

**VA/DoD Joint Executive Committee
Annual Joint Report
FISCAL YEAR 2016**

VA/DoD Joint Executive Committee Membership List

(as of September 30, 2016)

Department of Veterans Affairs (9)

Deputy Secretary of Veterans Affairs

Under Secretary for Health

Under Secretary for Benefits

Assistant Secretary for Information and Technology

Assistant Secretary for Enterprise Integration

Assistant Secretary for Public and Intergovernmental Affairs

Assistant Secretary for Congressional and Legislative Affairs

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Department of Defense (10)

Under Secretary of Defense (Personnel and Readiness)

Assistant Secretary of Defense (Health Affairs)

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Director, VA/DoD Interagency Program Office

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Assistant Secretary of the Navy (Manpower and Reserve Affairs)

Assistant Secretary of the Air Force (Manpower and Reserve Affairs)



VA/DoD Joint Executive Committee Annual Joint Report FISCAL YEAR 2016

A handwritten signature in black ink, appearing to read "S. Blackburn", written over a horizontal line.

Scott Blackburn
Interim Deputy Secretary
Department of Veterans Affairs

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A. M. Kurta
Performing the Duties of the Under
Secretary of Defense for Personnel
and Readiness

Table of Contents

SECTION 1 – INTRODUCTION	5
SECTION 2 – ACCOMPLISHMENTS	7
GOAL 1 – Benefits and Services	7
1.a. Benefits Data – BEC Information Sharing/Information Technology Working Group ...	7
1.b. Lead Coordinator – IC3 Community of Practice Working Group.....	9
GOAL 2 – Health Care	11
2.a. Base Access – VA Security Office and DoD Security Policy Oversight Division.....	11
2.b. Individual Longitudinal Exposure Record – HEC Deployment Health Working Group	12
2.c. Mental Health/Suicide Prevention – Psychological Health Work Group.....	13
2.d. Traumatic Brain Injury.....	14
2.e. Hearing Center of Excellence	16
2.f. Vision Center of Excellence	18
2.g. Extremity Trauma and Amputation Center of Excellence	20
2.h. Health Data Sharing Modernization – VA/DoD Interagency Program Office.....	22
2.i. Pain Management – HEC Pain Management Working Group.....	27
GOAL 3 – Efficiencies of Operations	29
3.a. VA/DoD Reimbursement Process and Joint Sharing – HEC Shared Resources Working Group	29
3.b. Credentialing – Credentialing Working Group	30
3.c. Joint Legacy Viewer – HEC Health Data Sharing Business Line	31
3.d. Disposition of Paper Service Treatment Records – BEC Medical Records Working Group	32
3.e. Mandatory Separation Health Examinations – Separation Health Assessment Working Group	33
3.f. Integrated Disability Evaluation System – Disability Evaluation System Improvement Working Group	35
3.g. Interagency Comprehensive Plan – IC3 Technology Tools and Change Working Group	36
3.h. Capital Asset Planning – Construction Planning Committee.....	38
Additional Accomplishment	41
Ad Hoc Working Group on Provision of VA Counseling and Treatment for Sexual Trauma to Members of the Armed Forces	41
SECTION 3 – NEXT STEPS	44
APPENDIX A – COST ESTIMATE TO PREPARE CONGRESSIONALLY-MANDATED REPORT	45
APPENDIX B – GLOSSARY OF ABBREVIATIONS AND TERMS	46

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) 2016 Annual Joint Report (AJR), for the period of October 1, 2015 to September 30, 2016, 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 Care Coordination Committee (IC3), the Director of the Interagency Program Office (IPO), an additional four Independent Working Groups (IWGs), 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 2016 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, IC3, and IPO are comprised of 37 working 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 and Privileging 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
- 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
- Medical Records WG

Interagency Care Coordination Committee (IC3)

- Policy and Oversight WG
- Community of Practice WG
- Technology Tools and Change WG

Interagency Program Office Executive Committee

- VA/DoD Interagency Program Office

Independent Working Groups (IWG)

- Construction Planning Committee
- Strategic Communications WG
- Wounded, Ill, and Injured Committee (WIIC)
- Separation Health Assessment WG (SHAWG)

SECTION 2 – ACCOMPLISHMENTS

This section highlights the FY 2016 accomplishments of the HEC, BEC, IC3, 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 2017.

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 Working Group

The BEC Information Sharing/Information Technology (IS/IT) WG 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 as outlined below in FY 2016.

Servicemembers' Group Life Insurance (SGLI) Online Enrollment System (SOES): The SGLI Online Enrollment System (SOES) made significant strides in FY 2016 regarding full implementation to support the needs of Service members and their families. SOES will provide 24/7 access to SGLI/Family Servicemembers' Group Life Insurance (FSGLI) elections for the Service member and will provide the same level of accessibility and efficiency for casualty officers working to settle claims for family members. In FY 2016, the SOES application was fully integrated into the Defense Manpower Data Center (DMDC) milConnect portal to provide quick and easy access to Service members within a familiar portal for the availability of information on other benefits. The DoD is in the final stage of issuing policy to govern the implementation of SOES by the Services in FY 2017.

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. Each implementation will take approximately 12 months to fully on-board its members and will conclude in FY 2018. 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 the DoD and Veterans Benefits Administration (VBA) to facilitate an orderly implementation.

DS Logon: In September 2016, the DoD Self-service Logon (DS Logon) celebrated a significant milestone of surpassing 6 million 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 66 applications.

Interagency Paperless DD 214: The Interagency Paperless DD 214, Certificate of Release or Discharge from Active Duty, project is focused on eliminating the paper form and manual processing of the DD 214 and DD 215, (i.e. Correction to DD 214). Transition from paper to electronic forms has a potential cost avoidance of \$58 million per year amongst all interagency stakeholders. The transition will also facilitate automatic enrollment in VA health care and eliminate the requirement to attach the paper DD 214 to the enrollment request. Joint management of electronic DD 214 (eDD214) information will further enable Veterans to research their record, submit evidence for inaccurate or missing information, and verify Service.

In FY 2016, the IS/IT WG made progress toward the transition of the eDD214 with interagency partners.

- The Marine Corps eliminated issuance of the DD 215 and incorporated reissuance of the DD 214 as part of its electronic data system.
- Worked with the Navy to develop and test its eDD214 interface. Implementation was projected for the end of CY 2016, but was delayed due to internal Navy system issues. Implementation is projected in Q2 FY 2017.
- Began coordination with the Air Force on development of the eDD215 and full incorporation of reissuance of the DD 214.
- Deployed the application that allows users to view eDD214 data for Warrior Care Policy (WCP) programs and services.
- Coordinated with VA on consumption of web services to view eDD214/215 data and Medals and Awards data. Deployment planned in FY 2017.

DMDC continued to improve data quality of key military service data elements by executing a reconciliation process to automate discrepancy reporting between eDD214 and Service personnel transaction data. DMDC focused on improving the quality of Character of Service code, SPD Code and Reentry Code contained within DMDC. Improved data will allow VA to access Character of Service and Narrative Reason for Separation in VA/DoD Identity Repository (VADIR) to support benefits adjudication. Likewise, DMDC enabled access to VA to view Purple Heart information via the data share.

DoD and Department of Labor (DOL) signed a Business Requirements Document (BRD) to serve as the foundation to support Service member transition via a web service solution. The web service solution provides DOL with computable military service data as requested upon submission of an unemployment compensation

request by a former Service member. DOL will continue to accept a paper DD 214 until the Web Service solution is delivered.

DMDC established a web service solution to provide the State Departments of Veterans Affairs (SDVA) with eDD214/215 data to eliminate mailed copies. The SDVAs are using the electronic data to provide timelier outreach and benefit determinations for Veterans within their states. During Q2 FY 2016, DMDC began sharing gender and mailing address information with the SDVAs. By the end of FY 2016, DMDC established access to the web service with 36 SDVAs, representing 79 percent of the total U.S. Veteran population. DMDC established a schedule to achieve full implementation with the remaining SDVAs that meet IT and privacy standards by Q2 FY 2017.

Common Veteran Population: In FY 2016, DMDC completed the addition of 2.9 million Veteran identities and their associated military history to the DMDC Person Data Repository (PDR). The Veteran records were extracted from VA's Beneficiary Identification Records Locator Subsystem (BIRLS) that contained both identity and military history information. DMDC also began processing an additional 14 million BIRLS records containing military history for Veterans that were already identified in PDR. DMDC added the BIRLS military data to the VA satellite of PDR. Processing will be completed in Q1 FY 2017. This project enhances the total Veteran population shared by VA/DoD and supports VA's goal to sunset the BIRLS database.

Dual Compensation WG: In FY 2016, the IS/IT WG completed Phase 1 of the interim solution for automating the annual process in June 2016. Phase 2 of the solution was completed in September 2016. VA executed the annual processing of FY 2015 drill pay adjustments due to VA compensation for 100,064 personnel in Q3 FY 2016. The automated due process success rate of Phase 1 and Phase 2 combined is 80.3 percent and required no manual involvement from the VA Regional Offices.

DoD will continue to update the Special Project Attachment (SPA), Verification of Disability Compensation and Verification of Disability Compensation Computer Matching Agreements (CMA) by Q2 FY 2017. DMDC will continue to support VA in implementing automated monthly processes by leveraging data available in VADIR through attendance at quarterly requirement sessions and bi-weekly working group meetings. VA is projecting to implement automated monthly processes for both the drilling reserve and return to Active Duty populations by Q4 FY 2017.

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

The IC3 is organizing VA/DoD care coordination and case management professionals around a "common operational picture" through the cultivation of a Community of Practice (CoP), implementation of the Lead Coordinator (LC) role, and technology solutions to improve coordination and management of care, benefits, and services for Service members, Veterans, and their families.

In FY 2016, the IC3 launched the virtual, borderless CoP and created processes and practices allowing for enhanced dialogue among the more than 50 VA and DoD programs in the CoP. Over 85 percent of programs participated in CoP leadership quarterly meetings. Positive feedback received suggested that future meetings in this unique format would assist LCs with access to the CoP when addressing the coordination of complex care needs for Service members and Veterans.

Training Activities:

- In FY 2016, the IC3 conducted 38 virtual live training sessions to reach care coordinators across the United States and overseas to equip them with the necessary tools and resources to assist Service members, Veterans, and their families on their journey of recovery.

Training Accomplishments:

- In FY 2016, 1,216 individuals participated in LC training (over 2,800 trained since initial roll out in July 2015) and 1,468 participated in Awareness training (over 1800 trained since July 2015).
- Sustainment training was implemented using recorded videos of the LC training and LC Awareness training, and provided CEU accreditation to existing and new LCs.
- Over 98 percent of care coordinators and case managers identified and designated as LCs are trained within VA or DoD.

