

**VA/DoD Joint Executive Committee
Annual Report
FISCAL YEAR 2013**

VA/DoD
Joint Executive Committee
Membership List
(as of September 30, 2013)

Department of Veterans Affairs (9)

Deputy Secretary
Department of Veterans Affairs

Under Secretary for Health
Veterans Health Administration

Under Secretary for Benefits
Veterans Benefits Administration

Assistant Secretary for Information
and Technology
Department of Veterans Affairs

Executive Director for Public &
Intergovernmental Affairs
Department of Veterans Affairs

Assistant Secretary of Policy and
Planning
Department of Veterans Affairs

Assistant Secretary for Congressional
and Legislative Affairs
Department of Veterans Affairs

Executive in Charge for the Office of
Management & Chief Financial Officer
Department of Veterans Affairs

Executive Director, Office of Acquisition,
Logistics & Construction
Department of Veterans Affairs

Department of Defense (21)

Under Secretary of Defense
(Personnel and Readiness)

Under Secretary of the Army
Department of Defense

Under Secretary of the Navy
Department of Defense

Under Secretary of the Air Force
Department of Defense

Vice Chairman of the Joint Chiefs of
Staff
Department of Defense

Vice Chief of the Army
Department of Defense

Vice Chief of Naval Operations
Department of Defense

Vice Chief of the Air Force
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Corps
Department of Defense

Special Operations Command
Department of Defense

Department of Defense (21)

Under Secretary of Defense
(Comptroller)
Department of Defense

Assistant Secretary of Defense for
Public Affairs
Department of Defense

Assistant Secretary of Defense for
Legislative Affairs
Department of Defense

Assistant Secretary of Defense for
Health Affairs
Department of Defense

Assistant Secretary of Defense for
Reserve Affairs
Department of Defense

Assistant Secretary of Defense for
Force Readiness
Department of Defense

Department of Defense Office of
General Counsel
Department of Defense

Director of Administration and
Management
Department of Defense

Deputy Chief Management Officer
Department of Defense

Director, DoD-VA Interagency Program
Office

Deputy Assistant Secretary of Defense
Warrior Care Policy
Department of Defense



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A handwritten signature in black ink, appearing to read "Sloan D. Gibson", written over a horizontal line.

Sloan D. Gibson
Deputy Secretary
Department of Veterans Affairs

A handwritten signature in black ink, appearing to read "Jessica L. Wright", written over a horizontal line.

Jessica L. Wright
Acting Under Secretary of Defense
for Personnel and Readiness

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VA/DoD Joint Executive Committee Fiscal Year 2013 Annual Report

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) 2013 Annual Report (AR)*, for the period of October 1, 2012, to September 30, 2013, to Congress and the Secretaries of Defense and Veterans Affairs as required by law¹. The intent of the AR is to provide Congress with the collective accomplishments between the two Departments and highlight the current efforts to improve resource sharing. This report does not contain recommendations for legislation related to health care resource sharing.

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 JEC meetings. JEC membership includes the VA/DoD co-chairs 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), and other senior leaders, as designated by each Department.

The JEC continues to invite other Federal Departments and agencies to meetings as appropriate. In 2013, representatives from the Office of Management and Budget (OMB), and the Government Accountability Office (GAO) attended for awareness and information sharing.

The JEC works to remove barriers and challenges which 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 the joint coordination and sharing efforts between the two Departments and oversees the implementation of those efforts.

The *VA/DoD Joint Executive Committee Joint Strategic Plan (JSP)* is the primary means to advance performance between VA and DoD and is continuously evaluated, updated, and improved. Historically, the JSP has been attached as an appendix to the AR; however, in

¹This report meets the reporting requirements for Public Law 97-174 and Public Law 108-136 codified at 38 U.S.C. 320 and 8111(f).

2011, the JEC co-chairs decided to permanently separate these documents and realign the publication timelines. The intent of this decision was to improve the JSP's ability to drive JEC activities while still allowing the AR to be published by the Congressional deadline.

SECTION 2 - ACCOMPLISHMENTS

This section highlights the FY 2013 accomplishments of the HEC, BEC, IPO, IC3, and IWGs. These accomplishments reflect the efforts of VA and DoD in improving resource sharing between the Departments and in furthering the mission to optimize the health and well-being of Service members, Veterans, and their eligible beneficiaries. The *VA/DoD Joint Executive Committee FY 2013 Annual Report* links the year's accomplishments to the sub-goals and performance measures established in the *VA/DoD Joint Executive Committee Joint Strategic Plan FY 2013-2015*. This approach clarifies the connection between strategic planning and outcomes achieved through VA and DoD's coordination, collaboration, and sharing efforts. The report also demonstrates achievements beyond planned activities.

GOAL 1

Benefits and Services

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

Sub-goal 1.1: Increase knowledge of VA and DoD benefits and services.

BEC Communications of Benefits and Services Working Group

The mission of the BEC Communications of Benefits and Services Working Group (CBSWG) is to increase awareness of VA and DoD benefits and services available to Service members throughout their military personnel lifecycle. This is accomplished by promoting benefits and services across VA and DoD Web sites, various publications, public service announcements (PSA), and social media channels.

The CBSWG achieved many beneficial outcomes in FY 2013 through leveraging both DoD and VA communication outlets to share benefits information. Specific marketing of the eBenefits portal contributed to a 58 percent increase in registered users with Defense Self-Service Logons (DS Logons) over FY 2012 and double digit increases in the use of numerous self-service features, such as an 83 percent increase in the generation of self-service letters and an 86 percent increase in the generation of home loan certificates. Self-service capabilities were enhanced for Service members by allowing direct Common Access Card (CAC) access into eBenefits and providing eBenefits accounts at accession and as well as at mandatory Transition Assistance Program (TAP). With the increase in DS Logons, the CBSWG was able to provide health, benefits, and personnel information to an increased number of Service members and Veterans.

The CAC enhancement was followed by the "CACcess" marketing campaign that was promoted on the eBenefits and VBA Web sites with a combined weekly reach of about two and a half million visitors. Additionally, CACcess was promoted via DoD's Infonet system with a

weekly reach of over 160,000 individuals within the Pentagon reservation. CACcess was also included on the National Resource Directory carousel which promotes to over one million visitors a year and over one hundred thousand subscribers.

The continued eBenefits marketing initiative included new pamphlets and the creation of an eBenefits Quick Book pamphlet that explains how to use eBenefits and its features, which has been distributed at outreach events. The eBenefits Web badge was promoted on Web pages from various states, by a member of the U.S. Senate, and marketed by Veterans Service Organizations (VSO). By marketing eBenefits to Service members, VA is able to engage individuals at the beginning of their military careers and throughout their lifecycle as a Veteran. The Quick Books were also marketed as part of the six DoD supported Yellow Ribbon Reintegration Program events that had participation by over 10 thousand Service members, families and support personnel present.

The Departments continued to utilize eBenefits early communication features that email benefit information to Service members and Veterans based on either career or life event triggers. From June through September 2013, over 3.5 million of these emails were delivered to Service members.

eBenefits was also covered externally in articles in Stars and Stripes newspaper, DAV, AMVETS, VFW, and American Legion magazines, and America Online (AOL) Government Publication.

The CBSWG also provided Post 9/11GI Bill transfer information to Service members via their Leave and Earnings Statements to ensure awareness of the transferability requirements prior to separation.

GOAL 2

Health Care

Provide a patient-centered health care system that delivers excellent quality, access, satisfaction, and value, consistently across the Departments.

Sub-goal 2.1: Quality – Promote measurable, safe, effective, timely, efficient and equitable, client-centered quality health care for all Service members, Veterans, and their beneficiaries.

HEC Patient Safety Working Group

In FY 2013, the VA/DoD HEC Patient Safety Working Group (PSWG) continued to enhance the overall quality of care to Service members and Veterans through collaborative efforts in strengthening and coordinating safe patient care. As a result of Departmental requirements, TRICARE Management Activity (TMA)² is in the process of updating its Data Sharing

² TRICARE Management Activity changed its name to Defense Health Agency (DHA) on October 1, 2013.

Agreement (DSA) with VA, which authorizes the DoD Patient Safety program to share data with the VA Patient Safety program.

VA and DoD continued to collaborate on key patient safety initiatives, including weekly Federal Partner meetings that addressed the Hospital Acquired Conditions (HAC) specified in the Department of Health and Human Services (HHS) Partnership for Patients national initiative. The Departments are considering a joint platform for the electronic patient incident reporting. The DoD Patient Safety Reporting System obtained Tier I functional review clearance and Tier II technical review clearance. Although it was not approved for funding through the VA/DoD Joint Incentive Fund (JIF), other interagency funding streams are being explored.

The Departments also continued participation in lessons learned sharing exchanges focused on preventing adverse events. The VA National Center for Patient Safety (NCPS) hosted a meeting with DoD patient safety representatives in FY 2013 leading to DoD's policy recommendations for Root Cause Analysis (RCA). VA and DoD RCA information will be shared when the DSA is finalized. NCPS also briefed to the Army Patient Safety Community on the topics of NCPS Action Hierarchy, a process that identifies effective interventions for RCAs and Healthcare Failure Mode and Effect Analysis; Just Culture; and Disclosure of Adverse Events. VA NCPS and DoD collaborated to reduce fall related injuries by discussing application of evidence based practices and exchanging fall prevention tools. VA presented lessons learned at the DoD Falls Community of Practice group, covering topics related to falls classification and data analysis.

In FY 2013, VA nationally adopted a new prescription label format to significantly enhance comprehension by the Veteran. The DoD Advisory Committee subsequently approved implementation of the new label format at the James A. Lovell Federal Health Care Center (JAL FHCC). Tripler Army Medical Center (TAMC) is being considered as a test site to determine feasibility for implementation within Army facilities. VA and DoD continued to share data methodologies and approaches related to medication reconciliation and medication safety that directly impacts hospital readmissions and continued to review and verify multiple measures for hospital readmissions/transitions to care.

VA and DoD conducted a joint virtual meeting on March 1, 2013, to further enhance educational opportunities and potential to share resources. Monthly Joint Medication Safety meetings focused on patient transitions and medications directly related to hospital readmissions. DoD is currently on the distribution list for all VA Pharmacy Benefit Management (PBM) services, safety bulletins, and newsletters. Additionally, PBM and the DoD Pharmacovigilance Center share monthly updates. The Medication Use Crisis virtual Webinar conducted quarterly included focus on VA/DoD transitions and clinical challenges faced by transitioning Service members.

HEC Evidence Based Practice Working Group

The Evidence Based Practice Working Group (EBPWG) continued to improve the health of VA and DoD beneficiaries by collaborating on the development of Clinical Practice Guidelines (CPG) using clinical and epidemiological evidence. CPGs assist VA/DoD direct care health

care teams by providing evidence based recommendations which lead to improved quality of clinical decisions and reduced variation in clinical practice for Veterans, Service members and their families. CPGs are posted on VA's Web site³ and the Army's Quality Management (QMO) Web site⁴. During FY 2013, the EBPWG completed the Assessment and Management of Patients at Risk for Suicide CPG. The annual target to complete four CPGs was not met due to delays in awarding a contract to facilitate CPG development. A robust contract and several working groups are now working to meet the annual target.

All CPGs submitted to the National Guideline Clearinghouse (NGC) have met their stringent inclusion criteria. The NGC's mission is to provide physicians and other health professionals, health plans, integrated delivery systems, purchasers, and others an accessible mechanism for obtaining objective, detailed information on evidence based CPGs to further disseminate, implement, and use. The EBPWG is committed to educating health care teams. Budgetary constraints this year allowed VA/DoD staff to exhibit at three VA, DoD, and national medical conferences, as compared to 19 conferences in FY 2012. The staff presented multiple formal podium presentations on several of the 24 CPGs at local VA and DoD educational settings. The VA presented at several national as well as two international conferences. The first presentation via video teleconference was done for Uniformed Services University of the Health Sciences (USUHS) students.

An unprecedented 18 new CPG tools were developed during FY 2013, making over 170 CPG tools available to VA/DoD health care team members. These products educate thousands of VA and DoD health care team members regarding the medical evidence behind the CPG recommendations and the value of implementation. The tools specifically provide health care teams valuable support materials to assist with implementation and ultimately facilitate improved care delivery for patients and families across VA and DoD. During FY 2013, VA/DoD had 804,404 CPG tools ordered from the Army's QMO Web site and the VA's Talent Management System (TMS) compared to 881,411 in FY 2012. While the decrease is a potential result of fiscal constraints, the data shows that health care teams across VA/DoD are actively ordering and utilizing tools to assist with CPG implementation. The Departments completed three CPG broadcasts: Chronic Opioid Therapy, Posttraumatic Stress Disorder (PTSD), and Assessment and Management of Patients at Risk for Suicide, which are available for on-demand viewing on the QMO and VA Web sites. All broadcasts have one hour continuing education credit available.

The WG continued to work jointly with the Guideline Development Collaborative, formerly known as the Interorganizational Guideline Forum (IOGF), which includes the Agency for Healthcare Research and Quality (AHRQ), Institute of Clinical System Improvement and Kaiser Permanente in which we are all members. Collaboration continued with the American Pain Society on the Peri-Operative Pain CPG. These efforts will result in the ability to produce a greater number of CPGs while at the same time conserving valuable personnel and monetary resources inherent in CPG development.

³ <http://www.healthquality.va.gov/>

⁴ <https://www.qmo.amedd.army.mil/>

The EBPWG continued to collaborate with the DoD Tri-Service Work Flow (TSWF) Group in the development of evidence based CPG Alternate Input Method (AIM) forms to facilitate implementation of CPGs at the point of care in DoD Patient Centered Medical Homes (PCMH). With CPG AIM use, depression screening increased from 29 to 89 percent as measured from November 2011 through December 2012. Compliance with key recommendations of the Low Back Pain CPG improved; specifically, focused neurological exams increased from 57 to 91 percent, and appropriate use of first line medications increased from 20 to 91 percent. In addition, a potential of \$2.7 million cost savings in multiple domains across the Military Health System (MHS) was realized in reference to compliance for medications associated with decreased morbidity/mortality in the diabetic population.

During FY 2013, VA and DoD more than doubled the number of CPG Internet requests over the previous year, increasing from 868,942 to 2,206,552 requests. This data provides evidence that health care teams across VA and DoD are successfully accessing CPG information via the Internet to enhance the delivery of quality health care. CPG tools provide health care teams with needed patient, family, and provider support tools to assist with CPG implementation.

HEC Health Professions Education Working Group

The Health Professions Education (HPE) WG remained committed to promoting accredited HPE trainee exchanges between VA and DoD. During academic year 2012-2013 (July 1, 2012-June 30, 2013), the WG worked with both Departments and successfully established 13 new HPE trainee exchange programs.

VA Facility	DoD Facility	GME, Associated Health, or Nursing	Specialty	One Way or Two Way
Biloxi VA Medical Center (VAMC)	Kessler Air Force Base (AFB) Military Treatment Facility (MTF)	Graduate Medical Education (GME)	Dermatology	VA to DoD, one way
VA Health Care Network Upstate New York at Syracuse	U.S. Army Medical Department (AMEDD) Center & School	Associated Health	Social Work	DoD to VA, one way
Oklahoma City	AMEDD Center	Associated	Social Work	DoD to VA,

VA Facility	DoD Facility	GME, Associated Health, or Nursing	Specialty	One Way or Two Way
VAMC	& School	Health		one way
Temple VAMC	AMEDD Center & School	Associated Health	Social Work	DoD to VA, one way
Salt Lake City VAMC	AMEDD Center & School	Associated Health	Social Work	DoD to VA, one way
Portland VAMC	AMEDD Center & School	Associated Health	Social Work	DoD to VA, one way
Iowa City VAMC	AMEDD Center & School	Associated Health	Social Work	DoD to VA, one way
Biloxi VAMC	AMEDD Center & School	GME	Occupational Medicine	DoD to VA, one way
JAL FHCC	USUHS	GME	Family Medicine	DoD to FHCC, one way
Hampton VAMC	Naval Medical Center (NMC) Portsmouth	GME	Mental Health	DoD to VA, one way
Hampton VAMC	NMC Portsmouth	GME	Medical	DoD to VA, one way
Hampton VAMC	NMC Portsmouth	GME	Surgical	DoD to VA, one way
Richmond VAMC	Fort Lee Army MTF	Associated Health	Psychology	two way

The HPE WG completed qualitative interviews with VA and DoD Resident trainees who have had training experiences in both a VA and DoD medical facility. Design and testing of VA's Short-Form Learner's Perception Survey is on track to be piloted and tested by June 30, 2014.

The Departments have continued to use the established VA and DoD Training Affiliation Agreement (TAA) template for exchanges between VA and DoD MTFs of HPE trainees in accredited academic programs, and have since learned that there are other DoD HPE training programs that are not affiliated with DoD MTFs. The HPE WG will develop a new TAA template for HPE training programs of trainees in accredited academic programs not affiliated with DoD MTFs.

The impact on quality health care is enhanced through these diverse trainee experiences. These exchanges provide trainees exposure to a variety of patient populations and clinical presentations not possible in a single institution. For example, VA civilian trainees see a younger, healthier patient population in DoD, which includes both women and children, while military trainees see an older population with a heavier chronic disease burden mixed with multiple socio-economic challenges. Trainees experience a greater holistic patient care perspective when they see the continuity of care from active duty service through Veteran status. Furthermore, trainee exchanges promote awareness and understanding of the capabilities and differing cultural aspects of both health care systems.

The HPE WG has continued to evaluate the challenges and barriers to successful interagency cooperation in GME. To date, the Base Realignment and Closure Act has not caused the Military GME programs to lose resident positions within the National Capital Region (NCR). However, with the creation of the DHA in FY 2014 and the ongoing modernization study, there may be changes to the military GME programs in and outside the NCR. Some of DoD's primary care residencies are at risk for closure because they are in small hospitals. Although these potential closings would result in fewer GME resident positions, DoD will still need a broad primary care base. Maintaining the number of military resident GME positions may require VA assistance in negotiating relationships with academic medical centers to create additional assignments.

HEC Deployment Health Working Group

The Deployment Health Working Group (DHWG) was established to ensure coordination to maintain, protect, and preserve the health of Armed Forces personnel. The DHWG focuses on the health of active duty and Reserve members and Veterans, during and after combat operations and other deployments. The primary emphasis is on Service members who have returned from Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND). In addition, the DHWG coordinates initiatives related to Veterans of all eras and historical environmental exposures on the Military Departments' installations.

The DHWG held 12 meetings in FY 2013 to coordinate VA and DoD responses to six major environmental exposures in Iraq, Afghanistan, Japan, and the U.S., as described below:

- Potential health effects of exposure to airborne hazards, including burn pit smoke in OEF/OIF/OND;
- Potential health effects of high ambient concentrations of particulate matter in OEF/OIF/OND;
- Potential health effects of chromate exposure at Qarmat Ali, Iraq in 2003;
- Potential health effects of embedded metal fragments from injuries during the 1990-91 Gulf War and OEF/OIF/OND;
- Potential health effects of exposure to the radiation release from the damaged Japanese nuclear power plant in 2011; and
- Potential health effects of exposure to contaminated drinking water at Camp Lejeune.

Exposure to smoke from the burn pits in OEF/OIF/OND could potentially impact tens of thousands of deployed Service members. In FY 2013, the DHWG evaluated a 2011 Institute of Medicine (IOM) report titled “Long Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan” to identify lessons for future health surveillance, research on airborne hazards in theater, and possible preventive measures for future deployments. The IOM committee concluded that there was limited or suggestive evidence of an association between exposure to combustion products and decreases in pulmonary function tests when examining non-deployment/non-military data. There was inadequate evidence to draw conclusions on the association of exposure to combustion products and cancer, respiratory diseases, and many other types of diseases. The committee also concluded that the air contamination of greatest concern could be the high ambient concentrations of particulate matter in OEF/OIF/OND, such as sandstorms, rather than burn pit emissions. The IOM provided recommendations on future health surveillance and research. VA’s response to the IOM report was published in the Federal Register on February 4, 2013.⁵

The DHWG facilitated VA and DoD responses to airborne hazards in theater by coordinating the development of a comprehensive VA/DoD Airborne Hazards Joint Action Plan, which was completed in late 2012. The plan includes four major activities: Follow-up Medical Care of Deployed Populations, Outreach and Health Risk Communication Products, Medical Surveillance, and Research Initiatives. The plan provides a comprehensive approach to health concerns related to airborne hazards, and it was coordinated with scientists in VA and the three Military Departments. In July 2013, this plan was updated to incorporate recent activities; it will be updated annually. Many of the initiatives of the Joint Action Plan are underway.

DHWG members planned and chaired a three-day VA/DoD Airborne Hazards symposium in August 2012. This symposium focused on potential long-term health effects of exposure to burn pits, high ambient levels of particulate matter, and other airborne hazards. More than 100 VA, DoD, and university scientists participated. In late 2014, the Borden Institute will publish the proceedings of this 2012 symposium as a book. In FY 2013, several DHWG members

⁵ Source: <http://www.gpo.gov/fdsys/pkg/FR-2013-02-04/html/2013-02264.htm>

authored chapters that originated from this symposium. Several DHWG members planned the second VA/DoD Airborne Hazards symposium, which was held in August 2013 and attended by approximately 75 scientists. This symposium included presentations on epidemiology research, clinical research, and toxicology research; Veteran outreach and clinician education; and development of the new VA burn pit registry. Representatives of several VSOs attended both the 2012 and 2013 symposiums. DHWG members are planning a third symposium in 2014.

The DHWG is leading the interagency coordination to implement the Open Burn Pit Registry required in Public Law 112-260 Section 201, which was enacted on January 10, 2013. This law requires VA, in coordination with the Secretary of Defense, to establish a burn pit registry within one year after enactment. VA plans to launch the registry and open enrollment to Veterans in spring 2014. VA will use this registry to provide outreach and health care to Veterans of Iraq and Afghanistan who have environmental health concerns. Veterans will use a Web-based registration to enroll. In February 2013, two joint VA/DoD committees started planning the questionnaires and procedures that will be used in the registry, including an occupational and environmental exposure questionnaire, which Veterans and Service members will complete online. Veterans will be given the option to request a medical examination. A committee of VA and DoD clinicians developed clinical guidance for VA primary care providers on diagnosis and treatment of Veterans who have post-deployment respiratory concerns. In June 2013, DoD provided relevant data to VA, including an operational definition for an "open burn pit," a list of known locations that had open burn pits in OEF/OIF/OND for use in the VA Registry, and an assessment of available DoD exposure data related to airborne hazards in theater.

In FY 2013, the DHWG coordinated outreach efforts to active duty personnel and Veterans on multiple environmental exposure incidents. One major example was the outreach related to Qarmat Ali. Between April and September 2003, 838 National Guard soldiers, 69 DoD civilian employees, primarily from the U.S. Army Corps of Engineers, and five active duty Service members were potentially exposed to sodium dichromate, a carcinogen, at the Qarmat Ali Industrial Water Treatment site in Iraq. The DHWG facilitated coordination of a joint medical surveillance program. VA and DoD sent a joint letter and fact sheet to these military personnel and former DoD civilian employees to invite them to participate in a medical evaluation. As of May 2013, approximately 200 Veterans and DoD civilians received a medical exam as part of this program. DoD sent the civilian participants a satisfaction survey. They reported they were generally satisfied with the exam program; and 86 percent planned to participate in the follow-up exams. VA also plans to send Veteran participants a satisfaction survey. The follow-up exams will be scheduled in 2016. VA and DoD members of the DHWG are currently writing an article on this medical surveillance program to publish in a medical journal.

VA and DoD established the Depleted Uranium (DU) Medical Surveillance Program, which provides biological monitoring for all Veterans of the first Gulf War and OIF. These Veterans can request a urine test for uranium concentration, regardless of potential exposure to DU. From the inception of the program in 1998 to June 2013, 4,135 urine specimens have been analyzed. Out of 1,752 specimens from Veterans of the first Gulf War, only one had a detectable DU concentration. Out of 2,383 specimens from Veterans of OIF, only three had

detectable DU concentrations. These four Veterans were invited to enroll in a medical examination program.

