlap within three training areas: managed equal

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[61]Forty-three percent of the staff we interviewed reported that supervisor understanding of union guidelines and other personnel rules had negative effects on daily work, while 35 percent of staff reported positive effects.

opportunity, diversity and discrimination, and sexual harassment. The FHCC reported this potential overlap to the HEC Continuing Education and Training Workgroup—a workgroup that was directed by the JEC to reduce overlap in training required of VA and DOD staff who serve both departments.[62] According to workgroup and FHCC officials, the workgroup and the FHCC determined that a local solution will be implemented each year when local FHCC officials identify training requirements that overlap. Specifically, the solution allows the FHCC to assign only the DOD versions of trainings to active duty staff. According to FHCC officials, in November 2015, the FHCC implemented this solution for the three training areas that were reported to the HEC for fiscal year 2016.

- **Clinical experiences for hospital corpsmen.** According to some FHCC staff we interviewed in small-group and other on-site interviews, hospital corpsmen—active duty clinicians who provide a wide range of treatment procedures under the direction of a registered nurse—were not always provided the clinical experiences necessary to help maintain their proficiency to serve at military treatment facilities and in combat environments per DOD's operational readiness mission.[63] The Executive Agreement specifically requires that active duty staff maintain clinical proficiencies needed to perform military duties upon deployment or reassignment. However, some staff told us that civilian managers were, at times, unsure how to properly oversee and utilize hospital corpsmen in clinical areas of the facility, often relegating them to administrative duties. Some corpsmen in our small-group interviews cited underutilization as a source of dissatisfaction, and one of these corpsmen expressed concern that their clinical skills would atrophy without use, potentially impeding their ability to be

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[62]The HEC Continuing Education and Training Working Group leverages sharing opportunities to improve education and in-service training quality for VA and DOD health care professionals. In fiscal year 2015, the workgroup coordinated activities to reduce overlap in computer security training requirements for VA and DOD staff, including staff at the FHCC. As a result, staff taking the DOD computer security courses may receive credit for the equivalent VA security training course, but not vice versa.

[63]According to FHCC officials, independent duty hospital corpsmen, an advanced designation of corpsmen with additional privileges (similar to physicians assistants), operate only on the East Campus Navy branch clinics and are supervised exclusively by other active duty medical officers. Hospital corpsmen that are not classified as independent duty hospital corpsmen are called general duty hospital corpsmen and are staffed to West Campus clinics (including inpatient units and specialty care clinics) and receive oversight from VA civilian managers.

operationally ready to support DOD's mission. During the demonstration, the FHCC has developed guidance and orientation programs directed at hospital corpsmen for specific clinical areas that are intended to develop their clinical proficiencies according to their scope of practice. However, although civilian managers were initially provided training on the supervision and management of hospital corpsmen at the outset of the demonstration, an FHCC official told us that such trainings have not continued. Nonetheless, the FHCC has taken steps to provide additional opportunities for corpsmen to develop their clinical proficiencies through a rotational program— implemented in January 2014—that rotates hospital corpsmen and other active duty providers through the Cook County Trauma and Burn Unit at the James L. Stroger Jr. Hospital in Chicago, Illinois.

- **Clarity of reporting structures.** Supervisory relationships and reporting structures within the directorates at times negatively affected daily work due to a lack of clarity, according to staff we interviewed in small groups and other interviews. For example, some staff told us that active duty staff may address certain military-specific administrative concerns through a military superior, while other concerns, such as clinical or operational concerns, may be addressed through a VA civilian supervisor. Staff also told us that VA and DOD chains of command operate differently. For example, according to FHCC staff, military chains of command follow a distinct protocol of progressive escalation, while civilian supervisory hierarchies may be less strict, resulting in staff immediately escalating an issue several levels above their immediate supervisor. Active duty staff at the FHCC reported that when civilian staff bypass levels in the military chain of command, intermediate active duty supervisors are criticized for failing to properly supervise their staff. Managers in the FHCC's laboratories have attempted to address this concern by developing an issue resolution flow chart that defines reporting structures based on the nature of a particular issue and the type of staff involved (active duty and civilian).

Difficulties Integrating IT and Certain Clinical and Administrative Operations Have Impeded the FHCC's Efficiency, but Steps Are Being Taken to Address These Issues

The FHCC faced difficulties effectively implementing local IT capabilities necessary for clinical care due to differences in VA and DOD's policies for network security and electronic health record user credentials. In addition, the integration of certain clinical and administrative operations was problematic for the FHCC, stemming from a range of departmental factors and initial decisions made at the outset of the demonstration. While these difficulties have impeded the efficiency of operations, the FHCC has been taking steps to improve integration when possible throughout the demonstration.

Effectiveness of the FHCC's IT Operations Has Been Limited by VA and DOD's Policies for Network Security and Issues with User Credentials

FHCC IT operations have been limited by differences in VA and DOD policies. In the absence of a single integrated electronic health record system across VA and DOD, the local IT capabilities developed as required by the Executive Agreement (e.g., medical single sign-on and orders portability) have been important for integrating certain functions of the FHCC's clinical operations. These capabilities were put in place to enable FHCC providers to log in one time to access both VA and DOD's electronic health record systems (VistA and AHLTA, respectively), concurrently view the same patient in both systems, and use either system to enter orders for (and see the results of) specialty consults, as well as laboratory and radiology tests. However, staff have not always been able to access these local IT capabilities or VistA and AHLTA due to problems with IT network reliability and user credentials, limiting the effectiveness of the FHCC's IT operations. Clinical staff in our small-group interviews had mixed views of IT operations at the FHCC. Although more than half of the 27 clinical staff we interviewed (59 percent) ranked at least one aspect of IT operations as having the most positive impact on their daily work relative to other aspects of integrating operations, nearly all (93 percent) ranked at least one aspect of IT operations as having the most negative impact on their daily work—the two most commonly cited

were the FHCC's overall IT network reliability and performance and the lack of orders portability for pharmacy.[64]

Of the clinical staff who ranked IT network reliability and performance as most negatively affecting their work, many noted that local IT capabilities or electronic health record systems had been frequently inaccessible or delayed, particularly for those who provided care to or assisted DOD patients on the FHCC's West Campus. Many of these staff cited examples of difficulties accessing AHLTA from the West Campus that included retrieving information, entering prescriptions, or transmitting test results to VistA—which they told us led to delays and dissatisfaction for both patients and staff. One West Campus provider estimated wasting 1 hour per clinic day, on average, due to issues accessing AHLTA. Another provider stated that problems accessing AHLTA, which reportedly occurred every 2 to 3 weeks, prevented them from seeing patients' complete history and caused patient appointments to run behind schedule on those days. One staff member characterized the FHCC's IT performance as, "When [IT] works, it works great. But because we've become so heavily reliant on it…we become completely blind when [the systems] go down."