IC3 initiated LC open forums to reinforce training, identify opportunities for improvement, and share best practices across the LC community. In 2016, IC3 conducted over 30 LC open forum calls. To enhance sharing of information and best practices, and build new relationships and increase VA/DoD network opportunities, IC3 launched the secure IC3 “Co-Lab” web portal on Max.gov and launched the Navigation, Advocacy, Community Engagement (NACE) website. NACE is in its early stages of usage; however, efforts are in progress to socialize and promote awareness.

IC3 also implemented CoP quarterly bulletins, LC newsletters and open forums to VA/DoD network to communicate and share resources to assist the LCs in their role. The newsletters continue to empower and heighten the awareness of improved tools/resources used by LCs to achieve the Service member and Veteran desired goals in their journey on recovery.

IC3 established an interagency agreement with the National Association of State Directors of Veterans Affairs (NASDVA). This agreement supports outreach to Service members and Veterans identified with complex care coordination needs by providing information and points of contact to connect them with appropriate state government agencies for additional tools/resources and benefits. The agreement provides additional resources and better synchronizes both national and local resources.

IC3 will continue to provide communication tools and resources to increase awareness and adoption of the LC role, and analyze the implementation to develop

a feasibility and implementation plan to improve coordination and management of care, benefits, and services for Service members, Veterans, and their families.

GOAL 2 – HEALTH CARE

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

2.a. Base Access – VA Security Office and DoD Security Policy Oversight Division

The VA Security Office and the DoD Security Policy Oversight Division are working the development and implementation of national level guidance for VA patient access to DoD installations. Veteran beneficiaries may require health care services from military Medical Treatment Facilities (MTF) or VA clinics co-located on military installations. Currently, there are approximately 25 MTFs providing medical care to Veterans across the country with roughly 600,000 Veterans (including dual-eligible beneficiaries) that may require access to military installations for care.

The medium-term plan for facilitating base access in these situations is for installations to accept electronically-verifiable Veteran Health ID Cards (VHICs). After an initial fitness check¹, Veterans can enroll in DoD's Identity Management Enterprise Services Architecture (IMESA) system² to facilitate future visits. VA has provided the technical specifications required for this solution, and DoD has incorporated them into our specifications. VA and DoD jointly developed this model and are actively working towards implementation, with a target of late FY 2017.

As a short-term interim measure, in December 2016, DoD published Under Secretary of Defense for Intelligence (USD(I)) - level Clarifying Guidance to existing policy. This guidance implements Federal law (the REAL ID Act of 2005) and publishes Department of Homeland Security implementation details on the use of REAL ID Act-compliant Driver's Licenses and State Identification cards (collectively "REAL IDs"). It also establishes requirements for the use of REAL IDs for DoD access control purposes, as well as adopts the *REAL ID Act of 2005 Implementation: An Interagency Security Committee Guide* for use in DoD. Veterans can use their REAL ID-compliant Driver's Licenses and State IDs to facilitate physical access to DoD installations and facilities to obtain medical benefits pursuant to this guidance. A revision to DoD's Instruction covering physical security, which will include the overarching policy and implementation details for the medium-term enrollment model described above is one year behind schedule and is now forecast for publication in 4th Quarter FY 2017, subject to the Federal Register publication process. In addition to adding the Veteran's Health Identification Card

¹ Fitness checks include an examination of an individual's criminal history and other derogatory information.

² IMESA is the same system used to monitor DoD personnel (CAC holders, retirees, dependents) and other personnel with recurring installation access for new derogatory information, such as Wants & Warrants or Terrorism flags.

(VHIC) as an acceptable credential for enrolling and granting access, this issuance will add guidance regarding caregiver access.

In collaboration, the VA Security Office and the DoD Physical Security Program and Policy Branch continue to develop and communicate enterprise-wide guidance to ensure VA patients have access to DoD installations/facilities that provide health care for Veterans through local sharing agreements.

VA and DoD continue to collaborate on any individual installation access issues as they arise directly with the Component. Since May 2016, no reports of Veteran access issues have been received.

2.b. Individual Longitudinal Exposure Record – HEC Deployment Health Working Group

The HEC Research BL provides ongoing oversight of the development of the Individual Longitudinal Exposure Record (ILER) project through the Deployment Health WG. The purpose of the ILER is to create a complete record of every Service member's occupational and environmental exposures over the course of their career. ILER will provide exposure-related data and medical information to VA and DoD to improve health care (diagnosis and treatment), epidemiological analyses and research, and support determination of disability evaluations and benefits determinations. ILER is a \$19.1 million Joint Incentive Fund (JIF) pilot project and the goals are to demonstrate the feasibility of producing ILER and develop a prototype that provides an Initial Operational Capability (IOC). At IOC, VA and DoD will decide whether to proceed to Full Operational Capability (FOC), which would require additional sustainment funding from both agencies in future years.

The ILER will mine several existing DoD data systems that contain in-garrison and deployment exposure-related information. It will link career location and year with exposure data and will be available to VA and DoD health care providers to inform diagnosis and treatment, and to help VBA claims adjudicators establish service connection. This will assist Veterans in establishing their individual exposures.

In FY 2016, the Departments continued the work necessary for the ILER pilot project. Major milestones and activities in this area included:

- Established the VA/DoD ILER joint integrated project team to guide reporting, acquisition, design, and technical activities.
- Initiated Phase II for VA/DoD ILER pilot development; awarded initial contracts to support the design and development of ILER pilot IOC and technical tasks.
- Developed and submitted the ILER pilot IOC spend plan for FY 2017-2018.
- Conducted a VA/DoD stakeholder off site to refine functional requirements, processes, and user stories for clinical, policy, claims and research capabilities.
- Established a use-case framework for ILER pilot IOC around which to identify IT architecture, data sources and potential IT and functional issues.

The VA/DoD ILER program office will demonstrate the ILER pilot to VA and DoD stakeholders and capture user feedback by January 31, 2018, and release the ILER pilot by May 31, 2018. Enhancements to the ILER will be coordinated through a joint VA/DoD ILER integrated project team, who shall oversee synchronization of business processes, manage technical development activities, and advocate for the funding needed to support future additional development and sustainment activities.

2.c. Mental Health/Suicide Prevention – Psychological Health Work Group

The Psychological Health (PH) WG develops clinical, non-clinical, Service member, and Veteran resources, training, and cultural sensitivity via multiple media venues to decrease negative perceptions of mental health problems and treatment and increases knowledge of suicide risk and prevention strategies in VA and DoD. In FY 2016, the PHWG met their objective through training activities, increased visibility through multiple outlets, and analyzing data as outlined below.

- The PHWG targeted audiences include DoD, VA, and civilian behavioral health providers with the goal of increasing access to culturally sensitive care. Over 21,300 medical providers accessed at least one of the four online Military Culture training modules including over 4,400 providers receiving continuing education units for Military Culture Module 1.
- VA's Make the Connection outreach campaign produced and distributed two national Public Service Announcements (PSAs) on Service members and Veterans psychological health, which experienced significant return on investment. For example, the campaign's Crossroads PSA (<http://maketheconnection.net/stories/653>) was in the top 5 percent of all PSAs aired nationally for several months and broke into the top 2 percent in February (ranking 33rd out of 1300 PSAs). The PSA, launched in the 2nd quarter of FY 2016, was aired in over 50 markets, on over 154 stations, for approximately 20,000 airings, resulting in more than 142 million impressions for an equivalent paid media value of over \$2.7 million.
- The Suicide Data Repository (SDR) Board of Governors (BoG) responded to all data requests within 60-days for FY 2016, fully meeting the established performance measure.
- The SDR received updated National Death Index (NDI) Data from the Centers for Disease Control and Prevention (CDC). The SDR can now process requests for data through CY 2014 and provide complete NDI+ data. The NDI is a United States resource available to researchers from the USA National Center for Health Statistics to obtain death status (regular NDI) or cause of death (NDI+) for deaths of USA citizens occurring within the USA.
- VA and DoD collaborated on a national PSA called "Be There: Help Save a Life." This PSA was disseminated through social media, internal and external stakeholder channels, to include the White House (through the Joining Forces initiative). The PSA was sent to broadcast and cable outlets and was

accessible via online channels. In addition, an audio version was offered to radio stations.

- On September 1, 2016, social media posts of support for Veterans and Service members were placed across VA and DoD along with posts of thousands of supporters across the Country, whose identical messages were posted at the same time.
- Post Deployment Health Reassessment (PDHRA) Follow Up: For those Service members completing a PDHRA in 2015 (40,735) and receiving a recommended referral to mental health specialty care and/or behavioral health in primary care (3,371), 54 percent (1,834) received follow-up mental health care from a VA, DoD, and/or TRICARE provider. (Data not available on Service members and Veterans who received follow-up care in the community).
- The *inTransition* Program is a free voluntary program to provide behavioral health care support to Service members and Veterans as they move between health care systems or providers. This program offers specialized Personal coaches that coach Service members during their transition period, empowering them to make healthy life choices. Coaches are available 24/7 via a toll-free call. In FY 2016, the program had over 13,000 coaching cases with 100 percent satisfaction from participants.

The PHWG is continuing to work towards decreasing negative perceptions of mental health problems and treatment across VA and DoD increasing the knowledge of suicide risk and prevention strategies. In FY 2017, the PHWG is focusing on advancing efforts to implement seven key activities in the JSP (military culture training; increase outreach and reduce barriers to obtaining mental health care; disseminate new and consistent knowledge about suicide prevention practices, programs, and tools to VA and DoD stakeholders; improve suicide prevention research efforts; develop and distribute coordinated awareness campaign materials; track the number of Service members referred for mental health follow-up on the PDHRA; and assist with continuity of mental health care during times of transition for Service members).

2.d. Traumatic Brain Injury

Traumatic Brain Injury (TBI) initiatives are reported through the HEC under the Clinical Operations BL, as well as the Military Health System (MHS) TBI Advisory Charter (TAC) and the VA's TBI Federal Advisory Committee. As outlined in the FY 2016-2018 JSP Objectives, the longitudinal study, "Improved Understanding of Medical and Psychological Needs in Veterans and Service Members with Chronic TBI (IMAP)," serves as one of several major collaborative activities of the VA/DoD TBI effort. IMAP research accomplishments were selected by the HEC to track VA and DoD TBI work actions and priorities in FY 2016.

The IMAP study is a research collaboration between VA and DoD TBI Model Systems, in partnership with the Department of Health and Human Services, that examines the rehabilitation and psychological needs of Veterans and Service

members with TBI, as well as the caregiver burden of caring for such members and Veterans. It enrolled 150 participants in FY 2016 with a total enrollment of 163 participants since initiated in June 2015.