VA established the Toxic Embedded Fragment Surveillance Center in 2008 at the Baltimore VAMC. The Center's purpose is to provide care and active surveillance for Veterans of OEF and OIF who have, or likely have, a retained fragment. These Veterans are included in the VA Embedded Fragment Registry. As of June 2013, this registry program has analyzed urine specimens from 513 Veterans. Veterans who have increased levels of metals in their urine samples are advised to obtain X-rays to document the location, size, and shape of the fragments. Three DoD laboratories provide the chemical analyses for this biological monitoring program. This includes analysis of urine specimens and metal fragments that have been removed surgically. Since the start of OEF and OIF, these DoD labs have received 1,688 fragments from 1,007 Service members. The composition of most fragments was not remarkable; the majority contained iron, copper, aluminum, zinc, lead, nickel, and/or chromium. Many of the fragments also contained non-metals, such as plastics, fabric, wood, and rocks. Electronic data transfer from DoD laboratories to VA has begun, and the VA Embedded Fragment Registry currently links embedded fragment chemical analysis data to 67 Veterans. These results provide useful information on the potential toxicity of heavy metal exposures for these Veterans.

In March 2011, a nuclear power plant in Japan was damaged in an earthquake and tsunami, which caused the release of low levels of radiation for months. The closest U.S. military base was about 150 miles from the power plant. The radiation measurements indicated that the radiation exposures and the risk of long-term health effects to DoD personnel were very low. DoD developed the Operation Tomodachi Registry (OTR), which includes radiation dose reconstructions for individuals, performed by the Armed Forces Radiobiology Research Institute. The goal was to establish a record of individuals who were potentially exposed to radiation in Japan in 2011, including Service members, DoD civilians, their family members, and DoD contractors. The OTR links an estimated dose to an individual or a population, based on their location. As of September 2013, approximately 69,000 individuals were eligible for inclusion in the OTR, who were in 63 locations in Japan. DoD scientists have created dose assessments for 13 shore-based locations, which were derived from 63 locations, and for shipboard personnel on 25 ships. The DoD database contains incident reports, including the data on 38,806 DoD personnel and 29,475 family members. The DHWG has coordinated VA/DoD communication related to the Japanese radiation release; including DoD plans to share registry data with VA. DoD developed a publicly accessible Web site to provide information about the incident and to allow individuals to request information. In late 2012, DoD launched this site, which featured the results of the dose reconstructions for the locations of each U.S. military base in Japan. DoD coordinated the key messages for the Web site with VA before launching it. The dose assessment work and scientific conclusions underwent external scientific review, which supported the DoD work. Communications to the public were well received, including positive feedback about the Web site.

The development of the OTR provided some lessons learned. One lesson learned was that accountability for reporting on DoD personnel was less than optimal during this environmental exposure incident. Seventeen different DoD organizations provided data in non-standardized

formats. The data were often incomplete, including missing location data. This difficulty could occur in the development of future environmental health registries, if there is a need to combine data from many sources. As the first of its kind of registry, the OTR will be useful for health surveillance, diagnosis, treatment, and claims adjudication; and it serves as an excellent model for future registries.

During the 1950s to 1985, some of the drinking water at Marine Corps Base Camp Lejeune was contaminated with low levels of industrial chemicals, including trichloroethylene and perchloroethylene. The Navy estimated that approximately 630,000 Marines and Sailors were potentially exposed to this contaminated drinking water, as well as DoD civilians and family members. In FY 2013, the DHWG coordinated VA and DoD responses to the exposures at Camp Lejeune. The DHWG built consensus by bringing experts together with different perspectives to plan the way forward on Camp Lejeune. The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 requires VA to provide medical care to Veterans and family members who lived at Camp Lejeune for 30 days or more from 1957 to 1987. This law includes a list of 15 specific diseases and disease categories for which VA must provide care. Family members who lived at Camp Lejeune will be eligible for medical care for the 15 diseases, but not for general primary care.

The DHWG facilitated the coordination of VA and the Marine Corps to determine the availability of personnel and housing records of Marines and family members who lived at Camp Lejeune from 1957 to 1987. Each case requires verification of residence. The Marine Corps does not have a master computerized list of all Marines who were based at Camp Lejeune during this time period. VA coordinated with the Marine Corps to develop a standardized process to confirm the residence of Veterans and family members. In March 2013, the Marine Corps provided a memo to the VA that outlined methods to verify residence at Camp Lejeune using paper records at the National Personnel Records Center in St. Louis. In September 2013, the Marine Corps funded a contract to computerize muster rolls of Service members who were stationed at Camp Lejeune during this time period. This process should take about 18 months. Together, the VA Business Office and the Marine Corps refined the procedures to verify residence at Camp Lejeune.

In October 2012, the DHWG formed a subcommittee to evaluate communications related to Camp Lejeune by evaluating themes, risk perception issues, and readability. In March 2013, the subcommittee provided recommendations to the DHWG to improve communications by making the government Web sites more consistent and to ensure that risk perceptions of the public were better addressed. In December 2012, VA published a fact sheet about the implementation of the Camp Lejeune law on its Web site, titled "IB 10-449 Camp Lejeune Water Contamination."⁶ In March 2013, the Marine Corps performed a mass mailing to the 189,000 self-reported former residents who are listed on their Camp Lejeune database. The mailing included both an Agency for Toxic Substances and Disease Registry and VA fact sheet on Camp Lejeune. This massive outreach effort exemplifies the excellent cooperation between VA and the Marine Corps.

⁶ Source: http://www.va.gov/healthbenefits/resources/publications/IB10-449_camp_lejeune_water_contamination_rev3_13.pdf

The Individual Longitudinal Exposure Record (ILER) is a DoD responsibility, with VA participation, to create an occupational and environmental exposure record for individuals over the course of their military careers. The development of ILER should enhance both health care and disability determination efforts. In January 2013, JIF funding was approved for a two-year pilot project to develop ILER, sponsored by the DHWG. The JIF provided \$19.1 million for the pilot, which will lead to Initial Operating Capability (IOC). The goals of the pilot project are to demonstrate the feasibility of producing ILER, and to develop a prototype that provides an IOC for ILER. At the end of the two years, VA and DoD will decide whether or not to proceed to Full Operating Capability (FOC), which would require additional funding from both Departments. In September 2013, an Integrated Product Team (IPT) of technical and functional experts started meeting every week to develop the requirements. Three sub-committees started to identify their specific requirements, including Clinical, Epidemiology, and Claims Adjudication/Benefits. The ILER prototype will be developed and tested by 2015.

In FY 2013, the DHWG analyzed research literature on environmental exposures during military service to mitigate the potential health effects of hazardous exposures. For a number of years, VA has been mandated by Congress to request IOM specific reviews of the evidence related to exposure to Agent Orange and exposures during the first Gulf War. These IOM reviews have been carried out every two years. VA has used the conclusions of these reports to determine if policy changes are warranted regarding the presumption of service-connection for specific diseases in Vietnam Veterans or Gulf War Veterans. In September 2013, VA published a determination about a new presumption for Agent Orange exposure, which is chronic peripheral neuropathy, as a result of a recent IOM report. IOM is currently working on "Veterans and Agent Orange: Update 2012, Volume 9," which will be published by late 2013. VA funded IOM to review and evaluate the best treatments for chronic multi-symptom illnesses among Veterans of the first Gulf War. In January 2013, IOM published "Gulf War and Health, Volume 9: Treatment for Chronic Multi-symptom Illness." VA provided a report to the Secretary of VA to respond to the 14 recommendations in the IOM report. The newest IOM study related to Gulf War Veterans focuses on the whole body effects of blast exposure, and it will be published in February 2014. This new report on blast effects will not include traumatic brain injury (TBI), because IOM already published a report on the long-term effects of TBI. VA recently used that report to make determinations about service connection for conditions resulting from TBI.

HEC Psychological Health/Traumatic Brain Injury Working Group

The Psychological Health (PH)/TBI WG goal is to increase and sustain communication and collaboration between VA and DoD on issues related to PH and TBI. This includes identification, evaluation, and provision of services for both VA and DoD beneficiaries with PH conditions and TBI.

Within the PH/TBI WG purview is the Integrated Mental Health Strategy (IMHS), which was developed to address the growing population of Service members and Veterans with needs related to PH. Mental health care provides challenges for the two Departments in that they serve the same population, but at different times in their lives and careers. As such, the IMHS

centers on a coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services for active duty Service members, National Guard and Reserve members, Veterans, and their families. The IMHS is defined by 28 Strategic Actions (SA) which fall under the following four strategic goals:

- Expand access to behavioral health care in VA and DoD;
- Ensure quality and continuity of care across the Departments for Service members, Veterans, and their families;
- Advance care through community partnership, education, and successful public communication; and
- Promote resilience and build better behavioral health care systems for tomorrow.

Although most of the 28 IMHS SAs will have fulfilled all of their originally planned milestones by the first quarter of FY 2014, the IMHS has laid the foundation for ongoing collaboration that will continue under the auspices of the PH/TBI WG. Four VA/DoD PH related initiatives that are follow-on projects to IMHS SAs have received two-year JIF funding and are well underway. These four initiatives address: the role of chaplains in provision of mental health services; piloting the use of local clinical champions to promote and support use of evidence based psychotherapies (EBP); establishment of a best practice-based implementation network across select VA and DoD facilities; and implementation of problem solving training in primary care settings.

The co-chairs have continued to engage each Department's TBI leads and additional subject matter experts (SME) to jointly address TBI issues in this venue. The PH/TBI WG established a standing TBI sub-WG with leadership from VA and DoD that has the lead on joint efforts to advance TBI care in both Departments and has revised the WG membership to ensure robust participation from TBI SMEs within the Military Departments.

Common Standard of Care to Support TBI

Training

VA and DoD continued to ensure that all clinicians, from medics/corpsmen to licensed independent providers, received training in evidence-based clinical practices to cover the full spectrum of TBI care. Army Office of the Surgeon General/Rehabilitation and Reintegration Division coordinated TBI staff from the Military Departments to develop a curriculum to teach/train a total of 120 providers at the TBI for Deploying Providers Course, which was held in November 2012, February 2013, May 2013, and August 2013. The training included medics, occupational therapists, physical therapists, psychologists, nurse practitioners, physician assistants, physicians, social workers, registered nurses from all Military Departments, and U.S. Air Force Independent Medical Technicians. The training included didactics, hands-on skills stations, and trauma training tracks. Navy has a live four-hour TBI training course including information on the Military Acute Concussion Evaluation, concussion management algorithms, and DoD policy guidance. In FY 2013, a total of 548 Navy personnel were trained. The U.S. Marine Corps has stood up a cadre of 270 trainers in each Marine Expeditionary Force, which utilizes a uniform TBI training slide deck. Trainers are specifically matched to Marine leaders, corpsmen, and providers. The training covers both pre-

deployment and annual training requirements. Each of the Military Department training events has a primary focus on early identification and diagnosis of TBI and initial treatment. New training programs that are focused on the joint force, including an interactive Web-based platform specifically geared to health care providers, are available on each of the Military Departments' Web sites. Additional TBI-related training can be found on the Defense and Veterans Brain Injury Center (DVBIC) Web site⁷. DVBIC distributed 632,675 TBI educational tools and pamphlets from January through September 2013. The DVBIC Regional Education Coordinator network delivered over 434 presentations, briefs, and training events to over 38,630 people including active duty Service members, members of the National Guard and Reserve Component, Veterans, family members, civilians, and providers.

The Army Training Network records show that in FY 2013, a total of 1,894,766 TBI training events were completed. Service members completed training on the basics of TBI (1,289,133), leaders and commanders completed TBI education (328,528), and health care providers completed more advanced training in care for TBI (147,507). Specific training for health care providers targeted non-primary care providers (44,138), primary care providers (28,659), and combat medics (56,801).

VA continued to offer comprehensive training through the TMS regarding TBI clinical presentation, symptoms, and treatment in Service members and Veterans through the Veteran's Health Initiative (VHI) course. Combining online and paper based versions of the training, over 2,100 VA providers have completed the VHI course through September 2013. TBI-related training options in TMS expanded to 36 different course offerings in FY 2013, and over 900 VA staff completed training events in TBI-related in TMS in these additional content areas.

In August 2013, VA and DoD collaborated on their first large scale virtual TBI training event titled "TBI Global Synapse - A Summit without Borders." The purpose of the event was to ensure that TBI education, training, screening, and care practices are uniformly disseminated and implemented across all care environments, from point of injury to recovery and reintegration, throughout VA and DoD. A total of 1,257 individuals registered from around the world including 60 Air Force, 287 Army, 160 Navy, two Coast Guard, 33 Public Health Service, 246 VA, and 469 additional clinicians supporting military TBI care. Feedback and effectiveness measures from this training opportunity are being collected and will be delivered in FY 2014.

TBI Grand Rounds, available to VA and DoD staff, were offered monthly throughout FY 2013 as a joint venture through Brooke Army Medical Center (BAMC) via Satellite/Content Delivery Network (CDN). These educational offerings spanned a range of topics related to TBI rehabilitation, and over 4,000 staff participated in these training events in FY 2013. Separately, a TBI Grand Rounds series was also supported by Walter Reed National Military Medical Center via Satellite/CDN across a variety of topics including sleep after TBI, learning principles for brain injury rehabilitation, long-term outcomes after mild TBI (mTBI), and more. Over 1,000 staff participated in these grand rounds in FY 2013. The VA Polytrauma System of

⁷ www.dvbic.org

Care (PSC) Grand Rounds resumed in FY 2013 and was available to VA staff via teleconference lines and Microsoft Live Meetings. PSC Grand Rounds were available across four separate training events, with over 300 teleconference lines utilized for training access, and over 150 attendees participating on a Live Meeting platform.

Active efforts are underway to define the catalog of TBI treatment training events across the two Departments. The catalog of all available training events was completed in May 2013, a month ahead of the target date. Future efforts by the WG will aim to ensure common training events are available to providers in both Departments, that resources are efficiently used to produce training events and disseminate them in both settings, and to develop training events more focused on a garrison based force.

Research Translation

VA and DoD continued to invest heavily in TBI research and actively participate in jointly reviewing each other's research portfolios. Translation of research to clinical practice is a top priority for both Departments given the pressing clinical needs of Service members and Veterans. During FY 2013, the translation of research into clinical practice was realized through the development of three evidence-based clinical recommendations for health care providers on neuroendocrine dysfunction, visual disturbances, dizziness, and neuroimaging following mTBI. The guidance provided in these documents was developed through a thorough evaluation of the published literature, as well as VA and DoD funded ongoing research. DoD led in the development of these clinical recommendations with the support of VA and DoD health care providers serving as SMEs. Inputs to these recommendations were also garnered from partners in other Federal agencies and academia to ensure the widest breadth of current knowledge was incorporated. These documents not only provide guidance to health care providers of Service members and Veterans, but also introduce a standardized approach to assure quality and continuity of care.

Other research efforts that drive enhancement of clinical programs are underway via the DVBIC, which is the primary TBI operational component under the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), and VA's Polytrauma/Blast-Related Injuries (PT/BRI) Quality Enhancement Research Initiative (QUERI). DVBIC completed a study looking at the test-retest reliability of four commercially available computerized neurocognitive assessment tools (NCAT) in order to provide information on the utility of NCATs in the assessment of Service members' cognitive abilities after mTBI. This is the first known study to assess four NCATs in an active duty military population. Findings indicated that all NCATs demonstrated acceptable reliability for at least one domain, and there is no clear evidence supporting one NCAT over the others. Additional psychometric studies are being conducted to further assess the validity of NCATs and inform best practices for their use in the identification of cognitive deficits related to mTBI. VA's PT/BRI QUERI also continues to drive enhancement of current clinical programs, including educational interventions to improve VA's TBI screening program; refining and validating the TBI screening and evaluation program; and driving innovation, including evaluation of smart phone applications to improve patient self-management of mTBI symptoms. VA's TBI screening and evaluation practices that were implemented in FY 2012 continue to be refined and validated, and shared monthly with senior leadership and the field.

Outcome Measures

A major focus for both Departments is to understand the chronic effects of mild to severe TBI. The VA TBI Model Systems Study has enrolled over 400 participants across the five Polytrauma Rehabilitation Centers (Richmond, Tampa, San Antonio, Palo Alto, and Minneapolis VAMCs). This study, conducted in partnership with the National Institute of Disability and Rehabilitation Research, utilizes common data elements to track the outcomes of, and course of recovery for, moderate to severe TBI. In 2010, the DVBIC initiated the Institutional Review Board (IRB) review of its congressionally mandated 15-year longitudinal study for Service members and Veterans from OEF/OIF/OND, as well as their caregivers. The required three-year interim report to Congress was submitted in FY 2013. This 15-year study parallels VA's TBI Model System project for moderate to severe TBI, but has a broader scope to include mTBI.

The DVBIC Concussion Health Care Outcomes Standardization Initiative was established in FY 2013 to coordinate outcomes activities across DoD with the goal to identify, standardize, and implement core measures that would be applicable across the continuum of care. DVBIC analyzed clinical care data from the MHS from 2010-2012 to inform the selection of core instruments. The next phase of development of common measures for tracking outcomes following rehabilitation of TBI includes development of implementation and reporting standards and use of a Web-based platform solution to collect and house the shared measures, and will allow for easy access and real-time feedback to providers caring for Service members with mTBI.

Common Standard of Care to Support Psychological Health

Evidence-based Psychotherapies

VA and DoD engaged in continued and expanded activities to provide consistent and coordinated training in EBP for PH conditions. As part of an IMHS SA on this topic, VA and DoD have implemented common and coordinated evidence-based training to increase the availability of effective psychological treatments for PTSD, major depression, and other PH conditions across both Departments. VA and DoD training program staff are working in close collaboration to implement the training and ensure comparable training content and treatment delivery.

In FY 2013, VA provided training to more than 670 staff in the delivery of Cognitive Processing Therapy (CPT) and/or Prolonged Exposure Therapy (PE); 82 percent of these staff are currently in consultation or have successfully completed VA's competency-based training process. VA added 12 new trainers/consultants to these programs, maintaining a capacity of more than 120 trainers/consultants. DoD provided training in EBPs to over 1,200 mental health providers from DoD and community based outpatient clinics that provide services to Service members and Veterans. This included over 500 providers being trained in CPT and/or PE for PTSD. Thirty-two providers have been trained to be DoD trainers/consultants in EBPs for PTSD, depression and other PH conditions. Additionally, 184 DoD providers received consultation through the Center for Deployment Psychology (CDP). Although receiving consultation is highly recommended, it is not required for providers within DoD. The EBP

Advanced Proficiency Pilot Project has been developed to assess a new model of providing consultation within DoD. CDP will continue to collect data for the Advanced Proficiency Pilot Project through October 2013.

VA continued to expand training efforts in Cognitive Behavioral Therapy for Depression (CBT-D), Cognitive Behavioral Therapy for Insomnia (CBT-I), Motivational Interviewing (MI), and a number of other evidence-based psychotherapies. VA provided training in one or more of these therapies to more than 880 staff; 99 percent of these staff are currently in consultation or have successfully completed the competency-based training process. These EBP training programs added 115 trainers/consultants in FY 2013, creating a capacity of more than 250 trainers/consultants. DoD continued expanded training efforts in CBT-I, CBT-D, Cognitive Behavioral Treatment of Chronic Pain, and an evidence-based focused curriculum focused on the assessment and treatment of suicidal ideation and behavior. CDP provided training in one or more of these therapies to over 700 mental health providers. The WG far exceeded its goals for 2013 for training providers and trainers/consultants.

Recently published program evaluation results in various outlets, including the Journal of the American Medical Association Psychiatry and the Journal of Consulting and Clinical Psychology, have shown that the training in and implementation of EBPs in VA resulted in significant, positive training outcomes for therapists and clinical outcomes for patients, including overall large reductions in symptoms and improvements in quality of life.

Military Culture

Through the IMHS, VA and DoD continued to work together to develop a comprehensive multimedia training for providers that focuses on military culture, signs and symptoms of deployment related mental health conditions, and effective methods for the treatment and prevention of mental health conditions. The target audiences included VA and DoD primary care and mental health providers, civilian primary care and mental health providers, and other care providers such as chaplains and case managers. An introductory module is currently available on the VA's TMS and the MHS training platform (MHS Learn). A more comprehensive, four-module curriculum will be available in FY 2014 and will be accessible on the VA TMS, the MHS Federal Health Care Consortium, and through national agencies that target rural providers, medical providers, and others.

The VA/DoD Military Culture Training working group has updated existing military culture courses with content from the new curriculum. In FY 2013, through September 18, 2013, over 9,400 providers have completed the online course currently offered through CDP and an additional 1,800 providers have attended a live training that includes a military culture course informed by the VA/DoD Military Culture Training working group content, far exceeding the target goal of 2,000 providers.

Research Translation

Clinical research results in new findings that can improve care by making it increasingly effective and efficient. However, these findings will not improve patient outcomes unless health care professionals and systems adopt them into routine practice. Failure to implement evidence-based practices results in costly and inappropriate care. Given limited resources, it

is more important than ever to provide proven, cost-effective mental health services. Unfortunately, there is frequently a gap between what research has demonstrated and the treatment provided in many mental health settings, including those in VA and DoD.

As an outgrowth of the IMHS, VA and DoD are implementing a new strategy to promote the improvement of high quality mental health care for Service members, Veterans, and their families by ensuring that the latest scientific findings translate into clinical practice. In addition to development, dissemination, and promotion of VA/DoD CPGs, the milestones of the VA/DoD IMHS SA on Research Translation involve the identification of at least two common innovations annually for potential implementation in the Departments. The Departments bridge the gap between research findings and clinical practice by providing a framework and a set of recommendations through which they can identify, implement, evaluate, and sustain adoption of new or modified evidence-informed practices based on research findings. In order to structure and expedite scanning of the scientific literature for promising findings, the following disorders and topics, as they relate to mental health research, will be routinely reviewed.

Mental Health Domains
1. Trauma- and Stress-Related Disorders
2. Anxiety Disorders
3. Substance Use Disorders
4. Mood Disorders
5. Psychotic Disorders
6. Traumatic Brain Injury
7. Suicide Prevention
8. Mental Health Research Related to:
a. Special Populations (e.g., rural etc.)
b. Women’s Mental Health
c. Integrated Mental Health (PCMH/Primary Care)
d. Complementary and Alternative Medicine (CAM)/ Integrative Medicine
e. e-health and Telehealth
f. Interpersonal Violence (including rape and sexual harassment)
g. Reintegration of Service Members
h. Individual, Family, and Communities
i. Resilience, Well Being, Recovery-Support
j. Access and Barriers to Care Including Stigma Reduction

During FY 2013, VA and DoD developed and launched a pilot to test mechanisms for identifying, prioritizing, and recommending changes in clinical practice for potential implementation across Departments. The results of the pilot will inform the next steps for the standardization mechanism by which ongoing VA/DoD mental health research is monitored and tracked. This mechanism will help ensure that earlier scientific discoveries arising from clinical or population studies are translated into clinical applications to reduce mental health

morbidity and mortality. Identification of evidence-based implementation strategies with the highest likelihood of success for rapid translation from research into VA and DoD mental health practices are currently being explored.

This pilot included participation from multiple organizations within DoD, including DCoE, the Deployment Health Clinical Center, DVBIC, the National Center for Telehealth and Technology (T2), CDP, and 15 VA Mental Health Centers of Excellence or VA's Mental Health QUERI. Each Department provided several expert scientific, clinical, and /or educational leaders with expertise in core psychological health domain areas. These experts nominated actionable psychological health research findings or new practices with potential benefit to Veterans or Service members for possible widespread implementation within VA/DoD. These nominations are currently being evaluated for prioritization for recommendation, placing VA/DoD on track to reach the goal of identifying at least two promising innovations in clinical practice for potential implementation. Upon pilot completion, the task group leads will recommend a process to inform an ongoing practice for VA/DoD to prioritize research findings for translation. The proposed process will be documented and reviewed by VA/DoD leadership in the first quarter of FY 2014.

Suicide Risk and Prevention Strategies

The joint VA/DoD suicide prevention activities are elements of one of the IMHS SAs. Extensive collaboration and cooperation in suicide prevention between VA and DoD continued in FY 2013 as the Defense Suicide Prevention Office (DSPO) more fully developed in its role as the focal point for all DoD suicide prevention policy, training, and programs and as the DoD lead for VA/DoD collaboration on suicide prevention.

DSPO now chairs the Suicide Prevention and Risk Reduction Committee (SPARRC) which includes participation from DoD Personnel and Readiness Directorates, each of the Military Departments, National Guard Bureau, VA, and other entities such as HHS and the Tragedy Assistance Program for Survivors. VA continued to participate in these ongoing meetings to discuss effective mechanisms to share resources, develop programs, and monitor best practices related to suicide prevention across the two Departments.