Many clinical staff who ranked the FHCC's lack of orders portability for pharmacy as negatively impacting their work told us that it resulted in inefficiencies, and some staff told us that it resulted in potential risks to patient safety or that it negatively affected patient care. In the absence of a single electronic health record system, FHCC providers must enter VA patient prescriptions in VistA, and DOD patient prescriptions in AHLTA, but information entered into one system does not automatically transfer to the other. During our small-group interviews, some staff told us that this lack of portability has resulted in inefficiencies. For example, staff must access both VistA and AHLTA to view complete patient prescription information. Additionally, providers may mistakenly order a patient's prescription in the wrong system, impacting FHCC pharmacy staff and providers, and ultimately patients waiting to get their prescriptions. As a workaround, the FHCC had to employ additional full-time pharmacists to

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[64]Respondents were asked to rank the following aspects of integrating IT operations: Ability to sign in one time to access VistA and AHLTA; concurrent use of VistA and AHLTA to view or make changes to patient records; orders portability for laboratory, radiology, or specialty consults; lack of orders portability for pharmacy; and overall IT network reliability and performance.

manually review pharmacy orders to reconcile patient allergy information prescribed in VistA and AHLTA.[65] DOD officials reported that the cost of employing these additional pharmacists totaled $1.9 million through fiscal year 2014. The workaround was discontinued in January 2015 after the FHCC made improvements to patient allergy information in VistA and AHLTA, and when it was determined that regular checks by providers and pharmacists as part of their routine patient care were sufficient to mitigate risks to patients. VA and DOD officials told us that there are currently no plans to pursue an orders portability capability for pharmacy at the FHCC. However, according to DOD officials, a review is planned for the near future that will determine the feasibility of implementing pharmacy orders portability as well as other FHCC IT capabilities.

Although the Executive Agreement calls for the FHCC to utilize efficient processes, issues related to its complex IT infrastructure initially affected the functioning of some of the FHCC's local IT capabilities and impeded efficiency by limiting the ability of some providers and staff to consistently access VistA and AHLTA.[66] Specifically, the facility's IT infrastructure comprises three networks to accommodate differences in VA and DOD's network security standards.[67] In addition, VA IT officials acknowledged that this infrastructure has created difficulties with managing network connections and providing seamless access to software applications, among other issues.[68] In addition, the related support and maintenance has been costly to the departments. According to DOD officials who were

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[65]This manual check was conducted for DOD beneficiaries receiving specialty or emergency care on the West Campus.

[66]Veterans Health Administration, Office of Quality, Safety and Value, Product Effectiveness. *Captain James A. Lovell Federal Health Care Center (JAL FHCC): Information Management/Information Technology Evaluation, Initial Evaluation Report* (Washington, D.C.: July 2015).

[67]The FHCC's IT infrastructure comprises the following three networks to meet separate VA and DOD security standards: (1) a network that supports VistA and other VA systems; (2) a network that supports AHLTA and other DOD clinical applications, as well as a virtual host environment for users to access VA and DOD systems across the separate networks, and (3) a network that supports Navy Medicine's recruit training command activities and day-to-day Navy operations.

[68]In addition, FHCC IT officials told us that when providers and staff are hired or promoted, FHCC IT officials must manually establish or update their accounts across the three networks—a process that can take up to 2 weeks. During this time, the affected staff are relegated to duties that do not require access to the electronic health record or other IT systems, which could substantially impact their productivity.

involved in overseeing the FHCC during the demonstration period, an estimated $6-7 million was spent by VA and DOD on contract IT personnel to specifically address problems with network and system administration, as well as other IT-related problems (such as equipment problems). During that time, according to officials, the departments also spent an additional estimated $17 million on civilian staff to support the FHCC's network infrastructure, local IT capabilities, and other IT issues.[69] DOD officials told us that they continue to work with VA to improve the reliability of the FHCC's IT infrastructure, such as through upgrades and expanding support for data sharing and interoperability. However, VA and DOD officials told us that the departments do not plan to resolve differences in network security standards to the extent that the FHCC would be able to have a single-network IT infrastructure. According to VA officials, this is due, at least in part, to the departments' different missions.

Despite improvements to overall IT network reliability and performance, some staff in our small-group interviews told us that they have continued to experience access difficulties with VistA and AHLTA.[70] FHCC IT and leadership officials told us that this is mostly due to providers and staff not maintaining current user credentials for both systems. These officials told us that this has been especially problematic for providers and other clinical staff who do not regularly see both VA and DOD patients and do not routinely log in to both systems, because user credentials expire after different lengths of time for VistA and AHLTA due to differences in VA and DOD policies—every 90 days for VistA and every 60 days for AHLTA. FHCC IT officials told us that providers and staff receive a notification warning that their passwords are about to expire when they log in to each system. If they do not regularly log in, they are not aware that their passwords have expired and that their accounts are at risk of being disabled. The Executive Agreement specified that the FHCC was

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[69]For spending on contract personnel and civilian staff hires, DOD officials provided the actual amount spent for fiscal years 2011-2014, and the estimated amount spent for fiscal year 2015. Officials were not able to determine the exact costs associated with these IT workarounds or with contract IT personnel due in part to data limitations.

[70]VA, DOD, and FHCC officials told us that they have implemented updates to improve network stability as well as enhancements to the FHCC's local IT capabilities. In 2014, the FHCC implemented an update to the virtual host environment, and also addressed a compatibility issue between the virtual host environment and one of the local IT capabilities that was causing issues with overall IT stability. Officials also told us that they implemented additional orders portability capabilities for laboratory, and improved the patient medication allergy information in VistA and AHLTA.

designed to improve quality of care and adopt efficient processes. However, FHCC IT officials and some staff in our small-group interviews told us that when access to VistA or AHLTA is lost, patient orders and test results may be incomplete, delayed, or not transmitted, potentially impacting patient care and impeding staff efficiency. FHCC officials told us that they have incorporated training for new staff on how to maintain current credentials, such as by setting electronic calendar reminders to log in to VistA and AHLTA. These officials also told us that as of October 2015, they were taking steps to require all clinical staff to periodically log in to both systems. These steps included plans for the FHCC to identify staff with disabled credentials and reactivate their accounts, provide training on credential maintenance, and evaluate the results of their efforts through March 2016.