IMAP accomplishments in FY 2016 included development of over 60 study briefs and knowledge translation products. Specifically, IMAP:

- Produced nine peer-reviewed scientific publications and published 13 abstracts from conference proceedings.
- Contributed a manuscript for a special issue of the *Journal of Head Trauma Rehabilitation* published in March 2016 on the topic of sleep, with focus on the importance of evidence-based sleep management to long-term outcomes of Service members and Veterans.
- Delivered results of early analyses to national and international professional audiences across the VA, DoD, academia, and industry with 27 poster presentations, and 19 symposia, oral presentations and instructional courses at annual conferences.
- Was awarded grant funding from the Patient-Centered Outcomes Research Institute (PCORI) to conduct a six-center comparative effectiveness study of sleep apnea screening and diagnostic tools for persons with TBI during inpatient rehabilitation to promote earlier identification and treatment in the recovery process.
- Supported and mentored the next generation of VA and DoD TBI researchers with 11 trainees and 11 Junior/Early Career investigators.
- Published biannual consumer newsletters providing consumer education specific to interim study findings and their impact on Veterans and Service members' care. The newsletters are available on the TBI Model Systems public-facing website at <http://va.tbindsc.org/>.

The VA/DoD IMAP and the VA TBI Model Systems research findings have important implications for early and long-term management of injured Service members and Veterans that will facilitate best outcomes. For example, emerging evidence within IMAP and the VA TBI Model Systems suggests that improving functional outcomes after TBI may be facilitated by offering integrated and coordinated services across mental health, vocational and rehabilitation programs. This preliminary evidence is being taken into consideration in the VA and DoD TBI 5-year strategic planning for long-term TBI care. Additional emerging evidence providing direction for follow up studies and guidance for the care of chronic TBI includes:

- The finding of a 50 percent prevalence of sleep disorders (i.e., primarily obstructive sleep apnea) in a preliminary sample of 86 consecutive admissions to a VA inpatient TBI unit, pointing to the need for further research to inform age-appropriate sleep apnea screening, diagnosis, and treatment for a military population which is younger and generally healthier than the typical civilian population associated with sleep apnea.

- The finding that 35 percent of Service members and Veterans who sustained a moderate to severe TBI required overnight caregiver supervision at 1 year after injury, pointing out the need for continued availability of resources and services to minimize the burden on TBI caregivers, especially those who care for those with the most severe injuries.

Based on these emerging findings, priorities for FY 2017 related to IMAP include:

- Standing up the PCORI funded study to inform choices on sleep screening and evaluations at multiple sites.
- Expanding education and maximizing resources for military caregivers, including devoting an IMAP newsletter to caregiver issues.

2.e. Hearing Center of Excellence

The Hearing Center of Excellence (HCE) met performance measures set forth in the FY 2016–18 JSP and made significant progress toward milestones. The achievements discussed below are aimed at ensuring and improving the hearing and balanced health care of Service members and their families and Veterans through collaborative efforts focused on prevention, diagnosis, mitigation, treatment, and rehabilitation of auditory-vestibular system injuries.

In support of assessing tools to standardize, streamline, and add sensitivity to annual/periodic testing (e.g., otoacoustic emissions, speech in noise) of Service member auditory function, the HCE collaborated with the Air Force (AF) to provide four Courses of Action (COAs) to the AF Surgeon General to develop a program for hearing monitoring among Airmen. The COAs are currently under review by the AF Surgeon General manpower and finance council (SG1/8). The HCE also provided program oversight and consultation to the AF for its Basic Military Training baseline hearing testing program to establish a reference audiogram and to identify individuals with military service disqualifying hearing loss in Calendar Year 2016. The efforts led to a DoD cost avoidance of \$7.1 million and VA cost avoidance of \$6.5 million.

The HCE also deployed a flexible architecture technology platform that tested approximately 6,400 Service members for distributed hearing studies that will allow increased access to and improvement of the quality of hearing health care for Service members and Veterans. The HCE continues to make progress towards achieving ninety percent of all Service members receiving a baseline and annual/periodic hearing health monitoring, education, and exit hearing audiograms by the end of FY 2018.

The HCE collaborated with the VA National Center for Rehabilitative Auditory Research (NCRAR) and Walter Reed National Military Medical Center (WRNMMC) to develop a comprehensive integrative approach to improve tinnitus care for Service members and Veterans. The HCE provided education and training for evidence-based tinnitus assessment/management practice to VA and DoD providers. In addition, HCE provided training materials on Progressive Tinnitus

Management to VA and DoD clinicians for use during the clinical encounter with patients. The goal is eighty percent of DoD hearing health professionals will use progressive tinnitus management by the end of FY 2017.

The HCE established an integrated VA/DoD networked procurement of hearing aids, accessories, and implants achieving one hundred percent access of DoD audiologists to VA Remote Order Entry System (ROES) records for hearing aids/accessories. The HCE worked with VA and DoD to establish a national contract for bone-anchored hearing aids, allowing cost-effective, rehabilitation options. A TRICARE network pilot program was proposed to provide Service members and family members with hearing aids from the VA National Hearing Aid (HA)/Accessories contract at considerable cost savings to the government.

In FY 2016, the HCE developed strategies for deployment of hearing loss prevention programs for VA as part of the continuum of care that VA audiologists provide to Veterans with the goal of seventy percent of VA audiologists providing this service by September 2017. A pilot was implemented for a VA hearing loss prevention education program that integrates hearing loss prevention practices into the VA hearing health continuum of care. An evaluation plan was developed to assess pilot program impact. The HCE also developed several Veteran-centric education materials for distribution to Veterans by VA hearing health providers to modify Veteran knowledge, skills, and behaviors regarding the prevention of Noise-Induced Hearing Loss (NIHL).

The HCE collaborated with VHA to develop and conduct a training course for 60 VA hearing technicians (HTs) with 59 HTs receiving certification as Certified Occupational Hearing Conservationists (COHCs) from the Council for Accreditation in Occupational Hearing Conservation (CAOHC, the current national standard). The training led to developing the Joint VA/DoD Hearing Technician Training and Certification VA/DoD JIF proposal that will provide a standardized online training program for VA and DoD HTs, ensuring all HTs are training to the nationally recognized standard (CAOHC), improving access to quality hearing health care.

The HCE Phase I build of the Joint Hearing Loss and Auditory System Injury Registry (JHASIR) is near completion. Phase II began in October 2016 incorporating over seven unique data sources to meet congressional mandate with the goal of one hundred percent of registry data feeds online by September 30, 2017. The Enterprise Clinical Audiology Application (ECAA) deployed to all DoD MTFs with Audiology services, an important source of computable hearing and auditory system injury data for JHASIR. The DoD Clinical Coding WG was established, facilitated by HCE that includes Tri-Service, DoD, and HCE subject matter experts with the goal of standardizing coding for audiology services across DoD.

The HCE is continuing to make progress on milestones established in the JSP to ensure and improve the hearing and balance health care of Service members and their families and Veterans through collaborative efforts focused on prevention,

diagnosis, mitigation, treatment, and rehabilitation of auditory-vestibular system injuries.

2.f. Vision Center of Excellence

The Vision Center of Excellence (VCE) continues to maximize potential for the effective prevention, diagnosis, mitigation, treatment, and rehabilitation of eye and vision injuries through collaborative efforts and facilitates the identification of research capabilities within and between VA and DoD.

In support of research, VCE publishes annually a vision research gap analysis in cooperation with VA and DoD Subject Matter Experts (SMEs). In FY 2016 VCE was an active part of the Congressionally Directed Medical Research Programs Clinical and Rehabilitative Medicine Capabilities-Based Assessment as a vision subject matter expert. It was also part of the programmatic review for the Clinical and Rehabilitative Medicine Research Program Neurosensory Award, the U.S. Army Medical Research and Material Command, and the Military Operational Medicine and Clinical and Rehabilitation Medicine Research Programs. VCE also provided input to the Blast Research Program Coordinating Office's Annual Report to the Executive Agency and is also part of the planning committee for the Blast Research Program Coordinating Office's State of the Science Symposium.

Publications and reports from the Defense and Veterans Eye Injury and Vision Registry (DVEIVR) informed multiple DoD and VA offices and exceeded the performance measure of two annually. The annual State-of-DVEIVR report to stakeholders was published in July 2016. The quarterly DVEIVR publication of the 2008 National Defense Authorization Act (NDAA) "Coordination of Care and Benefits Report" sent to VA's Blind Rehabilitation Service and VA Chief Consultants for Ophthalmology and for Optometry. VCE also provided two semi-annual stakeholder DVEIVR "Newly Injured and Enrolled in DVEIVR" Reports on operational medicine data to Tri Services Ophthalmology and Optometry Consultants. DVEIVR and other data sources were utilized in collaborations with the DoD, VA, and two Universities. These and other efforts resulted in seven presentations or scientific posters in FY 2016.

VCE provides care coordination to monitor worldwide ocular casualty movement from theater throughout the continuum of eye care to rehabilitation. In FY 2016 VCE published the following Vision Care Coordination best practices:

- Considerations for Blind or Visually-Impaired In- and Out-Patients, American Society of Ophthalmic Registered Nurses, ASORN (November 2015) and presented as a poster to the Association of Military Surgeons of the United States (AMSUS) (December 2015).
- Improving Health care Experiences for Visually Impaired Service Members and Veterans, published in Insight, the journal for ASORN (Spring 2016).

The VCE VA Blind Rehabilitation Specialist works with the DoD Vision Care Services Coordinator to coordinate, communicate, and facilitate access to VA, and also provides real-time, relevant information about services provided by VA Blind and Low Vision Rehabilitation to Service members, Veterans, family members, clinicians, and researchers in MHS.

The VCE convened and chaired to completion three clinical recommendations regarding TBI-related visual dysfunction, soliciting feedback from federal stakeholders (optometry, ophthalmology, and visual rehabilitation leads for VA and DoD) on each of the recommendations. The VCE presented on TBI-related injury at the Delaware Military Medicine Symposium (Nov 2015), AMSUS (Dec 2015), and the Military Health System (MHS) Speaker Series (March 2016). The VCE produces a monthly Worldwide Ocular Teleconference Call with VA and DoD clinical providers to provide clinical follow-up of ocular casualties as well as identify local- and system-level shortfalls and successes throughout the continuum of care.