The Suicide Nomenclature and Data WG, under the auspices of the PH/TBI WG, recommended the adoption of the Centers for Disease Control and Prevention (CDC) suicide nomenclature in VA and DoD. A VA/DoD Suicide Data Repository is being developed that will store all suicide related events for Service members and Veterans. VA created a temporary mirror repository to hold joint data in the interim, and initial data pulls have been received from CDC. In September 2013, VA initiated an initial report using the joint data. The VA/DoD Suicide Prevention Conference was not held in FY 2013 due to sequestration. Plans are now underway to hold limited one day summits in the beginning of FY 2014 as an alternative forum for suicide prevention education and dissemination.

The Veterans Crisis Line (VCL) was developed to be proactive in suicide prevention and reach people before they get to the point of being actively suicidal. An online chat function and texting services are also available to enhance the availability of this confidential resource for

Veterans, Service members, and their families. The Military Crisis Line (MCL) and Military Chat were established using the same numbers and resources of the VCL to increase access to Service members. The DSPO and VA Suicide Prevention Office continued to work with each Military Department to develop DoD and Military Department-specific promotional materials. Availability of toll-free calling is being expanded for locations outside of the continental U.S., including six European countries and a Korean line that opened in 2013. In FY 2013, there were 287,051 total calls to the VCL/MCL, as compared to 193,507 total calls in FY 2012. There were 54,835 online chats with the VCL/MCL. Overall, since its launch in 2007, the VCL/MCL has received more than 974,000 calls, more than 127,000 chats, more than 15,000 text messages, and has initiated more than 32,000 rescues of suicidal callers. A rescue occurs when a caller communicates an immediate suicidal intent and the crisis line respondent contacts local emergency services to attend to the caller and ensure his or her safety. Suicide Prevention information, a self-assessment, and resources for Service members, Veterans, family members, and professionals can be found at the VCL/MCL Web sites⁸.

In FY 2013, DSPO redesigned and expanded the functionality of the Suicide Prevention Web site⁹, which was first launched by the SPARRC in October 2010. The site provides suicide prevention resources for Service members and their family members, as well as suicide prevention for Command and staff across DoD and links to other suicide prevention resources such as the VCL/MCL Web site. During FY 2013, there were 19,654 visits to the DSPO site and 10,940 visits to informational resource pages, providing educational information about suicide and warning signs. The Web site also generated 593 immediate contacts to the VCL/MCL.

HEC Vision Center of Excellence

The Vision Center of Excellence (VCE) continued work to achieve full functionality as the leading advocate to improve vision care for Service members and Veterans. Working with the MHS, Veterans Health Administration (VHA), and other Centers of Excellence (CoE), the VCE provides critical leadership for efforts to enhance collaboration between VA and DoD. In FY 2013, the VCE made significant contributions toward achieving its mission and goals to improve vision health, optimize readiness, and enhance quality of life for Service members and Veterans through initiatives focused on the prevention, diagnosis, mitigation, treatment, and rehabilitation of disorders of the visual system. To support this mission, the VCE designed an educational pamphlet geared toward the inpatient care team caring for blind and visually impaired patients in the hospitalized setting. Once finalized, it will be distributed to hospitals throughout both systems. The VCE documented all policies, guidance, and recommendations related to eye care across VA and DoD. As part of this effort, VCE inventoried and catalogued over 100 policies across the continuum of eye care from prevention to rehabilitation. Finally, VCE developed an eLearning course on the proper application of post-trauma eye shields for ocular trauma cases. This instructional program will be available in FY 2014.

⁸ www.veteranscrisisline.net or www.militarycrisisline.net

⁹ www.suicideoutreach.org

VCE also played a lead role in identifying and documenting ocular simulation usage in VA and DoD training programs by establishing critical relationships with various external stakeholders including fellowship directors across the country for ophthalmic plastic surgery as well as military residency program directors. To facilitate this effort, the VCE obtained data on simulation programs currently in use as well as the strengths, weaknesses, and costs of each program from directors at the American Society of Ophthalmic Plastic and Reconstructive Surgery and the Association of University Professors of Ophthalmology. The VCE created interview guides for six ophthalmology sub-specialties in support of requirements identification for new simulation capability in VA and DoD ocular training programs. The guides are targeted for completion by FY 2014. This effort was also supported by completion of an environmental scan of patient and provider education tools related to vision loss and visual dysfunction. The VCE collected 150 paper, video, mobile application, and technology based (e.g., audio recordings) tools for patients, family members and caregivers, as well as 80 paper, video, mobile application, and technology based tools for providers. Finally, the VCE conducted an analysis of the gaps in existing tools as well as the identification of tools that may be adapted or adopted from external government agencies or non-government stakeholders. Recommendations for educational tools to be developed or adapted from existing tools will be completed in FY 2014.

Visual dysfunctions are a common consequence of TBI and have a significant functional impact on the lives of affected Service members and Veterans. VCE continued to engage across the continuum of care in support of evidence based solutions and advances in vision rehabilitation through development of clinical recommendations. VCE collaborated with DCoE to develop the Assessment and Management of Visual Dysfunction Associated with mTBI Clinical Recommendation. Three clinical recommendations are in the process of publication: VA/DoD Vision Center of Excellence Clinical Recommendation for the Eye Care Provider, Eye Care and Visual Dysfunction Following Possible TBI: Assessment, Management, Rehabilitation and Referral; VA/DoD Vision Center of Excellence Oculomotor Dysfunction Associated with TBI: Assessment and Rehabilitation; and VA/DoD Vision Center of Excellence Visual Field Loss Associated with TBI: Assessment, Referral and Rehabilitation.

In addition, VCE worked to address the clinical challenges of visual dysfunction associated with TBI through investigation and compilation of the current state of practice information. The VCE hosted a knowledge-based workshop in collaboration with the VA Employee Education System (EES), titled "Managing Vision Disorders Following Traumatic Brain Injury," to teach VA ophthalmologists and optometrists how to clinically assess and manage eye and vision disorders associated with blast injury and TBI. The VCE conducted a systematic review of literature with the intent to produce a meta-analysis of published literature regarding visual field losses and oculomotor dysfunction associated with TBI. The VCE collaborated with the Combat Critical Care Research Program of the U.S. Army Medical Research & Materiel Command (MRMC) to convene an expert working group that identified studies supporting the potential uses of eye movement techniques and technologies for the assessment of mTBI and concussion. Finally, the VCE compiled a glossary of terms to accompany the Eye Care Provider Clinical Recommendations.

In FY 2013, VCE continued to actively participate in the development of the DoD vision research portfolio by serving on the Telemedicine and Advanced Technology Research Center (TATRC) Vision Programmatic Panel which identifies capability gaps for vision research, develops program

announcements targeting the gaps, and evaluates research proposals. Preliminary discussions on the planned program announcements for 2013/2014 include TBI-related visual dysfunctions and vision restoration research.

HEC Hearing Center of Excellence

The Hearing Center of Excellence (HCE) delivers solutions that promote prevention, improve delivery and transition of care, and coordinate the translation of research. The HCE is focused on enhancing readiness and improving hearing health and quality of life for Service members and Veterans. The HCE is organized into five interactive directorates: Operations, Prevention and Global Outreach, Clinical Care and Rehabilitation, Research, and Informatics.

Throughout 2013, the HCE provided a unified voice as a cohesive, large-scale hearing health improvement network. Administratively, the HCE and VA representatives have worked closely to establish cross-Departmental support and funding to include an embedded VA Deputy and three additional positions to support the HCE. A deputy was identified in 2013 according to VA procedure and is pending confirmation. Personnel actions are underway to transition contract staff to civil service positions within the HCE headquarters. In 2013, the Air Force appointed a senior active duty audiologist to fill the first of three Military Department liaison positions. Contracted services and leveraged staff (clinicians, researchers, engineers, and administrators from across VA and DoD) actively collaborated to conduct operations delivering HCE mission requirements.

Information Management

The HCE has laid the groundwork for development of the Joint Hearing Loss and Auditory System Injury Registry (JHASIR). The JHASIR will identify and track every case of auditory injury and hearing loss in fulfillment of National Defense Authorization Act (NDAA) requirements. The past year marked the completion of critical Data Sharing, Data Use, and Data Transfer Agreements between all relevant informatics systems. A global TMA Data Use Agreement was signed in March 2013 for clinical data sources relating to hearing loss and injury. The Defense Occupational and Environmental Health Readiness System for Hearing Conservation (DOEHRS-HC) was also expanded via a VA/DoD data sharing agreement signed in February 2013. The HCE resources facilitated the availability of roles in the DOEHRS-HC Data Repository (DR) to allow VA direct access to DOEHRS-HC data to further enable data reliability and Military Department-level responsiveness. Individual VA practitioners are beginning to obtain access to DOEHRS data that will provide the information for disability determination and continuity for smooth transition of auditory care. Presently, approximately 230 VA practitioners have obtained access to the DOEHRS-HC DR. In 2013, an Air Force Defense Information Assurance and Compliance Process was completed, enabling the enterprise purchase of AudBase, a Commercial-Off-the-Shelf product to electronically capture clinical audiograms for inclusion within JHASIR. The Auditory Injury Module, built into the Joint Theater Trauma Registry (JTTR), was activated, identifying auditory injury and acute care metrics for patients cared for in the tertiary care Theater evacuation and management system.

Sharing data with VA to promote continuity and smooth transitions for patients and providers requires interconnectivity and compatibility in planning. VA's information technology (IT) teams at the Denver, Colorado-based hearing loss repository continued to work with HCE developers to ensure architecture compatibility and seamless flow that will enhance JHASIR longitudinal functionality (sharing of hearing loss data across the two Federal Departments). The VA team collaborated with the HCE to develop final DoD policy directing all DoD hearing aids purchases through the VA Denver Acquisition Logistics Center, with initial focus on active duty patients. Such reporting will help identify regional use of resources that may reflect concentration of injury and best conservational practices.

Prevention & Global Outreach

With the primary objective of preventing and mitigating hearing loss and auditory injury, the HCE developed a Comprehensive Hearing Health Program (CHHP) with components in various phases of execution. This program is designed to prevent noise-induced hearing loss through effective education, monitoring, training, and hearing protection access, fitting, and use. In 2013, the HCE developed a suite of educational tools (i.e. posters, tri-folds, videos) and released a hearing loss prevention Web and social media campaign to increase Service member awareness of the natural asset of hearing, the devastating effects of noise on hearing, and the insidious nature of this invisible injury. The HCE coordinated a translation plan to implement use of a computer based educational tool/hearing loss simulator sponsored by the Office of Naval Research and developed collaboratively with industry by the Navy Submarine Medical Research Lab with input from the DoD Hearing Conservation WG (HCWG). The HCE and VA are also partnering to transition computer based educational information piloted in stand-alone kiosks to achieve wider outreach on a Web-based platform.

The HCE is working with Army Public Health Command to develop a qualified products list for EarPro hearing protective equipment, as well as standardized testing requirements for EarPro acquisitions. The HCE and VA are exploring acquisition strategies for central funding of hearing protection and tactical communication devices through online VA processes.

The HCE continued to work as a unified team with the HCWG and VA representatives to develop acquisition strategies for central purchase of hearing protection devices and tactical communication and protection systems. The HCE and DoD HCWG continued to address the recommendations of a GAO audit of the Military Departments' hearing conservation programs. The CHHP is in line with all GAO recommendations to enhance training and education, improve data collection and reliability, and analyze and elevate best practices within Military Department programs. The HCE is also working with the DoD HCWG to update current policy documents in reassessment of accession, retention, and medical board standards. The HCE is working with all Military Departments to institute the necessary strategies for hearing surveillance that will enable early diagnosis and customized intervention to preserve and enhance hearing ability. These critical encounters occur at initial accession to the military, annually at readiness evaluations and/or periodic health assessments, pre- and post-deployment assessments, and separation and retirement exams.

In 2013, a thorough job task analysis of various military specialty codes identified hearing critical tasks required within each specialty. These were compiled into groups of identifiers

with similar hearing requirements and exposures, and will be used in developing auditory fitness for duty standards that will couple hearing ability or dysfunction with required operational performance. The HCE continued to participate in various DoD WGs to elevate hearing performance and mitigation strategies such as the Defense Safety Oversight Committee, the Hazardous Noise Source Reduction Initiative to preemptively establish acquisition noise standards or mitigate inventory sources, the Human Performance Optimization Working Group, and the Medical Personnel Executive Steering Committee Disability Working Group. The overall goal of HCE prevention is to ensure all Service members understand the importance of maintaining normal, healthy hearing throughout their military careers and lifetimes.

The HCE speaks as a unified tri-service voice to oversight councils for the reporting and dissemination of educational information, best practice guidelines, and DoD directives and instructions. The HCE formalized and continues to develop partnerships with national specialty academies and hearing health advocates, supporting four events in 2013. The HCE promoted hearing loss prevention and awareness through print, television, and radio media exposure, and dedicated focus on hearing during the Better Hearing and Speech month in May.

Throughout 2013, the HCE maintained and augmented its Web site¹⁰. This Web site supports a clearing house of clinical and research tools, education, outreach, and networking products and opportunities. In addition, the HCE developed and launched a prevention campaign to improve awareness and promote behavior change and accountability toward hearing protection.

The HCE led a North Atlantic Treaty Organization (NATO) research technical group effort to Optimize Hearing Loss Prevention, Treatment, Rehabilitation and Reintegration of Soldiers with acoustic trauma that includes developing a standardized data collection process for comparison and identification of best practices. Additionally, HCE representatives presented at international scientific forums building collaborations and alliances with conservation partners facing the world wide hearing loss pandemic. HCE, as the unified voice for DoD hearing and hearing loss concerns, advocated hearing importance on 13 DoD and joint working groups that include both VA and DoD representation, and actively contributed to the development of DoD and MHS planning, Senate appropriations responses, accession and separations standards, and also served as a model to improve research function and translation.

Clinical Care

Along with CHHP, Auditory Care Optimization (ACO) is the focus of HCE mission. With nearly 450,000 OEF, OIF, and OND Service members sustaining hearing loss and auditory system injury, HCE efforts to add awareness to the invisible and insidious injury, preserve function, streamline care, and improve hearing health and quality of life is paramount. Along with war injuries, VA documented 1,883,919 Veterans who received compensation for auditory system

¹⁰ <http://hearing.health.mil/>

conditions with 971,990 connected for tinnitus and 774,384 connected for hearing loss, the two most common individual disabilities.

VA and DoD clinical leaders have established clear communications through the HCE Hearing Health Improvement Network and have worked together to define resources and identify best practices. In 2013, DoD published new policy to improve DoD ordering practices for hearing aids and implants, directing DoD providers to use the VA's ordering system resulting in reduced costs and improved timeliness and continuity of care.

The HCE trained and educated surgeons and audiologists, and worked with industry to introduce four emerging technologies and two new techniques to rehabilitate difficult blast injury with conductive or mixed hearing losses, and severe noise-induced hearing losses that are difficult to rehabilitate with standard hearing aids or with cochlear implants. VA and DoD partners have planned for an industry day to evaluate bone conduction and middle ear implant technologies with potential for centralized contracting and improved care for these difficult injuries.

The HCE continued to work with the Recovering Warrior Task Force to improve transition between VA and DoD. The HCE is actively working to standardize care and provide clinical guidance. The HCE participated in the AHRQ review of the comparative effectiveness of tinnitus, and is in the process of the final review of the American Academy of Otolaryngology CPG for tinnitus management. The HCE is working with VA partners to place the VA Progressive Tinnitus Management Program and manuals online so providers and patients can easily reference help.

The HCE is analyzing guidelines for screening the unique military population with asymmetric sensorineural hearing loss. The HCE continued to support education and training of providers in vestibular assessment and rehabilitation, and completed a system wide assessment and analysis of current practices and resources across the MHS. Standardized guidelines for enhancing DoD vestibular assessment and treatment capability and capacity have been developed and are in review. The HCE continued work toward developing hearing profiling standards, and supported development of in-flight testing equipment for the purpose of aeromedical evaluation of hearing function.

In 2013, the HCE deployed new boothless diagnostic tools to the Afghanistan Theater and piloted care augmentation at other remote sites. HCE is working with concussion care centers to integrate this capability into their TBI acute diagnostic and disposition processes. The HCE assembled an integrated process team to identify the most practical vestibular assessment platform for implementation in the concussion care centers as well. The HCE participated in analyses of VA and DoD telehealth pilots, and was involved in the telehealth strategic planning seminar advocating for tele-audiology, a project that will add value and capacity across the Departments. The HCE brought simulated training to MTFs to enhance education and training of surgeons caring for acoustic injury.

Research

To optimally utilize registry and data sharing capabilities and support the CHHP and ACO, the HCE Auditory Research WG (ARWG) leveraged technical experts across VA, DoD, National Institutes of Health (NIH), academic, and industry partners. The ARWG constituted a Scientific Advisory capacity for Defense Health Program programmatic research reviews and development of gaps and priorities for three research activity directorates, development of strategic HCE initiatives, and participation in small business innovation research announcements, technical transfer activities, and capability briefs for various research-sponsoring agencies.

The intent of organizing a transparent, coordinated practice based research network (PBRN) is to encourage and facilitate the conduct of research and the development of best practices. This PBRN utilizes HCE-developed communications platforms and strategies to define capability and determine capacity across the system. The HCE acquired Elsevier SciVal software to augment transparency and profile ARWG members and partners, enhancing communication and collaboration building. The HCE developed a Memorandum of Agreement (MOA) for a centralized IRB with the MRMC and funded a central DoD IRB administrative scientist to facilitate multi-site research projects.

The HCE organized the Pharmaceutical Interventions for Hearing Loss WG, a collaborative group of VA, DoD, NIH, academic, and industry leaders focused on standardizing research methods and reporting standards and coordinating DoD interests related to pharmaceutical developmental strategies. Additionally, the HCE was a primary contributor to the first and second edition of the online resource, "The VA/DoD Collaboration Guidebook for Healthcare Research."

The HCE began developing a business case analysis (BCA) to define comorbid injuries, develop integrated gap analysis, and project the value of investigating injury patterns and interventions as an integrated CoE-led research consortium. The HCE also coordinated a consortium proposal for funding toward an effort to resolve gaps in the chronic effect of neurotrauma, and will play a guiding role in this consortium in 2014.

HEC Extremity Trauma and Amputation Center of Excellence

The Extremity Trauma and Amputation Center of Excellence (EACE) serves as the Nation's premier center for promoting excellence in the identification, mitigation, treatment, rehabilitation, and research for traumatic extremity injuries and amputation for Service members and Veterans. Administratively, the EACE is currently at IOC with 25 of 41 staff hired for a 61 percent fill rate. DoD is at a 62 percent fill rate with 23 of 37 staff hired, while VA is at 50 percent fill rate with two of four staff hired. The EACE is on track to achieve FOC by October 1, 2014.

As of the end of FY 2013, 68 Service members sustained limb loss, 16 of whom lost multiple limbs, bringing the 11 year total to 1,628 Service members who have sustained a major amputation from conflicts in the Central Command Area of Responsibility. Of the 456 amputees retained on active service following their amputations, 68 have deployed. As of

September 30, 2013, there were 246 Service members receiving care in one of the three DoD Advanced Rehabilitation Centers (ARCs). Within VA, 43,490 unique Veterans from all conflict eras with a major amputation received some level of service in VHA during FY 2013; 26,605 of those Veterans received either a prosthetic limb or repair, and/or visited an amputation care clinic. Since 2001, 1,422 OEF, OIF, and OND era Veterans with amputations have been seen within VA for some level of care or service. Through enhanced collaboration, VA and DoD continued to improve rehabilitation techniques, prosthetic/orthotic technology, and coordination of care, quality of life, and health care satisfaction for Service members and Veterans with amputations.

VA, DoD, and the EACE managed several outstanding initiatives in FY 2013 to meet the goal of promoting measurable, safe, effective, timely, efficient, and equitable patient-centered quality health care for all Service members, Veterans, and their beneficiaries. The EACE promoted state of the art care by executing clinical research and providing science-based evidence to clinicians to support prosthetic prescription so clinicians could better identify patients who may benefit from the most advanced prostheses. Such devices include the X3® lower extremity and BiOM® prostheses in both VA and DoD. The X3® is a ruggedized, water-resistant version of the X2®, which was the first prosthetic knee to enable above-knee amputees to run forward and backward and climb stairs and slopes foot over foot. The BiOM® is a powered ankle which can substantially benefit some lower limb amputees and potentially aid in community ambulation that might otherwise be impossible. The DEKA Arm Take Home Study was funded in FY 2012 by the VA to examine the feasibility, acceptance, and benefits of home use of an advanced upper limb prosthetic device, as well as the logistical support requirements utilized during three months of home use. There are three VA sites and one DoD site participating in the study. To date, 22 subjects have been screened for potential participation. Twelve subjects have been or are currently enrolled for the in-laboratory portion of the study. Seven subjects have been or are currently enrolled in the three month at-home portion of the study. Recruitment and enrollment will continue for the next two years.

In FY 2012, the EACE was authorized to develop a VA/DoD Upper Extremity Amputation Rehabilitation CPG. Significant progress has been made over the past year in developing the first clinical pathway/standard of care for this population of patients, and EACE is working with the EBP WG to complete this CPG. Having this CPG will culminate in reduced practice variance, an enhanced standard of care, accelerated research translation into clinical practice, and ultimately lead to improved health, quality of life, and satisfaction for this population of patients. The EACE has worked to further develop policy and information regarding hand transplant for Service members and Veterans with upper limb amputation. Although not yet considered standard of care, hand transplant research is supported by DoD funding. One OIF Veteran who sustained loss of all four extremities received a bilateral hand transplant at Johns Hopkins Transplant Center in Baltimore in FY 2013. Other Service members who are considering hand transplant are provided an opportunity to seek information from a multidisciplinary panel of VA and DoD providers, counselors, and scientists to assist the amputee and their family in making their decision.

Building on existing VA/DoD infrastructure and established training mechanisms, in FY 2013 the EACE collaborated with VHA and DoD educational and clinical programs to produce

monthly, combined Virtual Rehabilitation Grand Rounds. These seminars provide state-of-the-science programs and continuing medical education for providers across VA and DoD. This significant clinical training initiative is a collaborative effort which provides a rapid capability to translate research into practice, rather than the slower, traditional route via peer-reviewed publication and subsequent CPG development. The Virtual Rehabilitation Grand Rounds Program will reduce variation in care, meet provider need for continuing medical education, result in travel cost avoidance, increase provider availability for clinical duties, enhance information sharing, foster access to the latest science, and improve the provision of high quality patient care.

VA and DoD continued to work collaboratively on clinically relevant research for Service members and Veterans who have sustained amputations and extremity trauma. During FY 2013, DoD intramural research efforts directed and/or executed by EACE personnel led to 11 new IRB approved studies, 18 peer-reviewed publications, and 26 platform and podium presentations at national and international conferences. The EACE staff have successfully integrated with key VA and DoD amputation and advanced prosthetic research program efforts during FY 2013. The EACE exceeded its goal of three ongoing collaborative research protocols between extremity trauma VA/DoD patient care centers.

- EACE DoD and VA researchers published a series of papers describing clinical efficacy of the BiOM®. Further, EACE DoD and VA researchers successfully competed for and received \$1.4 million of research funding to collaboratively pursue this line of research.
- The Comprehensive High-level Activity Mobility Predictor was developed by a VA researcher as a performance-based assessment instrument to quantify high-level mobility in Service members with traumatic lower limb loss. Six papers authored collaboratively by VA, DoD, and EACE researchers were accepted for publication in FY 2013 that demonstrate the validity of this tool to discriminate between different levels of lower limb loss, and to establish reference ranges for Service members with and without limb loss. This valuable tool is now being used at the DoD ARCs to aid clinicians and patients in tracking progression of rehabilitation and in setting realistic goals to reach full functional potential following amputation.
- EACE personnel collaborated with VA Office of Research and Development (ORD) to develop the second edition of the VA/DoD Collaboration Guidebook for Healthcare Research, scheduled to be available online¹¹ in FY 2014. This updated guidebook will facilitate continued development of stronger collaborative human subject research relationships between VA and DoD. Such collaboration results in improved research initiatives, as well as pooled financial and human resources, which increases research efficiency and credibility.
- DoD EACE and VA personnel participated as Chair and members of the scientific steering committee for Neuromusculoskeletal Injury Rehabilitation, Clinical and Rehabilitative Medicine Research Program, MRMC, to identify and summarize clinically meaningful research gap areas that facilitated VA and DoD research funding decisions. The team modified key EACE research initiatives to align with defined gap areas. The agreed upon clinical goals will drive research funding in VA and DoD now and into the future.

