VA-DoD Joint Executive Committee
Annual Joint Report
FISCAL YEAR 2018

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VA-DoD
Joint Executive Committee
Membership List
(as of September 30, 2018)

Department of Veterans Affairs (10)	**Department of Defense (11)**
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Under Secretary for Health	Assistant Secretary of Defense (Health Affairs)
Under Secretary for Benefits	Assistant Secretary of Defense (Manpower and Reserve Affairs)
Assistant Secretary for Information and Technology	Principal Deputy Assistant Secretary of Defense (Health Affairs)
Assistant Secretary for Enterprise Integration	Director, DoD/VA Interagency Program Office
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Principal Executive Director, Office of Acquisition, Logistics & Construction	Deputy Commandant of the Marine Corps (Manpower and Reserve Affairs)
	Executive Director, Office of Force Resiliency

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SECTION 1 – INTRODUCTION

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Joint Executive Committee (JEC) is pleased to submit this VA-DoD JEC Fiscal Year (FY) 2018 Annual Joint Report (AJR), for the period of October 1, 2017 to September 30, 2018, to Congress as required by law. The intent of the AJR is to provide Congress with information about the collective accomplishments of the two Departments and highlight current efforts to improve joint coordination and resource sharing. This report does not contain recommendations for legislation.

The JEC provides senior leadership a forum for collaboration and resource sharing between VA and DoD. By statute, the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness co-chair the JEC. The JEC consists of the leaders of the Health Executive Committee (HEC), the Benefits Executive Committee (BEC), the Interagency Program Office (IPO), additional Independent Work Groups (IWG), and other senior leaders designated by each Department.

The JEC works to remove barriers and challenges that impede collaborative efforts, assert and support mutually beneficial opportunities to improve business practices, ensure high quality cost-effective services for VA and DoD beneficiaries, and facilitate opportunities to improve resource utilization. Through a joint strategic planning process, the JEC recommends to the Secretaries the strategic direction for joint coordination and sharing efforts between the two Departments and oversees the implementation of those efforts.

The VA-DoD JEC FY 2018 AJR links accomplishments to the three strategic goals established in the VA-DoD Joint Executive Committee Joint Strategic Plan (JSP) FY 2016-2018: (1) Benefits and Services, (2) Health Care, and (3) Efficiencies of Operation. This approach clarifies the connection between strategic planning and outcomes achieved through VA and DoD coordination, collaboration, and sharing efforts.

The HEC, BEC, and IPO are comprised of 36 Work Groups (WG), areas of oversight, and Centers of Excellence (CoE).

Health Executive Committee (HEC) Business Lines (BL) and WGs:

- Clinical Care and Operations BL
  - Credentialing WG
  - Sexual Trauma (area of oversight)
  - Pain Management WG
  - Patient Safety WG
  - Pharmacy Ad Hoc WG
  - Psychological Health WG
  - Telehealth WG
  - Vision CoE
  - Hearing CoE

    - Extremities Trauma & Amputation CoE
    - Traumatic Brain Injury (area of oversight)
    - Women's Health WG
- Financial and Business Operations BL
    - Acquisitions & Medical Materiel Management WG
    - Financial Management WG
    - Shared Resources WG
- Health Data Sharing BL
    - Interagency Clinical Informatics Board
    - Health data sharing for Clinical Care Transitions Sub-group
    - Health data sharing for Separating Service members and Integrated Disability Evaluation System and Benefits Adjudication Sub-group
    - Health data sharing for Patient Empowerment Sub-group
    - Health data sharing for Population Health & other Non-clinical use Sub-group
- Professional Development BL
    - Continuing Education & Training WG
    - Health Professions Education Ad Hoc WG
    - Evidence-Based Clinical Guidelines WG
- Research BL
    - Medical Research WG
    - Deployment Health WG
- Care Coordination Business Line
    - Policy and Oversight WG
    - Community of Practice WG
    - Technology Tools and Change WG
- James A. Lovell Federal Health Care Center (JAL FHCC) Advisory Board

Benefits Executive Committee (BEC) WGs

- Communication of Benefits and Services WG
- Information Sharing/Information Technology WG
- Disability Evaluation System Improvement WG
- Service Treatment Records WG

Interagency Program Office Executive Committee (EXCOM)

- DoD/VA Interagency Program Office (IPO)

Independent Work Groups (IWG)

- Construction Planning Committee (CPC)
- Strategic Communications WG
- Separation Health Assessment WG (SHAWG)

SECTION 2 – ACCOMPLISHMENTS

This section highlights the FY 2018 accomplishments of the HEC, BEC, IPO, and IWGs. These accomplishments reflect the efforts of VA and DoD to improve resource sharing between the Departments and further the mission to optimize the health and well-being of Service members, Veterans, and their eligible beneficiaries. The report also acknowledges some planned activities for FY 2019.

GOAL 1 – Benefits and Services

Deliver comprehensive benefits and services through an integrated client-centric approach that anticipates and addresses client needs.

1.a. Benefits Data – BEC Information Sharing/Information Technology Work Group

The BEC Information Sharing/Information Technology (IS/IT) Work Group continues the development of information technology that ensures appropriate Departments, Agencies, Service members, Veterans, and representatives have immediate and secure access to reliable and accurate data used in determining entitlements, verification of benefits, and Veterans' status. The IS/IT WG also facilitates electronic exchange of personnel and benefits data between VA and DoD and leverages VA-DoD enterprise architectures. The WG has enhanced benefits delivery through oversight and management of initiatives in FY 2018 as outlined below.

DoD Self-Service Logon

As of September 2018, the DoD Self-service Logon (DS Logon) reached 7,478,797 user accounts. The DS Logon provides a single sign on capability to the DoD beneficiary population for self-service applications. With the creation of eBenefits, the DoD extended DS Logon outside of the DoD and partnered with VA to provide a single enterprise logon for both Departments. Each month over 6.5 million logons occur across 64 applications. Additionally, VA.gov was redesigned and incorporated numerous features from eBenefits and MyHealthVet to include expanding digital access, thus allowing for an enhanced user experience.

Servicemembers' Group Life Insurance (SGLI) Online Enrollment System (SOES)

The SOES made significant strides in FY 2018 toward full implementation to support the needs of Service members and their families. SOES provides 24/7 access to SGLI/Family SGLI elections for the Service member and will provide the same level of accessibility and efficiency for casualty offices working to settle claims for family members.

The SOES implementation plan was accepted by all Services. The overall implementation approach staggers the start for adoption of SOES by each Service

throughout FY 2017, 2018, and 2019. Each Service will require approximately 12 months to fully on-board its members; efforts will conclude in FY 2020. Each Service developed a Service-specific strategy to manage the transition of personnel into SOES. Policy, training, and communications support was provided to the Services by DoD and the Veterans Benefits Administration (VBA) to facilitate an orderly implementation. The Navy and Air Force completed their implementation during Q3 and Q4 of FY 2018, respectively. The Army and Marine Corps started their implementation during Q1 and Q4 of FY 2018, respectively. Over 196,000 Service members certified their coverage using SOES by the end of FY 2018.

Interagency Paperless DD Form 214

The Interagency Paperless DD Form 214, Certificate of Release or Discharge from Active Duty, project is focused on eliminating the paper form and manual processing of the DD Form 214/5. Transition from paper to electronic data has a potential cost avoidance of $58 million per year among all interagency stakeholders. The transition to a paperless process will also facilitate enrollment into VA health care by eliminating the requirement to attach the paper DD Form 214 to VA benefits request. The electronic delivery of the DD Form 214 data and separation information will further enable Veterans to research their record, submit evidence for inaccurate or missing information, and verify service.

The Defense Manpower Data Center (DMDC) expanded a DD Form 214 Web service solution to provide the State Departments of Veterans Affairs (SDVA) with electronic military service and separation data to eliminate mailed copies for all service branches. The SDVAs are using the electronic data to provide timelier outreach and state benefit determination for Veterans within their jurisdiction. By the end of FY 2018, DMDC established access to the Web service with 50 states and 2 territories. DoD and DOL are working towards implementation of a Web service solution to provide DOL with electronic service and separation data upon receipt of an unemployment compensation request from a former Service member.

Education Benefits Fund (EBF)

DoD Office of the Actuary (OACT) uses VA data to perform cost calculations for the Education Benefits Fund (EBF). VA bills DoD monthly for the amounts of benefits paid under each education program that are DoD's responsibility. VA is currently sending DoD usage data which includes counts and amounts of benefits paid at the Veteran/Service member detail level. Although the amount billed is an accurate reflection of DoD payments to VA, the aggregate amount in the detail records does not match the amount billed per accounting reports. In FY 2018, VA completed software updates and validated test results which showed the 1606 data matched exactly to the amount billed to DFAS.

Dual Compensation

The automated processing of drill pay adjustments due to concurrent receipt of VA disability compensation continued in FY 2018. The Q1 and Q2 FY 2018 Return to Active Duty matches yielded 250 cases. During FY 2018, 133 cases (53.2 percent) were completed or no action was needed, 35 cases (14.0 percent) are either in due process or awaiting final action, and 82 cases (32.8 percent) are requiring due process to begin. The decrease in the number of cases worked in FY 2018 as compared to FY 2017 is due to expiration of agreements between VA and DoD, however, the new agreements are expected to be approved in early FY 2019.

1.b. Lead Coordinator – IC3 Community of Practice Work Group

The Lead Coordinator (LC) and Interagency Comprehensive Plan (ICP) efforts of the Interagency Care Coordination Committee (IC3) were realigned under the Health Executive Committee in March 2018 as the Care Coordination Business Line (CCBL). The CCBL provides joint leadership to drive continuous integration of care, benefits, and services provided to Service members, Veterans, and their families.

LC sustainment training has been implemented using recorded videos of the LC training and LC Awareness training and provides continuing education unit (CEU) accreditation to existing and new LCs. The Sustainment training is readily available 24/7 through VA-DoD's Employee Education Systems, Talent Management System (TMS), and VHA TrainingFinder Real-time Affiliate Integrated Network (TRAIN).

VA-DoD ICP interoperability was deployed in March of 2017. In November and December 2017, VA received eight ICPs from DoD via interoperability between the DoD Case Management System (DoD CMS) and VA's Federal Case Management Tool (FCMT). The ICPs were successfully received and validated. Errors were found and fixes were identified and deployed. In June 2018, VA migrated to new connection services between DoD CMS and FCMT. Interoperability temporarily ceased starting June 7, 2018, while the infrastructure was migrated from Electronic Messaging Infrastructure (eMI) to Data Access Services (DAS). Testers noted data translation issues after the DAS migration. IT experts from both systems are working to resolve the issues. Although the electronic interoperability is temporarily limited, coordination of care between VA and DoD continues uninterrupted through existing business processes between VA and DoD field staff.

Ongoing activities will ensure the institutionalization of a broader model coordinating care between VA and DoD for all transitioning Service members, including those who need complex care coordination.

GOAL 2 – Health Care

Provide accessible quality health care to the right person, at the right time, for the right price.