Difficulties Integrating Certain Clinical and Administrative Operations Have Resulted in Inefficiencies, but Steps Are Being Taken to Address Them

In addition to issues with the FHCC's local IT capabilities and performance, the FHCC faced additional difficulties with effectively integrating certain clinical and administrative operations, including some required by the Executive Agreement. Many of these difficulties arose from differences in VA and DOD policies, other departmental factors, or from decisions made at the onset of the demonstration, as shown in the examples below. In some instances, VA, DOD, and FHCC officials have taken steps to address these issues.

Patient Priority System

Although the FHCC implemented the patient priority system set forth in the Executive Agreement (see text box), there have been problems with how it has been used and monitored. The patient priority system is intended to prioritize the provision of care by beneficiary type in situations when the FHCC does not have sufficient capacity, and the Executive Agreement requires that the priority system be monitored to maintain the FHCC's "pipeline to the fleet" medical readiness goal for enlisted Navy recruits.[71]

One of the primary difficulties with effective use of the patient priority system has been the lack of complete and current data due to VistA's limited capabilities, according to FHCC officials. Specifically, FHCC officials told us that VistA only categorizes TRICARE beneficiaries as "recruit," "active duty," and "other TRICARE." For example, TRICARE Prime retirees and TRICARE Standard retirees would both be captured in the "other TRICARE" category, even though they are in different priority groups. Also, officials told us VistA is unable to automatically reflect any TRICARE beneficiary eligibility changes (such as beneficiaries' eligibility status changing from active duty to retiree) because it is not interoperable with DOD's beneficiary eligibility system, the Defense Enrollment Eligibility Reporting System (DEERS).[72] In addition, FHCC officials are limited in their ability to monitor the patient priority system, as required by the Executive Agreement, because they are unable to identify the reasons that veterans were referred to non-VA medical care as this information is not searchable in VistA. For example, FHCC officials cannot search VistA to determine the number of veterans referred for non-VA medical care due to capacity constraints, or for other reasons such as needing care not offered at the FHCC, or for continuity of care purposes (the veteran previously received care from a non-VA specialist). A VA official responsible for managing VA's clinical IT applications confirmed that this information cannot be systematically searched in VistA for monitoring purposes. The official stated that this issue has been elevated within the department, but VA has not yet taken action to address it. Federal internal control standards require agencies to have relevant, reliable, and timely information in order to meet their operational

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[71]DOD beneficiaries using TRICARE Extra are considered to be TRICARE Standard participants and are included as such in the patient priority system.

[72]As of September 2015, DOD officials told us that DOD plans to continue using DEERS and does not anticipate developing a new eligibility system as part of DOD's Defense Healthcare Management Systems Modernization program.

objectives and to help determine whether the agency is meeting its performance requirements.[73] Without complete and accurate information from VistA, the FHCC lacks appropriate data to measure its performance in adhering to its patient priority system to ensure it maintains the "pipeline to the fleet" medical readiness goal for enlisted Navy recruits.

VA officials told us that department-wide updates to VistA, planned through VA's VistA Evolution program, will address some of the data issues currently limiting the FHCC's use and monitoring of the patient priority system. For example, VA's planned updates will support categorization of DOD beneficiaries by TRICARE option (e.g., TRICARE Prime enrolled active duty dependent, TRICARE Standard nonenrolled retiree). VA officials also told us that planned interoperability efforts will enable VistA to automatically reflect changes to TRICARE beneficiaries' eligibility and enrollment status from DEERS. However, implementation of these changes is planned for fiscal years 2016-2020, and as a result, the problems associated with the patient priority system will likely persist, at least in the near future.

In addition to data limitations, effective use of the priority system has been limited by a lack of guidance for providers and appointment schedulers. This is inconsistent with federal internal control standards, which state that management should provide its personnel with the tools they need to maintain a level of competence that allows them to accomplish their assigned duties.[74] FHCC officials told us that, since the beginning of the demonstration, the FHCC has made monthly reports available to staff that list each specialty clinic's capacity to accept consults for specific beneficiary types (e.g., the May 2015 report indicated that the dermatology clinic was only accepting appointments for new active duty patients due to capacity constraints). However, these reports do not differentiate between all of the categories of TRICARE options defined by the priority system, and therefore do not contain complete information needed for providers to determine whether a referral should be accepted. For example, the reports contain a category for TRICARE retirees, but do not differentiate between TRICARE Prime enrolled retirees and TRICARE Standard nonenrolled retirees, which are two different priority system categories. Also, FHCC officials told us that

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[73]GAO, GAO/AIMD-00-21.3.1.

[74]GAO, GAO/AIMD-00-21.3.1.

specific written guidance for providers and schedulers on how to apply the patient priority system has not been developed.[75] These officials added that, due to VistA's data limitations, providers responsible for approving consults would need to check both VistA and AHLTA to determine a patient's status, and that this was not consistently done.[76] In addition, multiple FHCC staff told us that some individual specialty care providers still insisted on only seeing certain types of patients (i.e., TRICARE patients or veterans), for reasons such as the inconvenience of not having reliable access to both electronic health record systems, or a general unwillingness to learn a new system. Without guidance, the FHCC does not have assurance that its providers and other clinical staff are using the patient priority system as required by the Executive Agreement.

Primary Care

Although the FHCC's specialty care clinics have been integrated, the VA and Navy primary care clinics remain separate due to policy differences. Specifically, VA and the Navy require the use of specific models of care for primary care, each associated with their own requirements, such as for staffing and reporting.[77] FHCC officials told us that these models are conceptually very similar and said they believed that the primary care directorate would likely be more efficient if it were integrated. However, they noted that each model has different requirements and that the FHCC would likely need to request a waiver from VA and DOD to be able to adopt a model that was agreed upon by the departments. Navy and FHCC officials told us that maintaining separate primary care clinics has

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[75]In addition, prior to the start of the demonstration in March 2010, an FHCC leadership official presented the FHCC's approach for initially training staff on the patient priority system at an Advisory Board meeting. However, FHCC officials told us that, as of July 2015, the facility had not developed formal guidance or provided training for providers or schedulers on this topic.

[76]VA and FHCC officials also told us that staff can also use the joint legacy viewer to view patient information. The joint legacy viewer is a department-wide VA and DOD IT capability that FHCC providers can use to view (but not make changes to) patient information from both VistA and AHLTA in one record. The VHA Product Effectiveness team reported in 2013 that relatively few providers at the FHCC used this capability, in part because they already had access to both VistA and AHLTA. However, FHCC officials told us that the FHCC was expanding its use of a new version of the viewer, with approximately 1,750 FHCC users activated in August 2015, and training held in September 2015.