¹¹ <https://cdmrp.org/files/forms/generic/va-dod-guidebook-research-collaboration.pdf>

- DoD EACE and VA personnel collaborated with the DoD-funded Bridging Advanced Developments for Exceptional Rehabilitation Research Consortium team to successfully develop and receive \$1.4 million in funding for a study that builds on FY 2012 NATO recommendations to further develop a functional outcomes assessment toolkit that can be used to standardize outcomes measurement across the Departments. Execution efforts for this study are underway, which will collect data across five VA and DoD sites.

The EACE demonstrated significant progress in the area of clinical informatics. The legacy amputee database was significantly upgraded to a more robust, stable environment with an increased capacity for more secure data linkages and an improved database design and functionality. The EACE has simultaneously laid the ground work for a second generation extremity trauma and amputation registry, in concert with the integrated Health Registries effort led by the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)). This registry will require extensive development and collaboration to build. It will serve as the sole system of record for tracking Service members from point of injury through various levels of medical and rehabilitative care. The EACE is currently developing the comprehensive functional requirements to develop necessary technical specifications and pursuing OASD(HA) approval and funding to proceed to the next level of registry development.

The EACE established a Web presence this year on the MHS Web site¹² and introduced an EACE SharePoint portal to further facilitate VA/DoD collaboration and provide a future platform for collaboration with academia and industry. For example, the EACE Clinical Informatics and Technology Division was instrumental in the initiative to facilitate the VA/DoD Virtual Rehabilitation Grand Rounds Program by addressing VA/DoD technical system interoperability issues.

The EACE monitored criteria for assessing the patient care treatment programs within the VA/DoD Amputation System of Care (ASoC). Criteria established for DoD ARCs is accreditation by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics. Criteria for VHA ASoC is Amputation Specialty Accreditation by the Commission on Accreditation of Rehabilitation Facilities for the Regional Amputation Centers and Polytrauma Amputation Network Sites.

In FY 2013, the EACE adopted criteria to evaluate patient satisfaction of inpatient services received. Monitoring of services other than inpatient services is accomplished by each of the facilities in VA and DoD as a requirement for their designated accreditation. The next step will be determining a baseline satisfaction level to measure against. Additionally, an Office of the Inspector General report¹³ published March 2012 provided a baseline of satisfaction on a number of measures for OEF/OIF/OND Veterans with amputations.

The EACE is engaging key stakeholders in VA and DoD to design collaborative protocols to sustain medical, surgical, and rehabilitation staff competencies, develop new technologies, and improve life-long care which will lead to maximum functional outcomes and improved quality of

¹² www.health.mil

¹³ <http://www.va.gov/oig/pubs/VAOIG-11-02138-116.pdf>

life. The number of war-related amputations and catastrophic extremity injuries is decreasing. The EACE is working closely with VA and DoD leaders at many levels to help build a comprehensive plan and strategy to maintain appropriate capabilities for future Service members, Veterans, and their families.

HEC Medical Research Working Group

The Medical Research Working Group (MRWG) ensures coordination through the identification of new research directions and approaches, identification of gaps in scientific knowledge, and development of recommendations on future research coordination. Joint VA/DoD efforts have been responsible for major breakthroughs in many medical specialties. VA and DoD have identified several high priority medical research areas, including PTSD and other psychological conditions, TBI, multidisciplinary treatment of polytrauma, pain management, rehabilitation, advanced prosthetics, and the long-term health effects of deployments. VA scientists compete very successfully for funding from DoD resulting in hundreds of DoD-funded research projects in the VA system. These investigations include several high-priority topics, including PTSD, alcohol abuse, resilience to mitigate combat stress and post-deployment reintegration problems, treatment of TBI and spinal cord injuries, treatment of amputations and improved prosthetics, visual and hearing impairments, rehabilitation, and illnesses in Veterans of OEF/OIF/OND.

In FY 2013, senior VA and DoD research managers and scientists collaborated in five joint comprehensive program reviews. Each of these comprehensive portfolio reviews included hundreds of VA and DoD projects on rehabilitation medicine and orthopedics; PTSD, suicide, and other psychological conditions; TBI; infectious diseases; and health IT and medical simulation training. These joint program reviews identified complementary research projects, new research approaches, and gaps in scientific knowledge, leading to improved interagency research coordination. Four comprehensive reports on the program reviews were published: rehabilitation medicine and orthopedics; PTSD, suicide, and TBI; infectious diseases; and health IT and medical simulation training.

The MRWG developed a monthly update of a bibliography of medical articles related to Service members and Veterans deployed to OEF/OIF/OND. This monthly bibliography, focusing on the health of deployed Service members and Veterans, was distributed to senior VA and DoD research managers and scientists to improve their situational awareness. These monthly bibliographies included 1,846 articles during calendar year 2012 and 1,753 articles during the period of January to September 2013, far exceeding the WG's goal of updating 600 bibliographies in FY 2013. As a result of this continuous information flow, the response times of senior research leaders to new findings were considerably shortened.

In FY 2013, VA and DoD worked to increase coordination on studies of the long-term health effects of military service, and to improve collaboration on epidemiological studies that follow Service members from active duty through Veteran status. This effort could improve early identification of long-term health effects and enable early treatment and prevention. Joint oversight and funding of consortia to investigate the long-term health effects of PTSD and TBI represent an unprecedented collaboration by VA and DoD.

The purposes of the VA/DoD Chronic Effects of Neurotrauma Consortium are to investigate the long-term effects of mTBI and to develop biomarkers, such as blood biomarkers and neuroimaging. VA and DoD selected one consortium dedicated to establishing a comprehensive understanding of the chronic sequelae associated with neurotrauma, primarily focused on mTBI. Virginia Commonwealth University, the Richmond VAMC, and USUHS received the award. The purposes of the Consortium to Alleviate PTSD are to develop improved treatments and biomarkers for PTSD. VA and DoD selected one collaborative consortium dedicated to improving the health of Service members and Veterans with the most effective diagnostics, prognostics, novel treatments, and rehabilitative strategies to treat acute PTSD and prevent chronic PTSD. The University of Texas at San Antonio and the Boston VAMC received the award in August 2013.

The Millennium Cohort Study (MCS) includes more than 200,000 Service members, who started enrollment in 2001. The health of the cohort is evaluated every three years until 2022, to determine the course of diseases over time. Forty percent of the cohort has already separated from the military and are eligible for VA medical care. DoD has funded the MCS since its inception. In 2013, VA ORD and the VA Office of Public Health worked to increase collaboration with DoD in the MCS, through planning for substantial VA funding and dedicated VA research staff. Increased VA/DoD collaboration on long-term cohort studies will build on the effectiveness of the existing foundation of interagency research.

As reported by the EACE, a committee of VA and DoD scientists collaborated to update the VA/DoD Collaboration Guidebook for Healthcare Research. The guidebook will be available online in FY 2014 and distributed widely to VA and DoD scientists.

On August 31, 2012, an Executive Order, titled "Improving Access to Mental Health Services for Veterans, Service members, and Military Families," was issued with focus on PTSD, TBI, and suicide prevention. The Order included research mandates that required VA and DoD to develop a National Research Action Plan (NRAP). Senior research leaders in VA and DoD established an interagency committee, which also included scientists from the National Institute of Mental Health, National Institute of Neurological Disorders and Stroke, National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, and the Department of Education. The NRAP is a ten-year blueprint for interagency research to enhance the diagnosis and treatment of PTSD and TBI and to improve suicide prevention, including immediate, short-term, and long-term initiatives. The interagency research committee delivered the NRAP to the White House on April 30, 2013. The interagency research committee has started to implement the initiatives in the NRAP and will provide a progress report to the White House in December 2013.

Sub-goal 2.2: Access – Facilitate improved availability and access for all Service members, Veterans, and their beneficiaries, to assure that they receive responsive care whenever they need it, in traditional and evolving delivery methods, while eliminating or reducing disparities and removing barriers to care and health care utilization.

HEC Psychological Health/Traumatic Brain Injury Working Group

Availability and Access to Health Care for Service Members and Veterans at Risk for TBI

In FY 2013, VA screened 96 percent of all Veterans from the OEF/OIF/OND cohort who received services at VHA at their entry to the VA health care system (HCS) for a possible mTBI. From April 2007 through July 2013, VA screened 760,250 Veterans from OEF/OIF/OND for possible mTBI with a resultant 143,029 positive screens. Of those Veterans who completed follow-up comprehensive evaluations, a total of 61,769 were confirmed to have incurred a mTBI. The length of time to complete the comprehensive evaluation from the time of the initial positive screen averaged about 24 days, well below the 30 day target.

DoD Instruction (DoDI) 6490.11, “DoD Policy Guidance for Management of Mild Traumatic Brain Injury/Concussion in the Deployed Setting,” dated September 18, 2012, mandates Service members involved in potentially concussive events in the deployed setting be screened, identified, and treated promptly for concussion. The policy seeks to prevent long-term problems associated with concussions by providing early treatment and reducing the possibility that Service members could be exposed to further injury. The DoDI also identifies specific reporting requirements so that Service members who have been exposed to potentially concussive events are identified and tracked. Through the third quarter of FY 2013, a total of 1,076 Service member exposures to potentially concussive events were reported to the Combined Information Data Network Exchange/Blast Exposure and Concussion Incident Report event-triggered system. Among these, 937 (87 percent) had identifiable medical records and were evaluated for concussion, resulting in 227 identified concussions translating to a 21 percent positive screening rate. The initial identification of a concussion is provisional, pending confirmation by a comprehensive medical record review.

In June 2013, the Army released as policy a garrison concussion program that mandates TBI screening for potentially concussive events, reflecting the same requirements as in the deployed environment. This policy also outlines mandatory training requirements. The TBI worldwide numbers, which are posted on the DVBIC Web site, continued to show that an overwhelming 86 percent of TBI occurs in the non-deployed setting. This continued trend has been the driver to ensure early detection and prompt treatment remains the goal in the non-deployed environment as well as the deployed environment.

In FY 2013, VA established the capability to conduct TBI tele-evaluations. This pilot project began in December 2012 with 16 PSC sites. An additional 15 PSC sites were added in FY 2013. Thus far, 176 unique visits and 61 follow-up visits have been achieved through this tele-rehabilitation pilot program. A virtual training program for VA providers who will conduct tele-evaluations has been developed. The additional FY 2013 PSC sites will be trained in the first quarter of FY 2014,

resulting in at least one PSC site per Veterans Integrated Service Network (VISN) in this pilot. A SharePoint site has been established for VA TBI specialists and facility telehealth coordinators to access training modules selected for this standardized evaluation. The goal of this pilot project is to increase clinical accessibility to specialty care assessment for Veterans with a history of TBI, who live in geographically remote regions, or otherwise experience challenges accessing specialty care. The findings of this pilot will be used to develop joint telehealth evaluation protocol and implement those protocols at identified DoD sites in FY 2015.

Improve Access to and Reduce the Stigma Associated with Seeking Mental Health Care

Facilitating Connections with Care

inTransition is a program to assist Service members requiring behavioral health treatment and who are transitioning between health care systems, status, or location. *inTransition's* mission is to support continuity of care for the Service member during transition. A transition coach provides support and guidance on PH concerns, resources, and healthy living, while motivating and assisting the Service member to connect with a treatment provider post-transition. VA and DoD developed and provided joint training to promote referrals from VA and DoD providers to the *inTransition* program. Additional outreach efforts included activities such as presentations at Yellow Ribbon Reintegration Program events, virtual overviews of the program with Navy health clinics, meeting with the Director of Operations and Manager of Field Operations for the USO to support distribution of *inTransition* materials, and a presentation at the DCoE-sponsored Warrior Resilience Conference. This program is also one of the IMHS SAs.

Since the program began, there have been a total of 4,246 coaching cases through August 2013. Service members were asked to complete a voluntary satisfaction survey at the end of the program, and in January 2012, DoD issued an Interactive Customer Evaluation (ICE) satisfaction survey for this program. Of the 105 ICE satisfaction surveys completed by a Service member from January 2012 through August 2013, 95 percent of responders reported being satisfied with their experience; 95 percent of responders reported they would recommend this program to others; 95 percent of responders indicated that the program met their needs; and 93 percent of responders indicated that the assistance they received from the *inTransition* Program increased the likelihood that they would continue treatment at their new location. Data collected from 47 providers who returned a provider ICE survey, with the same date range as above, indicated 95 percent overall satisfaction with the program, 95 percent would recommend the program to others, and 100 percent reported the service met their needs.

National Efforts to Reduce Mental Health Stigma

VA and DoD have launched successful national public awareness campaigns aimed at reducing the stigma associated with mental health concerns and seeking treatment. VA's Make the Connection¹⁴ and DoD's Real Warriors Campaign¹⁵ are separate campaigns designed to target their specific audiences, but complementary to one another with ongoing coordination between the teams working on both campaigns.

¹⁴ <http://maketheconnection.net/>

¹⁵ <http://www.realwarriors.net/>

During FY 2012, VA launched Make the Connection, a national public awareness campaign to connect Veterans and their families with information about mental health resources and to help them discover ways to live more fulfilling lives. Testimonials from Veterans of all eras, genders, and backgrounds are at the heart of the campaign. The campaign goals are to: reduce the stigma Veterans and their families associate with seeking mental health services; educate Veterans and their families about the signs and symptoms of mental health issues; increase awareness of and trust in VA's advances in mental health services and its commitment to delivering accessible, high quality, patient-centered care; and promote help-seeking behavior for those who need care. The campaign experienced substantial high volume growth throughout FY 2013:

- 1,390,618 million Web site visits during FY 2013 for a total of over 2.8 million since launch; a 96 percent increase over the previous year.
- Launch of a mobile Web site that maintains the dynamic features of the desktop site, including the filter, the video gallery, and the resource locators.
- 3,461,449 Make the Connection video views in FY 2013 for a total of over 6.6 million since launch; an increase of 108 percent.
- More than 7,692 viewers have subscribed to the campaign's YouTube channel.
- Development of a social media plan and standard operating procedures, and launch of a Facebook page during FY 2012 yielded metrics and analysis including audience and reach, content and engagement, page visitor traffic trends, user demographics, user activity, and interaction with content.
- During the first six months after launch, from June 2012 to December 2012, the campaign's Facebook page was the fastest growing community in the government/military sphere. The page now has over 1.8 million fans and 734,994 were added in FY 2013. In addition, engagement rates continued to stay high with an 11 percent "People Talking About This" rate (reported by Facebook, this includes fans commenting on, sharing, or liking posts and/or the page on a weekly basis). This is five times greater than the average rate of engagement for similar pages. Finally, the Facebook page has achieved more than 4.2 billion total impressions¹⁶ from organic, viral, and paid advertisements.
- The campaign's second PSA, "Veteran Strength and Connection," began distribution in March 2013 and has achieved over 115 million impressions for a media value of over \$2 million. This is similar to results from the campaign's first PSA in FY 2012.
- The campaign's paid media has included online, television, radio, and print advertising, achieving more than 4 billion impressions.
- To date, the campaign has garnered more than 50 awards from many notable organizations and associations including the Association of Marketing and Communication Professionals, the Service Industry Advertising Awards, the Telly Awards, American Psychological Association, Interactive Media Awards, and the National Association of Government Communicators.
- The American Legion and the White House blogged about the campaign and it was referenced in congressional testimony multiple times since its launch.

¹⁶ Impressions are the number of times an ad is displayed and represents the potential number of people who are reached by that ad.

- The campaign has filmed over 300 Veterans, in 19 locations nationwide, for a total of almost 450 videos currently available on the Web site (approximately 20 hours of video content). These candid, powerful stories of Veterans' strength and resilience are the centerpiece of the campaign.
- VA and DoD continue to coordinate efforts and discuss Web resources, social media, and coordinated messaging. During FY 2013, VA and DoD campaign teams met for discussions multiple times and have submitted joint conference presentations.

DoD's Real Warriors Campaign is a multimedia public awareness campaign to encourage help-seeking behaviors among Service members, Veterans, and families coping with psychological health concerns, and to promote awareness and use of available resources. The campaign is an integral part of DoD's overall effort to eliminate stigma and encourage Service members and families to seek appropriate care and support for psychological health concerns. To reach the broadest audience possible, the campaign employs a variety of strategies including event outreach and partnership engagement, print materials development and dissemination, media outreach, an interactive Web site, and social media engagement. The campaign features stories of real Service members who reached out for psychological support or care with successful outcomes, including learning coping skills, maintaining their security clearance, and continuing to succeed in their military or civilian careers. There were 326,509 visits to the Real Warriors Campaign Web site in FY 2013 through August 2013. This reflects a 43 percent increase over Web site visits in FY 2012 and surpasses the 10 percent increase target. Additional FY 2013 accomplishments for the Real Warriors Campaign as of August 31, 2013, include:

- Garnered 350,704 interactions (i.e., likes, comments, shares, re-tweets) via social media channels, potentially reaching 850,000 unique individuals, through 4,557 campaign messages promoting campaign content and directing Service members and their families to actionable resources. Online audiences engaged with the campaign 24/7/365 and, on average, 1,042 times every day, representing an 889 percent increase in engagement from FY 2012. As a result, the campaign's social media presence is one of the most engaging and most mentioned brands in the military health space.
- Produced one video profile, two video PSAs containing excerpts from the video profile, one radio PSA titled "Coping With Invisible Wounds: Reach Out for Help," and eight podcast episodes.
- Posted five new Web articles, one new mini-brochure for Veterans, one new mini-brochure for active duty Service members, and 11 updated articles.
- Through video and radio PSAs on Armed Forces Radio and Television Service, the campaign continued to reach international military audiences. In FY 2013, campaign video PSAs aired 772 times and radio PSAs aired 13,175 times, reaching more than 2 million Service members in 177 countries each week, including Iraq and Afghanistan. A total of eight video and radio PSAs aired on five TV and 12 radio military stations or networks, potentially reaching an estimated 2 million individuals. Two radio PSAs aired 1,687 times on one civilian channel, reaching an estimated 4.43 million listeners. Four TV PSAs aired 1,426 times on 23 civilian channels, reaching an estimated 13.45 million listeners. A total of four audio news releases (ANR) were produced, featuring Service member profiles. A total of 6,264 stations and networks aired the ANRs 6,841 times, garnering an estimated 31 million impressions.

- The campaign confirmed 17 partners in FY 2013 for a cumulative 218 partners (DoD, Federal, national, and community groups) to offer the most relevant and updated resources to members of the military community and spread campaign communications and information to our target audience worldwide.
- The campaign potentially reached more than 135 million Service members, Veterans, and their families through 240 campaign articles in partners' blogs, newsletters, and publications since its launch in 2009.
- The Real Warriors Campaign won three industry awards in FY 2013, including a Public Relations Society of America Silver Anvil, honoring the campaign as an integrated campaign, and recognizing the achievements of its mobile site, video products, Web site, and social media channels.

Technological Innovations to Reduce Barriers to Care

There are a range of strategies being utilized in both VA and DoD to leverage technology in ways that reduce barriers to care, and educate and empower Service members, Veterans, and their families. These innovations provide increased access to information online, the ability to complete screening and self-assessments, and ready access to information and assistance via mobile tools. AfterDeployment.org is a multifaceted Web-based application providing information and self-help resources for Service members, Veterans, their families, and health care providers. The Provider Pro section of the site features information specifically for health care providers working with the military community. The site experienced 103,236 visits in FY 2013. Of the site's 20 modules, the top five most frequently visited through FY 2013 were PTSD, Families & Friendships, Sleep, Depression, and Alcohol & Drugs. Among the visitors to the site, 12.4 percent completed a self-assessment, which is 9 to 11 percent higher than a comparable industry average for engaging site visitors. The Military Pathways®¹⁷ Web site was established to assist Service members and their families who are facing various mental health challenges. Service members, Veterans, and family members can answer questions on a variety of mental health issues and receive feedback when further evaluation is needed, as well as guidance on where to seek assistance. In FY 2013, there were 471,604 visits to the Military Pathways® Web site, representing a 60 percent increase over the 295,037 visits in FY 2012. Compared to 43,888 completed screenings in FY 2012, there were 48,729 screenings completed in FY 2013, representing an 11 percent increase. PTSD screenings accounted for 33.5 percent of total screenings in FY 2013, representing a 3.5 percent increase over FY 2012. As providing online screenings is Military Pathway's primary purpose, the "conversion rate," defined as the number of visitors to the Web site who complete a screening, is a more accurate measure of the program's effectiveness than the number of Web site visits. Typical conversion rates for most Web sites are between one and three percent. In FY 2013, Military Pathway's conversion rate was 10.3 percent.

Collaboration between VA and DoD continued with the IMHS initiative focused on providing self-help resources for Service members, Veterans and their families. Two Web courses launched in FY 2013 are titled "Moving Forward"¹⁸ and "Parenting for Service Members and Veterans"¹⁹. While both courses are intended as anonymous, self-help resources that individuals can use on their own, the programs are also very useful within clinical care settings. The Moving Forward

¹⁷ <http://www.militarymentalhealth.org/>

¹⁸ <http://www.startmovingforward.org/>

¹⁹ <http://militaryparenting.org/> or <http://veteranparenting.org/>

course is based on the principles of Problem Solving Therapy and teaches problem solving and emotion regulation skills that individuals can apply to a wide variety of issues. Since the launch in October 2012, Moving Forward has had over 25,000 unique visitors to the site. Parenting for Service Members and Veterans initially launched in April 2013 with additional modules added in September 2013. The Web course provides military and Veteran parents with tools to help them reconnect with their families and build closer relationships with their children. Using stories from real Veteran and military families, videos, interactive activities, and an original curriculum developed by leading experts, the course helps parents learn how to address both everyday parenting problems and family issues unique to their military experience. Companion mobile applications related to both of these Web courses are planned for release in FY 2014.

In addition to innovative Web-based approaches, VA and DoD are leveraging mobile apps for smartphones and tablet computers to enhance access to mental health information and care for Veterans and Service members. For example, VA and DoD jointly launched the PTSD Coach smartphone application in April 2011. As of the end of FY 2013, the app had been downloaded 126,064 times in 78 countries, with 48,703 downloads in FY 2013. PTSD Coach helps users track their PTSD symptoms, links them with public and personalized sources of support, provides accurate information about PTSD, and teaches helpful strategies for managing PTSD symptoms. In FY 2013, the first of the nationalized versions of PTSD Coach were released: PTSD Coach Canada and PTSD Coach Australia, which integrated language, cultural, and local changes into the existing platform to create the foundation for the first truly global mobile resource for mental health. More countries will launch versions in FY 2014.

PE Coach, another joint VA/DoD mobile app, guides and facilitates evidence-based prolonged exposure (PE) treatment for PTSD. The app is designed to be installed onto a patient's personal smartphone and brought into therapy sessions to be used during and between treatment sessions. PE Coach was launched in March 2012 and has been downloaded 16,270 times, with 11,031 downloads during FY 2013. Studies in FY 2013 indicated that providers are using this tool in a significant number of cases across both health care systems, and that the patients and providers find it beneficial to enhancing care.

Following the success of PE Coach, VA and DoD have continued to collaborate to develop and disseminate apps for supporting the provision of face-to-face evidence-based psychotherapies. In FY 2013, two more apps were launched to public marketplaces: Stay Quit Coach for tobacco cessation and CBT-I Coach, which aligns with the national training programs for Cognitive Behavioral Therapy for Insomnia. These apps both allow users to engage with the central elements of the treatment protocols (e.g., homework completion, adherence to medication regimen, necessary self-monitoring), while decreasing implementation challenges associated with standard delivery and increasing opportunities to support sustained relapse prevention. CBT-I Coach has been downloaded 4,708 times since it launched on June 5, 2013. Stay Quit Coach launched on May 30, 2013, and has been downloaded 1,181 times. VA and DoD, in collaboration with the National Child Traumatic Stress Network, launched a mobile Psychological First Aid (PFA) app in August 2012 called PFA Mobile. PFA Mobile is a mobile phone app for mental health providers and other response workers who provide PFA shortly after disasters and emergencies to affected children, families, and adults, as part of an organized response effort. PFA Mobile has been downloaded 6,877 times, with 5,585 downloads in FY 2013.