2.a. Individual Longitudinal Exposure Record – HEC Deployment Health Work Group

The collaborative VA and DoD electronic Individual Longitudinal Exposure Record (ILER) will capture individual exposures to harmful substances for Service members and Veterans. ILER will connect individuals by time, place, event, and all-hazard occupational and environmental monitoring data, with medical encounter information (diagnosis, treatment, and laboratory data), across the Service member's career. ILER will be available to VA and DoD health care providers, epidemiologists, and researchers; and VA disability evaluation and benefits determinations specialists. ILER will deliver the following capabilities:

- Improve the quality and quantity of information available to facilitate exposure-related health care, assess individual and population-level exposures, conduct disability evaluations; and adjudicate benefits determinations.
- Relieve Service members and Veterans from burden of proof; reduce presumption of exposure and increase accuracy of claims processing and benefits determinations.
- Increase communication and transparency between DoD, VA, Congress, beneficiaries, and other stakeholders (e.g. Veterans Service Organizations, Military Service Organizations).
- Provide a foundation for prospectively following exposed cohorts for long-term or latent health effects that could be attributable to exposures.

In FY 2018, the Departments made significant progress toward delivering these capabilities by achieving the following major milestones and activities:

- Approved a funding strategy to support sustainment and continued development of the ILER Pilot, Initial Operating Capability (IOC), and Full Operational Capability (FOC).
- Completed the DoD Information Technology (IT) framework and infrastructure for the ILER Pilot.
- Built ILER Pilot system functionality for clinicians, epidemiologists, and benefits adjudicators.
- Integrated essential VA and DoD data sources for the Pilot and identified data sources for IOC and FOC.
- Completed independent pilot verification, validation testing, and initial training.
- Conducted product demonstrations and obtained and incorporated stakeholder/ user feedback.
- Continued VA and DoD collaborations on data management, technology integration, and information sharing.
- A functional ILER Pilot was available on September 30, 2018, for health care providers, epidemiologists, and benefits adjudicator's users.

Clinicians, epidemiologists, and claims adjudicators feedback reflect significant interest and urgent need for an ILER capability. This year's accomplishments established a clear roadmap for achieving ILER IOC in September 2019 and FOC in September 2023.

2.b. Psychological Health Work Group

The Departments collaborate to increase availability and access to mental health resources, decrease negative perceptions of mental health problems and treatment, and increase knowledge of suicide risk and prevention strategies through the development of resources and training for providers, Service members, and Veterans. In FY 2018, the Work Group actively collaborated in support of four primary initiatives: the inTransition Program, Separation Mental Health Assessment, public outreach campaigns, and the Community Provider Toolkit.

The inTransition Program is a voluntary, confidential telephonic coaching program that provides continuity of care (i.e., warm hand-off) within and between VA and DoD health care systems as Service members and Veterans with psychological health needs transition between duty stations and from active duty service to civilian life. For the period of October 2017 through August 2018, there were over 35,583 unique assessments completed by the inTransition program, resulting in over 7,146 coaching cases opened. VA is working with DoD to promote self-referral to inTransition among Veterans with any category of discharge and to strengthen referrals from inTransition to VA health care and Vet Centers.

In accordance with the National Defense Authorization Act for FY 2018, section 706, DoD is standardizing practices in support of separation Mental Health Assessments (MHA), which are part of the Separation Health Assessment/Separation History and Physical Examination process, for all separating Service members within 180 days prior to discharge. VA and DoD are collaborating on common mental health metrics to fulfill this requirement. In FY 2019, VA and DoD will establish a baseline percentage of those separating Service members who received a DoD referral to behavioral or mental health care at their MHA who were subsequently seen by either VA, TRICARE, or DoD within 90 days of referral.

VA's Make the Connection (MTC) campaign, which is coordinated with DoD's Real Warriors campaign (RWC) and shared through DoD networks, has reached millions of Service members, Veterans, and their families through www.maketheconnection.net. MTC uses social media and public service announcements (PSA) to feature Veterans telling their own stories of recovery. In FY 2018, there were approximately 3 million Web site visits and over 53 million views of Veteran videos. This year's two PSAs were displayed 232 million times.

The RWC is a multimedia public awareness initiative through the Psychological Health Center of Excellence (PHCoE) designed to encourage help seeking behavior among Service members, Veterans, and families, and reduce stigma surrounding psychological health. RWC uses digital platforms, such as its Web site (realwarriors.net) and social media (e.g., Facebook, Twitter and YouTube), to reach digital audiences, encourage

positive behavior change, and increase access to psychological health tools and resources. In FY 2018, there were 195,688 unique Web site visitors, 230,533 Web site visits, 66,974 social media interactions, and 3,933,952 post/tweet impressions. RWC also garnered 8,282 unique views of campaign videos featuring Service members and Veterans sharing their stories of seeking psychological health care. This year's six PSAs were displayed 657 million times.

Launched in March 2016, the Community Provider Toolkit (CPT) is a one-stop, Web-based interagency repository of resources and tools developed with input from VA, DoD, and the Substance Abuse and Mental Health Services Administration (SAMHSA). The repository provides a single point of access to resources including the National Resource Directory, SAMHSA Treatment Locator, Military OneSource, and Military Families Learning Network. CPT had 44,126 page views in FY 2018, and the interagency repository had 3,453 page views. In FY 2019, the CPT and its interagency resource page will be evaluated and re-designed for increased visibility and impact based on user feedback.

In FY 2019, the PH WG will begin collecting baseline data on the following goals:

- inTransition Program: Increase by 5 percent by end of each FY (2020 and 2021) the number of Service members in the inTransition program who successfully transition to VA care.
- Separation Mental Health Assessment: Facilitate DoD to VA warm hand-off transition for separating Service members needing follow-on mental health services.
- Increase percentage of Guard/Reserve members referred for mental health follow up on the Post Deployment Health Reassessment in FY 2019, from baseline, who were subsequently seen by either VA, TRICARE, or DoD within 90 days of referral.

2.c. Traumatic Brain Injury (area of oversight)

Traumatic Brain Injury (DVBIC)/Clinical Care and Operations

As the Traumatic Brain Injury (TBI) Center of Excellence, the mission of the Defense and Veterans Brain Injury Center is to promote state-of-the-science TBI care from point of injury to reintegration. To fulfill the National Defense Authorization Act (NDAA) for FY 2007 requirement as described in section 721: *The Secretary of Defense shall conduct a longitudinal study on traumatic brain injury incurred by members of the armed forces in Operation Iraqi Freedom and Operation Enduring Freedom, in consultation with the Secretary of Veterans Affairs,* the Departments are collaborating on prospective longitudinal studies.

The Improved Understanding of Medical and Psychological Needs in Veterans and Service members with Chronic TBI (IMAP) longitudinal study examines the health, rehabilitation, and psychological needs of Service members and Veterans for up to 5 years after inpatient TBI rehabilitation, as well as the caregiver burden of caring for those individuals. Now in its third year, IMAP enrolled over 400 subjects through FY 2018. Preliminary investigations describe key aspects of health, rehabilitation, and psychological needs of Service members and Veterans with TBI at 1 and 2 years after

inpatient rehabilitation. Initial findings have been released in a series of 16 peer-reviewed publications published in FY 2018. These findings delineate impediments to employment as well as predictors of employment outcomes, the relationship between Posttraumatic Stress Disorder (PTSD) symptoms and social participation, the prevalence and predictors of tobacco smoking, and risk factors impacting relationship stability. IMAP complements the ongoing 15-Year Studies on the long-term effects of TBI.

Building on these efforts is the Patient-Centered Outcomes Research Institute (PCORI)-funded study to inform choices on sleep screening and evaluation [Comparison of Sleep Apnea Assessment Strategies, C-SAS]. The C-SAS collected study data on over 250 subjects by FY 2018. The study team produced eight peer-reviewed publications in a special issue of Brain Injury Professional in FY 2018, providing guidance to clinicians who treat TBI survivors on the recognition and treatment of sleep disorders, including sleep apnea, in neurorehabilitation. Moreover, the C-SAS informs sleep screening and evaluation in Service members and Veterans following TBI.

IMAP and C-SAS findings have been widely disseminated to providers from multiple disciplines through more than 50 presentations at research, training, and educational venues throughout the U.S. The findings from these studies allow development and dissemination of best practice recommendations and clinical support products to improve screening, diagnostic evaluation, and treatment for Service members and Veterans with history of TBI and mitigates associated comorbidities which may negatively impact long-term outcomes.

2.d. Hearing Center of Excellence

The mission of the Hearing Center of Excellence (HCE) is to optimize operational performance, heighten medical readiness, and enhance quality of life through collaborative leadership and advocacy for hearing and balance health initiatives focused on prevention, diagnosis, mitigation, treatment, and rehabilitation. The HCE places special emphasis on Service members and Veterans with hearing loss or auditory system injury incurred while serving on Active Duty, including those with auditory-vestibular-dysfunction related to TBI.

In partnership with the DoD Defense Health Agency, VA Denver Logistic Center, and DoD Health Affairs, the HCE assisted with developing a proposal that is under consideration to use the VA national hearing aid/accessory contract and VA's Remote Order Entry System to reduce the TRICARE cost of these devices for active duty Service members and Active Duty family members receiving hearing aid services in the TRICARE network rather than the direct care system. The net TRICARE cost savings of this initiative is estimated to be $52.5 million.

The HCE continued to build the congressionally mandated Joint Hearing Loss and Auditory System Injury Registry (JHASIR). The database supporting JHASIR contains data on over 800,000 Service members and four million Veterans with hearing loss

and/or auditory system injury back to 2001. Full operational capability of JHASIR is expected by FY 2019.

HCE subject-matter expert participation in research panels and advisory boards resulted in 33 peer-reviewed publications. Studies were initiated to measure and validate the effectiveness of the Comprehensive Hearing Health Program (CHHP) educational products by measuring changes in Service members' knowledge, attitudes, and behaviors, as well as measuring noise exposure, genetic biomarkers for noise-induced hearing loss, current hearing status and medical and operational history as part of a precision medicine approach to behavior change. Study outcomes recommend use of specific educational products and messaging. Dissemination of CHHP materials has reached 80 percent of targeted DoD sites.

The VA-DoD Tinnitus Work Group, a collaborative effort founded by HCE, VA Rehabilitation Research & Development National Center for Rehabilitative Auditory Research (NCRAR), and Walter Reed National Military Medical Center, completed the first of four tinnitus educational modules for VA and DoD providers. Over 2,500 NCRAR products were distributed. The Tinnitus Work Group initiated planning for a centralized database of Tinnitus Functional Index outcomes across VA and DoD.

The Military Vestibular Assessment and Rehabilitation Course faculty conducted three regional courses both inside and outside the continental United States this year, training 92 VA and DoD providers to the national standard, which improves patient outcomes and reduces external referrals. In the 6 months post-course follow-up, 93 percent of course participants indicated the course positively impacted clinical care.

2.e. Vision Center of Excellence

The Vision Center of Excellence (VCE) maximizes potential for effective prevention, diagnosis, mitigation, treatment, and rehabilitation of injuries and disorders of the visual system through its collaborative efforts and facilitates the identification of research capabilities within and between VA and DoD.