[77]VA uses the Patient Aligned Care Team model, while the Navy uses the Medical Home Port model.

limited potential efficiencies because each clinic maintains a full set of primary care staff and uses duplicative IT tools.

Recently, the FHCC began two pilot initiatives for integrating primary care. One initiative, which began in July 2015, provides care for TRICARE for Life patients under the VA primary care model, served by a civilian care team. The other initiative, which began in October 2015, integrates primary care for women's health, by enrolling up to 100 female TRICARE beneficiaries into VA primary care under a hybrid care model that FHCC officials told us was developed to best meet the unique needs of this group. During an August 2015 Advisory Board meeting, FHCC officials noted that the only additional work that would be required of providers under these integrated pilots would be entering prescriptions in the patients' respective electronic health record systems, as is currently done in other integrated outpatient areas of the FHCC. They also noted that the outcomes of these pilots will help determine whether integration of primary care at the FHCC will further expand.

Financial Reconciliation

The FHCC was able to partially, but not fully, implement the Executive Agreement's provisions on financial reconciliation during the demonstration, resulting in some inefficiencies. Specifically, the FHCC was able to implement the provision to use a financial reconciliation process, validated by an independent entity, in order to determine the proportion of VA and DOD funds obligated to the FHCC's Joint Fund each year. According to FHCC officials, financial reconciliation was preferable, rather than an arrangement in which VA and DOD directly billed each other for services provided to their respective beneficiaries. These officials said a direct billing approach would have been administratively burdensome given the magnitude of claims that would have been involved. Officials also told us that reconciliation was a more efficient way to determine each department's share of the FHCC's costs.

However, the FHCC faced difficulties in implementing the Executive Agreement's provision for an automated financial reconciliation tool, which would automate the manual processes used to produce annual financial reconciliation reports. As of September 2015, the FHCC's automated tool had been developed, but it had not been approved for use because of concerns with the tool's accuracy. Specifically, FHCC officials told us that difficulties arose because the automated tool was not programmed to be sufficiently flexible to respond to organizational changes, such as the addition of clinics (which could impact the allocation of costs to VA and DOD) or accounting changes (such as modifications to VA financial accounting codes). According to FHCC officials, the lack of

an automated tool has resulted in inefficiencies because the manual process requires about a week of time for staff to gather relevant documentation, barring any data issues. In contrast, officials said an automated tool would allow staff to pull reports and conduct data checks in one day. Automation would also reduce the burden on a senior-level DOD official who is currently responsible for manually reconciling the final data. In September 2015, VA officials told us that both departments were supporting further improvements to the tool, and that an FHCC official was working to improve the tool's capabilities.

Contracting

In our small-group discussions and other interviews, FHCC officials and staff told us that difficulties resulting from initially designating VA with primary responsibility for contracting support, per the Executive Agreement, created numerous administrative and financial inefficiencies. According to these officials and staff, VA's contracting entity did not have sufficient capacity to meet the contracting needs of the integrated facility, resulting in delayed contracts, missed evaluation requirements, and funds that expired because contracts were not executed in time to meet end of the fiscal year deadlines. To remedy these and other issues, FHCC officials and the Advisory Board recommended to the departments that the FHCC use the Navy's contracting entity to provide additional resources. VA and DOD approved the use of Navy's contracting entity on the East Campus in February 2012 and on the West Campus in May 2015 after determining this change was necessary for mission fulfillment and thus still met the Executive Agreement's requirements that VA have primary responsibility for contracting support at the FHCC.

Asset Management

Some FHCC officials and staff in our small-group discussions and other interviews told us that there were difficulties with using VA's asset management system on the West Campus—a decision made at the onset of integration that has reportedly resulted in inefficient operations. Specifically, they told us that VA's system only accounted for supplies and equipment centrally, but not for specific areas within the FHCC, adding that this has resulted in a lack of transparency and additional work for staff to ensure that supplies have been properly ordered, delivered, and funded. One official noted that this lack of transparency also created potential problems with data accuracy for the financial reconciliation process, because unlike clinical costs (which are linked to specific areas and types of patients), costs for supplies and equipment were not linked to specific functional areas within the FHCC.

A joint VA and DOD pilot initiative at the FHCC—which stemmed from FHCC officials identifying a potential opportunity to leverage resources

from both departments—will expand the use of DOD's asset management system from the East Campus to the West Campus and may help address these inefficiencies.[78] Specifically, the initiative—if implemented as proposed—could increase the efficiency with which the FHCC procures and tracks assets, such as by increasing opportunities for joint purchasing and contracting. FHCC officials and staff also told us that using DOD's asset management system would increase transparency in accounting for supplies and equipment. As of August 2015, according to Advisory Board officials, the initiative had received VA and DOD's continued support and was moving forward to the design phase.

Conclusions

As the first joint facility of its kind, the FHCC represents an unprecedented level of integrated health care delivery for VA and DOD. Over the course of the 5-year demonstration period, VA, DOD, Navy, and FHCC officials have made significant progress with implementing the integration areas outlined in the Executive Agreement, at times requiring exceptional efforts from FHCC officials and staff, who had to develop local solutions and workarounds as needed. However, the FHCC continues to face difficulties in multiple areas, which require resolution at the VA and DOD departmental level.

- **Leadership Collaboration.** The FHCC serves as an important reminder that the effectiveness of interagency collaboration is dependent on local leaders' skill and commitment to work together. The FHCC does not yet have specific selection criteria and shared performance evaluations for the FHCC's director and deputy director positions to help ensure that the facility's leadership is well suited for an integrated, collaborative environment.

- **Workforce.** The FHCC continues to face difficulties maximizing the efficiency of its integrated workforce and ensuring opportunities for active duty staff to maintain clinical proficiencies. These difficulties have been due to a lack of comprehensive, data-driven staffing reviews and DOD's and VA's lack of collaboration on FHCC's authority to use personal services contracts to address fluctuating staffing needs across the facility. Also, civilian managers' lack of understanding and training on how to effectively utilize Navy hospital

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[78]DOD's asset management system—Defense Medical Logistics Standard Support—is used on the FHCC's East Campus.

corpsmen places these staff at risk of not being able to maintain clinical proficiencies needed for readiness.