VCE produces or contributes to multiple needs assessment reports annually that enhance readiness for VA and DoD vision care professionals. The VCE formally initiated a Capabilities-Based Assessment of Military Ocular Combat Casualty Care (MOC3) to investigate and identify as-is capabilities, evaluate shortfalls and gaps, and identify solutions to optimize MOC3 with the goal of achieving Joint Service doctrinal-level institutionalization of lessons learned. VCE contributed to the development of a rapid vision assessment tool for field use by combat medics and first responders, which was presented at Military Health System Research Symposium (MHSRS). VCE led the evaluation of U.S. Army Medical Command's Ocular Teleconsultation program and continues to collaborate, aiming for prevention, mitigation, and improvement of care coordination through telemedicine technologies, which was also presented at MHSRS. The VCE collaborated with Uniformed Services University of the Health Sciences (USUHS) and University of Pittsburgh by presenting at *Caring for Wounded Warriors State of the Science Symposia* on topics related to visual dysfunction. VCE provided support and assisted with curriculum development for the annual Uniformed Services University of the Health Sciences (USUHS) Tri-Service Ocular Trauma Course.

In FY 2016, VCE exceeded the goal of conducting two external stakeholders outreach efforts, including seminars, workshops, and virtual courses. The VCE produced the following training seminars for eye care providers, blind rehabilitation specialists, occupational therapists, and patients:

- Living with Sight Loss (November 2015, April 2016, August 2016), Access to Prescription Labeling (January 2016), and Assistive Technology for Blind and Low Vision (March 2016).
- The VCE Shields Save Sight video placed third in the "Internal and Public Information" category of the Defense Media Activity Department of Defense Visual Information Production competition. VCE presentations on rigid eye shields have been made at AMSUS (December 2015) and the Gathering of

Eagles Annual Scientific Symposium of Emergency Medical Systems (February 2016).

- VCE partnered with the HCE and Salus University to conduct combined vision, hearing, and balance screenings for Veterans at community colleges and provided immediate referral to VA for establishment of care. The VCE/Salus Memorandum of Understanding (MOU) is currently being updated to expand health screenings and outreach programs to Veterans.
- VCE conducted an 'Industry Day' with the Blinded Veterans Association (BVA) and HCE for disabled Veterans and representatives from information technology industries (September 2016) to guide future technology solutions for the dual-sensory impaired.
- VCE staff presented the following subjects at the BVA annual conference: Accessible Digital Television Services, Touchscreen Smart Device Technology, and Environmental Controls with Alternative Methods of Input (August 2016).
- VCE staff presented at the VA Blind Rehabilitation Services annual conference, New Advances in Treatment for Age-Related Macular Degeneration (August 2016).

In FY 2017, building upon the aforementioned accomplishments of FY 2016, VCE will continue to collaborate with VA and DoD to deliver evidence-based solutions and best practices in the prevention, diagnosis, mitigation, treatment, and rehabilitation of eye and vision injuries, thus furthering its mission of serving Service members, Veterans, and their families.

2.g. Extremity Trauma and Amputation Center of Excellence

The Extremity Trauma and Amputation Center of Excellence (EACE) is a joint VA/DoD center that promotes and facilitates continuous improvement and enhancement of care and implementation of programs, processes, and knowledge within and across VA and DoD, institutions of higher education, and other appropriate public and private entities (including international entities) to carry out these responsibilities. The EACE meets the requirements of Section 723 of the FY 2009 NDAA to implement a comprehensive plan and strategy for the mitigation, treatment, and rehabilitation of traumatic extremity injuries and amputations, conduct research to save injured extremities, avoid amputation, preserve and restore the function of injured extremities, and other activities to improve and enhance the care.

The following are FY 2016 major milestones and activities in this area:

- Conducted the third annual Federal Advanced Amputation Skills Training Symposium (FAAST) on Practical Integration and Implementation of Best Practices and Technology Advances in July 2016 with 158 VA/DoD attendees. The overall satisfaction score totaled over 95 percent.
- Conducted six Virtual Grand Rounds (VGR) in 2016 focused on training activities to offer collaboration opportunities among clinicians and researchers

from VA and DoD. The overall combined satisfaction score from attendee feedback forms was 92 percent.

- Published 25 peer-reviewed articles in the area of traumatic extremity injury and/or amputation in FY 2016 by EACE research staff. This exceeded the targeted goal of 15 in FY 2016 and furthers the EACE role as a global resource in traumatic extremity injury and amputation treatment, research, and rehabilitation.
- Conducted three international traumatic extremity injury and amputation outreach engagements with each of the following countries: Thailand, the Republic of Georgia, and the Ukraine. Each international support engagement was requested by U.S. Unified Commanders across the world to further their global health engagement mission(s).
- Presented at five national engagements to share EACE expertise to help further knowledge, skills, and abilities of clinicians on extremity trauma and amputation: The American Academy of Orthotists & Prosthetists; the American Physical Therapy Association's Combined Sections Meeting; the University of Pittsburgh Medical Grand Rounds; the Amputee Coalition National Conference; and the State of the Science Symposium on Global Health and Rehabilitation.
- Evaluated, fit, and trained Service members and Veterans with adaptive sports equipment competing at three (3) national disability sporting events: the National Veterans Winter Sports Clinic; the Veterans Summer Sports Clinic; and the INVICTUS Games.

The EACE is progressing as planned to pilot DoD participation in the VA lower extremity prosthetic component ROES procurement capability in FY 2017. VA and DoD established an overarching interagency agreement for DoD to procure prosthetics from VA as a prerequisite for the pilot program to achieve expedited delivery and order accuracy of lower extremity prosthetics.

The EACE is also sponsoring a RAND Arroyo Amputation Care Core Competencies Study to support the identification of key disciplines and capture advanced clinical competencies associated with optimal outcomes in rehabilitation for Service members with amputation. These findings will inform future planning, training, and education, and influence clinical recommendations and practice guidelines, to ensure a ready medical force in future years.

Lastly, the EACE established an integrated product team of clinical specialties, technical advisors, voting members from the Services, the Defense Health Agency (DHA), and VA to develop the functional requirements to support the Defense and Veterans Extremity Injury and Amputation Registry (DVEAR). The DVEAR is an integrated health registry to capture and quantify key characteristics and outcomes of Service members and Veterans affected by traumatic extremity injury and amputation to support clinical care and research. The registry is scheduled for completion in FY 2018.

2.h. Health Data Sharing Modernization – VA/DoD Interagency Program Office

The DoD/VA Interagency Program Office (IPO) provides Service members, Veterans, and their beneficiaries with world-class health care by ensuring the VA and DoD's Electronic Health Record (EHR) data is interoperable with each other and with the private sector. The IPO's goal is to support the interoperability of clinically relevant health data in accordance with the FY 2014 NDAA, which complies with Office of the National Coordinator for Health Information Technology (ONC) guidance on standards and interoperability for clinical records. The IPO is chartered to jointly oversee and monitor the efforts of VA and DoD in implementing national health data standards for interoperability. The IPO acts as the single point of accountability for identifying, monitoring, and approving the clinical and technical data standards and profiles to ensure seamless integration of clinically relevant health data between the two Departments and private health care providers.

Based on the FY 2016-2018 VA/DoD JSP, 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 JSP activities in FY 2016.

Interoperability Certification: Section 713(b)(1) of the NDAA for FY 2014, Public Law 113-66, requires the electronic health record systems of VA and DoD be interoperable with an integrated display of data by complying with national standards and architectural requirements identified by the IPO in collaboration with the ONC. In the second quarter of FY 2016, the Departments jointly certified that they had closely partnered to meet the interoperability requirements of the FY 2014 NDAA.

To establish a framework for implementing the Departments' data for compliance with the NDAA, the VA/DoD Interagency Clinical Informatics Board (ICIB) endorsed 25 prioritized data domains to support continuity of care and Veterans benefits adjudication. For all data domains with structured data, the IPO collaborated with VA and DoD to identify and establish the appropriate national standards for both Departments' electronic health record systems. Both Departments have mapped or natively standardized respective domains requiring national standard terminologies.

For domains that do not have structured data, the information is currently captured in the clinical notes in the Departments' legacy systems. These clinical notes are shared and provided in an integrated display. Moving forward, these domains will be included as part of each Departments' electronic health record modernization plan. As standards continue to evolve, the Departments will use a collaborative governance process to actively manage and continually improve utilization of national standards.

Joint Legacy Viewer (JLV): JLV allows VA and DoD health care providers to share and have immediate access to an integrated view of patients' medical records. Throughout FY 2016, the Departments continued to provide the JLV capability to new users. In FY 2015, the Departments had 26,445 users (8,480 DoD and 17,965

VA JLV users). In FY 2016, the user population for JLV increased significantly to 275,502 users (75,346 DoD and 200,156 VA users). This expansion is coupled with a significant increase in user activity. For instance, in August 2016, there were over 108,025 user logins (58,302 DoD and 49,723 VA user logins) with 258,375 records viewed (60,370 DoD and 198,005 VA records).

To build on these accomplishments, the Defense Medical Information Exchange (DMIX) Program successfully deployed JLV Release 4 in July 2016. Highlights of Release 4 include the establishment of an interface to the DoD's Health Artifact Imaging and Management Solution (HAIMS) for all non-Digital Imaging and Communications in Medicine (DICOM) documents. HAIMS is an enterprise-wide data sharing capability that stores scanned documents and artifacts as well as DICOM images such as radiographs, clinical photographs, and electrocardiograph. The HAIMS connection provides JLV user access to more than 12 million scanned documents. Other Release 4 features include a new report capability, a new "Documents" widget where the HAIMS scanned documents are available, consolidated VA alerts, a customizable personal view, and updates to maintain a consistent look and feel of information across all widgets.

Additionally, the DMIX Program Office and VA finalized the requirements for Release 5 scheduled for deployment in Q1 FY 2017. Release 5 will allow progress notes to be accessible from the Progress Notes widget and address VA-only changes such as the ability to look up patients in the Master Veteran Index without an Electronic Data Interchange Personal Identifier. Release 5 also will support MHS GENESIS ability to consume DoD legacy data, enable JLV to view MHS GENESIS data, and allows for JLV integration into the Theater Medical Data Store, providing the capability to view an individual patient's complete electronic medical record.

ONC Engagement. Throughout FY 2016, the IPO continued to collaborate with members from both Departments and ONC to discuss current interoperability and modernization efforts as well as industry best practices. These efforts not only ensure that the IPO and Departments are at the forefront of nationwide interoperability efforts but also guarantee our best practices and lessons learned are shared with the greater health information technology (HIT) community. In order to achieve this goal, the IPO embedded a full-time liaison at the ONC to serve as a conduit between the organizations. Specifically, the IPO representative provided insights at various forums, including the ONC HIT Policy and Standards Committees as well as Federal Health Architecture (FHA) Managing and Governing Boards. The liaison also provided feedback on ONC deliverables such as the Interoperability Standards Advisory and the Nationwide Interoperability Roadmap. In addition to embedding a liaison at the ONC, the IPO also engaged with ONC by hosting monthly Town Hall meetings with representatives from ONC, DoD, VA, and other public and private partners to discuss topics such as precision medicine, information modeling, and other emerging trends in health data interoperability. These events not only created a forum to discuss interoperability challenges and opportunities but also further enhanced collaboration efforts between ONC, DoD, VA, and the IPO. To further engage with ONC, IPO representatives actively participated in the ONC

Annual Meeting “Committed to Better Health through IT” which focused on three core commitments that market leaders have made to improve consumer access to their health information, combat information blocking, and implement federally recognized, national standards so that different health IT systems can speak the same language.