VCE continues to work in collaboration with a wide variety of government and private sector partners to inform the identification, prioritization, and evaluation of research proposals. In FY 2018, VCE participated as a panel member in pre-application and programmatic reviews with the Vision Research Program (VRP) Joint Program Committee 8 (JPC-8) and supported the development of the JPC-8 gap analysis. In conjunction with the US Army Medical Research and Materiel Command's (MRMC), Congressionally Directed Medical Research Program (CDMRP), and JPC-8/(CRMRP, VCE) chaired the VRP Scientific Steering Committee and Research Program Programmatic Review.

VCE continues to publish quarterly and annual reports to the DoD Service Consultants and the VA National Directors of Ophthalmology, Optometry, and Blind Rehabilitation regarding eye and vision injuries incurred by active duty Service members. VCE continues to engage international, multi-agency, cross-specialty attendees through the

World Wide Ocular Trauma Readiness Curriculum (WWOTRC) for the review of vision cases and identification of clinical process improvements. The monthly calls serve as a key platform for providing feedback and follow-up to deployed providers and for developing and disseminating best practices and clinical lessons learned.

In FY 2018, VCE completed a comprehensive literature review designed to estimate the prevalence of vision loss, visual field loss, convergence problems, accommodative problems, and photophobia associated with TBI. Two manuscripts were produced outlining the prevalence estimates for these five conditions found with TBI.

In FY 2018, VCE developed and began execution of a plan to expand vision care coordination services at three additional regional clinical centers. The first phase of this plan included the development of a support contract to place vision care service coordinators at four military treatment facilities by the end of FY 2019. Execution of the plan will bring the Departments one step closer to ensuring the right patient gets to the right place, with the right ocular capability, for the right treatment, at the right time. Building on a newly introduced regional program at the Buffalo VA wherein a hub and spoke telehealth Low Vision program is ongoing, VCE is supporting Washington DC VAMC Low Vision Services and Walter Reed National Military Medical Center (WRNMMC) to provide Low Vision Care via telehealth delivered directly into the eye department at WRNMMC. The program will deliver low vision care and provide services between VA and DoD. The Departments are exploring the use of this model across the National Capitol Region (NCR) and continued services expansion between VA and DoD at other locations nationwide.

VCE led the vision component for a series of executive statements about treatment and rehabilitation measures for Service members who suffered a TBI and participated in a state of the science review and forum for the Defense and Veterans Brain Injury Center (DVBIC). As a result of the review, the panel informed the research and clinical practice communities by: synthesizing and interpreting scientific evidence; identifying and documenting the current state of the science applicable to TBI clinical care; and providing recommendations and highlighting areas that warrant further investigation.

2.f. Extremity Trauma and Amputation Center of Excellence

The Extremity Trauma and Amputation Center of Excellence (EACE) is the joint DoD and VA lead element focused on the mitigation, treatment, and rehabilitation of traumatic extremity injuries and amputations. The EACE's charge is to implement a comprehensive plan and strategy to conduct clinically relevant research, foster collaboration, and build partnerships across the multidisciplinary international, Federal, and academic networks to enhance the quality of life of Service members and Veterans. The EACE's responsibility is to sustain and advance extremity trauma science and treatment within VA and DoD.

In FY 2018, the EACE delivered high quality, relevant continuing education to amputation care professionals through a variety of programs/media. First, it piloted the Amputation Care Extension for Community Healthcare Outcomes (ECHO) tele-

mentoring/tele-education program for amputation care professionals. This involved training 285 personnel in 10 sessions, two of which were focused on rapid translation of research findings to the clinical setting. Additionally, the EACE conducted six Virtual Grand Rounds training webinars with support from the VA Employee Education System. Providers of the training webinars were consistently rated above 90 percent for overall satisfaction and clinical presentation relevance.

The EACE continued IRB-approved research studies on extremity trauma and amputation. In FY 2018, it published 30 peer-reviewed scientific articles, contributed to the 2018 Military Health System Research Symposium with three podium and 20 poster presentations, and completed an extensive research gap analysis for extremity trauma and amputation detailing clinical needs and research prioritization within DoD in a report that was shared with Army Medical Research and Materiel Command.

The EACE conducted 11 theater security cooperation engagements at the request of Combatant Commanders in Iraq, Thailand, Mexico, China, and United Arab Emirates.

The EACE helped DoD begin procuring lower extremity prosthetic components through VA's Denver Logistics Center, providing opportunities for increased efficiency and acquisition flexibility for both Departments.

Additionally, the EACE leveraged preliminary core competency documents to develop lists of knowledge, skills, and abilities (KSA) needed by physical therapists and occupational therapists providing amputation care in an Advanced Rehabilitation Center. Orthotist, prosthetist, and physiatrist KSAs are under development.

Collaboration and efforts with DHA will result in an EACE Carepoint registry beta site in FY 2019. The EACE also established data sharing agreements to enhance collaboration. A data sharing agreement with the Joint Trauma System combines and enhances performance improvement registries. A data sharing agreement between EACE and the VA Amputation System of Care enhances the identification and longitudinal tracking of the VA-DoD joint patient population.

2.g.1. Health Data Sharing – VA-DoD Interagency Program Office (DoD/VA IPO)

The purpose of the DoD/VA IPO is to jointly oversee and monitor the efforts of the DoD and VA in implementing national health data standards for interoperability and act as the single point of accountability for identifying, monitoring, and approving the clinical and technical data standards and profiles to ensure seamless integration of health data between the two Departments and private health care providers. The IPO supports national interoperability efforts by closely collaborating with the Office of the National Coordinator for Health Information Technology. New mission requirements in FY 2018 included serving as Executive Secretariat for four new interagency governance bodies approved by the JEC: the DoD/VA Interagency IT Steering Committee and three new governance bodies to adjudicate decisions regarding VA and DoD implementation of the same electronic health record across VA and DoD enterprises.

Based on the FY 2018 VA-DoD Joint Interoperability Strategic Plan (JISP), the IPO continues to work with VA, DoD, and ONC, as well as other public and private partners to enhance standards-based data interoperability between the Departments' EHRs. Specifically, the IPO achieved the following Joint Strategic Plan activities in FY 2018.

Data Mapping

In order to maintain and enhance interoperability, the Departments and IPO continued regular mapping updates for data quality assurance. Throughout FY 2018, the IPO's Interoperability Standards and Documentation Change Control Board reviewed, analyzed, and approved a total of 8 DoD clinical data maps. VA continues to advance its data mapping capabilities as it proceeds with additional EHR enhancements. Moving forward, the IPO will continue working with VA and DoD to provide data quality assurance and explore opportunities to refine the process for reviewing and deploying data mapping updates.

Joint Legacy Viewer (JLV) Update

VA and DoD continued to provide the JLV capability to new users. At the end of FY 2017, there were 419,613 total JLV users (88,345 DoD /and 331,268 VA users (315,199 Veterans Health Administration / 16,069 Veterans Benefits Administration). Throughout FY 2018, VA and DoD continued deployment and infrastructure improvements of JLV including the deployment of Release 6 Patch 2, which incorporated the parsing of 6 domains of VA community health partner data for view by VA JLV users. In addition, requirements for the parsing of On-Demand & Aggregate MHS GENESIS Continuity of Care Document (CCD) data into JLV widgets were finalized and in turn, VA and DoD deployed Release 6 Patch 3 during the third quarter. In the fourth quarter, the Defense Medical Information Exchange (DMIX), in conjunction with VA, will deploy Release 7, which includes the redesign of the DoD Community Health Summaries Widget, a new Dental Documents Widget, and the ability to conduct date filtering for data returned from eHealth Exchange Partners. At the end of FY 2018, there were 422,370 total JLV users (96,187 DoD/ 308,529 VHA Users; 17,654 VBA Users). To further enhance data sharing, the DoD and U.S. Coast Guard signed a Memorandum of Agreement to expand the use of JLV.

Core Technical Guidance

The IPO continues to update its three foundational technical guidance documents: the DoD/VA Joint Interoperability Strategic Plan (JISP), the Health Information Interoperability Technical Package (I2TP), and the Health Data Interoperability Management Plan (HDIMP).

- The JISP is based on the Departments' emerging modernization strategies and gap analysis from the Health Executive Committee's (HEC) Health Data Sharing Business Line (HDS BL) memorandums. The plan identifies agreed-upon interoperability use cases, as well as the Departments' technical vision, near-term deliverables, and long-term overview.

- The I2TP identifies the domain and messaging standards the Departments are expected to implement for enhancing interoperability. Additionally, the I2TP provides a list of required standards to facilitate consistency in vocabulary and terminology.
- The HDIMP documents the IPO's organization and role in supporting the Departments' interoperability management efforts and outlines the necessary processes to support health data exchange and terminology standardization.

The IPO re-baselined the first version of the JISP in accordance with the Departments' emerging modernization strategies and was completed during Q2 FY 2018. The I2TP (Version 7) was completed in the third quarter of FY 2018, with plans to complete version 8 in FY 2019. Lastly, HDIMP (Version 4) was completed in Q3 FY 2018. The next HDIMP iteration (Version 5) will be updated and released in FY 2019.

Interoperability Metrics

In order to measure the impact of interoperability, the IPO works with the Departments, academia, and other subject matter experts to develop and monitor Transactional and Outcome-Oriented Metrics, enabling the Departments and the IPO to monitor and assess the impact of interoperability on our deserving beneficiaries. With this information, the IPO will be able to demonstrate the amount of data being exchanged (Transactional Metrics) and further improve the quality of care our beneficiaries receive (Outcome Oriented Metrics). Results from these metrics will ultimately determine interoperability's progress and its impact on our wounded warriors, our men and women in uniform separating from service, as well as the general population's health. The IPO analyzes and monitors HDI outcome-oriented metrics to assess interoperability's impact on the health care our Service members, Veterans, and their families receive through the DoD, VA, and their private partners. The *DoD/VA IPO Health - Metrics Roadmap* defines an outcome-oriented metric for interoperability as: "a measurement that evaluates the impact of interoperability on healthcare outcomes based on the Institute of Medicine's Six Domains of Healthcare Quality: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. A good metric is useful for establishing quality goals, monitoring progress toward those goals, and identifying opportunities for improvement."

The HDI Metrics Dashboard provides a high-level view of the health data sharing and interoperability activities occurring between the Departments and their partners over a given Fiscal Year quarter. These are categorized based on their relation to health data sharing and interoperability (e.g., National Standards Adoption, Improving Utilization of Interoperability Tools, Growing Private Partner Interoperability, Empowering the Patient, etc.).

In conjunction with the Departments, the IPO also prioritized metrics development to comply with recommendations from the Government Accountability Office,[1] namely to "establish a timeframe for identifying outcome-oriented metrics; define related goals to provide a basis for assessing and reporting on the status of interoperability; and update IPO guidance to reflect the metrics and goals identified." The IPO is assessing the feasibility and development of metrics in collaboration with the Health Executive Committee's (HEC) Health Data Sharing Business Line (HDS BL) Work Groups based on the joint strategic interoperability plan use cases. As shown below in Table 1, there are 6 use cases identified for metrics development that align to the four HDS BL Sub-Work Groups: Separating Service members (SSM)/Integrated Disability Evaluation System (IDES), Patient Empowerment, Transitions of Care, and Population Health.