- **Operations.** IT-related difficulties are among the greatest impediments to effective integration of the FHCC's operations, and have resulted in inefficiencies that are frustrating to staff and could potentially harm patient care. Such difficulties will require solutions both at the local FHCC level (as in the case of providers and staff maintaining their user credentials for VA and DOD's electronic health record systems) and at the department level (such as better aligning VA and DOD's network security standards). IT-related challenges have also contributed to difficulties with the FHCC's implementation and monitoring of the patient priority system. Furthermore, a lack of guidance for using the system provides little assurance that providers responsible for approving consults are appropriately verifying the TRICARE eligibility status of their DOD patients, or that FHCC officials can successfully evaluate the system's implementation to ensure patients' timely access to care.

VA and DOD's current and future efforts to collaborate on health care delivery have the potential to yield cost savings and efficiencies. However, the departments must continue to take steps to ensure that the right leadership is in place and to address integration difficulties that cannot be resolved at the local level to improve efficiencies and reduce the burden on staff. By doing so, VA and DOD can continue to make gains to ensure that the FHCC—and any similarly integrated medical facilities in the future —have the ability to improve access, quality, and costs, while also achieving clinical and administrative efficiencies.

Recommendations for Executive Action

We recommend that the Secretaries of Veterans Affairs and Defense collaborate to take the following five actions at the departmental level:

1. Establish FHCC-specific selection criteria for the FHCC facility director and deputy director positions that include responsibilities and leadership competencies for effective collaboration;

2. Ensure that the evaluation of the leadership performance at the FHCC is carried out jointly between VA and DOD;

3. Perform data-driven strategic workforce planning prior to implementing any future integration efforts;

4. Determine how best to fill the FHCC's short-term staffing needs, including any additional statutory authorities that might be necessary to implement the desired approach; and

5. Resolve differences in IT network security standards to the extent possible prior to implementing any future integration efforts.

We also recommend that the Secretary of Veterans Affairs take steps to:

6. ensure that the FHCC is able to systematically monitor the reasons for referrals to non-VA medical care.

Further, we recommend that the Secretaries of Veterans Affairs and Defense direct FHCC leadership to take the following two actions:

7. Provide routine training to civilian managers, who supervise active duty staff on the West Campus, on how to effectively utilize such staff, particularly Navy hospital corpsmen; and

8. Provide additional guidance on the patient priority system to all staff responsible for approving consults and ensure that the monthly capability and capacity reports include information on all categories of FHCC patients defined by the patient priority system.

Agency Comments

VA and DOD each provided written comments on a draft on this report. In their comments, both departments generally agreed with our conclusions and concurred with each of the recommendations directed to their respective Secretaries. In VA's written comments, reproduced in appendix IV, VA provided an action plan for implementing each of our recommendations, with estimated completion dates between June 2016 and July 2018. DOD's written comments, reproduced in appendix V, provided information on DOD's plan for implementing some, but not all, of our recommendations; DOD noted that many of our recommendations will be included as part of VA and DOD's planned way forward in their upcoming required report to Congress on the FHCC. DOD also provided technical comments that we incorporated, as appropriate.

We are sending copies of this report to the Secretary of Defense, Secretary of Veterans Affairs, and appropriate congressional committees. In addition, the report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at draperd@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix VI.

Debra A. Draper
Director, Health Care

List of Committees

The Honorable John S. McCain
Chairman
The Honorable Jack Reed
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Johnny Isakson
Chairman
The Honorable Richard Blumenthal
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable Mac Thornberry
Chairman
The Honorable Adam Smith
Ranking Member
Committee on Armed Services
House of Representatives

The Honorable Jeff Miller
Chairman
The Honorable Corrine Brown
Ranking Member
Committee on Veterans' Affairs
House of Representatives

Appendix I: Prior GAO Recommendations Related to the Captain James A. Lovell Federal Health Care Center (FHCC)

The FHCC's Executive Agreement defines the sharing relationship and roles of the Department of Veterans Affairs (VA) and Department of Defense (DOD) and contains key provisions to be met in 12 integration areas. In 2011 and 2012, we reported on the implementation status of the FHCC's Executive Agreement integration areas and made a number of recommendations.[1] See table 2 for our previous recommendations and the status of their implementation.

Table 2: Status of Prior GAO Recommendations Related to the Captain James A. Lovell Federal Health Care Center (FHCC), as of January 2016

Recommendations from		
VA and DOD Health Care: First Federal Health Care Center Established, but Implementation Concerns Need to Be Addressed, GAO-11-570 (Washington, D.C.: July 19, 2011)	**Agency concurrence**	**Status**
The Secretary of Defense should seek a legislative change to designate the FHCC as a military treatment facility (MTF).	DOD disagreed with the recommendation to pursue an MTF designation for the FHCC	Closed – not implemented
The Secretaries of Veterans Affairs and Defense should direct FHCC leadership to conduct further evaluation of the scorecard reporting tool and its methodology and make revisions that will better ensure the transparency and accuracy of the information reported.	General concurrence	Closed – implemented
Recommendations from		
VA/DOD Federal Health Care Center: Costly Information Technology Delays Continue and Evaluation Plan Lacking, GAO-12-669 (Washington, D.C.: June 26, 2012).		
The Secretaries of Veterans Affairs and Defense should determine the costs associated with the workarounds required because of delayed information technology (IT) capabilities at the FHCC for each year of the demonstration, including the costs of hiring additional staff and of managing the administrative burden caused by the workarounds.	General concurrence	Closed – implemented
The Secretaries of Veterans Affairs and Defense should develop plans with clear definitions and specific deliverables, including time frames for two IT capabilities—documentation of patient care to support medical and dental operational readiness and outpatient appointment enhancements—and formalize these plans, for example, by incorporating them into the Executive Agreement.	General concurrence, however agencies did not agree that formalization should be incorporated in the Executive Agreement	Open

[1]See GAO, *VA and DOD Health Care: First Federal Health Care Center Established, but Implementation Concerns Need to Be Addressed*, GAO-11-570 (Washington, D.C.: July 19, 2011), and GAO, *VA/DOD Federal Health Care Center: Costly Information Technology Delays Continue and Evaluation Plan Lacking*, GAO-12-669 (Washington, D.C.: June 26, 2012).