Providing Care in Alternative Settings

Integrating mental health care into primary care settings is a critical element of improving access to and reducing stigma associated with seeking mental health care. Through the IMHS, considerable work is underway to develop consistent models of care, and a VA/DoD task group was established to address common issues related to integrating behavioral health care into primary care programs.

DoDI 6490.15 “Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Services Settings” was published on August 8, 2013. This DoD policy for integrating behavioral health into primary care, addresses Service responsibilities, program standards, and quality assurance mechanisms. The policy outlines minimum staffing requirements of at least one full-time behavioral health provider at each primary care clinic with 3,000-7,499 adult enrollees and at least one full-time behavioral health provider and one full-time behavioral health care facilitator at each primary care clinic with 7,500 or more adult enrollees. Per minimum staffing policy, 302 MHS direct care primary care clinics will be staffed. As of September 15, 2013, 225 (75 percent) clinics are staffed with 225 full-time behavioral health providers and 73 behavioral health care facilitators. This is an increase of 91 full-time behavioral health staff from September 2012. Each Military Department has established funding, hiring, and training practices and are expected to be fully staffed at the end of FY 2014. VA’s Primary Care-Mental Health Integration Programs combine co-located collaborative care and care management functions to support primary care providers within the Patient Aligned Care Teams in treating common mental health conditions within the primary care setting. Expansion of the scope of these activities continued in FY 2013, as did support of virtual education and regional-based training of integrated mental health and Patient Aligned Care Team staff. As of August 31, 2013, 319 (93 percent) of the 342 VAMCs and Community-Based Outpatient Clinics (CBOC) classified as large and very large have integrated behavioral health programs, compared to 89 percent at the end of FY 2012. Furthermore, seven percent of all primary care patients at these sites were directly served by the program, compared to six percent at the end of FY 2012. In FY 2014, efforts will focus on maintaining program penetration and reducing undesirable variation across sites.

HEC Pain Management Working Group

During FY 2013, the Pain Management Working Group (PMWG) continued work on the development of strategies and processes to ensure eligible beneficiaries receive the highest standards of pain care, delivered seamlessly across both health care systems. This includes the development of education and training programs for clinicians and beneficiaries, and the development of guidelines and training for integrative medicine (IM - formerly termed complementary and alternative medicine) therapies for pain management, such as acupuncture, for use within VHA and DoD. IM training is focused on how these techniques can complement existing pain management best practices rather than being used as ‘alternatives’ to standard care, which is often the case at present. In addition, the PMWG is working on developing standardized assessment and treatment guidelines for use in a stepped care pain management model throughout both systems.

Standardizing Pain Measurement

The May 2010 Army Pain Management Task Force report called for a standardized pain assessment tool to provide a common set of pain measurement questions and visual cues. Until recently, the most commonly used tool to measure pain in both VHA and DoD facilities was the Visual Analog Scale. Although this scale is broadly used, even in the civilian community, many health care providers found the scale to be inconsistently administered and subjective. Therefore, VHA and DoD pain specialists sought to develop a new tool that would be validated, objective, adaptable, standardized, and easily integrated into VHA and DoD databases. During FY 2012, the Defense and Veterans Center for Integrative Pain Management (DVCIPM) developed the Defense and Veterans Pain Rating Scale (DVPRS). This was the first attempt by a major medical system to develop a new pain scale and to standardize the way we measure pain throughout the military care continuum. The first validation study of the DVPRS was published in January 2013. Given the value of this tool to clinicians, deployment to DoD health care facilities has begun, and further validation will continue as its utilization increases within both the VHA and DoD. Additionally, a Spanish language version of the tool was created at the request of South American health care officials. It is expected that standardization of how patients are queried about their pain will provide VHA and DoD a tremendous advantage in evaluating treatment outcomes and developing effective pain treatment strategies.

The Pain Assessment Screening Tool and Outcome Registry (PASTOR)

During FY 2013, the PMWG continued to collaborate with the DVCIPM on further development and deployment of the Pain Assessment Screening Tool and Outcome Registry (PASTOR), a patient self-reported, Internet-based information system designed to assist primary care physicians and pain specialists in enhancing care by increasing awareness of real or potential pain-related health problems. PASTOR will be the key resource for pain management outcomes data for both VHA and DoD and is being designed to work with and complement the PCMH. The first phase of the PASTOR demonstration project confirmed the value of obtaining patient reported outcomes data from patients who access the tool using their own Internet capable devices. The next phase of this project is the development of a Federally owned tool, PASTOR. The PASTOR tool software was recently completed and is undergoing beta testing prior to its projected deployment within the Madigan AMC in early 2014. The program will provide pain patient focused outcomes data to improve clinical decision making, develop data driven and military specific CPGs, obtain critical data to assure needs based alignment of resources, and integrate existing validated outcomes measures into a central data repository that clinicians can use to track patient progress over time.

The Patient Centered Medical Home, Patient Aligned Care Teams, and the Stepped Care Model of Pain Management

To ensure a patient's care needs are coordinated and/or integrated across the entire health care system as well as the patient's community, the PMWG fully endorses the concept of the PCMH. In the PCMH model, the primary care provider leads a team of health care professionals who collectively take responsibility for the ongoing care of the patient. To accomplish this effort, VA and DoD have adopted a single model of care, the Stepped Care Model. In this model, the Primary Care Team (Patient Aligned Care Team in the VHA) is responsible for either personally providing care for the patient, or for appropriately arranging treatment by other qualified health care professionals. In FY 2013, the PMWG received JIF funding to develop, pilot, evaluate, and

implement a Tiered Acupuncture Training Across Clinical Settings (ATACS) program for VHA and DoD providers in order to provide initial access to this modality across VA and DoD treatment facilities. ATACS will provide near-term, standardized integration of this modality into routine pain management across both health care systems, through a practical program of training and certification for providers in battlefield acupuncture to manage pain.

The PCMH facilitates education of both the patient and his/her family on the etiology and management of acute and chronic pain, which may reduce the likelihood of disability, address the under-treatment of pain, and provide for individual tailoring of treatment plans. By the end of FY 2013, DoD obtained formal recognition by the National Committee for Quality Assurance for 172 of its 435 primary care medical home clinics. Both VHA and DoD have developed models to integrate pain teams within their primary care medical homes to improve access to pain management services and improve the quality of care provided to their beneficiaries. The PMWG has a sub-WG to continue to explore additional ways to further integrate pain management treatment and education for providers and beneficiaries into the PCMH model. This sub-WG reports its findings monthly to the main workgroup to ensure full integration with other ongoing efforts. Education efforts to help establish this model are described below.

Pain Management Education and Pain Medicine Training

The lack of a consistent approach to pain management education results in considerable variation in pain management understanding and practice within all medical professions. During FY 2013, VHA and DoD continued to collaborate on the development of a standardized pain management curriculum and training program. In FY 2013, the PMWG received JIF funding to develop a Joint Education and Training and Program for providers in both systems. This program will create a basic, shared conceptualization of strong pain care practices that will be the standard in both organizations. Enactment of this curriculum will enhance not only pain care, but also the general health care of all individuals with complex comorbidities such as TBI, depression, and substance abuse. The program should be fully developed within the next twelve months, and implemented across VA and DoD within the next eighteen months.

The PMWG continued to work with VHA and DoD on their Specialty Care Access Networks/Extension for Community Healthcare Outcomes (SCAN-ECHO™) projects for patients and providers in remote areas. The ECHO™ program uses video technology to offer local providers the opportunity to co-manage difficult and complex patients, while simultaneously affording them with the training and technical skills that will allow them to become highly skilled in the treatment of these chronic and complex diseases. Ultimately, this creates a center of excellence in their own community, and diminishes the need to obtain specialty evaluations in these remote areas. VHA adopted the ECHO™ model, and since 2011 has been transforming their Specialty Care Services program by developing SCANS, so that all Veterans, even those distant from medical centers, will have access to specialty level care for chronic disease management when needed. Presently, seven regional VHA centers host SCAN-ECHO™ training in pain management. During FY 2013, DoD continued to adapt and deploy the ECHO™ program to provide pain management services in remote sites and smaller MTFs.

During FY 2013, a DCoE joint task force completed development and deployment of a toolkit that will assist clinicians practically implement the VA/DoD Chronic Opioid Therapy CPGs in the clinics

and at the bedside. The toolkit is available electronically by accessing DoD²⁰ and VA²¹ Web sites, and in hard copy as well. A separate task force of DCoE finalized a VA/DoD CPG for peri-operative pain care, which is in external review prior to final overall review and publication.

Patient Education

Consistent with the PCMH model of care, VHA and DoD are working together to develop patient pain education tools that will be available for both Veterans and Service members to help them understand the integrated, biopsychosocial model of care and their own participation in care. Materials developed in VISN 20 for patient education are being utilized by the T2 Program at Madigan AMC to develop new interactive educational resources on www.afterdeployment.org. These programs will help VA and DoD patients develop, with their providers, specific, personalized plans for self-management of common pain conditions to improve function and quality of life.

The Navy developed a lecture series to assist providers in educating patients, produced a handout on pain management to assist patients and their families better understand the pain management process, and developed an interactive video training tool aimed to be released as “General Medical Training” about prescription medication misuses for all Service members. DoD will continue to collaborate with VA to determine if some of VA’s projects can be adapted to meet the needs of their beneficiary population. The Navy’s Health Promotion and Wellness Wounded, Ill, and Injured team at the Navy and Marine Corps Public Health Center developed a patient information Web site with the objective of facilitating effective pain management, improved level of functioning, and return to mission through the provision of resources to meet the needs of those who are wounded, ill, and injured, their family members, and caregivers.

HEC Telehealth Working Group

The Telehealth WG’s mission is to identify opportunities to expand the joint telehealth program and optimize joint capabilities between VA and DoD. During FY 2013, the Telehealth WG identified several areas of focus to improve standardization and integration of telehealth activities between Departments:

- Report – produce report on current state of, and plans for, telehealth in and between Departments.
- Policy – analyze and make recommendations on policy improvements that impact the Departments’ ability to collaboratively develop telehealth services.
- Credentialing and Privileging – streamlining process in and between Departments.
- Training – develop options for sharing existing telehealth training resources between Departments.
- Joint Demonstration Projects – foster existing joint telehealth collaborations between Departments, and implement new collaborations.

The WG reported on the current state of telehealth in and between the Departments and the efficacy and efficiencies of inter-Departmental telehealth care. These products were significant

²⁰ <https://www.qmo.amedd.army.mil>

²¹ <http://www.healthquality.va.gov>

in establishing the first baseline for telehealth activity within and between the Departments. They informed the subsequent MHS Telehealth Strategic Planning Forum with VA collaboration held on September 17, 2013. The Forum resulted in the DoD decision to develop telehealth as a core MHS capability.

Additionally, the WG identified policy issues impacting cross-Departmental telehealth but did not find significant legal or regulatory issues requiring legislative relief at this time. With the goal of developing recommendations to link credentialing and privileging processes between the Departments, the WG reviewed existing telehealth credentialing and privileging processes within each Military Department, and determined no significant discrepancies. In FY 2014, the WG will begin the next phase by comparing VA and DoD credentialing and privileging processes to make recommendations to link these processes across Departments. The WG established a SharePoint collaboration site for sharing telehealth training resources. In concert with IMHS SA 6, the WG established a VA/DoD demonstration project to deliver tele-behavioral pain consultation from VA clinicians with specialized expertise to DoD patients. A Memorandum of Understanding (MOU) is currently in development to establish a tele-insomnia demonstration project between Camp Lejeune and the VA's National Center for Telemental Health. The provision of these services from a VA specialist to DoD patients will not only provide needed clinical care, but will also provide models for further joint telehealth services.

Sub-goal 2.3: Value – Encourage substantive improvement for patient-focused, high-value care, which includes the delivery of the right health care to the right person, at the right time, for the right price through the use of reliable health care cost and quality information.

HEC Vision Center of Excellence

The VCE was tasked to implement a Vision Registry to collect longitudinal data on eye injuries, guide research, promote best practices, and guide clinical education for the treatment of eye and vision related injuries for Service members and Veterans. During the first quarter of FY 2013, the Defense Veterans Eye Injury and Vision Registry (DVEIVR) transitioned from the pilot/prototype phase and into a program of record.

DVEIVR used a Community of Interest and agile development approach, allowing the registry to remain flexible in design to meet user expectations. The Business Case Analysis was completed ahead of schedule and used to acquire a milestone decision, allowing the project to move forward in the acquisition process. The DVEIVR team refined the service interface between the VA Eye Injury Data Store and the DVEIVR, enabling a seamless transition of ocular clinical related data. Testing and evaluation was scheduled for the end of FY 2013 to support deployment decision. DVEIVR data quality is consistently at the 98 percent level, exceeding the 96 percent accuracy requirement.

In addition, VCE facilitated collaboration within VA and DoD ocular communities to present a research proposal to TATRC for development of an optimal vision care application focused on the standardization of vision care documentation. The proposal was accepted for award consideration. Using human factors and cognitive workflow analyses to improve understanding of

care processes, the functional requirements for an optimal vision care application will be developed. This project is expected to be a useful component of the interoperable VA and DoD electronic health record systems.

HEC Interagency Clinical Informatics Board

The Interagency Clinical Informatics Board (ICIB) serves as the primary source of input from clinical stakeholders in recommending priorities for enhancing information sharing in support of the care delivery process for common beneficiaries of VA and DoD. The ICIB provides input to the integrated Electronic Health Record (iEHR) and Virtual Lifetime Electronic Record (VLER) Health programs to ensure that clinical input from practicing health care providers is received for iEHR, VLER, and other health IT programs across their full development and implementation lifecycles. Given the fast-moving or “agile” schedule of the iEHR program, the ICIB is focused almost entirely toward these programs.

Beginning in FY 2012, the ICIB held a series of meetings called iEHR Rehearsal of Concept (ROC) drills with a goal of synchronizing essential input from practicing providers across the full lifecycle of the iEHR program. The ROC Drills each leveraged the participation of not only clinicians, but also the staff of the VA/DoD IPO to ensure feedback from the clinical community into iEHR implementation strategies. The fourth and final ROC drill occurred on October 2, 2012. The results of the ROC drills, along with an integrated master schedule of functional activities across the lifecycle of the iEHR program were provided as inputs to the IPO for program execution.

The ICIB and dedicated providers and support staff across VA and DoD exceeded their goal by completing Business Justification Packages (BJPs) for seven iEHR Capabilities by March 31, 2013 including User Experience, Access Control, Patient Identity Management, Laboratory/Anatomic Pathology, Orders Service, Clinical Decision Support and Identification and Data Capture Service. As the Departments continued support of the iEHR initiative in FY 2013, the ICIB activated four additional Capability IPTs (C-IPTs) including Care and Disease Management (CDM) in November 2012, Registration Enrollment and Eligibility (REE) in February 2013, Disability Evaluation (DE) in April 2013, and Consults & Referral Management (C&RM) in May 2013. The BJPs for CDM and REE were accepted as completed at the end of FY 2013. Each iEHR C-IPT brought together SMEs from all three Military Departments, TMA, and VA to perform business architecture assessments, requirements development, and business process re-engineering activities to produce the documentation required to support the acquisition of iEHR capabilities.

In February 2013, the Secretaries of VA and DoD redirected the acquisition strategy of the iEHR program from a single, “integrated EHR” serving both Departments to two, “interoperable” EHR systems supporting a single electronic record for each Service member and Veteran. As a result of this new guidance, the ICIB is piloting an Information Exchange IPT (IE-IPT) approach that may replace the C-IPT process and structure with a focus on health care data. In addition to the IE-IPT process, clinical experts in specific data domains are working closely with iEHR development teams in the IPO to ensure effective clinical integration of iEHR solutions. ICIB is currently assessing its charter and WG structure to better support the changes in iEHR program direction.

Additionally, enterprise-wide requirements for the iEHR program were completed and approved by the HEC, to include the clinical quality requirements in the Enterprise Level Clinical Quality Requirements document, as well as the functional and technical requirements in the Integrated Program Level Requirements Document. The ICIB received delegation authority for the approval of project-level requirements within the iEHR program, which shortens processing time within the program. The ICIB also developed additional program-level documents including the iEHR Guiding Principles and iEHR Scope Statement.

DoD/VA Interagency Program Office

FY2013 marked a change in strategy for the DoD/VA IPO. IPO first focused on executing iEHR Increment 1 and Increment 2.²² This strategy changed beginning in February 2013, when Secretary Panetta and Secretary Shinseki revised the iEHR Program strategy and agreed to a series of “quick wins” to accelerate data interoperability between the Departments.

The Departments are now pursuing two distinct goals to attain the President’s vision to “define and build a seamless system of integration with a simple vision: When a member of the Armed Forces separates from the military, he or she will no longer have to walk paperwork from a DoD duty station to a local VA health center; their electronic records will transition along with them and remain with them forever.” Specifically, the Departments’ goals are to:

1. Provide seamless, integrated sharing of standardized health data among DoD, VA, and private sector providers.
2. Modernize the Electronic Health Record (EHR) software and systems supporting DoD and VA clinicians.

Throughout FY 2013, IPO worked with the Departments in the pursuit of standards-based data interoperability between the Departments’ EHR systems.

Progress on Goal 1: Interoperability

As of September 2013, the Departments exchange more than 1.5 million elements of data daily, most of it in read-only format. To improve data sharing in FY 2013, IPO began working with the Departments to implement national standards-based “computable” data formats within each of their EHR systems. This process includes identifying national standards-based data formats and initiating data mapping to standardize patient data for seven of the highest priority health data domains: medications, allergies, labs, vitals, immunizations, documents / notes, and problems list.

To further support standards-based data sharing, throughout FY 2013, IPO engaged in the national dialogue on health IT, participating with standards requirements and delivery

²² iEHR Increment 1 (DoD only) consisted of the following baselined capabilities: Single Sign On/Context Management, Application Virtualization Hosting Environment in one location. iEHR Increment 2 (DoD and VA) consisted of various infrastructure components and the drafting of Requests for Proposals to procure pharmacy, laboratory, and immunization applications.

organizations such as Office of the National Coordinator for Health Information Technology (ONC), National Library of Medicine, and Health Level 7 (HL7).²³ As presented at the Accelerator Design Review in August 2013, IPO implemented the HL7 Fast Health Interoperable Resources model, the HL7 Retrieve, Locate, and Update Service standard, and the HL7 Common Terminology Service. IPO also provided feedback to standards bodies in order to influence subsequent versions of the standards.

Lastly, IPO finished all of the key Accelerator projects scheduled for completion in FY 2013. The Departments will develop and deploy follow-on Accelerator initiatives (e.g., Identity Management, Data Federation, Joint Legacy Viewer (JLV) and Medical Community of Interest) during FY 2014. These efforts will continue to expand the already robust level of interoperability among DoD, VA, and private sector healthcare providers.²⁴

Progress on Goal 2: Modernization

In February 2013, VA determined that its best course of action would be to evolve its legacy EHR system, Veterans Health Information Systems and Technology Architecture (VistA), to serve the Department's modernization goal. The decision to proceed with this system update (known as VistA Evolution) included such factors for consideration as VistA's large installed base, trained workforce, and in-house development and support capacity. The VistA Evolution program lead is the VA Chief Information Officer, the senior official responsible, in coordination with the clinical stakeholder community as they help prioritize module modernization. This process will assist with the development of VistA Evolution deliverables and will help achieve health data interoperability by including lessons learned from external health systems, open source communities, and industry.

On May 21, 2013, Defense Secretary Hagel announced the DoD decision to pursue a full and open competition to modernize its EHR systems. His memorandum directed the Under Secretary of Defense for Acquisition, Technology, and Logistics (USD (AT&L)) to assume responsibility for "DoD health care records interoperability and related modernization programs" and serve as the Milestone Decision Authority for the DoD Healthcare Management System Modernization (DHMSM) Program. The DHMSM Program Management Office will use a competitive acquisition process that considers commercial alternatives that may offer reduced cost, reduced schedule and technical risk, and access to increased current and future capability by leveraging advances in the commercial marketplace. Based on market research, a VistA-based solution will likely be part of one or more potential solutions that DoD evaluates.

As mentioned, VA decided in early 2013, to modernize their VistA platform, and, following Secretary Hagel's May 21st memorandum, in July 2013, DoD decided to establish a Program Executive Office to initiate a competitive acquisition to replace legacy EHR systems. The Departments agreed to reassign responsibility from IPO to the Departments for the

²³ HL7 is a global application-level standard for interoperability of health IT.

²⁴ Interoperability is defined by the Institute of Electrical and Electronics Engineers as the "ability of a system or a product to work with other systems or products without special effort on the part of the customer" and is made possible via standards. (http://www.ieee.org/education_careers/education/standards/standards_glossary.html)

modernization of their respective EHR systems. Consequently, the IPO role will change as each Department moves forward. However, both Departments will continue working closely to remain synchronized as they achieve Goal 2.

GOAL 3

Efficiency of Operations

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

Sub-goal 3.1: Jointly refine and improve the Integrated Disability Evaluation System (IDES) process.

BEC Disability Evaluation System Working Group

The VA/DoD DES Pilot program was instituted under the Senior Oversight Committee (SOC) in 2007 and was incorporated into the JSP for FY 2009-2011. As of January 2012, when the SOC was consolidated into the JEC, the JEC and subordinate BEC began overseeing the Integrated Disability Evaluation System (IDES). IDES was formerly known as the DES Pilot (ended in 2010). The BEC DES WG, an action officer-level joint oversight body officially chartered August 24, 2012, provides quarterly briefings to the BEC, which in turn informs the JEC.

DoD and VA initiated the DES Pilot in November 2007 in the National Capital Region at three MTFs: Walter Reed Army Medical Center, Bethesda National Naval Medical Center, and Malcolm Grow Medical Center (Air Force). Compared to the previous separate DoD and VA disability evaluation processes, the IDES process is simpler and more transparent for seriously ill or injured Service members. Service members in the IDES undergo a single disability examination instead of separate examinations by each Department. They receive more consistent DoD and VA disability ratings and anticipated benefits information simultaneously, prior to separation, which enables them to make better informed decisions about their future.

In July 2010, the co-chairs of the SOC agreed to expand the DES Pilot and rename it IDES. Senior leadership of DoD, VA, the Services, and the Joint Chiefs of Staff strongly supported this plan and the need to expand the benefits of this improved process to all Service members. Expansion and full implementation of IDES was completed by September 30, 2011. Currently, there are 139 IDES sites operational worldwide, including the original DES Pilot sites.

Since November 26, 2007, DoD enrolled 95,058 Service members in the IDES. A total of 59,409 Service members completed IDES by returning to duty or receiving VA benefits and 3,930 were removed for other reasons (e.g., additional medical treatment, administrative discharge). As of September 30, 2013, 31,718 Service members were enrolled in the IDES.

Active Component Service members who completed IDES in September 2013 by returning to duty or receiving VA benefits averaged 374 days from entry. This 374-day average is 27 percent slower than the IDES goal of 295 days established for Active Component Service

members, but includes an average of 84 days of transition time during which Service members out-process from their installation and take voluntary, pre-separation leave and permissive travel which are not part of the IDES process. The 374-days also includes an average of 134 days for proposed ratings and 72 days for benefit notifications. Reserve Component and National Guard Service members who completed IDES averaged 404 days from entry to receipt of VA benefits, which is 32 percent slower than the IDES goal of 305 days. Overall, IDES was 30 percent faster in FY 2013 than the 540-day benchmark for the separate pre-IDES DoD and VA disability evaluation processes. As of September 30, 2013, 32 percent of Service members (Active and Reserve combined) met the overall timeliness goal. IDES also reduced the post-separation gap between military pay and receipt of VA disability benefits.