Data Mapping: While VA and DoD certified their status as interoperable in the second quarter of FY 2016, the IPO and the Departments continued to improve baseline mapping by focusing on terms used most frequently and addressing maps with progressively lower usage thereafter. Specifically, the Departments further enhanced their data quality assurance efforts with the IPO’s Interoperability Standards and Documentation Change Control Board reviewing, analyzing, and approving 8 DoD and 50 VA data maps throughout the fiscal year. Moving forward, the IPO will continue working with VA and DoD to refine the process for reviewing and deploying data mapping updates.

Core Technical Guidance: The IPO continued to provide key strategic and technical guidance to the Departments. Specifically, the IPO continued to update the three foundational documents: the Health Data Interoperability Management Plan (HDIMP), the Health Information Interoperability Technical Package (I2TP), and the VA/DoD Joint Interoperability Plan (JIP).

- The HDIMP documents the IPO’s role in supporting interoperability management and outlines necessary governance to support health data exchange and terminology standardization.
- The I2TP serves as an implementation guide with IPO required interim and emerging national HDI standards.
- The JIP guides the Department’s technical vision for interoperability and outlines plans for achieving seamless data integration.

The IPO finalized the I2TP (version 5) in Q1 FY 2016. The next iteration of the I2TP is scheduled for release in Q1 FY 2017. The most recent update of the HDIMP (version 3) was finalized by the IPO in Q4 FY 2016 and is scheduled for release in the Q1 FY 2017. Additionally, the JIP (version 4) is being re-baselined based on the Departments’ emerging modernization strategies and pending gap analysis from the Health Data Sharing BL WGs.

Health Interoperability and Exchange Alliance (HIEA): Throughout FY 2016, the HIEA, with the support of Department leadership and the HIEA Joint Steering Committee, completed several Joint Exploratory Team (JET) initiatives. Each initiative was a collaborative effort between VA, DoD, and other public and private providers to address interoperability challenges facing the Departments, and concluded with a technical report and other artifacts. Initiatives described below:

- Interoperability Architecture Gap Analysis: Conducted and documented a gap analysis that assessed current and planned improvements to existing VA and

DoD information exchanges including their maturity level and robustness to inform prioritization of future interoperability initiatives.

- Improve Consolidated Clinical Document Architecture (C-CDA) Deployment: Identified problem areas with C-CDA deployment and proposed solutions for recommendation to ONC and Standards Development Organizations as appropriate, such as Health Level Seven International (HL7).
- HL7 Fast Health Information Resource (FHIR) Proving Ground: Established a central development and testing environment designed to foster joint FHIR development and serve as the cross-Departmental resource for validating conformance of FHIR interface profiles between VA, DoD, and other Federal and private providers.
- Mobile Security and Transport (S&T): Analyzed existing VA and DoD health security and transport initiatives, pilots, and lab activities with the mobile health care industry in order to identify alignment opportunities and build a shared roadmap. Established processes to enable the identification of common needs and security and transport results across the Departments for existing and future efforts.

In Q4 FY 2016, the HIEA initiated two new JET initiatives that are expected to be completed in FY 2017. Each initiative is a collaborative effort between VA, DoD, and other public and private providers to address interoperability challenges facing the Departments. The objectives of each initiative are detailed below:

- HL7 FHIR Proving Ground, Phase 2: Utilize the newly established central development and testing environment to coordinate nascent VA and DoD FHIR development efforts in aligning with the implementation best practices established in the Argonaut Project industry collaboration.
- Health Care Cybersecurity Best Practices: Identify health care cybersecurity practices used across VA and DoD and progressive industry Health care Delivery Organizations and document the best practices and gaps to be shared across the Departments and with the Department of Health and Human Services (HHS) Health care Industry Cybersecurity Taskforce.

HL7: In Q3 FY 2016, the IPO became a Benefactor Member of HL7, a not-for-profit Standards Development Organization that provides standards for global health data interoperability. Moving forward, IPO representatives will participate in HL7's balloting process, which incorporates four types of ballots: Comment, Informative, Draft Standard for Trial Use, and Normative. During this process, HL7 members review each ballot item and choose to provide an affirmative or negative vote, abstain from voting altogether, or give constructive comments on content/ language. This process helps ensure that proposed standards support industry-identified interoperability requirements from the public and private sector. The membership enables IPO to have an active role in the standards development process and remain at the forefront of emerging standards and health data interoperability.

Standards Engagement: In addition to becoming a member of HL7, the IPO focused on building strategic relationships with other public and private partners throughout the fiscal year to position the IPO and the Departments to remain at the forefront of health IT innovations, trends, and emerging standards. Also in 2016, the IPO established and hosted several VA/DoD Industry Interoperability Roundtables. These forums brought together health IT leaders from ONC, DoD, VA, and other public and private partners to discuss the “state of the state”, as well as challenges on topics such as Health Information Exchanges (HIE) standards and specifications, onboarding with the Departments industry-wide in the coming years, and the future of medical device interoperability. In addition to these roundtables, the IPO has also worked to develop strategic relationships with the health IT innovation and academic community participating in events with partners such as the Advanced Technology Academic Research Center (ATARC), Defense Innovation Unit Experimental (DIUx), Massachusetts Institute of Technology (MIT), and the University of Michigan. Additionally, the results of a JET on the utilization of the Most Common Allergen Terms in the VA and DoD led to a report at an HL7 conference, and submission and selection for poster presentation at the 2016 American Medical Informatics Association (AMIA) Symposium. The “Developing a Baseline Set of Allergen Terms for the C-CDA Using RxNorm ‘Ingredient’ Level Abstraction” poster describes the results of a study investigating the most common allergen terms used in VA and DoD’s electronic health records. The purpose of the study was to update the development of interoperability data models for exchanging health record information and to identify a small subset of allergen terms, objectives, methods and results that are frequently reported in the two systems. Moving into FY 2017, the IPO will continue to collaborate with strategic partners in health to enhance interoperability between the Departments and their private providers.

Health Data Interoperability (HDI) Outcome-Oriented Metrics: In FY 2016, the IPO, VA, and DoD continued to collaborate to monitor baseline Health Data Interoperability HDI metrics to track the Departments’ progress on health data interoperability. In accordance with the FY 2014 NDAA, these transactional metrics are monitored and reported to the appropriate congressional committees on a quarterly basis. In parallel, the IPO, in collaboration with Department experts in metrics and the joint Health Data Sharing Business Line, worked to develop outcome-oriented HDI metrics to measure the impact interoperability has on health delivery system process and outcome, and health outcomes of our patients and providers attributable to the availability of data as a result of greater interoperability. To that end, the IPO, in collaboration with VA and DoD, developed and finalized the “Health Outcome-Oriented Metrics Roadmap” describing the process for identifying and defining measures, assessing data source feasibility, conducting data collection and analysis, and measuring the impact of interoperability on health care outcomes. The IPO made considerable progress in establishing Data Use Agreements with the VA and DoD, by completing a Proof of Concept to develop, demonstrate, and validate a methodology for measuring and reporting on outcome-oriented interoperability metrics. The IPO also hosted quarterly Metrics Summits to discuss industry best practices for the development and management of metrics, bringing together experts in the public and private sectors. The four Health Data Sharing BL

WGs are working as subject matter experts, with IPO Metrics staff to identify several candidate outcome-oriented interoperability metrics for the use cases that each Workgroup is analyzing for data exchange.

- Health Data Sharing Business Line (HDSBL): The IPO collaborates with the HDSBL to define and recommend priorities for enhancing health data sharing to enable health care continuity, active engagement in care, timely and accurate benefits decisions, and continuous improvements in the health and care of Service members, Veterans, and other VA and DoD beneficiaries. The HDSBL Sub-Working Groups align with six JIP use cases as outlined below:
 1. Clinical transition of care for patients between organizations
 2. Service member separating from Military Services
 3. Wounded warrior involved in the Integrated Disability Evaluation System (IDES)
 4. Benefits adjudication
 5. Population Health
 6. Empowering patients to drive their own care

The IPO's HDI Outcome-Oriented Metrics Team, in collaboration with the Departments, the HDSBL, and other entities are responsible for the development, mapping, and evaluation of metrics and how each relates to health outcomes; the use cases; clinical practice guidelines; and medical industry best practices and standards of care.

The HDI Outcome-Oriented Metrics Team uses this roadmap as the primary tool for managing the evolution of the HDI outcome-oriented metrics as a measurement of the impact of interoperability on health outcomes. The roadmap also builds on quarterly Metrics Summits to drive key milestones and ensure open communication and participation from all stakeholders.

The Departments remain fully committed to continuing to enhance and measure health data interoperability between their electronic health record systems as well as their private partners. Enabling health information exchange between EHR systems in VA, DoD, and the private sector will serve as the foundation for a patient-centric health care experience, seamless care transitions, and improved care for our Service members, Veterans, and their families. The IPO will continue to monitor data sharing between the Departments and report on this transactional data. Finally, the IPO will continue to work with both VA and DoD to develop outcome-oriented metrics that will assess the impact that interoperability is having on our patients and providers.

2.i. Pain Management – HEC Pain Management Working Group

The primary goal of the Clinical Care and Operations BL's Pain Management Work Group is to ensure patients across VA and DoD facilities receive a common standard of care for pain management that meets or exceeds national standards,

and ensure successful transitions across health care systems for Service members, Veterans, and other beneficiaries.

In FY 2016, the Pain Management Work Group completed version 1.0 of the VA/DoD Joint Pain Education Project (JPEP). The JPEP focuses on the needs of providers and patients in primary care and provides a holistic, multi-modal, and multi-disciplinary care model that supports the balanced use of medications, procedures, behavioral treatment, integrative health, specialty care, rehabilitation, and self-care approaches for pain management. The current curriculum consists of 31 modules with topics focused on pain management needs of primary care providers and teams. The modules are formatted to integrate into existing VA and DoD Extension of Community Healthcare Outcome (ECHO) tele-mentoring programs.