GAO-16-280 VA and DOD Federal Health Care Center

Recommendations from *VA/DOD Federal Health Care Center: Costly Information Technology Delays Continue and Evaluation Plan Lacking,* GAO-12-669 (Washington, D.C.: June 26, 2012).	Agency concurrence	Status
The Secretaries of Veterans Affairs and Defense should expeditiously develop and agree to an evaluation plan, including the performance measures and standards, such as target scores, to be used to evaluate the FHCC demonstration, and formalize the plan, for example, by incorporating it into the Executive Agreement.	General concurrence, however agencies did not agree that formalization should be incorporated in the Executive Agreement.	Closed – implemented
The Secretaries of Veterans Affairs and Defense should establish measures related to the cost-effectiveness of the FHCC's care and operations to be included as a part of the evaluation plan.	General concurrence.	Closed – implemented

Source: GAO. | GAO-16-280

As part of our methodology for identifying any difficulties faced by the Captain James A. Lovell Federal Health Care Center (FHCC) in integrating its workforce and operations (objectives 2 and 3 of our report), we conducted 27 in-person, semi-structured interviews with small groups of FHCC managers and non-managerial staff (six participants or less per interview). We interviewed staff from selected FHCC clinical and administrative areas of the facility in order to obtain a range of perspectives and experiences. We conducted all of the small-group interviews during our site visit from April 28 through May 1, 2015. Of the 27 interviews, 15 focused on workforce integration and 12 focused on operations integration. For workforce integration, we asked FHCC staff to discuss the positive and negative effects of having a workforce where civilian and active duty staff work together. For the integration of FHCC operations, we asked FHCC staff to discuss the positive and negative effects of integrating key aspects of operations, such as the FHCC's information technology (IT) systems, physical facility space, patient population, and clinical guidelines and operating policies.

To identify participants for our 27 small-group interviews, we randomly selected FHCC staff using employee data provided to us by FHCC officials for the specific areas of the FHCC we requested.[1] (See table 3.) To account for the potential sensitivity of the subject matter, we separated our participant selection for the workforce interviews into civilian and active duty groups, and manager or non-manager groups. We also grouped participants for the operations interviews into manager or non-manager groups, although we combined civilian and active duty staff for these discussions.[2] To reduce burden on FHCC staff, whenever possible, we designed our participant selection to avoid scheduling the same

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[1]In order to randomly select participants, we constructed lists of staff from the data provided by FHCC officials for each area we initially selected for sampling. We then assigned each person on the list a random number and sorted by the assigned random number and our grouping variables (e.g., managers, non-mangers) in order to select participants for each interview. We randomly selected primary participants as well as alternates for each interview and provided these lists to FHCC officials for scheduling purposes.

[2]Although we did not group our selection of operations interview participants by civilian or active duty status, we designed our participant selection in a way that enabled us to ensure a mix of civilian and active duty staff in each operations interview, to the extent possible. One exception was selection of participants for the scheduling interviews: All scheduling staff we interviewed within the Patient Administration Department were civilians.

person for both a workforce and an operations interview. Whenever possible, we also took steps to ensure that we scheduled active duty staff in interviews with other active duty staff of comparable rank. Participation in all small-group interviews was voluntary.

Table 3: Workforce and Operations Small-Group Interview Structure for Captain James A. Lovell Federal Health Care Center (FHCC) Staff

Interview Groups	Types of staff	Facility areas selected for interviews
	Workforce interviews (15 total)	
1	Active duty managers	Clinical
2	Active duty non-managers	• Primary care: Medical Home Port Department; Patient Aligned Care Team Department
3	Civilian managers	• Specialty care: Department of Medicine (Medical Specialties Division, Emergency Division); Department of Surgery (Surgical Sub-Specialties Division)
4	Civilian non-managers	
		• Nursing: Department of Intensive Care; Department of Inpatient Acute Care
5	Active duty managers	Nursing[a]
6	Active duty non-managers	• Department of Intensive Care; Department of Inpatient Acute Care; Nursing Services; Sterilization and Processing Service
7	Civilian non-managers	
8	Active duty managers	Clinical support services
9	Active duty non-managers	• Department of Diagnostic Services (Pathology and Laboratory Medicine Division, Imaging Division, Blood Donor Center); Department of Ancillary Services (Pharmacy Division)
10	Civilian managers	
11	Civilian non-managers	
12	Active duty managers	Administrative
13	Active duty non-managers	• Department of Human Resources Management (Military Personnel Division, Civilian Personnel Division); Department of Financial Management (Budget Division, Payroll Division); Department of Logistics (Purchasing and Contracting Division); Department of Managed Care Operations
14	Civilian managers	
15	Civilian non-managers	
	Operations interviews (12 total)	
1	Managers	Primary care
2	Non-managers	• Medical Home Port Department; Patient Aligned Care Team Department
3	Managers	Specialty care
4	Non-managers	• Department of Medicine (Cardiology Section, Dermatology Section, Neurology Section); Department of Surgery (Ear, Nose, and Throat Section; General Surgery Section)
5	Managers	Intensive care
6	Non-managers	• Department of Intensive Care
7	Managers	Clinical support services
8	Non-managers	• Department of Diagnostic Services (Pathology and Laboratory Medicine Division, Imaging Division, Blood Donor Center); Department of Ancillary Services (Pharmacy Division)

Interview Groups	Types of staff	Facility areas selected for interviews
9	Managers	<u>Scheduling</u>
10	Non-managers	• Department of Patient Administration
11	Managers	<u>Administrative</u>
12	Non-managers	• Credentialing Department (Credentialing and Privileging); Department of Facility Management; Department of Financial Management; Department of Health Care Business; Department of Human Resources Management (Military Personnel Division, Civilian Personnel Division); Department of Logistics (Purchasing and Contracting Division)

Source: GAO. | GAO-16-280

[a]We originally scheduled four nursing interviews but for one of our scheduled interviews (active duty non-managers), no one participated.

We conducted each small-group interview using the same script and a combination of a written data collection instrument (DCI), a response table, and semi-structured discussion:[3]

- **DCI.** Using Likert scale response options, participants responded in writing to questions about the extent of integration in their work area, how effective that integration was in their work area and overall at the FHCC, and the impact of integration on their efficiency, quality of care or support provided or quality of work, and job satisfaction.[4]

- **Response table.** Participants were given a list of key aspects about integration derived from sources such as prior interviews with FHCC officials; evaluative work found in previous GAO and Institute of Medicine reports; FHCC Advisory Board meeting minutes; and the Executive Agreement and an executive decision memorandum. Participants were asked to indicate in writing whether each item had a positive impact on their daily work, a negative impact on their daily work, no impact, or was not applicable. Participants were also able to indicate if an aspect had both a positive and negative impact, and were able to write in

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[3]During the development of our DCIs and response tables, we pretested the workforce and clinical operations DCIs and response tables with FHCC staff to ensure that our questions and response choices were clear, appropriate, and answerable. We made changes to the content of the DCIs and response tables based on their feedback.