Table 1: Use Cases Identified for Metrics Development

HDS BL Sub-Work Group	JISP Use Case
Health Data Sharing for SSM, IDES and Benefits	#2 – Service member separating from Military Services
	#3 – Wounded Warrior involved in the IDES
	#4 – Benefits adjudication
Health Data Sharing for Patient Empowerment	#6 – Empowering patients to drive their own care
Health Data Sharing for Population Health, Patient Safety, and Quality	#5 – Population Health
Health Data Sharing for Clinical Care Transition	#1 – Clinical transition of care for patients between organizations

SSM/IDES completed a pilot and is preparing to apply metrics to the new enterprise production processes. Patient Empowerment, Population Health, and Transition of Care are currently conducting preliminary analysis of proposed metrics.

The Health Metrics and Analytics Roadmap is currently being updated to reflect current efforts and is expected to be completed in FY 2019. In addition to developing this roadmap, the IPO continues to collaborate with the HEC HDS BLs to develop, implement, and analyze outcome-oriented interoperability metrics across the individual business line areas. The current timelines for the individual projects are shown in Table 2.

[1] Government Accountability Office. (2015) Electronic Health Records: Outcome-Oriented Metrics and Goals Needed to Gauge DOD's and VA's Progress in Achieving Interoperability. (GAO Publication No. 15-530) Washington, D.C.: U.S. Government Printing Office. Retrieved from GAO Reports Main Page via GPO Access database: http://www.gao.gov/assets/680/671979.pdf.

Table 2: Individual Project Timelines

HDS BL Sub-Work Group	Completion Timeline	Status
SSM/IDES	March 2016 – September 2019	In Progress
Patient Empowerment	November 2016 – September 2019	In Progress
Population Health	July 2017 – September 2019	In Progress
Transition of Care	January 2019 – September 2019	Begins January 2019

External Collaboration

Throughout FY 2018, the IPO continued to maintain and build strategic relationships with public and private partners to position the IPO and Departments at the forefront of health IT innovations, trends, and emerging standards. To this end, the IPO conducted HDS BL Joint Program Synchronization Workshops to facilitate discussions on the synchronization of integrated capabilities delivered to VA and DoD clinicians. This supported efforts to jointly prioritize interoperability and health data sharing outcomes; synchronize DoD, VA, and IPO health data sharing activities; and coordinate on matters impacting both Departments. Additionally, the IPO hosted DoD/VA Industry Interoperability Roundtables to foster collaboration with the Departments, industry, and academia regarding interoperability challenges, future opportunities, and the ongoing need for collaboration to transform healthcare delivery.

To ensure that the IPO and the Departments remain involved in nationwide interoperability efforts, the IPO continued to participate in the monthly Federal Health Architecture Managing and Governing Boards, as well as the ONC's Health IT (HIT) Policy Committee, HIT Standards Committee, Interoperability Standards Advisory Task Force, and monthly IPO Town Halls. To expand these relationships, the IPO extended its ONC liaison position into FY 2018 to continue serving as the intermediary between the IPO and ONC. This participation not only ensures the IPO and the Departments are involved in nationwide interoperability efforts but also allows the IPO to share its experiences and insights with Federal partners.

The IPO further enhanced its external engagement by continuing its membership with the Institute of Electrical and Electronics Engineers Standards Association (IEEE-SA). The IEEE-SA is a consensus building organization that develops, nurtures, and advances global technology by facilitating standards development and standards-related teamwork. Through its membership, the IPO remained focused on collaborating and recommending proposed standards to represent the Departments' mission of maturing data, standards, and interoperability. Moving forward, the IPO will continue to foster collaboration and focus on current and emerging standards under medical and mobile devices and facilitate dialogue on security, interoperability, and additional best practices.

Health Level Seven International (HL7) Balloting

HL7 is a not-for-profit Standards Development Organization that provides standards for global health data interoperability. As a Benefactor Member of HL7, the IPO participated in HL7's balloting process which incorporates four types of ballots: Comment, Informative, Draft Standard for Trial Use, and Normative. During this process, members vote on data standards by reviewing each ballot item and choosing to provide an affirmative or negative vote, abstain from voting altogether, or give constructive comments on content and language. Throughout FY 2018, the IPO actively participated in this balloting process ensuring proposed standards support industry-identified interoperability requirements from the public and private sector. The IPO also continues to make progress on several ongoing HL7 projects that focus on improving interoperability between the Departments and the broader health care industry and clinical community, including continued support of solving issues with errata in the Consolidated Clinical Document Architecture, to ultimately play a significant role in emerging standards and health data interoperability.

VA-DoD Electronic Health Record (EHR) Modernization Efforts

The IPO supports the EHR modernization efforts of VA and DoD, encouraging and enabling collaboration by serving as an interagency resource for EHR modernization and supporting system IT governance and health data interoperability.

MHS GENESIS

After completing focused efforts towards initial operating capability (IOC) implementations, including the deployment of MHS GENESIS at Fairchild Air Force Base, Naval Clinic Oak Harbor, Naval Hospital Bremerton, and Madigan Army Medical Center, throughout FY 2018, the DoD Healthcare Management System Modernization (DHMSM) Program Management Office (PMO) remains focused on preparations for the Full Deployment Decision Authority to Proceed. In the second quarter, the DHMSM PMO was granted a 9-month Authority to Operate with Conditions by the DoD's Chief Information Officer (CIO) and during the third quarter, the PMO executed a successful upgrade to MHS GENESIS 1.0.1.0 that included user-facing and hosting-environment changes. The DHMSM PMO, in partnership with the Defense Health Agency (DHA) and site personnel, facilitated the successful implementation of the iAccess (Tap & Go) Solution at Naval Hospital Bremerton and Naval Health Clinic Oak Harbor. The DoD plans to deploy MHS GENESIS to more than 9.4 million beneficiaries and 205,000 medical personnel and staff by the end of 2022.

VA Electronic Health Record Modernization

During FY 2018, VA completed significant milestones to further their EHR modernization efforts. Throughout the first and second quarters, VA remained in contract negotiations and continued its modernization planning efforts, and during Q3

FY 2018, VA signed its contract with Cerner Corporation. This milestone solidified VA's efforts to adopt the same EHR as the DoD, with its core consisting of Cerner Millennium. During Q4 FY 2018, VA significantly expanded their efforts associated with the adoption of a common framework and platform with the DoD. Internal organizations, such as the Office of the Electronic Health Record Modernization, began to evolve, and several large stakeholder meetings were coordinated with clinicians, commercial off-the-shelf (COTS) product representatives, and subject-matter experts. Additional Departmental meetings were established to discuss the use of a single instance of Cerner Millennium serving both Departments and to review lessons learned and experience from DoD's initial COTS implementations. As the Departments continue their efforts, the IPO will continue to support interoperability and modernization goals of the Departments to ensure our Veterans and transitioning Service members receive seamless health care.

IPO Modernization Coordination

The newly-chartered DoD/VA Interagency IT Steering Committee convened in September. The DoD/VA Interagency IT Steering Committee's mission is to ensure VA and DoD technical alignment, planning, and implementation oversight of technical infrastructure and required solutions in order to meet the business needs of joint activities. As the Executive Secretariat of the committee, the IPO coordinates activities for the committees and Work Groups such as charter development, issue escalation and resolution and group facilitation. The current Work Groups under the DoD/VA Interagency IT Steering Committee are: Identity Management, Joint Engineering Architecture, Information Protection, Joint IT Operations, and Military Personnel Data. These Work Groups provided updates, risks, and status, during the September session. Their efforts will result in a comprehensive plan to ensure the seamless operation and transmission of military personnel data for use by VA for health care, benefits, and added services. In addition, the IPO facilitated monthly sessions of the DoD/VA Engineering and Architecture Work Group, providing a forum to share VA and DoD EHR modernization updates and technical strategies. Lastly, the IPO continued the development of the Joint IMS Timeline and Related Projects to capture deployment activities, milestones, and cross dependencies. Moving forward, the IPO will continue to support collaboration efforts across the Departments and facilitate information sharing between VA and DoD.

During the 4th quarter, 2018, the IPO supported the development of the EHRM Joint Commitment statement, signed by the Secretaries of VA and DoD, that reiterated the dedication of VA and DoD to implement a single, seamless integrated EHR that will accurately and efficiently share health data between the two. The Departments reaffirmed to ensure health record interoperability with their networks of supporting community health care providers. Moving forward, the Departments' EHR modernization teams will continue to work their respective EHR program implementations, while maximizing collaborative strategies, opportunities, and projects whenever possible.

In addition, the IPO's Director testified before the House Committee on Veterans' Affairs, Subcommittee on Technology Modernization, regarding our role supporting the Departments' EHR activities. She highlighted the IPO's commitment to assisting VA and DoD as they continue their EHR modernization. She also remarked that enabling health information exchange between EHR systems in DoD, VA, and the private sector will serve as the foundation for a patient-centric healthcare experience, seamless care transitions, and improved care for our Service members, Veterans, and their families.

Looking Ahead

Under the ongoing direction of the Executive Committee, the IPO will continue to collaborate with the DoD, VA, ONC, standard development organizations, and other partners in health to enhance interoperability and support the Departments' modernization efforts through joint governance. Throughout FY 2019, the IPO will continue to serve as Executive Secretariat of the DoD/VA Interagency IT Steering Committee, an organization that serves as the single point of convergence for technical issues which impact joint VA and DoD IT systems. In addition, during FY 2019, the IPO, as the Executive Secretariat of the VA-DoD EHRM Governance structure, will stand up the Joint Technical Governance Board, Joint Functional Governance Board, and the Joint EHR Decision Board, to ensure Department collaboration when a common issue is identified. The IPO will also provide a support and facilitation role to the boards, manage the process to collect information, and communicate assessments and board decisions. The IPO will also provide best practices and a common standard operating procedure for capturing artifacts needed to support requested decisions which will arrive to the VA-DoD boards.

Lastly, the IPO will also maintain collaboration efforts with the DoD, VA, ONC, SDOs, and other partners in health to enhance interoperability alongside the Departments to measure interoperability's impact on our patients and providers. Finally, the IPO will continue to provide technical guidance to the Departments by updating its core documents, including the HDIMP, I2TP, and JISP.

2.g.2. Health Data Sharing – HEC Health Data Sharing Business Line

The Health Data Sharing Business Line (HDS BL) provides joint leadership to drive continuous improvement in VA-DoD and private sector partner health data sharing. In FY 2018, VA and DoD delivered joint viewer enhancements through multiple joint software releases to support access to DoD's MHS GENESIS data and add additional functionality to improve Joint Legacy Viewer (JLV) user experience and further improve access to clinical information.

In VA, JLV is accessible from every VA site of care and regional office. Users represent all health care and benefits professional roles and workflows requiring access to health data. VA no longer anticipates significant increases in users given that all Computerized Patient Record System (CPRS) users (VHA staff) and all Compensation and Pension Records Interchange (CAPRI) users (VBA staff) automatically have access to JLV and access now keeps pace with staff turnover. In DoD, JLV is accessible from

all DoD health care facilities and supports clinical care, clinical support, and administrative (health care operations) activities. During FY 2018, VA and DoD continued to provide access to and increase usage of integrated health records through JLV as summarized below.