As of September 30, 2013, VA has completed the following number of cases in the four core areas of responsibility in FY 2013:

- Claims Development – 32,461 (cases developed)
- Medical Exams – 32,442 (exams)
- Proposed Ratings – 28,136 (ratings)
- Benefit Notifications – 27,310 (benefit letters)

The Departments continue to refine and improve the IDES with numerous efforts, both independently and in close collaboration. In FY 2013, major efforts in this area included:

- In April 2012, the Secretary of Defense and Secretary of Veterans Affairs directed their respective Departments to implement a paperless, searchable claims file for the IDES. The Departments developed an electronic case file transfer capability (eCFT) for IDES cases. The Departments conducted a pilot test of that capability at 9 locations from September through November 2012 and very limited evaluation continues at two Air Force installations. The requirement to establish a bi-directional data exchange capability between VA's Data Access Service (DAS) to Veterans Benefits Management System (VBMS) was identified. Interfacing both systems should reduce redundancies and increase the speed, accuracy, and transparency of the IDES process by synchronizing the systems to allow for automatic transfer of case documentation, real time case updates, and required notifications to the appropriate users from each Department. Once the bi-directional capability is established the system will have to be retested.
- Surveys of over 18,000 Service members in the DES from 2009 – 2011 showed that IDES participants were more satisfied with their overall experience and fairness of the process than participants in the legacy DES process. DoD began using an improved IDES customer satisfaction survey in July 2013 to ensure better coverage and to provide more actionable results.
- Disability Benefits Questionnaires (DBQs), already in use with Veterans claims, were implemented for use at all IDES sites on October 1, 2013. Use of DBQs should help decrease rates of inadequate medical exams and allow digitalization of IDES medical exam information for input into VBMS.

- VA, in coordination with the Defense Financial Accounting System (DFAS), is implementing a “VA Pay First Concept” which enables VA to pay separating Service members quicker. Phase I of the DFAS system changes were implemented in September 2013 and phase II is scheduled for completion in 2014. The pay first concept, upon full implementation, will remove the necessity for VA to delay processing until DFAS has completed development of military retired pay.
- VA began exploring the feasibility of eliminating duplicate internal rating action that is required in the current process model. The ability to streamline the proposed and final rating actions by utilizing existing rating data will reduce time and work required to finalize IDES awards and deliver benefits to separated Service members. This action is pending system changes before it can be implemented.
- In May 2013, VA added 182 claims processors and 36 additional raters at the Seattle Disability Rating Activity Site (DRAS) to assist with the backlog of Army claims. DoD also provided 20 Army personnel to perform administrative tasks associated with preparing cases for rating. Seattle DRAS increased production to 4,000 ratings per month by October 2013 and is projecting 5,000 ratings per month by May 2014. The new raters are currently attending training and began rating cases in October 2013.
- During FY 2013, overall DoD IDES timeliness improved for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) parts of the process and the Navy and Marine Corps met or exceeded the overall Active and Reserve Component processing timelessness goals. As of September 30, 2013, 60 percent of Service members completed the DoD core process steps (referral, MEB, informal PEB, and transition) within the established timeliness goals. The number of Army enrollments began to decline with reduced combat operations and this trend is expected to continue. In December 2012, DoD assumed responsibility to download DD Form 214s from the Defense Personnel Records Information Retrieval System (DPRIS) and upload them into Virtual VA to assist VA in completing IDES final benefit determinations sooner. DoD has provided VA with over 13,000 DD Form 214s enabling VA to complete its disability benefit notifications for those cases sooner.
- Established the Senior Leader Council, Chaired by the Office of Warrior Care Policy (WCP) Deputy Assistant Secretary of Defense, and consisting of Military Department Manpower and Reserve Affairs and Surgeons General Principals, collaborating to improve DoD’s disability evaluation program; and to begin informing and pursuing a strategy to improve DES IT support. WCP worked with IDES subject matter experts provided by the Senior Leader Council to document each Service specific end-to-end IDES business process and each Service’s “As-Is” and desired “To-Be” IT environments supporting IDES. WCP developed a Business Needs Statement for a future Joint Disability Evaluation System (JDES) IT Solution (October 2013), began developing a Business Requirements Document for the JDES IT Solution (by December 2013), and began developing a Data Dictionary of standard data elements required by each Service and the VA to process IDES cases (by December 2013).

Additional IDES improvement during 2013 included:

- Published semi-monthly IDES Performance Reports to provide installation and overall case-level performance information for use by stakeholders at all levels. In FY 2013, the BEC DES WG developed a comprehensive case-level workbook (the IDES Case Tracker), expanded measurements and improved stage/phased accounting, developed actionable visualizations that reveal the current state of enrolled cases, and reported metrics which clearly measure the prevalence or effect of inadequate or insufficient medical exams.
- Developed Physical Evaluation Board Liaison Officer (PEBLO) Training Standards and Performance Objectives (TSPO) Guidebook. In process of developing TSPOs for additional IDES stakeholders to include MEB Physicians, MEB Convening Authorities, PEB Physicians, PEB Line Officers, Patient Administration Officers, and Administrative Assistants.
- Developed the Disability Evaluation System Quality Assurance Program (DES QAP) study. In December 2012, Congress requested the Secretary of Defense to develop a plan to standardize, assess, and monitor the DES QAP of the Military Department. To that end, the DoD has implemented a QAP with the objective of ensuring the accuracy and consistency of MEB and PEB determinations, as well as monitoring and sustaining the proper performance of the duties of the MEBs, PEBs, and PEBLOs. DoD is required to provide an annual report to Congress on the status and results of the QAP beginning in June 2014.
- WCP conducted the IDES PEBLO Study to address Congressional concern with PEBLO staffing, experience, and training. Through site visits, comparison of training curricula, review of regulations, data calls, and Military Department manpower studies; WCP determined the number of authorized and assigned PEBLOs at each MTF, the effectiveness of PEBLO training, the current ratio of PEBLOs to Service members in DES, the optimal PEBLO staffing levels, and the sufficiency of PEBLO experience levels. WCP published an interim report to Congress in July 2013, and will publish a final report by February 2014 displaying these findings.
- VA incorporated a review of IDES operations into its standard protocol for Central Office oversight visits to Regional Offices. This review ensures consistency in application of IDES policies and procedures and provides an opportunity to conduct on-site retraining when needed. These on-site reviews allow VA to review individual IDES case files, validate data collection, and identify unique challenges and best practices.
- VA updated its training materials and curriculum for Military Services Coordinators (MSCs) supporting the IDES program. A two week, interactive, Web-based training program was conducted in December 2013. The training session was made available to all MSCs who had completed pre-requisite claims-development training and had not yet attended centralized IDES training. VA plans to offer this training program on a

continuing basis to ensure that all MSCs, including new hires, will be provided IDES-specific training in addition to the standard claims-development training.

Sub-goal 3.2: Oversee the entire life-cycle of the paper military service treatment record (STR).

BEC Medical Records Working Group

The BEC Medical Records Working Group (MRWG) was established to oversee the entire life-cycle of the paper military STR, with an emphasis on ensuring accurate and complete STR related information for all Service members is available to VA and DoD designated benefits adjudicators. In FY 2013, the working group continued its work on enhancing and improving collaborative efforts in managing paper records in support of improving Veterans' disability claims processing, and also added preparing for digitizing paper STRs with the deployment of the Health Artifacts and Images Management Solution (HAIMS).

In FY 2013, the Military Departments continued to reduce the amount of loose and late medical documentation sent separately from the transfer of the official STR to the VA Records Management Center. This metric is important because loose and late flowing documentation creates delays in claims processing for VA and can result in Veterans having claims denied due to lack of medical evidence. The baseline at the end of FY 2012 was 285,000 documents, and at the end of this fiscal year the amount of loose and late flowing medical documentation was 155,000 documents, an additional 44 percent drop in the volume that has been tracked since FY 2009, when the initial documentation totaled 3.6 million. The overall drop for the 5 year time period is 96 percent, meeting the established target a year early.

The MRWG oversaw the implementation of a new Gold Standard for providing VBA with "certified and complete" STRs. The Gold Standard for STRs is the complete Medical Record (to include military treatment facility care, contract civilian treatment facility care [TRICARE], inpatient discharge summaries, entrance and exit examinations, radiology and laboratory results reports), Complete Dental Record, DD 214 "Certification of Release or Discharge from Active Duty"/Separation Orders, and the DD Form 2963 "Service Treatment Record Transfer or Certification." In July 2013, the DD Form 2963 "Service Treatment Record Transfer or Certification" was approved and promulgated to the field for certifying STRs as complete. This effort was undertaken in order to assist VBA in meeting its duty to assist requirements under the Veterans Claims Assistance Act of 2000, and is anticipated to have a large impact on preventing future claims backlogs. The Military Services steadily improved their performance in meeting the Gold Standard, and at the end of the fiscal year were at 69.3 percent, well on the way to meeting the goal of 98 percent by November 1, 2013.

The MRWG intensified its work with the Military Health System Chief Information Officer's (MHS CIO) office as they entered the final stages of deploying HAIMS, by December 31, 2013. This technology will enable DoD to scan STRs into a repository so that the STRs are electronically available to VBA. Beginning January 01, 2014, VBA will be able to access, in real time, the STRs for all Service members separating from military service on and after January 01, 2014.

Sub-goal 3.3: Ensure appropriate Departments, Agencies, Service members, Veterans, and representatives have immediate and secure access to reliable and accurate benefits-related data.

BEC Information Sharing/Information Technology Working Group

The purpose of the VA/DoD BEC Information Sharing/Information Technology (BEC IS/IT) WG is to facilitate the electronic exchange of personnel and benefits data between DoD and VA. The BEC IS/IT leverages VA and DoD enterprise architectures to support the appropriate Departments, Agencies, Service members, Veterans, their beneficiaries, and their designees for immediate and secure access to reliable and accurate administrative/personnel and beneficiary data. The BEC IS/IT WG continued to enhance benefits delivery through oversight and management of the following initiatives.

DoD Self-Service (DS) Logon

DS Logon is a secure identity (username and password) that is used by various DoD and VA Web sites, including eBenefits. The BEC IS/IT was successful in implementing the capability to provide all Service members DS Logon accounts, which are being provided to all new accessions and all Service members that are separating or transitioning from the Service. Additionally, all Service members can now access eBenefits using a CAC. Services continue to socialize the benefits of having a DS Logon (in addition to using a CAC to access eBenefits). The Defense Manpower Data Center (DMDC) provided monthly metrics that reflect DS Logon accounts by Service (Active and Reserve Components) and Veteran accounts. As of September 30, 2013, there were 3,059,696 registered users in over 180 countries. This growth of registered eBenefits users represents a growth rate of over 57 percent in FY 2013 as compared to the previous fiscal year.

eBenefits

eBenefits is a joint VA/DoD initiative that, through a single, self-service portal, increased access to information and streamlined the application process in the delivery of benefits and health care for Service members, Veterans, and their families. The BEC IS/IT WG has provided proactive and transactional self-service capabilities through 14 consecutive quarterly releases since October 2009 in support of the VLER Capability Area 4. In FY 2013, additional eBenefits self-service features and major enhancements were deployed, bringing the total number of self-service capabilities to over 50. The BEC IS/IT developed the fourth consecutive yearly eBenefits Roadmap for calendar year 2013, showing the scheduled releases of enhancements and new capabilities, for each quarter. The quarterly releases in FY 2013 provided users with new or improved access to information and resources as follows:

Release 4.3 was deployed on January 6, 2013 (Winter 2012) and contained the following features:

- Direct Express Debit Card Personal Contact Information Update – Allows users to view their Direct Express accounts, and in certain situations, allows users to change to either a Direct Deposit/Electronic Funds Transfer account or standard banking account.

- Benefits Explorer (updated for Vocational Rehabilitation and Employment Phase 1) with Chapter 31 (Training and Rehabilitation Chapter in US Code (Title 38)) Requirements – This feature provides Veterans with the capability to determine if they are eligible for Chapter 31 benefits. Verification presentation is provided on-screen as well as printable.
- Veterans Authorization and Preferences – Consumer Policy and Preference system – Allows users to submit Nationwide Health Information Network and Social Security Administration authorizations and revocations.
- CAC Enable User Access – Enables users to use their CAC to log on to eBenefits.

Release 4.3.1 was deployed on February 17, 2013 (Winter 2012) and contained the following features:

- Compensation and Pension (C&P) Claims Enhancement – This feature enhances uploading supporting documents for Compensation or Pension claims.
- Service members Group Insurance (SGLI) online enrollment system (SOES) Requirements – This feature provides Service members the capability to enroll and manage SGLI policies and beneficiaries' information through the eBenefits portal. This feature is hidden until all branches of Services have been integrated into SOES.
- VONAPP (Veterans On-Line Application) Direct Connect (Automated) Form 21-22/22a – Allows users to request a representative thru VONAPP Direct Connect.
- CAC Enable User Access – Requires CAC for logon to eBenefits.

Release 5.0 was deployed on March 24, 2013 (Spring 2013) and contained the following features:

- Payment History feature– This feature allows Veterans, surviving spouses and other dependents to view their payment history in eBenefits and on their mobile device.
- Knowledge Management Integration Link– This feature provides a link to the Knowledge Management portal.

Release 5.01 was deployed on April 21, 2013 (Spring 2013) and contained the following features:

- View modifications to payments for Veterans.
- View modifications to payments (Mobile).

Release 5.02 was deployed on May 19, 2013 (Spring 2013) and contained the following features:

- Veterans Online Application (VOA) – Allows Veterans to access the VA Form 1010ez form (allows request for VA ID Card) from the VOA Web site from eBenefits.
- VLER Health – Allows users to access authorization forms with a link in eBenefits to manage health information exchanges.
- Payment History (Modification of Code) – Allows users to view payment types of regular and irregular compensation and pension.
- Dependency and Indemnity Compensation (DIC) Claims Status – Allows Surviving Spouses of Veterans to view four new claims types for a DIC status.
- Deployment of PTSD and un-employability statements when pending claim exists for Veteran.

Release 5.1 was deployed on August 25, 2013 (Summer 2013) and contained the following features:

- Letter Generator Enhancement – Allows Veterans to select and customize information such as service periods, dollar amount of benefits, or percentage of disability online that are representative of the hard copy versions of the letters they received from the VA through the mail.
- VetSuccess Integration – Veterans who access the VetSuccess application by going through the eBenefits portal are required to have a DS Logon account. First time users, selecting the VetSuccess link within eBenefits, are guided to set up a basic VetSuccess profile. This integration makes Veteran access to VetSuccess more secure and positions VetSuccess for expanded future eBenefits functionality by moving all VetSuccess access through the eBenefits and DS Logon.
- DoD Human Resource Links – These links allow Veterans to easily link to Service specific Human Resources and personnel pages.
- VLER Authorization Forms Integration Phase II – Included:
 - VA Form 10-0525: Request to revoke restrictions for eHealth Exchange.
 - VA Form 10-0525a: Request to add restrictions for eHealth Exchange.
 - VA Form 10-05345a-My Health Vet (MHV) Individuals' Request for a Copy of Their Own Health Information. (Note: This form is hidden until the MHV team has completed integration tasks scheduled for March 2014.)

Through eBenefits, over 60 Early Communications Messages based on “life-changing” events have been deployed. Early Communications messages are sent via email to notify Service members and Veterans of potential eligibility for health, education, and disability benefits. This proactive approach encourages them to use online self-service features such as applying for benefits, checking claims or appeals status, obtaining home loan certificates, and generating self-service letters (e.g. civil service preference). The frequency of logged-in users for specific key features from October 1, 2012, through September 30, 2013, is as follows:

- Compensation and Pension Claims (16,410,377)
- VA Home Loan Certificate of Eligibility (222,075)
- Official Military Personnel File (189,158)
- Chapter 33 Post 9-11 GI Bill Enrollment-Released December 2012 (2,574,429)
- Payment History (8,073,857)
- Appeals (2,977,025)
- Letter Generator (1,948,278)

The eBenefits portal is continuously reviewed in an effort to respond to customer feedback. Overall customer satisfaction has improved in FY 2013. September 2013 satisfaction numbers have increased six points (eBenefits online satisfaction survey uses the American Customer Satisfaction Index and is a point based scoring system scaled 0-100) from September 2012. In addition, five out of the previous six months have met or exceeded historical highs. Web site traffic visits have effectively doubled, increasing from 19.57 million visits in FY 2012 to 47.28 million visits in FY 2013. March 2013 delivered a historical “high” for monthly eBenefits site visits of 5.18 million. The most active pages on eBenefits related to self-help/self-service

features. Checking compensation and pension claim status was the most active feature. Other top features included access to online forms through VOA, checking payment history, Chapter 33 enrollment Post 9-11 GI Bill Enrollment, and access to documents including Military Personnel File and "Letter Generator" where users can download their DD Form 214 and other service and benefits verification letters.

Servicemembers SGLI Online Enrollment System (SOES)

SOES is a Web-based application that will allow Service members across all branches of Service (BoS) to view and update their SGLI and Family SGLI coverage online. Service members will access SOES via eBenefits using a DS Logon or CAC. SOES is being designed, built and deployed through a collaborative effort between VA Insurance, DMDC and the BoS.

In FY 2013, VA Insurance Service, DMDC and the BoS made great strides toward the deployment of SOES for the BoS. The SOES portal was integrated with eBenefits in February 2013. This year, SOES efforts completed BoS usability testing for enhancements to the baseline SOES application, conducted SOES demos for all BoS, and completed development and user testing of SOES Administrator application.

The Marine Corps is scheduled to begin using SOES in the first quarter of calendar year 2014. In preparation for their use, the development of document transfer from DMDC to the Marine Corps Optical Digital Imaging Records Management System and data transfer from DMDC to Marine Corps Total Force System (Marine Corps personnel and pay system) have been completed. An initial round of Marine user testing has also been completed and will require a subsequent testing event. DoD is currently coordinating a plan for all BoS to begin utilizing the SOES application.

Interagency Paperless DD Form 214

The Interagency Paperless DD Form 214 project is focused on executing an implementation strategy to eliminate the mailing of the DD Form 214 / 215 while satisfying the business requirements of its stakeholders. A detailed report, published in August 2013, identified current process inefficiencies and provided a future vision and implementation strategy to execute a paperless DD Form 214/215 distribution process by December 2014. The report also identified a potential cost avoidance of \$58 million per year amongst all interagency stakeholders when the new distribution process is operational.

Additional Data Sharing Enhancements

VA and DoD identified data requirements for all agencies that receive a copy of the DD Form 214 to ensure electronic data is collected and made available to these agencies electronically. These efforts were in support of the Interagency Paperless DD Form 214 Project to enable a timelier and consistent claims adjudication process. Personnel and Readiness Information Management (P&R IM) is currently working with DMDC to provide Department of Labor the data elements they need to adjudicate the Unemployment Compensation for ex-Service members benefit. DMDC undertook several projects under the guidance of the DoD/VA Data Sharing Summit to improve the accuracy of data being shared with VA regarding Medals and Awards, Dental Indicator, Character of Separation, and Narrative Reasons. P&R IM continues to collaborate with State

Directors of Veterans Affairs to provide electronic access to the Official Military Personnel File (OMPF) via DPRIS to support more timely benefits processing for Veterans. Twenty six states have now obtained electronic OMPF access (Veteran population of 7.2 million), an increase of five states and 56 percent in Veteran population since July 2013. Twenty two additional states have received initial contact and MOAs process has been initiated.

Sub-goal 3.4: Ensure the highest level of economic and organization efficiency, effectiveness, and productivity of VA and DoD health care systems while utilizing systematic measurement that leverages information technologies and data sharing efficiencies.

HEC Continuing Education and Training Working Group

The Continuing Education and Training WG leverages sharing opportunities to improve continuing education and in-service training quality for VA and DoD health care professionals. In FY 2013, the WG coordinated and/or managed the sharing of 280 clinical or clinically related programs between VHA and DoD; 234 training events from VHA and 46 from DoD. The direct cost avoidance reported for shared training exceeded \$3 million in FY 2013. Previous reports from the WG included cumulative shared training data. The WG will no longer use the statistical model that reports data cumulatively. Currently, the WG is formulating recommended metrics for future reports.

In FY 2013, the WG continued to optimize resources with archived e-learning programs accessed by health care professionals from VA and DoD via the electronic learning systems MHS Learn, Defense Health Services System,²⁵ and the VA TMS. The FY 2013 participation completion data from MHS Learn reported more than 6,600 successful completions, from 88 archived shared training events. MHS Health.mil hosts training programs developed by the VHA Interagency Health Care Training Consortia, which is composed of 12 Federal entities. These shared training events are available for DoD and the Military Departments in training their personnel. The FY 2013 aggregate data from MHS Health.mil reported 1,025 archived training programs with 2,967 unique user sessions to the Web site with programs viewed 6,009 times. The course completion data of training events deployed from VA TMS to both VHA and DoD learners at JAL FHCC is 35 courses with a total of 83,000 participations reported in FY 2013.

In an effort to leverage special initiatives to develop and deploy high value education and training programs, the WG was awarded JIF funding in FY 2013 for the Medical Interagency Satellite Training - Next Generations (MIST-NG) program. The MIST-NG program proposes a series of technical upgrades to the VA Knowledge Network and the Content Distribution Network. Once fully implemented, the MIST-NG will expand the shared-training partnership with DoD's Education and Training Network by increasing access, sharing, and the delivery of non-interactive video and computer-based programs to VA and DoD facilities. The ability to share content between Departments facilities reduces overlap in the creation of similar content and provides a more

²⁵ <http://health.mil/>

consistent level of training to those caring for active duty Service members and those transitioning to the VA HCS.

In FY 2013, the WG exceeded its goal by successfully deploying 26 virtual clinical grand rounds training programs to VHA and DoD health care providers with more than 6,600 staff members participating. More than 1,200 health care providers received continuing education credits to meet licensure and certification requirements to practice. The WG, in collaboration with VHA and DoD clinical officials and staff, successfully identified, designed, and developed high priority clinical topics relevant to the health care of Service members and ongoing care of Veterans in areas such as TBI, PTSD, Mental Health, Telemedicine in Rehabilitation, and Evidence Based Practice and Interventions.

The WG achieved its objective of deploying 100 percent of requested training curriculum to the JAL FHCC in FY 2013. This allowed the FHCC to meet its VHA and DoD staff orientation, in-service, and continuing education training needs. The curriculum model is refined as needed and will be used as a basis for developing and deploying training to other VHA/DoD integrated or joint venture health care facilities. This training curriculum will support these joint facilities' efforts to provide state of the art health care. A steering committee was formed to review needs and current inventory of training with plans to develop new training as needed.

In FY 2013, the WG coordinated activities intended to decrease redundancies between VHA and DoD for in-service training programs. The WG continued to consult with VHA and DoD SMEs and training management officials to review required mandatory training to assess overlapping curricula between VHA and DoD. In July 2013, the WG selected four courses for SME review: Computer Security, Pain Management, Government Ethics Administration, and Suicide Awareness. The consensus from SMEs regarding course content and learning competencies for each of these selected courses continues. Once determined, the WG will develop a tactical plan to review the reciprocity memos previously initiated by VHA and implement a waiver process to address in-service training program redundancies between VHA and DoD personnel.

HEC Information Management/Information Technology Working Group

The Information Management (IM)/Information Technology (IT) WG provides executive oversight of joint integrated legacy health information sharing activities and ensures that commonly accepted government IT program management practices are utilized. DoD continued to provide VA with one-way historic health information on separated Service members through the Federal Health Information Exchange on a monthly basis. Sharing electronic health information at the time a Service member separates allows VA providers and benefits specialists to securely access data for use in delivering health care and making claims determinations. For shared patients being treated by both VA and DoD, the Departments continued to maintain the jointly developed BHIE. Using BHIE, VA and DoD clinicians are able to securely access each other's health data in real-time. VA and DoD continued to use the Clinical Health Data Repository to share computable outpatient pharmacy and medication allergy data. To identify patients being treated in both Departments, DoD employs an active dual consumer (ADC) "flag" which facilitates the exchange of outpatient pharmacy and medication allergy data. Exchanging computable electronic health

data on patients supports improved patient care and safety through the ability to conduct drug to drug and drug to allergy interaction checks using data from both VA and DoD systems.

In FY 2013, the IM/IT WG successfully completed 100 percent of FY 2013 quarterly metric milestones to support the bidirectional exchange of electronic health data between the Departments. The benefit of this progress is that more Service members and Veterans than ever have had more health data available, electronically, securely, and in real-time, to support the provision of health care and the adjudication of benefits claims.

- The number of DoD Service members with historical data available to VA increased from over 5.8 million to over 6.1 million.
- The number of deployment health assessments available to VA increased from over 3.4 million to over 3.7 million.
- The number of individuals with deployment health assessments available to VA increased from over 1.5 million to over 1.6 million.
- All DoD inpatient facilities continued to provide VA clinicians electronic access to a limited number of inpatient document types.
- The number of DoD beneficiaries with viewable data available real-time to VA and DoD providers increased from over 4.6 million to over 5 million.
- The number of data queries by VA and DoD providers increased from over 25.2 million to over 36.6 million.
- The number of shared patients flagged as ADCs for computable pharmacy and allergy data exchange increased from over 1.5 million to over 1.8 million.