[4]A Likert scale is an ordered scale from which respondents answer questions by choosing one option along a provided continuum of options that best aligns with their view. For example, we asked small-group interview participants to rate the impact of workforce integration on their daily work efficiency, on a scale of 1 to 5 (with 1 being a "very negative impact" and 5 being a "very positive impact").

other aspects of integration not listed on the response table. Once completed, participants were then asked to indicate in writing which of these items had the most positive impact on their daily work (if any), and the most negative impact on their daily work (if any).[5]

- **Semi-structured discussion.** We asked each participant to provide more detailed information about the aspects of integration they ranked from the response table as having the most positive and negative impacts on their daily work.[6]

Our analysis has some limitations. While we randomly selected participants to reduce potential sampling bias, the results of our interviews are not generalizable to all FHCC staff, nor to FHCC staff in the specific clinical and administrative areas from which we selected our interview participants. In addition, the difficulties of structuring and conducting interviews using a DCI may introduce errors, commonly referred to as nonsampling errors. For example, difficulties in how a particular question was interpreted or the extent of the respondents' knowledge on an issue could introduce unwanted variability into the DCI results. In addition, some interview participants expressed difficulty in ranking the aspects of integration presented in the response tables given how an issue was worded or the complexity of the issues being discussed. We took steps to proactively address potential nonsampling errors by providing clarification as requested during the small-group interviews. When analyzing the data, we also performed data reliability checks (such as examining the data for missing values). After taking these steps, we determined that the small-group interview data we used were sufficiently reliable for the purposes of our report.

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[5]We adjusted our definition of "operations integration" and created three different response tables for our operations interviews, depending on the interview area. Staff in the primary care, specialty care, intensive care unit, and clinical support services interviews discussed the integration of clinical operations and completed the same version of the response table containing aspects of integrating clinical operations. Scheduling staff and administrative staff discussed the integration of scheduling and administrative operations, respectively. They also completed different versions of the response table that contained aspects of integrating scheduling operations (scheduling staff) and administrative operations (administrative staff).

[6]The interviews were recorded for transcription purposes, and prior to starting each interview participants were provided with information about the purpose of the interview, the transcription service, and how the information would be used. Each participant signed a consent form indicating that they were aware the interview was being recorded, and were given a copy of the form for their records.

Appendix III: Clinic-Level Staffing for Captain James A. Lovell Federal Health Care Center Specialty Care Directorate

The Specialty Care directorate within the Captain James A. Lovell, Federal Health Care Center contains clinics responsible for medical and surgical specialty care. Within these clinics, there are differences in the levels of civilian, active duty, and contract staff between medical and surgical specialty areas. Many of the medical specialties are exclusively civilian supported, while many of the surgical specialties have a larger active duty and contractor presence. (See fig. 9.)

Figure 9: Number and Proportion of Captain James A. Lovell Federal Health Care Center (FHCC) Civilian, Active Duty, and Contract Staff within the Specialty Care Directorate, as of September 2014

Source: GAO analysis of FHCC information. | GAO-16-280

Note: Data derived from official FHCC organizational charts and are current as of September 30, 2014, the most recent authorized versions of these documents. Figure includes authorized civilian positions, some of which may be vacant.

Appendix IV: Comments from the Department of Veterans Affairs

February 9, 2016

Ms. Debra A. Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the U.S. Government Accountability Office's (GAO) draft report, *"FEDERAL HEALTH CARE CENTER: VA and DOD Need to Address Ongoing Difficulties and Better Prepare for Future Integrations"* (GAO-16-280). VA agrees with GAO's conclusions and concurs with GAO's seven joint recommendations to VA and the Department of Defense, and one recommendation to VA.

The enclosure specifically addresses GAO's recommendations in the draft report and provides an action plan to the draft report.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

Robert D. Snyder
Interim Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
*"FEDERAL HEALTH CARE CENTER: VA and DOD Need to Address Ongoing
Difficulties and Better Prepare for Future Integrations"*
(GAO-16-280)

**GAO Recommendation: We recommend that the Secretaries of Veterans Affairs
and Defense collaborate to take the following six actions at the departmental
level:**

**Recommendation 1. Establish FHCC-specific selection criteria for the FHCC
facility director and deputy director positions that include responsibilities and
leadership competencies for effective collaboration.**

VA Comment: Concur. Federal Health Care Center (FHCC)-specific selection criteria
are being established for the Director and Deputy Director positions at the FHCC. While
this has recently been done informally at the Executive Session of the FHCC Advisory
Board, it will be formalized by the Advisory Board for communication to both agencies.
Target Completion Date: July 2016.

**Recommendation 2. Ensure that the evaluation of the leadership performance at
the FHCC is carried out jointly between VA and DOD.**

VA Comment: Concur. The FHCC Advisory Board will ensure that the evaluation of
the leadership performance (VA Director and Navy Deputy Director) at the FHCC is
carried out jointly at the conclusion of fiscal year (FY) 2016 and beyond. Target
Completion Date: January 2017.

**Recommendation 3. Perform data-driven strategic workforce planning prior to
implementing any future integration efforts.**

VA Comment: Concur. The Veterans Health Administration (VHA) is in the process of
further developing staffing models that can be applied to future integration efforts based
on the analysis of practice area complexity, characteristics of the local Veteran
population, and productivity measurements. VHA will share a summary of the staffing
models when completed. Target Completion Date: January 2017.

**Recommendation 4. Determine how best to fill the FHCC's short-term staffing
needs, including any additional statutory authorities that might be necessary to
implement the desired approach.**

VA Comment: Concur. Based on the results of the data-driven strategic planning as
noted in recommendation 3, FHCC will review both VHA and Department of Defense
(DoD) funding and staffing models to validate the FHCC short-term staffing needs and
determine the best strategy for filling those positions. VHA will explore the need for
statutory authorities that might be necessary specifically for the FHCC. Target
Completion Date: July 2018.

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
*"FEDERAL HEALTH CARE CENTER: VA and DOD Need to Address Ongoing
Difficulties and Better Prepare for Future Integrations"*
(GAO-16-280)

<u>Recommendation 5:</u> Resolve differences in IT network security standards to the
extent possible prior to implementing any future integration efforts.

VA Comment: Concur.

    a. Hardware and a DoD provided circuit was deployed at each Trusted Internet
Connection (TIC) Gateway. This is used to facilitate secure connectivity to
the DoD via the shared/private Medical Community of Interest (Med-COI)
network. Connectivity via this method was completed in Q1, FY 2015.

    b. Future integration efforts will traverse a TIC-approved connection method,
such as the VA/DoD Med-COI network. Transition efforts for existing
connections are ongoing. FHCC is planned for transition by Q1, FY 2017.

    c. VA and DoD continue to work toward a common network security baseline.
VA adheres to National Institute of Standards and Technology (NIST) 800-53
Rev4 controls, while DoD adheres to DoD Information Assurance Certification
and Accreditation Process (DICAP) 8502. DoD is working toward moving to
NIST 800-53 Rev4 so both agencies can work from a common baseline.