Table 3: JLV Access – Number of staff with access to JLV

Department	September 30, 2017	September 30, 2018
DoD	88,345	96,187
VA	315,199	322,898*
Total	403,544	418,317

*Includes 17,654 VBA staff

Both Departments demonstrated significant increases in usage reflected by patient record views.

Table 4: JLV Usage – Number of record views in JLV by Fiscal Year

Department	September 30, 2017	September 30, 2018
DoD	1,699,569	3,594,281
VA	3,341,867	9,298,600
Total	6,902,668	12,892,881

The Departments continue to monitor system performance and ensure capacity in support of DoD MHS GENESIS deployment and VA's transition away from the legacy VistAWeb viewer and toward the VA Office of Electronic Health Record Modernization (OEHRM) platform.

2.h. Pain Management – HEC Pain Management Work Group

The Departments actively collaborate to support development of a model system of integrated, timely, continuous, and expert pain management for Service members, Veterans, and other beneficiaries. This includes the development and implementation of pain management and opioid safety strategies and associated performance measures.

As directed by the Comprehensive Addiction and Recovery Act (CARA) of 2016, the Pain Management Work Group focused on the nine key areas of the following:

1. Opioid safety;
2. Pain management best practices;
3. Provider education and training;
4. Patient education;
5. Integration of Complementary and Integrative Health (CIH) for pain management;
6. Transition of pain care between DoD and VA;
7. Acute and chronic pain care for patients with substance use disorder;
8. Implementation of VA-DoD clinical practice guidelines; and
9. Collaboration and consultation with other HEC Work Groups.

In June 2018, DHA published a Procedural Instruction (DHA-PI) for Pain Management and Opioid Safety in the Military Health System (DHA-PI 6025.04). It includes a directive for DoD to implement the Stepped Care Model of Pain Management; a model developed and implemented in VHA and subsequently championed by the Work Group. Utilizing a common model of pain management will reduce unwarranted variability and improve transitions of pain care across DoD and VHA.

The Work Group coordinated meetings between VHA pain management and opioid safety leaders and the DoD leaders tasked to develop the implementation plan for the pain management DHA PI. The objective of this coordination was to align existing elements from VA's Opioid Safety Initiative and Opioid Education and Naloxone Distribution (OEND) initiative with implementation of the pain management DHA PI. Specific areas of recommended alignment include the following:

- Urine drug screening for patients on opioid therapy;
- Expanding utilization/access to complementary integrative health pain management therapies;
- Use of Informed Consent document and process for patients on opioid therapy;
- Provider and patient education;
- Co-Prescribing Naloxone;
- Opioid management and tapering strategies; and
- Developing common analytics, metrics, and reporting capabilities.

Activities for FY 2019 will focus on continued VA and DoD alignment on pain management and opioid safety initiatives.

GOAL 3 – Efficiencies of Operations

Establish a national model for the effective and efficient delivery of benefits and services through joint planning and execution.

3.a. VA-DoD Reimbursement Process and Joint Sharing – HEC Shared Resources Work Group

The Shared Resources Work Group identifies opportunities for, and develops standardized guidelines to facilitate, sharing resources between VA and DoD to improve access, quality, safety, clinical readiness of providers, and cost effectiveness of care provided to VA and DoD beneficiaries. In FY 2018, the group focused on developing and implementing a standard set of referral and consult management business rules under the VA-DoD National Resource Sharing Memorandum of Understanding (MOU) guidelines.

In November 2017, the group developed a draft procedural appendix to the Supplement to the VA and DoD Health Care Resources Guidelines MOU to provide a uniform set of standardized referral management and care coordination instructions for DoD-VA clinical resource sharing activities. The DoD service components and the Defense

Health Agency approved the appendix in December 2017. Currently the Departments are working to incorporate the procedural appendix into appropriate VA and DoD policy documents.

In the interim, the current draft procedural appendix is used by the Biloxi VAHCS-Pensacola Naval Hospital advance payment resource sharing pilot site, and provides clear and succinct referral and care coordination instructional guidance to the pilot site without reservation.

3.b. VA-DoD Financial Operations & Business Operations

In FY 2018, the Departments initiated a unidirectional prospective resource sharing Advance Payment (AP) pilot between Biloxi VAHCS – Pensacola Naval Hospital. The pilot objective is to test and validate a simplified central data payment reimbursement model to replace the current resource intensive individual claims-billing reimbursement process. Based on the prospective payment methodology, the resources should be available in a timelier manner to the DoD locations.

The standardized consult system deployment and training took longer than anticipated, which resulted in delays in achieving implementation goals between the two sites. The site will continue as a pilot for FY 2019 to resolve remaining issues surrounding data quality and to evaluate validity of a simplified central data payment reimbursement model.

In FY 2019, the Departments will add a pilot site at the Las Vegas VAMC – 99th Medical Group (Nellis Air Force Base) to expand AP testing for inpatient and emergency services before a final determination is made to expand the AP model to all current and future DoD-VA resource sharing locations. Prior to nationwide expansion (roughly 50 to 100 plus sites), need consistent input of VA consults using agreed upon rules for matching to care provided by the DoD.

3.c. Credentialing – Credentialing Work Group

The Departments are working together to facilitate sharing of health care providers across VA and DoD facilities. Sharing health care providers supports the Departments strategic objectives by enabling supplemental staff to respond to high demands thereby improving patient access, creating more opportunities for providers to maintain skills, and increasing collaboration among providers. The Credentialing Work Group is responsible for standardizing the VA and DoD credentialing process by expediting provider credentialing at health care facilities to which a provider applies, and by sharing non-time limited primary source verifications of provider credentials between the respective facilities. The Credentialing WG manages the collaborative efforts to explore the credentialing requirements of both agencies and Joint Commission, and to ensure the needs of both VA and DoD are met within a common credentialing software platform.

To achieve the desired end-state, the Joint Centralized Credentialing Quality Assurance System (JCCQAS) was approved as a VA-DoD Joint Incentive Fund (JIF) project in 2014. JCCQAS consists of a Web-based application and integrated database to capture, store, and share provider credentialing information.

The DoD completed a phased rollout of JCCQAS to all DoD facilities worldwide in April 2018. The DoD deployment was supported by third party independent development, testing and evaluation, DoD user acceptance testing, and a cybersecurity risk assessment on DoD baseline code.

In preparation for the initial VA development and deployment, the joint VA-DoD requirements elaboration and functional design activities completed in October 2017. These activities included the integration of new VA-DoD shared provider business processes. The Credentialing WG decomposed 44 high-level requirements into detailed user stories and acceptance criteria to fully identify and document agency needs and work processes, as well as complete critical technical design and construction milestones that included development and system integration testing for the baseline joint IT provider credentialing solution.

VA phased rollout of JCCQAS will occur after completion of the remaining implementation activities, to include rebuilding and reengineering of the JCCQAS database, testing of the server load capacity, and validation of VA requirements. Requirements validation includes: development; regression analysis and production of the final product; VA legacy system data migration; VA user acceptance testing; and VA user training. Once deployment is accomplished at both agencies, JCCQAS will merge over 13 million documents and over 1 million credentialing records, including the active files for over 500,000 current health care providers into an integrated, secure database.

3.d. Joint Legacy Viewer – HEC Health Data Sharing Business Line

See 2.g.2 above.

3.e. Disposition of Paper Service Treatment Records – BEC Medical Records Work Group

The MRWG is charged with coordinating between the DoD, VA, Military Services (to include United States Coast Guard (USCG)), and National Archives and Records Administration (NARA) to develop guidance and promote accountability for facilitating the timely exchange of the Service Treatment Records (STR).

Disposition of Stored Paper STRs

The disposition of paper STRs is under consideration by VA and DoD. VA began digitizing STRs in its possession and the MRWG is exploring the technical feasibility of migrating the electronic STR data back to DoD's HAIMS system when the digitization is complete and the bidirectional capability within the interface between both Departments is implemented. VA and DoD are weighing data quality, storage volume, identity,

privacy, and other technical and legal constraints during this process. The MRWG is also coordinating the recertification of VA's VBMS system by DoD's Joint Interoperability Test Command to ensure it is authorized to continue storing DoD records in compliance with both NARA and DoD policy.

Quality Assurance

DoD conducted a pilot audit to measure the quality of scanned STR documents in December 2017. A second quality assurance audit will be conducted by DoD in January 2019. The results of both audits will inform MRWG efforts to synchronize VA and DoD quality assurance standards for digitized STRs.

Storage at NARA

The MOU between DoD, VA, and USCG for Electronic Storage, Access and Retrieval of Military Service Treatment Records from NARA was signed on January 30, 2017, and will undergo review as the MRWG considers the disposition of the VA-stored paper STRs and the potential bidirectional exchange of digital STR data.

3.f. Mandatory Separation Health Examinations – Separation Health Assessment Work Group

The SHAWG continues to coordinate VA and DoD responsibilities to perform separation and disability exams to meet requirements and enable the delivery of VA benefits at discharge in a way that avoids duplication of effort and minimizes burden on the separating Service member. Effective coordination also ensures completeness of the Service Treatment Record so that it will efficiently support any future claim by the Veteran.

In FY 2018, the SHAWG developed and tested a common workflow to enable VA and DoD electronic systems to interface. Once implemented, this interface will eliminate the need for the Service member to be the courier of the copy of the Service Treatment Record to VA and the VA claims processor to manually return the VA Disability Benefit Questionnaire (DBQ) to DoD. The system updates for this new workflow were initially launched in March 2018. VA and DoD then initiated a limited pilot within the National Capitol Region to test the new system interface for the transfer of the Service Treatment Record and the return of DBQs. The team developed and implemented system fixes to cover gaps discovered in the initial trial period. Based on lessons learned, the team developed requirements for system improvements to be implemented over the following 6 months to improve the work flow. In addition, the team initiated revisions to Memorandum of Agreement between VA and DoD to reflect the new system interface.

The SHAWG coordinated VA and DoD efforts to develop a joint implementation plan for Separation Mental Health Assessments to meet two new requirements from Congress and the President intended to support mental health care for transitioning Service members. Section 706, Public Law 115-91, the FY 2018 National Defense Authorization Act (NDAA), added the requirement for a mental health assessment for

every separating Service member in addition to the existing requirement for a physical examination. The VA-DoD Joint Action Plan for Suicide Prevention, mandated by Executive Order 13822, *Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life*, included the requirement to offer mental health screening to 100 percent of transitioning Service members. Once implemented, the Separation Mental Health Assessments will ensure separating Service members with mental health needs are appropriately referred for transition services.

3.g. Integrated Disability Evaluation System – Disability Evaluation System Improvement Work Group

The Disability Evaluation System Work Group (DES WG) continues to support process improvements to make the Integrated Disability Evaluation System (IDES) process faster and more efficient.

On July 30, 2018, DoD published policy reducing the timeliness goal for the Integrated Disability Evaluation System (IDES) from 295 days to 230 days. This change impacts ill and injured Service members who are no longer medically fit for continued military service. DoD benefits from enhanced lethality and readiness by reducing the time Service members process through the IDES and transition to Veteran status. VA benefits from increased efficiencies by reducing the time to evaluate and award VA disability benefits to former Service members.