The DoD NCAT IT solution was designed to support pre- and post-event screenings of possible mTBI at all echelons of care, including Theater and sustaining base. Additionally, the DoD NCAT IT solution was designed to provide Web-based access and enable VA and DoD clinicians the ability to electronically track and trend mTBI data in a central database. All three Military Departments expressed concerns regarding the NCAT IT solution's limitations and cost, resulting in decommission of the program in January 2013. The Automated Neuropsychological Assessment Metrics is the DoD-designated neurocognitive assessment tool to support neurocognitive assessments by the Military Departments; DoD will continue to use this tool.

Interagency patient registry collaboration continued with the DVEIVR pilot project. In FY 2013, DVEIVR successfully interfaced with the following systems: the Clinical Data Repository of Armed Forces Health Longitudinal Technology Application (AHLTA), DoD's EHR, Theater Medical Data Store, Defense Manpower Data Center, JTTR, the VA Eye Injury Registry, and Combat Trauma Registry Expeditionary Medical Encounter Database. VCE contractor data abstraction and structuring of reports is ongoing. More information on DVEIVR can be found in the VCE section of this report.

The DoD HAIMS is a MHS program that enhances medical informatics through integration of medical digital artifacts and images (A&I) with AHLTA. The objective of HAIMS is to give health care providers global awareness and access to essential A&I throughout the continuum of care from Theater to garrison to VA, and from VA to DoD when needed. When fully deployed, HAIMS will provide an enterprise-wide data sharing capability for multiple types of A&I, including

radiographs, photographs, waveforms, audio files, video, and scanned documents. As of August 2013, 145 VA sites and 133 DoD sites have access to A&I through HAIMS and over 16,895 artifacts and images have passed through the HAIMS interface. The MHS Program Office collaborated closely with the Military Departments to support accelerated HAIMS deployment and completed training 6,000 additional DoD users in September 2013.

The MHS Enterprise Infrastructure (EI) directorate provided quarterly briefings regarding bandwidth and network performance of the north, south, east, and west multipurpose VA/DoD network gateways to the HEC IM/IT WG. EI continues to monitor traffic analysis reports to identify traffic levels, types, and patterns (including protocol type and distribution of imaging traffic) and overall bandwidth demand levels for inbound and outbound wide area network traffic. The current assessment is that the existing FY 2013 network infrastructure and available bandwidth is more than adequate to supporting current data traffic. VA/DoD network bandwidth utilization did not exceed 90 percent and network availability was maintained at 98.5 percent or better across the four multipurpose gateways.

Health Architecture Review Board

The VA/DoD Health Architecture Review Board (HARB) continued to provide oversight and influence the direction of joint VA/DoD health programs to facilitate interagency cooperation on interagency Health Information Technology (HIT) initiatives.

In the first quarter of FY 2013, the HARB focused on the implementation of iEHR, including significant efforts preparing for a Request for Proposal that would support the future joint iEHR IOC capability solution sets (lab, immunization, and pharmacy).

The Secretaries of VA and DoD then redirected the iEHR effort to pursue two separate but interoperable core system strategies for VA and DoD. Upon issuance of this decision, the HARB readjusted its focus to achieving interoperability while the Departments pursue the acquisition of different EHR systems. This new focus for the HARB complements the JSP designation of *interoperability* as one of the three cross-functional foundational elements fundamental to all VA/DoD efforts, the others being *client centric focus* and *partnerships*.

In September 2013, the HARB completed a gap analysis of the IPO's plans for interoperability. In doing so, the HARB created and applied an analysis framework that established a set of alignment criteria to evaluate current efforts at interoperability across the Departments. After validating the findings with the IPO, the HARB created a set of gap closure recommendations, and initiated tracking of follow up activities by DoD, VA, IPO, and the HARB, for subsequent reporting to the HEC.

Additional FY 2013 HARB activities focused on overseeing development, approval, and distribution of architecture artifacts developed by VA, DoD, and the IPO, in support of the effort to achieve interoperability. Significant activities included publishing the VA/DoD Target Health Standards Profile (THSP) in September 2013, which prescribes a common set of information, data, security, and technical standards to be used by both Departments and in information exchanges with external healthcare organizations. The HARB played an active role in ensuring

new open standards support the ongoing needs of DoD and VA. The HARB participated in data format discussions with HL7 International and other standards development organizations. Recently, the HARB provided direction to both departments by clarifying information interoperability questions and issues related to the use of the FHIR standard (Fast Healthcare Interoperability Resources). In doing so, the HARB created a new category for emerging standards in the THSP. The HARB recognized FHIR as an emerging standard, and directed DoD and VA to monitor the justifications, alternatives, and risks considered with choosing FHIR over other approved national standards for development.

Additionally, the HARB maintained the VA/DoD Information Exchange Tool for FY 2013. This tool enables stakeholders to establish and prioritize measurable data sharing, compliance with interoperability standards, and approval of the annual interoperability standards for the Departments. The Information Exchange Tool also identifies the current state of exchanges to assist in the prioritization of new requirements, identify interoperability information gaps, and provide a reference for future architecture development.

During the past year, the HARB identified the need to build an end-state vision to guide VA, DoD and mission partner interoperability, incorporating the benefits of moving to flexible RESTful approaches, Open APIs and Open Standards to maximize interoperability. The HARB also continues to consider how to improve engagement with the Open Source Electronic Health Record Alliance (OSEHRA) and other open source community efforts to tap into community innovation to help VA and DoD solve interoperability challenges.

HEC Acquisition and Medical Materiel Management Working Group

The Acquisition and Medical Materiel Management WG (A&MMMWG) continued to identify, review, and implement joint VA/DoD medical materiel management sharing initiatives to achieve joint operational and business efficiencies.

Identifying and Leveraging Spend

During FY 2013, VA and DoD received three new vendor proposals in response to a Digital Imaging Network – Picture Archive and Communications Systems (DIN-PACS) open season solicitation. All three are currently under review for contract award. For radiology, VA and DoD awarded the second new contract from last year’s open season, and received six new proposals under this year’s open season solicitation. The new long-term contract awards for radiology and DIN-PACS expand the vendor base and product offerings for all VA and DoD customers.

As evidenced in the chart below, total joint pharmaceutical and equipment sales showed an increase from FY 2012 to FY 2013. Total joint sales increased by 3.9 percent; joint equipment sales increased by 25.3 percent; and joint pharmaceutical sales increased by 2.5 percent.

**Joint VA/DoD Sales (Through Third Quarter)
(Dollars in Millions)**

Commodity	FY 2012	FY 2013	Change
Pharmaceuticals	\$1,957.27	\$1,962.26	+2.5 percent
Medical/Surgical	\$0	\$0	0 percent
Equipment	\$331.79	\$415.86	+25.3 percent
Total	\$2,289.06	\$2,378.11	+3.9 percent

VA and DoD cost avoidance from using acquisition programs based on the use of joint requirements approached \$3.9 million for VA in high tech medical equipment and exceeded \$468 million in pharmaceuticals.

Medical Surgical Business Intelligence

The VA/DoD data synchronization program stabilized its operations in FY 2013 and is seeking methods at the national, regional, and facility level to automatically identify the lowest contracted price on medical surgical items. To this end, DoD began executing its implementation plan in FY 2013 to integrate the medical/surgical business intelligence (BI) tools and data into its enterprise medical logistics systems. Product Data Bank (PDB) medical/surgical data feeds were formalized in the Defense Logistics Agency (DLA) enterprise Medical Master Catalog (MMC) pre-processing, enabling the two-step process of researching and purchasing using two different applications to merge into a single transactional session for many DoD users. The program also developed a list of potential enterprise system improvements to spur further integration efforts. DLA development teams began to streamline and improve the Medical Supplier Directory process, which is the basis for the synchronization of data. While DoD has accomplished its initial integration of PDB cleansed and synchronized data into the enterprise MMC, other integration efforts are ongoing. The teams are in the process of exploring the viability of more frequent Federal Logistics Information System data feeds for consumption by the PDB in relation to its benefit to the MMC.

The spend analysis capability in the Medical Surgical PDB (MedPDB) continued to play an active role in VA's implementation of the VHA Logistics Program Executive Office (PEO). Objectives of the PEO are to minimize program cost by implementing VHA wide procurements, reducing duplication, and leveraging resources (people, technology, and communication). VA acquisition project process flows were developed and approved in FY 2013. The data synchronization program continued to enable VA national and regional procurements which allowed VA program managers the ability to analyze candidates by clinical category using program tools and working potential cost reductions in the range of \$35-50 million. National and regional opportunities were also identified on clinical categories that are not on national contracts. VA continued to investigate and develop compliance reports to assist in monitoring compliance with committed volume and VA enterprise contracts.

The A&MMMWG targeted increased cost efficiencies, as evidenced by increasing the dollar amount of product price reductions achieved as a result of using the BI tool from FY 2013 through FY 2015 by \$5 million per year for a total of \$15 million. In the first year of reporting on this goal, VA and DoD users accepted purchase recommendations in FY 2013 that, if implemented, could reduce medical/surgical product costs by a projected \$13.5 million, exceeding the annual \$5 million target by 170 percent.

HEC Financial Management Working Group

The Financial Management Working Group (FMWG) collaborates to ensure the highest level of economic and organizational efficiency, effectiveness, and productivity related to financial operations in support of VA and DoD health care systems, and manages the JIF. The JIF provides incentives for VA and DoD field activities to increase and engage in creative health care coordination and sharing initiatives. In FY 2013, ten projects totaling \$26.2 million were approved for the customary annual call for projects.

In September 2012, additional contributions above the usual \$30 million were made to the fund. The FMWG coordinated with various HEC and JEC WGs to promote innovative sharing initiatives at the national level that met the highest joint priorities of the Departments. As a result, an out-of-cycle call for proposals was released in August 2012 and resulted in the approval and funding of 18 national projects totaling more than \$189 million.

During FY 2013, 19 JIF projects were brought to completion. In December 2012, the Interim Progress Review (IPR) template was revised to include current and projected obligations to evaluate the progress of each project and identify any that may be at risk for not meeting their stated objectives. Through the quarterly IPR process, the FMWG also monitored the operational progress of all active JIF projects to determine acceptable progress, with a specific focus on reducing the number of active projects older than three years.

VHA/Disability and Medical Assessment (DMA)/Integrated Disability Evaluation System (IDES), in conjunction with VHA's Chief Business Office (CBO), continued to review and revise the IDES registration and billing guidance to improve data capture of accurate clinic set-up, scheduling, and other revenue cycle activities. The MOA for the Registering and Processing Payments for Disability Compensation and Pension Examinations in the IDES is being revised to reflect updated procedures. This enhances the quality of claims regarding payment for exams performed as part of IDES. Guidance updates were shared with key program offices within VHA, Veterans Benefits Administration, DoD, and TRICARE managed care support contractor (MCSC) partners. Efforts were made throughout FY 2013 to continue to educate VAMC staff on those requirements. VHA/DMA/IDES personnel monitor a SharePoint Site and Decision Systems Support reports to review billing and collection data, as well as workload and no-show information.

The VHA/DMA/IDES Program Office established and continues to monitor the quality of claims submitted to TMA for examinations of referred conditions and associated ancillaries. As a result of a combined effort between the IDES Program Office and TMA, the FY 2013 IDES claims for reimbursement experienced a 59 percent performance improvement.

Finally, TMA personnel and VHA/DMA/IDES staff are working together to review and closeout all remaining outstanding paper claims submitted prior to the transition to Electronic Data Interface. This has resulted in a marked improvement and has allowed VA to receive most reimbursements on a timely basis.

HEC Joint Venture & Resource Sharing Working Group

The Joint Venture/Resource Sharing Working Group (JV/RS WG) mission is to explore, identify, and make recommendations on opportunities for increased collaboration between VA and DoD to maximize care available to beneficiaries of both health care systems. In February 2013, the WG expanded the site selection criteria to include GME and the availability of access to direct outpatient and inpatient care within Federal treatment facilities. The JV/RS WG plans to use the new expanded site selection criteria to identify new potential joint market and JV sites. The selection of new joint market sites for FY 2013 was postponed while awaiting the results of an OMB tasking for VA and DoD to conduct health system modernization and VA/DoD Comparability Studies, which could potentially impact the current or future design of joint market areas. Additionally, with the DoD reorganization and establishment of the Defense Health Agency in FY 2014, the results may influence the future direction and requirements of the JV/RS WG. Furthermore, the JV/RS WG's ability to conduct site visits was hampered as a result of budget related travel restrictions.

The JV/RS WG began monitoring site-selected SMART objectives and metrics from JV and joint market sharing sites to measure their performance related to quality improvement, access, and cost based sharing activities. For initial reporting, 14 selected sites submitted 36 measures that yielded the following performance metrics: 36 percent of sites reported purchased care cost savings/avoidance; 36 percent of sites reported improved VA/DoD referral processing; 19 percent of sites reported improved patient access; and 8 percent of sites reported business process improvements.

The JV/RS WG assisted the Charlie Norwood VAMC in Augusta, Georgia, the Carl Vinson VAMC in Dublin, Georgia, and the Dwight D. Eisenhower AMC in Fort Gordon, Georgia with education and support in preparing a proposal to become the newest JV location. That request was approved by the HEC in June 2013.

James A. Lovell Federal Health Care Center Advisory Board

The James A. Lovell Federal Health Care Center (JAL FHCC) Advisory Board is a fully-integrated five-year medical facility demonstration project, begun on October 1, 2010, with VA and DoD staff working together toward a single, combined VA and Navy mission serving active duty Service members, Veterans and TRICARE dependents (military families, including infants and children). The FHCC provides care to over 75,000 individuals per year including Veterans, active duty Service members and their families, and over 44,000 new Navy recruits. The FHCC leads the Navy with an IDES average completion time of 49 days, 51 days below the DoD standard. The FHCC was one of the first government health care facilities in the nation to provide a Caregiver Support Center for patients' families, and the second facility to open 10-bed small homes for

geriatric patients in need of skilled care. Special programs in alcohol, substance abuse, homeless and post-traumatic stress disorder provide support to active duty as well as Veteran patients.

The FHCC Advisory Board functions as the link between the FHCC and the HEC/JEC. A FHCC Stakeholder Advisory Committee meets quarterly to advise the Director on how well the FHCC is meeting the needs of local VA and DoD beneficiaries. During the first three years of operation, the FHCC has had numerous inspections resulting in positive evaluations of patient care. The Joint Commission granted three-year full accreditation in January 2012; the Commission on Accreditation of Rehabilitation Facilities granted accreditation in community integration, community services coordination, employment planning services and residential treatment in 2011; and most recently the Bureau of Medicine and Surgery Medical Inspector General completed a very successful review of over 70 FHCC programs.

In January 2013, a JIF project was approved for a contract to perform an enterprise evaluation of the FHCC model for the future. This will include the requirements of the evaluation required by the FHCC authorizing authority, except IT. The VA's Product Effectiveness team will develop the IT evaluation. Both evaluations will comprise the requirements of the comprehensive evaluation of the FHCC to be submitted as a final report to Congress by October 28, 2015 (no later than 180 days after the fifth anniversary of the date of execution of the Executive Agreement) and meeting all requirements of Public Law 111-84, NDAA for FY 2010.

IT Capability Delivery to Support FHCC Operations

In order to safely exchange data between VA and DoD IT systems and allow health care providers and administrative personnel to deliver high-quality services at the FHCC, the Departments developed and refined the numerous IT capabilities to support JAL FHCC during FY 2013. As the capabilities and need to implement various products at JAL FHCC grew, the requirement to have a dedicated team of test engineers to perform joint testing of all capabilities with the VA Software Quality Assurance (SQA) testing team was apparent. The team implemented an agile methodology for all of their joint testing approaches. The FHCC testing team is involved from the inception phase through the deployment phase of all products/capabilities. The test team performed requirements analysis, created test scripts and cases, executed the tests jointly using live online meetings with their VA SQA counterparts, and managed all identified defects jointly with the VA SQA team. In addition, the testing team completed testing for Consults Sprint 6 and Consults 2A, Financial Management Increment 3 and Reconciliation, Single Sign-On and Context Management, Maintenance Release 13.1.1 and 13.2 through 13.6, and Orders Portability Laboratory/Radiology.

The IT activities and accomplishments at JAL FHCC during FY 2013 support the transition from VA's and DoD's legacy health care IT systems to iEHR. Product development efforts in FY 2013 and beyond are required to support the health IT framework, enhancing the provider's ability to provide seamless health care to both VA and DoD beneficiaries in the FHCC integrated environment.

- Operating Beds: 369 (Authorized beds: 442)
- Total outpatient visits captured in VistA and AHLTA: 643,148
- Total inpatient admissions: 4,809
- Total dental visits to West Campus: 494,759 (9.742 Relative Value Unit)

- Total dental visits to East Campus: 191,636 (702,751.2 Dental Weighted Values)
- Pharmacy prescriptions (all sites: VA/DoD): 1,055,309
 - Total outpatient prescriptions filled: 611,567
 - Total inpatient prescriptions filled: 27,656 (window scripts processed by inpatient pharmacy for both VA and DoD patients)
 - Total unit-dose prescriptions filled: 1,225,332
 - Total mail-order prescriptions filled: 6,720
 - 3443,742 (total mail) – 437,022 (CMOP mail) = 6,720 (local mail)
- USS Red Rover processed more than 43,476 Navy Recruits, delivering more than 400,000 immunizations

DoD/VA Interagency Program Office

Throughout FY 2013, the IPO Development Team and the DoD and VA Pharmacy functional communities continued with identification and analysis of interim solutions for implementation to support the JAL FHCC Pharmacy. In July 2013, by IPO request, the Veterans Health Administration Product Effectiveness Office began development of a performance assessment framework to evaluate the effectiveness and efficiency of the five-year demonstration project as outlined in an Executive Agreement for the JAL FHCC signed by DoD and VA in April 2010, in accordance with the NDAA for FY 2010. The initial plan was approved, and analysts began metrics development. The performance assessment will continue to analyze information and data through FY 2014-2015. In addition, the JAL FHCC Business Process Reengineering (BPR) activity was initiated. This will enable BPR to escalate the efforts of process improvement methodologies as part of the JAL FHCC demonstration. The scope of work is the formation of recommendations or process improvement based on the interagency Health IT programs and solutions in use, or lack thereof. The focus for this work includes representation of the business policies via business process flows, alerts, and notifications, data exchanges or movement, and standard operating procedures.

Activities and Milestones Progress

To develop a comprehensive evaluation plan of the JAL FHCC, to enable VA and DoD to make an informed decision about whether the JAL FHCC should continue after the end of the demonstration, and to provide useful information for other integrations that may be considered in the future, the Departments will undertake the following initiatives:

- Determine the costs associated with the workarounds required due to Information Technology capabilities at the JAL FHCC for each year of the demonstration, including the costs of hiring additional staff and of managing the administrative burden due to the workarounds, by October 31, 2012 and annually, thereafter.
Status: Ongoing
- Develop an evaluation plan, including the performance measures, standards, and target scores, to be used to evaluate the 15 integration benchmarks for the JAL FHCC demonstration by June 30, 2013.
Status: Complete; routine and ad hoc reports are briefed out through both internal and external stakeholder meetings

- Establish measures related to the cost-effectiveness of the JAL FHCC care and operations to be included as a part of the evaluation plan by June 30, 2013.
Status: Complete
- Submit a Final Report to Congress based on a comprehensive evaluation of the JAL FHCC March 29, 2016 (no later than 180 days after the fifth anniversary of the date of execution of the Executive Agreement) and meeting all requirements of Public Law 111-84 – October 28, 2009 – National Defense Authorization Act for FY 2010.
Status: Ongoing; contract has been awarded to conduct the comprehensive evaluation
- Fix pharmacy capability at North Chicago JAL FHCC to address current operational issues, by December 31, 2014. Provide updated capability in support of IOC for the iEHR effort by September 30, 2014.
Status: Both development teams are currently engaged in this activity through the end of calendar year 2014; completed two phases of HDD Terminology Mapping and received approval for the Governance Process
- As a risk reduction effort to inform the overall iEHR enduring solution, conduct a pilot of Janus Graphical User Interface Write-back of Allergies Data to clinical data stores. This will allow practitioners to update patient electronic health records with allergy information to determine drug-drug interactions prior to dispensing; thereby improving patient safety. It is planned to be operational in North Chicago by March 31, 2013.
Status: This was not executed due to: the Secretaries' redirection in February 2013; the May 21, 2013, Secretary of Defense Memorandum, "Integrated Electronic Health Records"; and the June 21, 2013, Acquisition Decision Memorandum (ADM) from the Under Secretary of Defense for Acquisition, Technology, and Logistics (USD AT&L), "DoD Healthcare Management System Modernization and Integrated Electronic Health Records Acquisition Decision Memorandum," which strategically refocused iEHR program scope and execution plans.

Sub-goal 3.5: Inform Veterans, Service members, military families, and other stakeholders of key, identified strategic messages, priorities, and accomplishments of the JEC and VA/DoD collaboration.

JEC Strategic Communications Working Group

The JEC Strategic Communications Working Group (SCWG) works to increase awareness and transparency of VA/DoD strategic messages, priorities, and accomplishments among Veterans, Service members, military families, Congress, and other key stakeholders, by maintaining and executing coordinated communications plans, and collaborating with JEC sub committees and working groups on an ongoing basis.

FY 2013 communications activities in support of the specific objectives in the JEC JSP for FY 2011-2013 included:

- Production of the FY 2014 JEC SCWG Communications and Outreach Plan.
- Regular coordination with representatives from the HEC, BEC, IPO, Transition Assistance Program Redesign (Transition GPS) Camp Lejeune Working Group, Gulf War Task Force, VA-DoD legislative affairs, and VA-DoD public affairs to enable ongoing collaboration between subject matter experts and communications professionals.

The JEC SCWG continued to build on the outreach activities of FY 2013, and conducted:

- Briefings and hearings to Congressional stakeholders on: suicide prevention; health care including mental health care, employment of separating and recently separated Service members; electronic health records, military sexual trauma, disability ratings and care coordination.
- VA and DOD program manager joint briefings for congressional staff from stakeholder committees on the status of several transition programs for Service members and Veterans.

Joint VA and DoD communication efforts facilitated several collaborative events with major news organizations and stakeholders on a myriad of issues. The Secretaries of Defense and Veterans Affairs met regularly to focus on priority issues. VA-DOD public affairs worked to jointly communicate on significant issues, including increasing access to mental health care, joint research investments on PTSD and mild TBI, disability claims transformation, and the eBenefits joint self-service Web portal.

These collaborative efforts ensured message consistency throughout both Departments and gained media coverage on these significant issues. The JEC SCWG ensured all communications efforts in support of the JSP reflected the values, mission, and goals of both departments' strategic plans and Secretaries' guidance.

Sub-goal 3.6: Identify opportunities to further improve collaboration for Joint Capital Asset Planning and increase the number of projects for shared medical facilities the Departments submit for consideration.

JEC Construction Planning Committee Working Group

The VA/DoD Construction Planning Committee (CPC) provides a formalized structure to facilitate cooperation and collaboration in achieving an integrated approach to planning, design, construction (major and minor), leasing and other real property related initiatives for shared medical facilities that are mutually beneficial to both Departments.

Beginning in 2011, the CPC developed a concept for a common approach to capital asset management planning through identification and sharing of planning data. That work has continued to be refined in FY 2013 through the addition of 'access' and 'space', to the data set

(population, workload, and purchased care) provided to VA and DoD planners. This information aids in the early identification of potential joint construction and collaborative lease opportunities at the field level. The data sets are now distributed to the VA Capital Asset Management Service annually as part of Strategic Capital Investment Planning Action Plan guidance for Action Plan development. The data is also provided to the Services for use in future Capital Investment Decision Model processes via the Military Health System World-Class Facilities site. In accompaniment to the data sets, a facility-related Point of Contact list is shared to ensure communication occurs with the appropriate contacts at the local, regional and national levels based on the potential need (i.e., medical resource sharing versus facility space sharing). DoD has formally included the access and space data elements in a semi-annual report and is examining mechanisms to map the facility data, currently at a zip code level, to its corresponding County to further improve data sharing with the VA. The committee is also exploring using geographic information system tools as a mechanism in support of joint facility planning.