Target Completion Date: FHCC transition to Med-COI: December 31, 2016

We recommend that the Secretary of Veterans Affairs take steps to:

<u>Recommendation 6:</u> **Ensure that the FHCC is able to systematically monitor the
reasons for referrals to non-VA medical care.**

VA Comment: Concur. The FHCC has been monitoring referrals based on patient
priority to Non-VA Medical Care Consults on a manual basis.

To ensure more systematic monitoring, FHCC will coordinate with VHA's Access and
Clinic Administration Program to develop a modification to the drop down menu in the
"justification for Non-VA Care." This would enable electronic tracking and reduce the
use of the "other" field to identify referrals based on patient priority at the FHCC. The
FHCC Compliance Office will continue the use of the "other" field to ensure compliance
with the new drop down menu. Target Completion Date: June 2017.

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Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
*"FEDERAL HEALTH CARE CENTER: VA and DOD Need to Address Ongoing
Difficulties and Better Prepare for Future Integrations"*
(GAO-16-280)

**Further, GAO recommends that the Secretaries of Veterans Affairs and Defense
direct FHCC leadership to take the following two actions:**

**Recommendation 7: Provide routine training to civilian managers, who supervise
active duty staff on the West Campus, on how to effectively utilize such staff,
particularly Navy hospital corpsmen.**

VA Comment: Concur. FHCC has previously completed an internal needs
assessment, and based upon that assessment, a training plan is being developed and
instituted for FHCC supervisors (military and civilian) to provide an understanding of
how to best utilize staff in the most effective manner, with a focus on utilization of DoD
Navy hospital corpsmen. Target Completion Date: December 2016.

**Recommendation 8: Provide additional guidance on the patient priority system to
all staff responsible for approving consults and ensure that the monthly
capability and capacity reports include information on all categories of FHCC
patients defined by the patient priority system.**

VA Comment: Concur. FHCC will provide additional guidance to all staff responsible
for approving consults on the patient priority system. The FHCC monitors the Capability
and Capacity report to confirm that the information contained reflects the capabilities of
the organization. Target Completion Date: June 2016.

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Appendix V: Comments from the Department of Defense

Ms. Debra A. Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

FEB 0 4 2016

This is the Department of Defense response to the GAO Draft Report, GAO-16-280, "FEDERAL HEALTH CARE CENTER: VA and DOD Need to Address Ongoing Difficulties and Better Prepare for Future Integrations," dated December 23, 2015 (GAO-16-280). My specific comments to the report's recommendations are attached, as well as technical comments to the Draft Report.

Overall, I generally concur with the Draft Report's findings and conclusion. Many of Government Accountability Office's recommendations include efforts that the Departments intend to implement as part of the Federal Health Care Center Way Ahead plan, and will be reported in the Report to Congress (RTC) as required by National Defense Authorization Act 2010, Section 1701.

My points of contact for this issue are Ms. Sylvia Farias (Functional) and Ms. Joyce Forrest. Ms. Farias may be reached (703) 275-6067, or at Sylvia.n.farias.civ@mail.mil. Ms. Forrest (Audit Liaison) may be reached at (703) 681-6741, or at Joyce.forrest2.civ@mail.mil.

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

Jonathan Woodson, M.D.

Attachment:
As stated

GAO DRAFT REPORT DATED December 23, 2015
GAO-16-280 (GAO CODE 291252)

"FEDERAL HEALTH CARE CENTER: VA and DOD Need to Address Ongoing
Difficulties and Better Prepare for Future Integrations"

DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATIONS

RECOMMENDATION: The Government Accountability Office (GAO) recommends that the
Secretaries of the Department of Veterans Affairs (VA) and Department of Defense (DoD)
establish Federal Health Care Center (FHCC)-specific selection criteria for the FHCC facility
director and deputy director positions that include responsibilities and leadership competencies
for effective collaboration.

DoD RESPONSE: DoD concurs with this recommendation. The FHCC Executive Agreement
will be updated to include a revised selection and evaluation process for the FHCC Director and
Deputy Director, including FHCC-specific selection criteria. The Department plans to include
this effort in the Report to Congress (RTC).

RECOMMENDATION: GAO recommends that the Secretaries of VA and DoD ensure that
the evaluation of the leadership performance at the FHCC is carried out jointly between VA and
DoD.

DoD RESPONSE: DoD concurs with this recommendation. The FHCC Executive Agreement
will be updated to include a revised selection and evaluation process for the FHCC Director and
Deputy Director, including formal involvement by both Departments in the evaluation of
leadership performance. The Department plans to include this effort in the RTC.

RECOMMENDATION: GAO recommends that the Secretaries of VA and DoD perform data-
driven strategic workforce planning prior to implementing any future integration efforts.

DoD RESPONSE: DoD concurs with this recommendation.

RECOMMENDATION: GAO recommends that the Secretaries of VA and DoD determine
how best to fill the FHCC's short-term staffing needs, including any additional statutory
authorities that might be necessary to implement the desired approach.

DoD RESPONSE: DoD concurs with this recommendation, and strongly concurs that VA
should seek legislative authority to execute personal services contracts at FHCC.

RECOMMENDATION: GAO recommends that the Secretaries of VA and DoD resolve
differences in information technology (IT) network security standards, to the extent possible
prior to implementing any future integration efforts.

DoD RESPONSE: DoD concurs with this recommendation.

RECOMMENDATION: GAO recommends that the Secretaries of VA and DoD direct FHCC
leadership to provide routine training to civilian managers, who supervise Active Duty staff on
the West Campus, on how to effectively utilize such staff, particularly Navy hospital corpsmen.

DoD RESPONSE: DoD concurs with this recommendation.

RECOMMENDATION: GAO recommends that the Secretaries of VA and DoD direct FHCC
leadership to provide additional guidance on the patient priority system to all staff responsible
for approving consults and ensure that the monthly capability and capacity reports include
information on all categories of FHCC patients defined by the patient priority system.

DoD RESPONSE: DoD concurs with this recommendation.

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Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Bonnie Anderson, Assistant Director; Mark Bird, Assistant Director; Jennie Apter; Hernán Bozzolo; Jessica Farb; Jacquelyn Hamilton; Linda Galib; William Garrard; and Richard Lipinski made key contributions to this report.