Training initiatives to supplement JPEP didactic module content included the development and release of seven Pain Education Videos: Pain Assessment Rating; Chronification of Pain; Pain Outcomes Measurement; Medication Take Back/Safe Disposal; Six Essentials of Quality Pain Care; Stepped Care Model of Pain Management; Safe Opioid Prescribing and Tapering. Several of the JPEP videos and didactic content were adapted for use by both VA and DoD in their respective Opioid Prescriber Training programs in response to the Presidential Memorandum – Addressing Prescription Drug Abuse and Heroin Use (October 2015).

The Pain Management Work Group integrated emerging clinical standards of care and regulations into VA and DoD pain management education and training activities, such as Centers for Disease Control Opioid Prescribing Guidelines in March 2016.

In FY 2016, the work group also identified established pain management “best practices” developed either by DoD or VA to leverage solutions in the alternate department to save time and resources required to field new solutions:

- VA Urine Drug Screening policy identified as a model to adapt for use in DoD. Policy is currently in DoD governance.
- Defense and Veterans Pain Rating Scale (DVPRS), validated and piloted by DoD clinics and medical treatment facilities and identified for piloting in VA.

In FY 2016, the work group completed Acupuncture Training Across Clinical Settings (ATACS) project that trained over 2,000 VA and DoD providers in basic acupuncture protocol and developed consensus guidelines for VA/DoD utilization, education/training, credentialing, documentation, and coding to be used as template for expanding capacity of this non-medication/non-opioid pain management modality. The work group also trained over 100 Medical Acupuncturists to become Battlefield Acupuncture (BFA) Faculty to sustain our progress in creating wide access to acupuncture across our health systems.

The Pain Management Work Group continues to collaborate across the Departments to establish improved VA/DoD collaboration on pain training for primary care providers, and further refine metrics and outcomes for pain management related systems. In accordance with the language in the Comprehensive Addiction and Recovery Act of 2016, the work group also collaborates across other work groups, specifically, the HEC Evidence Based Practice Work Group, to review draft versions of VA/DoD Clinical Practice Guideline for Long Term Opioid Therapy to ensure patients across VA and DoD facilities receive a common standard of care for pain management in FY 2017.

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 Working Group

The Financial and Business Operations BL's Shared Resources Working Group (SRWG) is developing principles for joint sharing initiatives to guide VA and DoD in systematic planning for the optimal degree of integration in the future. The VA/DoD Comparative Study Pilot tested a data-driven approach to identify and select VA/DoD market areas for enhanced clinical resource sharing. The pilot performance results for VA to DoD referred care were completed in Q1 FY 2016 and briefed to the HEC in April 2016. The overall results from the pilot validated that enhanced clinical sharing has potential for replication and operational use across VA/DoD facilities for referred care. Results from the pilot are outlined below.

- In general, all sites showed an upward trend in number of complex cases and a decrease in 30-day wait times.
- Data suggests VA referred relatively complex patients to DoD needed to support DoD's readiness mission.
- All VA sites reported a decrease in number of patients on the 30-day wait list from base year of FY 2013.
- All sites reported outstanding collaboration, with notable growth in referrals for target specialties.
- Data showed a continual decline in the number of VA patients on the wait list throughout the pilot, however, there was a slight increase in the final quarter of the pilot. This may be a result of an increased number of patients referred to meet VA's requirement to refer patients as part of the Veterans Choice Program.

In FY 2016, the SRWG developed a Supplement to the 2008 MOU between the Department of Veterans Affairs and the Department of Defense Health Care

Resources Sharing Guidelines designed to standardize how referrals, care coordination, and billing and claims adjudication processes will work between VA and military health care facilities. The Supplement will eliminate variations and simplify how current and future resource sharing agreements will be developed.

The Financial and Business Operations Business Line's Financial Management WG developed and included financial guidance in the Supplement of the 2008 Guidelines. In FY 2016, the HEC Leadership approved the Supplement to be bi-directional, an enhancement that ensures streamlined reimbursement for both Departments. This was the first step in establishing and implementing enterprise-wide uniform billing and reimbursement standards.

In order to process FY 2015 and FY 2016 payments, a medical encounter data aggregation and processing methodology supporting enterprise-wide reimbursement was refined and tested. This was done to ensure adequacy in meeting workload accounting, audit and Veterans Equitable Resource Allocation model needs. This methodology was used to support \$17.3 million in FY 2016 payments and \$5.7 million in FY 2015 payments. A new approach will explore prospective payment, a practice that ensures resources are immediately available to the service provider.

In FY 2017, the SRWG will develop a Procedural Appendix to the Supplement to the 2008 MOU to capture how each Agency will refer beneficiaries between partners and the FMWG will implement financial guidance to the Supplement.

3.b. Credentialing – Credentialing Working Group

The Credentialing WG is charged with standardizing the VA and DoD credentialing process to facilitate the sharing of health care providers across VA and DoD facilities. Standardization will create greater efficiencies by enabling both Departments to electronically track and verify the credentials for all of the health care providers within their combined organizations. The Joint Centralized Credentialing Quality Assurance System (JCCQAS) is a JIF Project that will bridge the information sharing gap and eliminate the duplication of effort for credentialing VA and DoD health care providers. The Departments continue to refine and improve this goal through numerous efforts, both independently and in close collaboration.

FY 2016 accomplishments:

- Successfully completed Phase 1 of a two-phase JCCQAS initiative on September 9, 2016, demonstrating the proof of concept and prototype modeling for a single joint credentialing system.
 - Upgraded the existing DoD legacy Centralized Credentials and Quality Assurance System (CCQAS) code to .NET framework and standards to improve scalability, sustainability, and compliance with DoD Section 508 of the Rehabilitation Act of 1973 and Rehabilitation Act Amendments of 1998.

- Successfully deployed the upgraded CCQAS to DoD MTFs, credentialing and privileging over 115,000 health care providers worldwide.
- Completed feasibility testing, data mapping, user stories, sprints, and prototype modeling for VA and DoD stakeholders to begin Phase 2.
- HEC Credentialing Work Group identified analogous and unique business processes between both organizations and worked collaboratively to develop methodologies to ensure standardization to the fullest extent possible.
- Initiated JCCQAS Phase 2 to develop, test, train and deploy the final joint solution to both Departments.
 - Awarded JCCQAS developer contract September 10, 2016 for Phase 2.
 - VA and DoD collaborated to identify capabilities-based functional and non-functional requirements for the final joint credentialing solution and incorporated those requirements into an integrated Performance Work Statement for Phase 2 vendor tasks that will encompass both VA and DoD needs.

The Credentialing Work Group will continue to meet the needs of and provide support for the FY 2016-18 JSP activities and milestones. The WG will focus on policies and business practices in order to standardize the VA and DoD credentialing processes, reduce redundancies and facilitate the sharing of health care providers between VA and DoD facilities.

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

The Health Data Sharing (HDS) BL is focused on driving continuous integrative progress for VA, DoD, and private sector health data sharing that addresses priorities, needs, and issues. In FY 2016, Health Data Sharing focused on the development and implementation of the future VA and DoD sharing data exchange protocols and Graphic User Interface (GUI) viewer software enhancement to modernize or replace the legacy viewers with the JLV.

In FY 2016, VA and DoD user access to interagency health information through JLV was accelerated resulting in a 788-percent increase in DoD and a 1,014-percent increase in VA as detailed below.

Department	September 30, 2015	September 30, 2016
DoD	8,480	75,346
VA	17,965	200,156*
Total	26,445	275,502

Table 1: Summary of JLV users in VA and DoD.

* Includes over 14,000 VBA staff

In VA, JLV is accessible from every VA site of care with users at every VA Medical Center and Regional Office. JLV users in VHA represent historical users of the Bi-Directional Health Information Exchange (BHIE) applications and represent direct clinical care, clinical operations support and administrative occupations and workflows that support health care delivery and require access to health data. JLV users in VBA represent historical users of BHIE applications such as VistAWeb and Compensation and Pension Record Interchange (CAPRI) and staff identified by leadership at each Regional Office. Users represent the full range of benefits professional roles and workflows that require access to health data. In DoD, JLV is accessible from all DoD health care facilities and supports clinical care, intake evaluations, care coordination, pharmacy, registries, and administrative activities.

- Additional user functionality added in July 2016 (DMIX release 4) included a Report Builder feature and new data including access to more than 12 million DoD Scanned Documents from the HAIMS, additional document types from external health partners, additional DoD Demographics information for Next of Kin and Emergency Contact and usability enhancements.

In FY 2016, VA supported activities to transition from JLV to the Enterprise Health Management Platform (eHMP) across VA and in collaboration with DoD. eHMP leverages the data access functionality of JLV while expanding the clinical read/write functionality.

- eHMP v1.2 framework completed installation at all sites in July 2016.
- eHMP v1.2 viewer reached 260 users by the end of FY 2016. The number of users will continue to increase as resources for expanding hosting capacity become available.
- VA adopted a more efficient development strategy for the eHMP program and now focuses on progressing directly from eHMP v1.2 to v2.0.
- eHMP v2.0 (basic functionality for outpatient primary-care encounters) entered IOC ahead of schedule in September 2016.

The Departments continue to monitor system performance and to develop plans to accommodate anticipated capacity levels for full JLV implementation including VA transition activities to the eHMP platform.

3.d. Disposition of Paper Service Treatment Records – BEC Medical Records Working Group

The BEC's Medical Records Working Group (MRWG) continues to foster and facilitate improvements to the electronic transfer of Service Treatment Records (STRs) and business processes across and within VA and DoD until paper records are decommissioned. In addition, the working group continues to advance the solution for disposition of paper STR accumulation at VA regional offices and DoD scanning facilities between VA, DoD, and National Archives and Records Administration (NARA).

In FY 2016, the MRWG drafted the Memorandum of Agreement (MOA) governing access to and storage of STRs. The MRWG facilitated the resolution of key requirements between the Departments to maintain momentum for formal coordination and signature of the MOA. The signed MOA is expected in December 2016.

DoD developed an enterprise-wide quality assurance methodology with associated metrics to analyze STR disposition. In June 2016, the Military Operations Group approved the program and funding for the pilot. The information gathered from the pilot will be analyzed to inform DoD leadership on the way forward with respect to final disposition of paper STRs currently in physical storage. The following activities are scheduled to be completed in FY 2017:

- Implement DoD quality assurance measures to meet requirements for record disposition in Q1 FY 2017.
- Implement IT capability for DoD to access STRs stored in VA's Veterans Benefits Management System (VBMS) in Q1 FY 2017.
- Implement VA and DoD procedural guidance for disposition of STRs following a certified system of record in Q4 FY 2017.

In FY 2016, the VBA submitted 129,544 STR requests to DoD through the HAIMS to VBMS interface to support Veteran claims processing and timely benefits delivery.