VA and DoD developed the technical capability to electronically transfer Service Treatment Records and Disability Benefits Questionnaires between VA and DoD. This capability was established in March 2018. Stakeholders from both VA and DoD have worked together to test the new document transfer capability through a series of Work Groups. Upon completion of successful testing, VA and DoD will roll out the capability across the enterprise, an important step in establishing an electronic Disability Evaluation System case management capability.

The WG continues efforts to pursue the 2018 JEC priority objective to electronically transfer IDES case files and transactional data to eliminate the need for manual updates to the Veterans Tracking Application. The BEC co-chairs requested the DES Work Group engage the DoD/VA Interagency IT Steering Committee to discuss requirements and obtain joint Departmental governance in developing this capability moving forward.

3.h. Interagency Comprehensive Plan – IC3 Technology Tools and Change Work Group

Accomplishments related to this objective were consolidated under the Lead Coordinator objective. Please see section 1.b. above.

3.i. Capital Asset Planning – Construction Planning Committee

The CPC was established in 2005 to provide a formalized structure to facilitate cooperation and collaboration in achieving an integrated approach to planning, design,

construction (major and minor), leasing, and other real property related initiatives for medical facilities that are mutually beneficial to both Departments.

The CPC provides the oversight necessary to ensure collaborative opportunities for joint capital asset planning are explored, evaluated, and optimized to enhance service delivery.

The CPC staff continued to pursue developing flexible authorities to allow the Departments to work together more efficiently and effectively. The Departments have sought like-legislation to enable VA and DoD to enter into cross Department agreements for the planning, design and construction, or leasing of facilities to be operated as shared facilities. The lack of authority results in a loss of opportunities for joint facility planning. The Departments, with JEC support, are preparing legislative engagement strategies.

The CPC is preparing an update for their Charter.

The CPC worked to develop a collaborative evaluation criteria, process, and timeline for potential joint VA-DoD opportunities. This process consists of the following three tracks:

- Track 1: Three near-term opportunities to jointly plan and execute facility acquisition based on collaborative evaluation criteria; reflects three distinct acquisition strategies; developed as demonstration programs.
- Track 2: Evaluate Additional Current Opportunities.
- Track 3: Enhance System-wide Facilities Planning that will be implemented in future years.

Additional Accomplishments

VA-DoD Suicide Strategic Decision Team (SDT)

The Secretary of Defense (SecDef) and Secretary of Veterans Affairs (SecVA) agree that DoD and VA should increase their collaborative suicide prevention efforts. A Memorandum of Agreement (MOA) advancing agreed-upon suicide prevention initiatives was signed by the Secretaries on November 21, 2017. Leadership in both Departments oversees the implementation of the MOA and reports to the JEC. To ensure members of the USCG are included in suicide prevention efforts, the MOA is currently undergoing expansion to include the Department of Homeland Security.

In 2017, the SecDef and SecVA directed the Departments to collaborate to provide accurate and actionable recommendations to the JEC and ensure that Veterans, Service members, and their families have access to suicide prevention resources. The MOA introduced an approach to suicide prevention that covers the lifecycle of a Service member, recognizing that every Service member becomes a Veteran. VA and DoD provide logistical and administrative support for the collaboration.

The collaboration between the Departments directly impacts suicide prevention efforts aimed at transitioning Service members, including members of the National Guard and Reserve Component and USCG, and Veterans.

Activities and milestones accomplished in FY 2018 include the following:

- DoD assisted VA in developing a strategy for suicide prevention, similar to the Defense Strategy for Suicide Prevention.
- The Departments collaborated on several outreach initiatives including public service announcements; educational webinars; communications and messaging during Suicide Prevention Month; and gun lock distribution, with VA providing DoD with approximately 65,000 gun locks to distribute to Service members and families.
- The Departments maintained a joint database, including cause of death data for individuals with a history of military service, to inform suicide prevention efforts. VA and DoD analyzed existing data from Veterans' health records and identified those at a statistically elevated risk for suicide to provide care and support.
- VA and DoD collaborated to provide a toll-free, confidential crisis hotline and peer support services for Service members, Veterans, and their family members.
- All recommendations made by the VA/DoD Suicide Prevention Strategic Decision Team were completed or are ongoing as part of a cross-Departmental collaboration. These recommendations include addressing gaps in suicide research funding, joint activities for Suicide Prevention Month, sharing training competencies, and updating the clinical practice guidelines for suicide prevention.
- Suicide prevention leads from both Departments provided joint oversight for the implementation of the VA-DoD Joint Action Plan for Suicide Prevention, mandated by Executive Order 13822, Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life. Joint Action Plan objectives included: expanded peer support services from 180 to 365 days post-separation, capability for

transitioning Service members to apply online for VA health care during the Transition Assistance Program, mental health screening offered to 100 percent of transitioning Service members, and warm hand-offs for transitioning Service members in need of (or requesting) additional psycho-social support following peer support.

The impact of collaboration efforts between the Departments included the following:

- Increased awareness of mental health and suicide prevention resources for all transitioning Service members.
- Expanded access to peer support and non-medical counseling for transitioning Service members and Veterans.
- Seamless transition of mental health care for Service members and Veterans.
- A proof of concept for a joint approach to predictive analytics, to specifically direct suicide prevention resources to at-risk Service members and Veterans.

Ad Hoc Work Group on Provision of VA Counseling and Treatment for Sexual Trauma to Members of the Armed Forces

In FY 2018, the JEC Ad Hoc WG continued to implement section 402 of the Veterans Access, Choice, and Accountability Act, which authorizes VA, in consultation with DoD, to provide military sexual trauma (MST)-related services to Active Duty Service members without a DoD referral (section 707 of the National Defense Authorization Act for FY 2018 further expanded this authorization to include all Service members regardless of duty status.) This authority was initially implemented in 2015 with HEC approval to offer access to confidential MST-related counseling services at VA Vet Centers only. In 2016, the JEC co-chairs directed creation of an ad hoc VA-DoD Work Group to revisit section 402 and establish a plan to expand implementation to include VA medical centers as well as Vet Centers. The VA-DoD Work Group worked intensively to develop this plan and encountered a number of significant barriers to implementation. Due to these barriers, the VA-DoD Work Group recommended the JEC return to the course of action (COA) previously approved by the HEC, to focus implementation of section 402 at VA Vet Centers, with agreement to revisit expanding access to VAMCs in the future (if and when the identified barriers are mitigated). In March 2018, the JEC co-chairs approved this recommendation.

In FY 2018, additional achievements toward the JEC co-chair-approved VA-DoD concept and implementation strategy include the following:

- Development of a detailed referral process and guide for Vet Center staff to inform them how to assist Service members who request/require care outside the scope of Vet Center services.
- Developed and implemented a Training and Dissemination plan for Vet Centers and DoD inTransition staff regarding section 402 referral processes and their implementation.

VA and DoD are continuing to collaborate to expand Service member access to VA MST-related care without a referral in a way that preserves their privacy to the greatest

degree possible. This includes continued VA and DoD staff training so staff is able to inform Service members who disclose sexual assault about the services available to them from both Departments, as well as ongoing evaluation of the implementation and utilization of the newly developed referral processes.

The term "Military Sexual Trauma" (MST) is specific to VA and is defined by Public Law 113-146 as "psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment that occurred while a Veteran was serving on AD, AD for Training, or Inactive Duty for Training." VA services available under VA's specific MST-related treatment authorities (38 United States Code 1720D) are related to sexual assault and sexual harassment occurring during military service. This treatment authority does not authorize care related to sexual assault and harassment that occurred outside of military service. It is important to note DoD does not use the term "MST" to refer to sexual trauma during a covered period of military service, but rather uses the terms "sexual assault" or "sexual harassment" separately. For the purposes of this report, the term "MST" will be used to refer to sexual assault and/or sexual harassment that occurred during military service if discussing VA-related care.

James A. Lovell Federal Health Care Center (JALFHCC)

The James A. Lovell Federal Health Care Center (FHCC) currently operates multiple outdated information systems and processes to provide health care logistics support to its medical operations. As the only fully integrated VA-DoD medical facility, the disparate, outdated, and inadequate supply chain management capability creates management challenges that directly impact patient care. To address these challenges, the Health Executive Committee on February 2012 approved the adoption of Defense Medical Logistics Standard Support (DMLSS) as the Asset Management System for the FHCC. The Joint Medical Logistics Functional Development Center (JMLFDC), Defense Health Agency, VHA, and VA's Office of Information & Technology (OIT) oversee the project. In 2018, VA OIT, FHCC, and JMLFDC worked together to produce an approved interface control document between DMLSS and legacy VA applications, outline methodologies for data migration from the VA legacy applications to DMLSS, and outline a test plan to validate the end-to-end connectivity from DMLSS to the VA financial system of record. FHCC developed a change management plan (technical/functional/organizational) that is currently being executed with a go-live date of September 30, 2019.

Integrated Purchase Care Network (IPCN) Team

The Departments are exploring the feasibility of integrating their purchased care networks in order to maximize economies of scale, create a seamless journey, improve readiness, increase access, and decrease variability in care for Service members and Veterans. VA and DoD contracted with a Federally Funded Research and Development Center to conduct a preliminary assessment of the feasibility of an integrated purchased care network to serve both VA and DoD. The study showed it is feasible to integrate

purchased care networks, but it may not be practical and more analysis is required. There are multiple levels of possible integration to include shared lists/network providers, different joint contracting options, and full health system integrations with functions merged. The Joint Executive Committee approved establishing a joint office with dedicated resources to analyze the integration options and present a timeline and way forward to leadership by December 31, 2019.

Health Care Staffing Services

The Departments are pursuing ways to optimize health care staffing in Federal markets by reducing competition for the same resources. To this end, the Departments are assessing the feasibility of a common DoD-VA Health Care Staffing Services contract within 2 years that allows the Agencies to share procurement vehicle(s) and thereby eliminate redundancies and maximize efficiencies. The strategy will include all Federal Q-coded health care staffing services (direct professional services) for VA and DoD requirements in the Continental United States and territories. The new program will include professional health care workers in the following broad functional categories supporting inpatient and outpatient facilities: ancillary, dental, nursing, and physician services. The services will not include purchased care or network services (ex: TRICARE, CHOICE, or PC3) or performance in foreign countries.

VA and DoD began by staffing a joint team in July 2018 to begin the multi-step acquisition process to determine the feasibility of this initiative. The charter and stakeholder communication plan were completed and approved. VA and DoD current strategies were reviewed to assess and confirm scope, magnitude, and complexity of the requirements and to identify risks. The team began market research and a spend analysis was completed. The team concluded VA and DoD bought the same services in the same geographic locations and in the same manner. Other extensive research was done to gain additional market intelligence including from Department of Labor, Bureau of Labor Statistics, IBS World, protest decisions, solicitations, and white papers. A detailed Request for Information with a 55-question vendor survey was posted and remained open into early October 2018. Analysis of Alternatives with the Business Case Analysis for max.gov was completed and posted on max.gov for the required amount of days.

The market research report will be complete by October 31, 2018, and a milestone decision will be requested from the JEC in December 2018. If the decision is to move forward, then the team will continue with the next steps in the acquisition process with an anticipated contract award and rollout in FY 2020.

VA Hiring of Retired/Separated Military Medical Professionals

The Departments are collaborating to promote the non-competitive hiring of Service members currently enrolled in the military transition process who anticipate being released from active duty. This initiative will help mitigate the number of vacancies in VA as well as help to increase efficiency and access to care. The ability of the transitioning Service member to bring a unique experience that directly identifies with a

Veteran's experience is invaluable to the VA workforce. Ensuring these Service members have adequate employment when leaving active duty will help to prevent homelessness, suicide, depression, and other issues associated with unemployment. Partnering with the DOD not only ensures the well-being of the Service member whether active or a newly transitioned Veteran but also creates an environment of transition seamless to the Service member and his or her career. VA has developed a three-pronged approach to encourage transitioning Service members to consider employment at VHA.

VHA has partnered with DoD military installations in the National Capital Region on an initiative called Military Transition and Training Advancement Course (MTTAC). MTTAC is an entry-level training program for Service members currently enrolled in the transition process, who anticipate being released from active duty within 90 to 120 days. Service members hired through MTTAC will be trained to become Medical Support Assistants (MSA), with the goal of hiring them into VHA immediately upon separation. VA has partnered with Walter Reed National Military Medical Center to pilot this program and has successfully completed three classes (May, July, and September) with 15 transitioning Service members graduating from the course. To date, one Service member has transitioned to civilian status and has been offered employment. The MTTAC pilot classes will be ongoing until March 2019, with the goal of full deployment of the MTTAC Program within installations across the country by December 2019.

VHA is also using a direct marketing campaign to military medical professionals currently enrolled in the transition process. VHA uses the VA-DOD Identity Repository (VADIR) data to identify Service members, time of discharge, and military occupation specialty (MOS). The campaign launched on June 28, 2018, and 103,558 emails were sent and 241,133 postcards mailed. To provide continual engagement, there have been three additional subsequent mailings blasts to this cadre of Service members.

In addition, the Intermediate Care Technician (ICT) Program is an established VHA program to recruit former military medics and corpsmen into positions in VAMC Emergency Departments and other specialty areas. ICTs are aligned organizationally under Licensed Independent Practitioners (LIP) in the clinical setting to maximize utility and value to Veteran care. This program was deployed to 23 VAMCs at the start of FY 2018. VHA continues to expand this program to all 170 VAMCs. A targeted campaign for medics and corpsmen launched on September 21, 2018, by sending 107,062 emails advertising opportunities as ICTs. In FY 2018, the number of ICTs hired into the VA has grown by 35 percent and will continue to grow as the program expands and is advertised.

SECTION 3 – NEXT STEPS

The accomplishments described in this VA-DoD JEC FY 2018 Annual Joint Report demonstrate concerted efforts between VA and DoD to improve the multiple areas of joint responsibility that directly affect the care and benefits of Service members and Veterans. This report provides updates in strategic areas that will continue to evolve until these joint initiatives become fully institutionalized into everyday operations. Both Departments are sincerely committed to maintaining and improving the collaborative relationships that make this progress possible.

Moving forward, the JEC will continue to set the strategic direction using the FY 2019-2021 JSP framework for joint coordination and sharing efforts between VA and DoD. The Departments will continue to demonstrate and track progress toward defined goals, objectives, and end-states, and provide the continuum of care needed to successfully meet the needs of Service members and Veterans.

Appendix A – Cost Estimate to Prepare Congressionally-Mandated Report

Title of Report: VA-DoD JEC FY 2018 Annual Report

Report Required by: Public Law 108-136, National Defense Authorization Act

In accordance with Title 38, Chapter 1, Section 116, the statement of cost for preparing this report and a brief explanation of the methodology used in preparing the cost statement are shown below.

Direct Labor Cost	$	74,600
Contract(s) Cost	$	0
Production and Printing Cost	$	0
Total Estimated Cost to Prepare Report	$	74,600

Brief explanation of the methodology used to project cost estimate:

The DoD Cost Assessment and Program Evaluation Cost Guidance Portal was used to develop the project cost estimate. The net direct labor cost was calculated by multiplying the estimated labor hours by costs of grade.

Appendix B – Glossary of Abbreviations and Terms

A&I – Artifacts and Images
A&MM WG – The Acquisition and Medical Materiel Work Group
AAO – American Academy of Ophthalmology
AC – Access Control
ACO – Auditory Care Optimization
ADC – Active Dual Consumer
ADL – Automated Decision Letter
AF – Active Duty Air Force
AFB – Air Force Base
AFFDWG – Department of Dense Auditory Fitness for Duty Work Group
AHLTA – Armed Forces Health Longitudinal Technology Application
AHRQ – Agency for Health Care and Research Quality
AIM – Alternate Input Method
AJR – VA-DoD JEC Annual Joint Report
AMC – Army Medical Center
AMSUS – Association of Military Surgeons of the United States
ANRs – Audio News Releases
APG – Agency Priority Goal
APPs – Applications
ARWG – Auditory Research Work Group
ASoC – Amputation System of Care
ATACS – Acupuncture Training Across Clinical Settings
ATO – Authority to Operate
ATSDR – Agency for Toxic Substances and Disease Registry
AY – Academic Year
BAMC – Brooke Army Medical Center
BCA – Business Case Analysis
BDD – Benefits Delivery at Discharge
BEC – Benefits Executive Committee
BFA – Battlefield Acupuncture
BHIE – Bidirectional Health Information Exchange
BI – Business Intelligence
BJPs – Business Justification Packages
BLs – Business Lines
BOG – Board of Governors
BRAC – Base Realignment and Closure
BRD – Business Requirements Document
BVA – Blind Veterans Association
C&P – Compensation and Pension
CAC – Common Access Card
CAPC – Capital Asset Planning Committee
CAPG – Cross-Agency Priority Goal
CAPRI – Compensation and Pension Record Interchange
CAREN – Computer Assisted Rehabilitation Environment

CARF – Commission on Accreditation of Rehabilitation Facilities
CAUT – Catheter Acquired Urinary Tract Infections
CAVRN – Collaborative Auditory/Vestibular Research Network
CBO – Veterans Health Administration Chief Business Office
CBOC – Community-Based Outpatient Clinic
CBSWG – Communication of Benefits and Services Work Group
CBT-D – Cognitive Behavioral Therapy for Depression
CBT-I – Cognitive Behavioral Therapy for Insomnia
CCD – Care Coordinator Directory
C-CDA – Consolidated-Clinical Document Architecture
CCQAS – Centralized Credentials Quality Assurance System
CDC – Centers for Disease Control and Prevention
CDP – Center for Deployment Psychology
CDR – Clinical Data Repository
CE – Continuing Education
CEIP – Clinical Enterprise Intelligence Program
CEUs – Continuing Education Units
CFI – Department of Defense Center for the Intrepid
CHHP – Comprehensive Hearing Health Program
C-IPT – Capability-Integrated Product Team
CM – Context Management
CMEs – Continuing Medical Education Credits
CMI – Chronic Multi-symptom Illness
CMS – Centers for Medicare & Medicaid Services
CMT – Care Management Team
CNE – Continuing Nursing Education Credits
CoE – Center of Excellence
CoEPE – Centers of Excellence in Pain Education
CONOPS – Concept of Operations
CoP WG – Community of Practice Work Group
COPEs – Continuing Optometrists Education Credits
CPC – Construction Planning Committee
CPE – Clinical Pastoral Education
CPG – Clinical Practice Guideline
CPT – Cognitive Processing Therapy
CR – Clinical Recommendation
CRMRP – Clinical and Rehabilitation Medicine Research Program
C-STARS – Center for Sustainment of Trauma and Readiness Skills
CT – Cardiothoracic
CTBIE – Comprehensive Traumatic Brain Injury Evaluations
CWA – Chemical Warfare Agent
CY – Calendar Year
DALC – Denver Acquisition and Logistics Center
DBQ – Disability Benefits Questionnaire
DCMO – Deputy Chief Management Officer

DCoE – Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DD – Department of Defense Forms 214, 2807, and 2808
DDEAMC – Dwight David Eisenhower Army Medical Center
DES – Disability Evaluation System
DFAS – Defense Finance & Accounting Service
DFC – Duty First Consulting
DGMC – David Grant USAF Medical Center
DHA – Defense Health Agency
DHB – Defense Health Board
DHMSM – DoD Healthcare Management System Modernization
DHWG – Deployment Health Work Group
DIN-PACS – Digital Imaging Network – Picture Archiving Communication Systems
DiscovEARy Zone – a VCE/HCE hearing and vision health campaign for Service members and Veterans
DLA – Defense Logistics Agency
DMA – Disability and Medical Assessments
DMDC – Defense Manpower and Data Center
DMLSS – Defense Medical Logistics Standard Support
DoD – Department of Defense
DoDI – Department of Defense Instruction
DoDTR – Department of Defense Trauma Registry
DOEHRS – Defense Occupational and Environmental Health Readiness System
DOEHRS-HC – Defense Occupational and Environmental Health Readiness System for Hearing Conservation
DOL – Department of Labor
DP – Design Principles
DPRIS – Defense Personnel Records Information Retrieval System
DRAS – Disability Rating Activity Site
DS Logon – Defense Self-Service Logon
DSA – Data Sharing Agreement
DSPO – Defense Suicide Prevention Office
DSS – Decision Systems Support
DTA – Data Transfer Agreement
DTC – Development and Test Center
DU – Depleted Uranium
DVBIC – Defense and Veterans Brain Injury Center
DVCIPM – Defense and Veterans Center for Integrative Pain Management
DVEAR – Defense and Veterans Extremity Injury and Amputation Registry
DVEIVR – Defense and Veterans Eye Injury and Vision Registry
DVPRS – Defense and Veterans Pain Rating Scale
EA – Executive Actions
EACE – Extremity Trauma and Amputation Center of Excellence
EBP – Evidence-Based Psychotherapy
EBPWG – Evidence-Based Practice Work Group
ECAA – Enterprise Clinical Audiology Application

eCFT – Electronic Case File Transfer
ECHO – Exercise in Communication and Hearing Operation
ED – Department of Education
eDR – Enhanced Document Referral
EES – Employee Education System
EHR – Electronic Health Record
EMS – Emergency Medical System
e-MSM – enhanced Multi-Service Market
EP – End Product
ePER – electronic Patient Event Report
FAAST – Federal Advanced Amputation Skills Training
FCMT – Federal Case Management Tool
FDM – Fully Developed Claim
FHA – Federal Health Architecture
FHCC – Federal Health Care Center
FHP&R – Force Health Protection and Readiness
FISIG – Federal Interdisciplinary Skin Integrity Group
FMWG – Financial Management Work Group
FOC – Full Operating Capability
FRS – Federal Resource Sharing
FTE – Full-Time Equivalents
FTEE – Full Time Employee Equivalents
FY – Fiscal Year
GAO – Government Accountability Office
GME – Graduate Medical Education
HACs – Hospital Acquired Conditions
HAIMS – Health Artifact and Image Management Solution
HARB – Health Architecture Review Board
HCE – Hearing Center of Excellence
HCP – Hearing Conservation Program
HCS – Health Care System
HCWG – Hearing Conservation Work Group
HDI – Health Data Interoperability
HDIMP – Health Data Interoperability Management Plan
HDR – Health Data Repository
hEARoes Tour – large airshows in military dense communities focused on mobile health outreach providing hearing health care through music experiences
HEC – Health Executive Committee
HEDIS – Healthcare Effectiveness Data and Information Set
HHS – Department of Health and Human Services
HIE – Health Information Exchange
HIEA – Health Information Exchange Architecture
HIPPA – Health Insurance Portability and Accountability Act
HIT – Health Information Technology
HL7 – Health Level 7
HPE – Health Professions Education