- 91 percent (117,843) of the STR requests were completed and certified within the 45 calendar day metric; this is a 14-percent increase from FY 2015.
- 94 percent (11,025) of the remaining requests were completed and certified within 30 days of the 45 calendar day metric; this is a 3-percent increase from FY 2015.

In December 2015, the MWRG also implemented an enhancement to the HAIMS to VBMS interface to allow benefits adjudicators to manually generate a STR request for currently serving Reserve and National Guard members and transition cases.

The MRWG is dedicated to improving the electronic transmission of all STRs from the Military Services to VA to ensure all Service members receive timely claims processing and benefits delivery and disposition of paper STRs. Improvements to the VA/DoD interfaces in FY 2017 also support the SHAWG and other VA/DoD working groups to improve Service member and Veteran satisfaction.

3.e. Mandatory Separation Health Examinations – Separation Health Assessment Working Group

The SHAWG is charged with establishing a mechanism to ensure that each departing Service member receives an SHA based on an agreed upon common standard between VA and DoD. A standardized health assessment at separation from military Service is a long-standing recommendation for improving the transition of Service members to Veteran status. The possible benefits include:

- Eliminating redundant physical exams and medical procedures
- Decreasing resource expenditures
- Increasing the timeliness and accuracy of VA's disability rating decisions
- Establishing an objective baseline medical assessment that can be referred to when disease is suspected or claims are made months or years after leaving the Service
- Documenting health concerns, exposures, or risk factors that would help DoD identify readiness and safety issues

The Departments agreed to share the workload for this effort: VA will conduct the SHA when a Service member chooses to file a pre-separation claim within 180 to 90 days from release from Active Duty, and the Services will conduct SHAs for all other separating Service members. Implementing the SHA process in VA exposed process inefficiencies requiring automated solutions. In FY 2016, the SHAWG developed plans for a pilot program to demonstrate a process eliminating the need for separating Service members to provide hard copies of the STRs by leveraging the JLV capabilities. The goal of the pilot will be to validate efficiencies and for further decision making on expansion of the SHA initiative.

VA and DoD are continuing to test new strategies in the pilot program to facilitate the claim process and eliminate the need for Service members to function as couriers for their STRs. In FY 2016, the Departments developed critical requirements for the IT capability to eliminate paper copies of DoD service treatment records and VA exam reports through existing medical record sharing systems. Building and implementation of the corresponding functionality from those requirements is still in progress. Major milestones and activities in this area included:

- Combined detailed work flow analysis with health IT system expertise to develop detailed requirements for system modifications that will result in greater efficiency of pre-separation claims processing, including electronic upload of STRs in June 2016.
- Modifications to VA's Veterans Benefits Management System (VBMS) in January 2016 enabling manual activation of a "subscription" ("notification of interest") to provide a tool to VBA users for facilitating retrieval of the electronic STR.
- Deployment of new JLV capabilities in July 2016, specifically, the ability to access and retrieve archived record artifacts and the ability to create and save an excerpt of the record containing all items viewed during a review session.
 - Operational testing began in June 2016 of the STR Processing Operations Reporting Tracking System (SPORTS), which is an upgrade to DoD's artifact management system. This system improves the efficiency of artifact upload and greatly increases the ability to monitor record completion times.

- DoD awarded a contract in July 2016 that will enable reserve component members to obtain a separation exam as they demobilize from a period of active Service.

The requirements agreed upon by VA and DoD in June 2016 will support the development of automated system functionality to eliminate the burden on Service members that are currently required to hand-carry their record to VA for filing a benefits claim. The new workflow will demonstrate a process that effectively engages the Service member in transition planning, providing confidence that the records maintained by DoD and shared with VA, are complete and available when the Veteran needs them. This system functionality will also reduce the time necessary to complete the VA exam. In addition, more Service members will be able to take advantage of the process and obtain benefits delivery at discharge. The planned modifications to VA and DoD systems will enable feedback loops to improve both Departments' ability to perform exams to standard and track completion rates. These improvements will also include automation of the return of exam reports performed by VA to the DoD for inclusion in the STR, improving the integrity of that record for the lifetime of the Veteran.

Approximately 20,000 Service members separate each month and roughly 2,000 obtain an SHA from VA as part of a pre-separation claim. The working group anticipates that roughly 10,000 Service members will conduct a pre-separation claim once the process matures.

The SHAWG continues with planned improvements for this initiative to build upon and reinforce the VA/DoD transfer of official record archives. As the number of Service members taking advantage of this initiative increases, we anticipate many more records being completed ahead of the current timeline goals.

3.f. Integrated Disability Evaluation System – Disability Evaluation System Improvement Working Group

The IDES provides a more streamlined, transparent, and efficient process for making VA and DoD disability determinations for ill or injured Service members who are separated or retired due to disability. Service members in IDES undergo a single disability examination and receive a disability rating used by both Departments to determine anticipated VA and DoD benefits prior to discharge. IDES enables Service members to make more informed decisions about their future and significantly reduces the gap between separation from Service and receipt of VA benefits.

IDES emphasizes the success of the Departments' collaborative effort to improve how transitioning Service members are evaluated and awarded VA and DoD disability benefits. In FY 2016, achievements in this area include:

- 28,306 Service members completed the IDES process.

- Active Component IDES case timeliness averaged 232 days against a 295-day goal; Reserve Component IDES case timeliness averaged 284 days against a 305-day goal.
- Insufficient exams for rating purposes were reduced by 25-percent in 3rd Quarter FY 2016 exceeding the goal of 20-percent.
- Improved oversight of IDES performance reporting measures by reclassifying FY 2017 reporting goals based on duty rather than component status; the goal for Active Duty cases will be 295 days and for Non-Active Duty cases will be 305 days.
- Attained total accountability of all time in the process by reallocating 15 previously unassigned days in the Physical Evaluation Board phase (10 days to DoD's Disposition Stage/5 days to VA's Proposed Rating Stage) for the first time in IDES.
- Eighty-seven percent of customer satisfaction survey responses indicated Service members were satisfied with the overall IDES process.

The Departments continue to refine and improve IDES with numerous efforts, both independently and in close collaboration. DoD is finalizing requirements for acquiring a DoD DES management IT solution. Next steps are to determine a technical solution for DES IT effort, develop a cost estimate, and an acquisition timeline for achieving IOC. This solution will provide DoD an end-to-end case management capability to more effectively manage, track, report, and electronically transfer case data and documents throughout the DES processes. DoD and VBA functional and IT technical representatives met in October 2016 to identify technical requirements and evaluate existing systems and potential options for establishing bi-directional capability for the IDES. The Departments will meet in January 2017 to establish a joint project team that by March 2017 will develop a project plan for the Departments to target IOC bi-directional capabilities in FY 2018.

3.g. Interagency Comprehensive Plan – IC3 Technology Tools and Change Working Group

The IC3 Technology Tools and Change WG is developing and implementing the Interagency Comprehensive Plan (ICP) Information Technology (IT) solution for complex care coordination with VA/DoD interoperability to encompass the full spectrum of care, benefits, and services for Service members and Veterans with complex care needs. The creation of a common complex care management approach for VA and DoD will enhance the Service member and Veteran experience, optimize coordination of care, and provide a common engagement model as the Service member transitions across Department boundaries.

The ICP will facilitate improved access to information across the continuum of care settings; facilitate efficient care coordination; improve satisfaction of Service members, Veterans and their families; and improve resource utilization.

As a single, interoperable, individualized plan, the ICP contains the care, benefits, and services associated with a Service member or Veteran's recovery, rehabilitation, and reintegration. The ICP:

- Serves as a single patient/family centric plan that assists in managing the Service member or Veteran goals for recovery, rehabilitation, and reintegration;
- Reduces the need for SM/Vs to retell their story as they transition and relocate; and
- Allows programs to communicate and share data.

The following activities in support of this effort were completed by VA and DoD in FY 2016.

- DoD awarded the contract for the sustainment of DoD Case Management System (DoD-CMS) and development of interoperable technology between VA and DoD on December 7, 2015.
- VA deployed an electronic Lead Coordinator Checklist (LCC). (The LCC existed in the DoD system of record (SOR) prior to this reporting period). The LCC provides the LC with process reminders and a summary view of the needs and goals identified in the ICP.
- VA and DoD achieved IOC as defined by the secure electronic transfer of the LCC from DoD to VA (using Safe Access File Exchange or other secure transfer process) by December 31, 2015.
- VA deployed the ICP in the Federal Case Management Tool (FCMT), the VA SOR, in April 2016 in preparation for interoperability with DoD. The ICP existed in the DoD SOR prior to this reporting period.
 - As of October 1, 2016 FCMT contains 5,210* LCCs.
 - As of October 1, 2016 FCMT contains 810* ICPs.

* These numbers do not reflect interoperability. Interoperability scheduled for February 2017.
- VA trained all VA Transition and Care Management (TCM) case managers on use of FCMT and the ICP. The majority of VA LCs will be from TCM. This will enable VA LCs to provide ICPs to those Service members and Veterans who have been identified as needing complex care coordination:
 - Those designated as Seriously Injured, Category 3.
 - Those identified by an LC based on complex care needs as Category 2.
- VA and DoD completed mapping the ICP data points within both VA and DoD SORs in preparation for interoperability. The data mapping includes client goals, activities, target dates and care management team members, points of contact and status updates. This will enable the LC to have up to date information on the Service member or Veteran at any point of transition or transfer.

- VA and DoD wrote and obtained approval of an interagency Interface Control Document to guide the interoperability efforts.
- VA and DoD received approval from the Enterprise System Change Control Board for connection and testing.
- VA and DoD agreed to a joint interoperability testing schedule with FOC in February 2017.
- VA and DoD submitted the Joint Integration and Test Command (JITC) application and JITC testing is scheduled. JITC provides risk based Test Evaluation & Certification services in support of interoperability.

The IC3 Technology Tools and Change WG continue to work toward 100 percent of ICP sites achieving FOC of the secure electronic interoperable ICP between VA and DoD in FY 2017. The WG will also continue to monitor and report to assess the capability across and within the Departments.

3.h. Capital Asset Planning – Construction Planning Committee

The VA/DoD CPC is established to provide a formalized structure to facilitate cooperation and collaboration in achieving an integrated approach to construction planning initiatives that are mutually beneficial to both Departments. The CPC also provides the oversight necessary to ensure that collaborative opportunities for joint capital asset planning are maximized by serving as the clearinghouse for the final review and approval of all joint capital asset initiatives recommended by any element of the JEC or Department-specific body.