I2F – Intent to File
I2TP – Information Interoperability Technical Package
IBHC – Integrated Behavioral Health Consultant
IC3 – VA-DoD Interagency Care Coordination Committee (deactivated in December 2017)
ICD-9 – International Classification of Diseases, ninth revision
ICE – Interactive Customer Evaluation
ICIB – VA-DoD Interagency Clinical Informatics Board
ICP – Interagency Comprehensive Plan
IDES – Integrated Disability Evaluation System
IE – Information Exchange
iEHR – Integrated Electronic Health Record
IE-IPT – Information Exchange Integrated Product Team
ILER – Individual Longitudinal Exposure Record
IMESA – Identity Management Enterprise Services Architecture
IM/IT – Information Management/Information Technology
IMHS – Integrated Mental Health Strategy
IMHS – Integrated Mental Health Strategy
IMIMIHI – Institute of Healthcare Improvement Model
IMP – Integrated Master Planning
IOC – Initial Operating Capability
IOGF – Inter-organizational Guideline Forum
IOM – Institute of Medicine
IOM – Institute of Medicine
iPLRD – Integrated Project Level Requirement Document
IPO – Interagency Program Office
IPR – Interim Progress Reports
IRB – Institutional Review Board
IS/IT – Information Sharing/Information Technology
ISA – Interoperability Standards Advisory
IT – Information Technology
IWG – Independent Work Groups
JACC – Joint Ambulatory Care Center
JAL FHCC – James A. Lovell Federal Health Care Center
JBLM – Joint Base Lewis McChord
JCCQAS – Joint Centralized Credentials Quality Assurance System
JEC – Joint Executive Committee
JET – Joint Exploratory Team
JFU&RS WG – Joint Facility Utilization and Resource Sharing Work Group
JHASIR – Joint Hearing Loss and Auditory System Injury Registry
JIC – Joint Immunization Capability
JIF – Joint Incentive Fund
JIP – Joint Interoperability Plan
JLV – Joint Legacy Viewer
JPC-8 – Joint Program Committee-8
JPEP – Joint Pain Education Project

JPSR – Joint Patient Safety Reporting
JSP – VA-DoD JEC Joint Strategic Plan
JTSs – Joint Trauma Systems
JTTR – Joint Theater Trauma Registry
JV/RS WG – Joint Venture and Resource Sharing Work Group
Lab/AP – Laboratory/Anatomic Pathology
LC – Lead Coordinator
LINAC – Linear Accelerator
LINKS – Linking Information Knowledge and Systems
MAAG – Military Health System Application Access Gateway
MAP-D – Modern Awards Processing Development
MCiS – Military Health System Cyberinfrastructure Services
MCL – Military Crisis Line
MCS – Millennium Cohort Study
MCSC – Managed Care Support Contractor
MDG – Medical Group
MDW – Medical Wing
MEB – Medical Evaluation Board
MEBTO – Military Evaluation Board Tracking Office
MedPDB – Medical Surgical Product Data Bank
MHICS – Mental Health Integration for Chaplain Services
MHS – Military Health System
MHS Learn – Military Health System Learning Portal
MHSRS – Military Health System Research Symposium
MHV – MyHealtheVet
MIST-NG – Medical Interagency Satellite Training-Next Generations
MMC – Medical Master Catalog
MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MP – Management Plan
MRI – Magnetic Resonance Imaging
MRMC – United States Army Medical Research and Material Command
MRWG – Medical Records Work Group (changed to STR WG at the end of FY 2018)
MRWG – Medical Research Work Group
MSC – Military Services Coordinator
MSSO – Medical Single Sign-On
mTBI – Mild Traumatic Brain Injury
MTEC – Medical Technology Enterprise Consortium
MTF – Military Treatment Facility
MVAR – Military Vestibular Assessment and Rehabilitation
NAC – National Acquisition Center
NATO – North Atlantic Treaty Organization
NAVFAC – Naval Facilities Engineering Command
NCAT – NeuroCognitive Assessment Tool
NCC – National Capital Consortium
NCC – National Call Center

NCPS – National Center for Patient Safety
NCR – National Capital Region
NCRAR – VA National Center for Rehabilitative Auditory Research
NDAA – National Defense Authorization Act
NGC – National Guideline Clearinghouse
NH – Naval Hospital
NHCC – Naval Health Clinic Charleston
NIH – National Institutes of Health
NIHL – Noise Induced Hearing Loss
NMCSD – Naval Medical Center San Diego
NPRC – National Personnel Records Center
NRAP – National Research Action Plan
NRD – National Resource Directory
NSSP – National Strategy for Suicide Prevention
OASD(HA) – Office of the Assistant Secretary of Defense for Health Affairs
OEF – Operation Enduring Freedom
OIF – Operation Iraqi Freedom
OIG – Office of Inspector General
OMB – Office of Management and Budget
ONC – Department of Health and Human Services Office of National Coordinator
OND – Operation New Dawn
ONR – Office of Naval Research
OP – Orders Portability
ORD – Office of Research and Development
OTR – Operation Tomodachi Registry
PAN – Polytrauma Amputation Network
PASTOR – Pain Assessment and Outcome Registry
PBI – Practice-Based Implementation
PBM – VA Pharmacy Benefit Management
PBRN – Practice-Based Research Network
PCC – Patient-Centered Care
PCMH – Patient Centered Medical Home
PDB – Product Data Bank
PDHA – Post-Deployment Health Assessment
PDHRA – Post-Deployment Health Reassessment
PE – Prolonged Exposure Therapy
PEB – Physical Evaluation Board
PEBLO – Physical Evaluation Board Liaison Officers
PFA – Psychological First Aid
PH – Psychological Health
PHI – Public Health Information
PIDM – Patient Identity Management
PIHL – Pharmaceutical Interventions for Hearing Loss
PMO – Program Management Office
PMR – Private Medical Records
PMWG – Pain Management Work Group

POA – Power of Attorney
POA & MS – Plans of Actions and Milestones
PPDHA – Pre- and Post-Deployment Health Assessment
PPS-L – Pharmacy Product System – Local
PPS-N – Pharmacy Product System – National
PRSA – Public Relations Society of America
PSA – Public Service Announcements
PSC – Polytrauma System of Care
PSE – Patient Safety Events
PSR – Patient Safety Reporting
PST – Problem Solving Training
PSWG – Patient Safety Work Group
PT/BRI – Polytrauma/Blast-Related Injuries
PTM – Progressive Tinnitus Management program
PTSD – Post Traumatic Stress Disorder
QAP – Quality Assurance Program
QMO – Quality Management Office
QUERI – Quality Enhancement Research Initiative
RBPS – Rules Based Processing System
RCA – Root Cause Analysis
RCP – Recovery Coordination Program
REC – Regional Education Coordinator
ReCoord – Research Coordination
REDCap – Research Electronic Data Capture
RHJVAMC – Ralph H. Johnson VAMC
RIE – Rapid Improvement Event
RMC – Records Management Center
ROES – Remote Order Entry System
RoG – Republic of Georgia
ROs – Regional Offices
RSA – Resource Sharing Agreement
RTN – Routing Numbers
RTO – Research and Technology Organization
SA – Strategic Actions
SAIL – Strategic Analytics for Improvement and Learning Value Model
SBHP – STAR Behavioral Health Providers
SBIR – Small Business Innovative Research
SBIRT – Screening Brief Intervention and Referral to Treatment
SCAN-ECHO™ – Specialty Care Access Networks-Extension for Community Healthcare Outcomes
SCORE! – Study for Cognitive Rehabilitation Effectiveness
Scribd – a tool used to upload and host 508-compliant PDFs to easily direct audiences to content and track the number of reads for each document
SCWG – JEC Strategic Communications Work Group
SDR – Suicide Date Repository
SDSU – Same Day Surgery Unit

SGLI – Servicemembers' Group Life Insurance
SHA – Separation Health Assessment
SHAWG – Separation Health Assessment Work Group
SHPE – Separation History and Physical Examination
SME – Subject Matter Expert
SMMAC – Senior Military Medical Advisory Council
SOA – Service Oriented Architecture
SOC – Senior Oversight Committee
SOES – SGLI Online Enrollment System
Songs for Sound – a 501c3 charity supporting people with hearing loss
SOR – System of Record
SPARRC – Suicide Prevention and Risk Reduction Committee
SPC – Suicide Prevention Conference
SRWG – Shared Resources Work Group
SSA – Social Security Administration
SSO – Single Sign-On
STR – Service Treatment Record
STRWG – Service Treatment Records Work Group
STVHCS – South Texas Veterans Health Care System
T2 – Department of Defense's National Center for Telehealth and Technology
TAA – Training Affiliation Agreement
TAP – Transition Assistance Program
TATRC – Telemedicine and Advanced Technology Research Center
TBI – Traumatic Brain Injury
TBIMS – Traumatic Brain Injury Model Systems Study
TCAPS—Tactical Communication and Protective System
TCCC – Tactical Combat Casualty Care
TED-I/NI – TRICARE Encounter Data – Institutional/Non-Institutional
TFL – Tricare for Life
TFMC – Total Force Management Committee
TFMO – Theater Functional Management Office
THSP – Target Health Standards Profile
THWG – Telehealth Work Group
TMA – TRICARE Management Activity
TMS – Talent Management System
TRAIN – Training Finder Real-Time Affiliate-Integrated Network
TSWF – Tri-Service Work Flow
USCG – United States Coast Guard
USMC – United States Marine Corps
USMLE – United States Medical Licensing Exam
USTRANSCOM – United States Transportation Command
USUHS – Uniformed Services University of the Health Sciences UX – User Experience
VA – Department of Veterans Affairs
VA CARES – Veterans Affairs Capital Assets Realignment for Enhanced Services
VAMC – VA Medical Center
VANCHCS – Veterans Affairs Northern California Health Care System

VAS – Visual Analog Scale
VASDHCS – Veterans Affairs San Diego Health Care System
VBA – Veterans Benefits Administration
VBMS – Veterans Benefits Management System
VCE – Vision Center of Excellence
VCL – Veterans Crisis Line
VHA – Veterans Health Administration
VHCS – Veterans Health Care System
VHI – Veteran's Health Initiative
VISN – Veterans Integrated Service Network
VISTA – Veterans Health Information System Technology Application
VLER – Virtual Lifetime Electronic Record
VONAPP – Veterans Online Application
VOW Act – Veterans Opportunity to Work Act
VR&E – Vocational Rehabilitation and Employment
VSO – Veterans Service Organization
VTA – Veterans Tracking Application
VTA IDES – Veterans Tracking Application for the Integrated Disability Evaluation System
WCP – Office of Warrior Care Policy
WG – Work Group
WIIC – Wounded, Ill, and Injured Committee
WRNMMC – Walter Reed National Military Medical Center