The working relationship between VA and DoD within the Capital Investment Decision Making (CIDM) and Strategic Capital Investment Program (SCIP) initiatives has four key components:

- **Data Sharing:** Data sharing is necessary for defining requirements for planning. In FY 2016, DoD developed the capability for identifying the necessary data, formatting the data delivery elements, gathering, and reporting the data to VA. The close cooperation and coordination resulted in a joint schedule for an annual data exchange. VA had a robust in-house capability for retrieving and reporting the required data. By bringing this data function in-house to DoD, it will realize annual savings.
- **Lessons Learned:** VA and DoD share the details of their CIDM and SCIP process to continue lessons learned. The proposed projects are also shared, giving both organizations an opportunity to have deeper discussions about sites where joint opportunities may exist.
- **Project Priority:** The final 1-N project priority lists are shared so both can see the proposed funding cycles over an approximate 5-year period.
- **Collaboration:** There are regular and frequent discussions about on-going opportunities for sharing existing as well as developing projects.

In FY 2016, DHA studied the potential of shared VA/DoD services in two major markets (Puget Sound and San Diego). The study in Puget Sound confirmed the need to continue seeing VA patients at Madigan Army Medical Center for specialty care cases that enhances Graduate Medical Education (GME) for military providers. In addition, DoD discovered an opportunity to use the VA Medical Center for DoD beneficiaries requiring advanced Cardiac Care/Surgery and continue to explore enhancements to current and potential new resource sharing agreements. DoD is in the early stages of discovery on the shared services in San Diego and will consider both VA and DoD beneficiaries as we continue with the market study in FY 2017.

- San Diego and Puget Sound are two of the largest Soldier/Sailor/Marine populations in DoD with roughly 700,000 military beneficiaries and a substantial Veteran population that can benefit from operational efficiencies and facility improvements to support.
- In the Seattle (Puget Sound) market, MHS and VA currently coordinate services to provide optimal health care to military and federal beneficiaries. The VA Puget Sound Health Care System (VAPSHCS) establishes separate agreements with each MTF. The CPC has active sharing agreements across several services between VA and the Naval Hospital Oak Harbor, Naval Hospital Bremerton, and Madigan Army Medical Center.

In addition to the above sharing agreements, the CPC collectively explored and evaluated possible co-location opportunities as well as opportunities to enhance ongoing sharing arrangements. Prospects that emerged were:

- Branch Health Clinic Bangor Military Construction (MILCON) Replacement Request (Naval Hospital Bremerton Submarket)
- VA Expansion in the Everett Submarket with the possibility to share resources
- National Capital Region Market Study is under initial planning by DoD. Veterans Integrated Service Network (VISN), VA/DoD Program Coordination Office (DVPCO), and other VA representatives will participate in this market effort.

The CPC is developing a more standardized Space, Equipment, and Planning Systems (SEPS) tool for use by MHS and VA. In collaboration with VA, DoD provided SEPS training to eleven (11) DoD-MHS new SEPS users. There are approximately 650 SEPS users across DoD-MHS and VA. VA and DoD continue to pursue an aggressive integrated strategy for facility planning, design, construction, operation, and retirement/modernization to reduce the total life-cycle cost and create world-class facilities.

The SEPS application applies a carefully planned, coordinated effort orchestrating business processes, workflows and technologies to support an efficient flow of facility data in all aspects of facilities planning, design, construction, and operations.

SEPS will also be used to develop Courses of Action and implement sustainability requirements for energy intensity and consumption; water, steam and natural gas

consumption in support of the DoD Strategic Sustainability Performance Plan 2015; and the Enterprise Energy Information Management System 2012 initiative.

The MHS Enhanced Multi-Service Market (eMSM) and VISN Integrated Planning (IP) process is performed jointly with both Departments every 3 years and reviewed annually for investment opportunities.

Initiatives such as Federal Integrated Facility Management (FED iFM), Space and Equipment Planning to Building Information Modeling (SEPS2BIM), the VA/DoD SEPS Strategic Plan, and VA/DoD system change requests continue to have significant design and architectural impacts on the SEPS system. The standardized SEPS tool for use by VA and DoD will continue to operate on parallel upgrade and support tracks as additional capabilities are implemented.

In FY 2016, the CPC submitted the Like-Legislation proposal through the DoD Unified Legislative and Budgeting process and it was approved. The proposal will go forward for intended inclusion in the FY 2018 NDAA. In 2017, the proposal will be reviewed across DoD and, eventually, at OMB.

The Like-Legislation will extend the collaborative relationship between the VA and DoD beyond the sharing of existing health care resources. It will permit proactive, joint planning and capital investment in shared medical facilities with the goal of improving access, continuity, quality and cost effectiveness of the direct health care provided to the Departments' respective beneficiaries.

The CPC will continue to coordinate capital asset planning to achieve greater efficiencies in future operations. In FY 2017, CPC will continue market studies and will submit the DoD/VA Geospatial Information System (GIS) JIF Proposal to support the strategic missions of both Departments through joint information resource planning. The proposed Joint Use Market Planning (JUMP) Enterprise Web Portals will be a shared initiative by the VA and DoD for strategic planning that will help to significantly improve both VA and DoD beneficiary access to care in the most cost effective manner possible by providing information sharing capabilities crucial to effective planning of shared care sites.

Additional Accomplishment

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

The JEC Ad Hoc Working Group On Provision of VA Counseling and Treatment for the consequences of sexual assault/sexual harassment of Members of the Armed Forces was formed in FY 2016 to review VA's implementation of Section 402 of the Veterans Access, Choice, and Accountability Act (VACAA) and to streamline access to VA military sexual trauma-related counseling, care, and services for Service members.

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 Active Duty, Active Duty for training, or Inactive Duty for training." The VA services available under VA's specific MST-related treatment authorities (38 U.S.C. 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 consequences of sexual assault/harassment will be used to refer to sexual assault and/or sexual harassment that occurred during military service.

Section 402 of VACAA amended 38 USC § 1720D, in part, to authorize VA, in consultation with DoD, to provide counseling, care, and services related to the consequences of sexual assault/harassment to Service members on Active Duty (including members of the National Guard and Reserves) without the need for a referral from DoD. In October 2015, the VA/DoD HEC approved a plan to implement Section 402 by expanding confidential sexual assault/harassment related readjustment counseling services through VA Vet Centers.

- Vet Centers are community-based sites offering a range of counseling, outreach, and referral services aimed at assisting eligible Veterans with successful readjustment to civilian life. Vet Centers are independent from VA's network of medical facilities and maintain a separate line organization, budget, and confidential system of records.
- Per 38 CFR § 17.2000(e), Vet Center records are confidential and maintained independent of VA or DoD medical records, and are only disclosed with either the Veteran or Service member's explicit, voluntary, and signed release, or a specific legal exception permitting their release. Since VA and DoD clinicians are able to view each other's medical records, this level of confidentiality could not be assured at VA Medical Centers (VAMCs).
- Vet Centers offer a number of sexual assault/harassment related counseling services including evidence-based individual and group counseling, marital and

family counseling, referral for benefits assistance, and substance abuse information and referral. Vet Center providers who work with Veterans and Service members who have experienced sexual assault and harassment have received specialized training and certification.

- Vet Centers are now authorized (via implementation of Section 402) to provide free readjustment counseling to Active Duty Service members, including the range of sexual assault/harassment related services available to Veterans. Service members do not need a referral from DoD to access Vet Center services, and Vet Centers do not receive reimbursement from DoD for readjustment counseling provided to Service members.
- If a Service member presents with medical care needs outside the scope of readjustment counseling, Vet Center providers can assist the Service member with an appropriate referral.

The JEC was briefed on this plan in June 2016, and decided Active Duty Service members who have experienced sexual assault and/or sexual harassment during their military service should not be limited to Vet Centers for access to VA sexual assault/harassment related care without a referral. The co-chairs directed the Departments to establish a plan to expand implementation of 402 to include access to VAMCs. To develop this new course of action, a JEC Ad Hoc Working Group was formed under the leadership of the VA Assistant Secretary for Policy and Planning and the DoD Director of the Sexual Assault Prevention and Response Office (SAPRO).

In September 2016, the JEC co-chairs approved a new VA and DoD concept, implementation strategy, and timeline to expand access to sexual assault/harassment related VA health care for Active Duty Service members to include care at VAMCs.

This care option will be introduced using a phased approach of expanding implementation while assessing processes and building capacity:

- Initial enterprise-wide guidance will communicate basic policy and logistics information to VAMCs.

A brochure will be developed to inform Service members about available DoD resources and also of the responsibility of Service members to inform their flight surgeon or competent medical authority of any medical limitations or duty impairment. The brochure will also inform the Service members that VAMC records of their care may be accessed by DoD personnel under certain circumstances on a need to know basis

An additional brochure will be developed to inform Service members about available VA resources and eligibility.

- VA will conduct focused reviews at select sites near high population DoD installations to help define scope of needed services and to refine processes. VA and DoD are working closely together to develop training materials for VA providers, as well as developing an infrastructure for VA providers to consult with DoD subject matter experts as needed.

The implementation plan will be finalized in the second quarter of FY 2017. This effort is a priority for the JEC co-chairs who are interested in expanding the access to sexual assault/harassment related care without a referral for Active Duty Service members beyond the Vet Centers to include VAMCs while preserving their privacy to the greatest degree possible.

SECTION 3 – NEXT STEPS

The accomplishments described in this VA/DoD JEC FY 2016 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 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 2016 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	\$	52,540
Contract(s) Cost	\$	0
Production and Printing Cost	\$	3,600
Total Estimated Cost to Prepare Report	\$	56,140

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. The estimated cost of production and printing was developed using previous year production invoice.

Appendix B – Glossary of Abbreviations and Terms

A&I – Artifacts and Images
A&MM WG – The Acquisition and Medical Materiel Working 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 Working 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 Working 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 Working 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 Workgroup
COPEs – Continuing Optometrists Education Credits
CPC – Construction Planning Committee
CPE – Clinical Pastoral Education
CPG – Clinical Practice Guideline
CPT – Cognitive Processing Therapy
CR – Clinical Recommendation
CRM RP – 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

DCE – 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 Working 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 Working 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 Working 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
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 Working 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 Working 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 Working 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 – MyHeatheVet
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 Materiel Command
MRWG – Medical Records Working Group (BEC)
MRWG – Medical Research Working 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
NMCS D – 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 Working 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 Working 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 Working Group
SDR – Suicide Date Repository
SDSU – Same Day Surgery Unit
SGLI – Servicemembers' Group Life Insurance

SHA – Separation Health Assessment
SHAWG – Separation Health Assessment Working 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 Working Group
SSA – Social Security Administration
SSO – Single Sign-On
STR – Service Treatment Record
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 Working 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 – Working Group
WIIC – Wounded, Ill, and Injured Committee
WRNMMC – Walter Reed National Military Medical Center