The CPC is hopeful that legislative relief will be forthcoming through final approval of the proposed legislative language of both Departments. If passed, the Departments will have inherent authority to transfer funds to one another for the purposes of building and leasing a shared medical facility to meet each other's needs when appropriate. This legislation is important because it would improve the access, continuity, quality and cost effectiveness of direct health care provided to Veterans, Service Members, and their beneficiaries.

The CPC coordinated the preparation of two mandated reports to Congress on VA/DoD Joint Medical Facilities in response to the House Appropriations Committee (House Report 112-94) and the Senate Appropriations Committee (Senate Report 112-29).

The revised CPC charter remains in circulation for departmental reviews and final approval. It includes a proposed name change from the CPC to the Capital Asset Planning Committee to more accurately reflect the group's efforts to support not only construction projects, but also leasing and other real property initiatives. The charter also expands the committee membership to include field-level representation for both Departments.

Sub-goal 3.7: Develop a pilot to test performing Separation Health Assessments for eligible Service members who are leaving the military, to meet the requirements of both Departments. The pilot will allow Service members to choose either VA or DoD to perform their exam in accordance with governing statutes and regulations to assess likely workload (and cost) for the two Departments.

JEC Separation Health Assessment Working Group

On December 4, 2012, DoD and VA agreed to share responsibility for ensuring that each departing Service member receives a mandatory Separation Health Assessment (SHA). A MOA was drafted outlining how DoD/VA will share the responsibility for completing the SHA

and the specific criteria required. The SHA will be mandatory for all Service members both active and reserve who have been on Title 10/32 orders for longer than 180 days. Retiring/Separating select members of the Reserve component not coming off active orders may request an SHA. DoD completes DD Forms 2807-1/2808 on all Service members not making a disability claim; including required ancillary testing, threshold audiogram and full audiology evaluation, if the threshold test is abnormal.

VA has developed and fielded an electronic SHA General Medical (SHA Gen Med) template which incorporates the necessary elements of DD forms 2807 and 2808, including required ancillary testing; air conduction threshold audiogram; and full audiology evaluation using a hearing loss template, if the threshold test is abnormal.

The VA pilot tested a mock-up of a SHA Gen Med DBQ in the spring of 2013 and DOD was able to view this report in their electronic health record through the Bidirectional Health Information Exchange. This has only been tested in the National Capital Area. All disability examinations related to pre-separation claims will include the VA SHA Gen Med DBQ beginning October 2013. In July 2013, VA provided training to all VA C&P clinicians. Implications of the new transition assistance programs on the DoD/VA Separation Health Assessment program were still being researched by VBA. The MOA was signed on October 2, 2013, and implemented in the Integrated Disability Evaluation System, Benefits Delivery at Discharge, and Quick Start programs by October 10, 2013. The DoD is developing a Directive Type Memorandum for the Services' concurrence and the target for full implementation of the initiative is the end of calendar year 2014. Work continues on development for improved information sharing between the Departments to fully support this initiative electronically.

Sub-goal 3.8: Virtual Lifetime Electronic Record Health – Ensure portability and accessibility to health data for Service members, Veterans, and authorized representatives.

DoD/VA Interagency Program Office

Through IPO guidance, both Departments implemented the VLER Health Exchange Program initiative at four joint locations, partnering with private sector Health Information Exchange (HIE) organizations. Additionally, VA partnered with private sector HIEs in implementing the VLER Health Exchange at 15 additional sites, including the Idaho Health Data Exchange in Boise, Idaho, and the Pensacola Health Information Exchange in the Gulf Coast Veterans Health Care System, both of which were added in the third quarter of FY 2013. At the end of FY 2013, VA was completing the testing to add the Walgreens national pharmacy chain so VA clinicians can retrieve data on immunizations provided to Veterans at Walgreens outlets. In addition, at the end of FY 2013, DoD completed the required software upgrades and testing to add San Diego Health Connect as a VLER Health Exchange partner to support a non-active duty beneficiary Opt-out pilot. This will add a cohort of approximately 10,000 patients in San Diego, California and approximately 12,000 patients in Puget Sound, Washington. In addition, the IPO:

- Released VA VLER Health Adaptor Software to Open Source Electronic Health Record Agent.
- Reviewed and provided health information exchange content for ONC Standards and Policy Committees.
- Activated 100 percent (130 out of 130) of VistAWeb databases, allowing VA Medical Center (VAMC) clinicians to retrieve VLER Health data from existing private sector production partners on matched patients.

DoD implemented a Direct Project pilot at the 75th Medical Group at Hill Air Force Base, Ogden, Utah. The pilot tested the security, privacy, and trust of the Direct secure email that returns clear and legible reports of mammogram results for TRICARE patients from McKay Dee Hospital to the 75th Medical Group. In addition to the pilot, through IPO sponsorship, the DoD provided a copy of the DoD-developed Direct software to the Indian Health Service and to VA for their use as they move forward with their Direct Project pilot. IPO also helped lead Federal agency discussions sponsored by the Office of the National Coordinator (ONC) Federal Health Architecture Office concerning the Federal Public Key Infrastructure, which will be used by the Direct Project. In addition, the IPO:

- Delivered a DoD Direct Secure Messaging capability, launched a pilot in Salt Lake City in July 2013 with 74 secure transactions as of September 30, 2013.
- Completed Software development for DoD “Direct as a Service” (DaaS) for use with TRICARE Online.
- Established Office of the National Coordinator for Health Information Technology workgroup on Direct Trust and Security Issues and Direct Patient Mediated Exchange Issues with DoD VLER Health IT and VA Health IT Team participation.

Lastly, IPO efforts to compile and evaluate lessons learned from the Direct Project pilot by September 30, 2015, are ongoing and on schedule.

Additional Accomplishments

Interagency Care Coordination Committee

The Interagency Care Coordination Committee (IC3) oversees implementation of the November 2012 Secretaries' Intent on Warrior Care and Coordination (attached), declaring One Mission, One Policy, One Plan, in response to ongoing stakeholder concerns about interagency coordination of care, services, and benefits for wounded, ill, and injured Service members and Veterans. The IC3, via its standing Work Groups, is tasked with developing: (1) a common, interagency, overarching guidance; (2) a community of practice, connecting the DoD and VA clinical and non-clinical case managers of recovering Service members and Veterans; (3) a single, shared comprehensive plan for each wounded, ill and injured Service member and Veteran; and (4) guidance for the establishment of a Lead Coordinator for wounded, ill and injured Service members and Veterans to better coordinate care and services across all stages of recovery, rehabilitation, and reintegration. Success in these areas will result in the synchronization and coordination among the Departments across the spectrum of care, benefits, and services to create a common operational picture for a wounded, ill and injured Service member or Veteran at all points in his or her care experience.

The IC3 functions via its three standing Work Groups: Community of Practice, Comprehensive Plan, and Policy and Oversight.

IC3 Community of Practice Work Group (One Mission)

The Community of Practice Work Group is responsible for:

- Establishing the Lead Coordinator role;
- Developing and maintaining a central inventory of all DoD and VA programs that directly involve services to wounded, ill, and injured Service members, Veterans, and their families;
- Establishing a national community of practice for care coordinators, case managers, and other providers who offer care, benefits, and services to recovering Service members and Veterans to connect, learn, trouble-shoot, and build institutional knowledge; and
- Developing an enterprise plan for integrating data across the entire community of practice.

The Community of Practice Work Group began working toward these objectives in 2013. From January to September 2013, the Lead Coordinator Feasibility Assessment was implemented at multiple sites in the capital region (Walter Reed National Military Medical Center and Washington, DC and Richmond VA medical centers) and San Antonio region (San Antonio Military Medical Center and all VA medical centers in VISN 17). Data and metrics collected have determined the effectiveness of the Lead Coordinator role and informed recommendations for implementation of procedures and process for the nationwide rollout of the concept.

Beginning with the Warrior Care Coordination Task Force in the summer of 2012, stakeholders from the 51+ VA-DoD wounded Warrior programs drafted an initial inventory of programs and services including information on the mission, services, population, and numbers of practitioners for each and clients served by each. This inventory was the first of its kind, creating one central list of all the known programs and services. In 2013, the Community of Practice Work Group assigned a team to add more dimension to the inventory (e.g., referral guidelines) using data gathered through stakeholder interviews, review of program materials, and analysis of qualitative and quantitative data from available Federal databases. This will be done in concert with the Comprehensive Plan Work Group's effort to map business processes for the technology solution to enable the Interagency Comprehensive Plan.

In July of 2013, the Community of Practice Work Group began developing a vision for a single, borderless, national community of practice, which will support the ongoing communication and collaboration of care coordinators, case managers, and other providers who offer care, benefits, and services to recovering Service members and Veterans. The Work Group intends to finalize its vision and to start operations during the remainder of the year to initiate connectivity among the community, which will include the introduction of a PIV- and CAC-accessible SharePoint site designed to inspire collaboration, information sharing, and knowledge development around interagency care coordination. The site design will commence in October 2013. In the meantime, Community of Practice members are being invited to a fully-functional Yammer group, which has already proven effective at helping members get connected to fellow care coordinators.

Lastly, the Community of Practice Work Group is leading a case matching activity to evaluate the wounded, ill, and injured populations and care coordinators of DoD's five and VA's three care coordination programs. They are conducting quarterly matching practices related to 30,000 Service member- and Veteran-related data elements. The outcomes are to determine gaps in patient enrollment, and subsequently identify best practices in successful transitions, care integration, and care synchronization.

IC3 Comprehensive Plan Work Group (One Plan)

The Comprehensive Plan Work Group is responsible for creating a common operational picture for interagency complex care coordination processes for these Service members and Veterans, including an Interagency Comprehensive Plan (ICP), which will become the centerpiece around which all members of the care management team will synchronize care, benefits, and services for wounded, ill, and injured Service members and Veterans. Without a common operational picture, there is a lack of shared visibility of available resources, which has led to duplication of efforts and a failure to effectively utilize the extensive subject matter expertise available throughout the two Departments. The Comprehensive Plan Work Group began working toward this objective in 2012.

Beginning with the Warrior Care Coordination Task Force in the summer of 2012, the Comprehensive Plan Work Group created an initial draft of the common categories and domains of care, benefits, and services and specific activities associated with each that inform

a Service member/Veterans recovery, rehabilitation, and reintegration goals and opportunities. This document was created in collaboration and with concurrence from representatives and leadership from both DoD and VA clinical and non-clinical care coordination programs. The Work Group also created an abbreviated, three-page “checklist” that is being used in the field by Lead Coordinators and care management teams.

The Work Group has also been working to automate the ICP on an IT platform. The Work Group members finalized an overall scope and vision for the IT solution and are drafting requirements for an single, interagency Business Requirements Document (iBRD) to be submitted for concurrence and signature by the end of 2013. A cross-functional, interagency group of subject matter experts and technical analysts from DoD and VA are collaborating to complete the iBRD. In parallel, Air Force Lead Coordinators at San Antonio Military Medical Center are piloting the VA’s Federal Case Management Tracking (FCMT) tool to determine the usability of the system for care coordination and to test the ability to exchange a care plan between the DoD and the VA Lead Coordinators. This pilot will inform and support aspects of the iBRD for the ICP.

IC3 Policy and Oversight Work Group (One Policy)

The Policy and Oversight Work Group is responsible for:

- Creating overarching policy guidance that supports a single model of management and coordination of care, services, and benefits throughout recovery, rehabilitation, and recovery of wounded, ill, and injured Service members, Veterans, and their families;
- Developing a set of common terminology and language;
- Developing and assessing metrics across the IC3 in order to enable data driven assessment of IC3 initiatives and performance of programs; and
- Advising the IC3 on policy compliance and providing recommendations to the policy owner(s).

Beginning with the Warrior Care Coordination Task Force in the summer of 2012, the Policy and Oversight Work Group identified 140 VA and DoD policies which reference care coordination and subsequently began drafting the overarching, interagency policy guidance in collaboration and with concurrence from representatives from both DoD and VA clinical and non-clinical care coordination programs. In May 2013, the overarching policy guidance was submitted for coordination in both Departments. At the direction of the IC3 co-chairs, the Policy and Oversight Work Group continues to pursue a format appropriate for a single policy shared by both Departments, but also began preparing the policy in the format of a MOU. The intent of the MOU is to provide overarching guidance for improved VA-DoD care coordination.

Through the development of the overarching policy guidance, a common set of terminology and language was initially developed. The Work Group will revise terminology as necessary based on feedback from the IC3, Work Group members, and the field.

In the summer of 2013, the Policy and Oversight Work Group began leading efforts to (1) develop and assess metrics across the IC3 initiatives and (2) analyze the current policy inventory and provide recommendations.

The Work Group is developing a performance management dashboard that will help stakeholders understand and illustrate the impact of each Work Group's initiatives and interagency care coordination. The effort to identify appropriate metrics for the IC3 has started with interviews of Work Group co-chairs, the IC3 Executive Secretariat and additional key stakeholders in the community of practice.

The existing policy impact analysis effort is intended to identify the priority areas for policy modification, sunset or creation, as a result of the overarching guidance. An inventory of over 140 policies was established as part of the initial Policy and Oversight Work Group efforts and is being reviewed for relevance to the overarching guidance and analyzed for potential content modification.

Overarching IC3 Management

Roughly 150 people are involved in the Interagency Care Coordination Committee, including formal Committee members, Work Group members and Committee leadership. The formal Committee is comprised of 35 members and is led by two co-chairs who represent VA and DoD. The Work Groups are led by 10 Work Group co-chairs and include roughly 100 Work Group members. These Work Groups are working to develop policies, procedures and systems to coordinate care across 48 programs that currently operate using 15 unique systems and according to 140 policies across VA and DoD.

The effort required to manage a project with this much complexity is significant. In addition to the sheer number of people involved, the number of programs impacted by this work, and the number of systems and policies that are currently used to support those systems, the IC3 leadership is working to balance the needs of two different departments with different policies, procedure and priorities. The leadership has tried to be agile, flexible, and collaborative, and provides top down administrative support to the Committee and the Work Groups. This includes planning, participating in, and reporting out from the eight full Committee meetings that have occurred since its inception in October 2012 and roughly 12-15 meetings each week of various subsets of the Committee and the Work Groups. The leadership also plays the critical role of monitoring activities both to ensure that progress is being made and to facilitate coordination of those activities across the Work Groups and the full Committee.

Secretaries' Intent – Warrior Care and Coordination



November 2012



SUBJECT: Department of Defense - Department of Veterans Affairs Secretaries' Intent for Warrior Care and Coordination

One Mission – One Policy – One Plan

A decade of combat has placed enormous demands on a generation of Service members, Veterans and their families – particularly our wounded, ill, and injured. These individuals require the complex coordination of medical and rehabilitation care, benefits, and other services to successfully transition from active duty to veteran status, and to optimally recover from their illnesses or injuries. Their well-being is our highest priority and both of our Departments share this common mission.

In order to meet these demands and this mission, programs and staff in both Departments have grown exponentially. While these efforts are well-intentioned, we must now better harmonize our efforts, simplify processes, and reduce confusion for those we serve. The first step is to designate a Lead Coordinator for Service members and Veterans at each stage of their recovery. This individual will coordinate care and services among the various supporting programs to ensure that wounded, ill, or injured Service members, Veterans, and their families know who to turn to for answers and how to plan for the future. The next step is to create a single shared comprehensive plan for each wounded, ill, or injured Service member between the two Departments and among all supporting programs. This plan, managed by the Lead Coordinator, will guide the Service member, Veteran, and their families through the various transitions of recovery and rehabilitation while allowing each supporting programs to access relevant information to optimize benefits and services.

Our common mission requires common overarching governance, policy and a single shared comprehensive plan for each Service member and Veteran: One Mission – One Policy – One Plan. To execute this mission and consistent with existing law:

- We will establish common **interagency guidance** driven by an overarching, formal **interagency governance structure**;
- We will establish an integrated, **interagency community of practice**, comprised of professionals that coordinate and manage care, benefits, and services, informed by shared measures of success to include utilization, quality, and satisfaction;
- We will establish a single, **comprehensive, interagency plan** developed and shared by both Departments, that produces a **common operational picture**, and is visible to the patient, family, and care recovery team. It will drive effectiveness and efficiencies for

Secretaries' Intent – Warrior Care and Coordination

the recovery process in support of both the recovering Service member and the recovery team;

- We will ensure the care and recovery across the two Departments always meets the needs of Service members, Veterans and their Families and is **sustained** whether we are at war or at peace. This means that we will be **agile** and sensitive to new needs and better ways of providing care;
- We will ensure that the system is **transparent and accountable** to all.

We will cultivate and reward a culture that builds upon a foundation of mutual respect, collegiality, and patient-centeredness in which “our soldier...our sailor...our airman...our marine...our coast guardsman...our Veteran” remains the central focus around which our two warrior care systems are organized.

We appreciate the hard work that has been accomplished by the Warrior Care and Coordination Task Force. This work now transitions from planning to execution. The new governance committee being established will begin implementing our vision in the coming months.



Leon E. Panetta
Secretary of Defense



Eric K. Shinseki
Secretary of Veterans Affairs

Health Care Resource Sharing

Naval Hospital Guam

Naval Hospital (NH) Guam has a longstanding sharing agreement with VA Pacific Islands HCS. The master sharing agreement covers inpatient services, outpatient specialty services including emergency medicine, ambulatory surgical services, and ancillary services for radiology, laboratory and pharmacy in support of approximately 3,400 Veterans receiving primary and behavioral health care services at the VA community based outpatient clinic. The total billing for all health care services provided by NH Guam to VA beneficiaries in FY 2013 was \$2.8 million. NH Guam's monthly average workload provided to VA beneficiaries in FY 2013 is listed below:

- Inpatient admissions: 20/month
- Outpatient visits: 289/month
- Laboratory tests: 3,643/month
- Radiology exams: 79/month
- Prescriptions filled: 350/month

This agreement allows increased access to care for Veterans who would otherwise have to wait for the care to become available or go off island for the care.

NMC San Diego (NMCS D) and VA San Diego HCS (VASDHS)

Obstetrics Program

NMCS D and VASDHS are completing their second year of sharing obstetrics services. VASDHS does not offer obstetrics services, therefore, NMCS D assists by seeing their Veterans for obstetrics services at the main hospital and two branch medical clinics, further maximizing access for the beneficiaries. The table below demonstrates FY 2012-FY 2013 statistical information on this sharing agreement.

NMCS D/VASDHS OB Program	FY 2012	FY 2013
Pregnant Veterans Treated	72	70
Antepartum Complications	1	4
Postpartum Complications	1	3
Mother Dispositions – Home	72	70
Baby Dispositions – Home	72	69
Complicated Deliveries	12	21

NMCS D/VASDHCS OB Program	FY 2012	FY 2013
NICU Babies	5	5
Total Mom/Child Network Cost	\$865,800.92	\$1,024,441.87
Total Amount Billed to VASDHCS	\$278,559.28	\$327,167.34
Total Savings Amount	\$587,241.64	\$697,274.50
Total Savings Percentage	66 percent	68 percent

Consolidated Mail Outpatient Pharmacy (CMOP)

NMCS D continues to use VA's CMOP to process prescriptions for NMCS D beneficiaries. In FY 2013, CMOP fulfilled 546,526 NMCS D prescriptions at a processing cost of \$1.58 plus \$1.71 for delivery to the beneficiaries' home. Drug costs for FY 2013 were \$22,706,921. Based on beneficiary surveys, NMCS D patients rate CMOP services as very good or excellent 97.1 percent of the time.

Foot and Ankle Surgery

NMCS D has agreed to perform foot and ankle surgery for the VASDHCS based upon excess capacity. To date, NMCS D has performed four surgeries. Three of these surgeries were done on an inpatient basis and one as an ambulatory procedure visit. Analysis of the Medicare Severity Diagnostic Related Group (MS-DRG) demonstrated the Composite Health Care System (CHCS) cost for these four patients amounted to \$83,9000. The cost to the VASDHCS resulted in billing for \$20,800, yielding cost savings of \$63,000 and representing a 75 percent cost savings to VA.

Charleston-Beaufort Joint Venture

NHC Charleston, South Carolina (NHCC); Ralph H. Johnson VAMC (RHJVAMC); 628th Medical Group (MDG), Joint Base Charleston, South Carolina; NH Beaufort, South Carolina (NH Beaufort) RHJVAMC shares spaces with NH Beaufort and NHCC to provide CBOC services to Veterans. In Charleston, services are shared at the Captain John G. Feder Joint Ambulatory Care Center (JACC) and at the JIF funded Joint Optometry/Ophthalmology Clinic. In FY 2013, the JACC continued to provide mobile MRI services to both VA and DoD beneficiaries with equipment purchased through the JIF. This arrangement resulted in providing 2,014 images at a net savings of \$528,272 in TRICARE network expenditures and savings of \$111,124 in travel and other expenses for RHJVAMC. Through resource sharing agreements, NHCC/628 MDG/RHJVAMC provided joint services in cardiology, diagnostic radiology, phlebotomy, consultant pathology services, and shared training/clinical skills enhancement opportunities. In Beaufort, RHJVAMC and NH Beaufort initiated MRI services through a JIF project, providing 2,716 images for VA and DoD beneficiaries at a cost savings of over \$1.2 million. Additionally, NH Beaufort and RHJVAMC have resource sharing agreements for laboratory, radiology, podiatry, audiology and optometry services. Benchmarking and communications are coordinated through the Lowcountry Federal

Healthcare Alliance, a coordination committee that meets monthly to discuss potential JIF initiatives, resource sharing agreements and other topics that increase the sharing of services and information between VA and DoD health care organizations in the Lowcountry.

Key West Joint Venture

VA Medical Clinic-Key West (DVAMC-KW) and Naval Branch Health Clinic Key West (NBHC KW)
 DVAMC-KW shares space within NBHC KW, authorized by a sharing agreement between the Miami VAHCS and NH Jacksonville. Through resource sharing, NBHC KW provides laboratory, radiology, and pharmacy services to DVAMC-KW patients on a routine basis. Additionally, optometry, spirometry, and audiology services are provided to DVAMC-KW patients on a space available basis. This allows the Veterans access to care from a single location rather than several locations throughout the community. They are also able to receive pharmaceuticals at a reduced rate. DoD beneficiaries are referred by NBHC KW to DVAMC-KW for mental health (psychiatry) and physical therapy services on a space available basis, allowing them better access to a psychiatrist more equipped to address the mental health needs of an active duty Service member. In addition, NBHC KW and DVAMC-KW submitted a FY 2014 JIF proposal with the desired goal to increase physical therapy services provided by DVAMC-KW to DoD beneficiaries, to include both active duty and active duty dependent patients. This proposal will allow Service members to be treated by a VA physical therapist that is aware of and focused on injury prevention and returning the Service member to full duty.

NH Pensacola

NH Pensacola, VA Gulf Coast Veterans HCS (GCVHSC), Memphis VAMC
 There are currently 11 sharing agreements between NH Pensacola and the two VA partners. The resource sharing program at NH Pensacola covers the following: emergency room services, inpatient services, JACC (radiology, laboratory, dental and obstetrics/gynecology), sleep lab, surgical services, and urology services. Naval Branch Health Clinic Millington has a MRI agreement. The table represents NH Pensacola’s average monthly workload shared with its VA partners.

Monthly Average Workload Comparison			
	FY 2011	FY 2012	FY 2013
Inpatient Admissions	12	13	21
Outpatient Visits	182	203	569
Laboratory Tests	934	1140	2083
Radiology Exam	64	86	166

In January 2013, NH Pensacola started an aggressive marketing campaign to become the Veterans first choice for emergency and hospital care. This led to an increase of 44 percent of Veterans workload compared to FY 2012.

79th Medical Wing (MDW), Andrews AFB and Washington DC VAMC

In March 2013, the 79 MDW and Washington DC VAMC entered into a master sharing agreement that optimizes the use of their VA and DoD medical resources. The Prince George CBOC sits in close proximity to the 79 MDW providing easy access for care that would otherwise be sent out to the community. This creates an environment that benefits the providers at the 79 MDW by bringing more complex cases to their clinics and allows VA beneficiaries access to care in the local area at a reduced cost to the government. Clinical services currently offered under this agreement include mammography, general surgery, ophthalmology, otolaryngology, ambulatory surgery, a variety of women's health outpatient procedures, and most available ancillary services to include cardiothoracic (CT) surgery and MRI. This is the first sharing agreement at this location and a long sought joint alliance.

60th MDG, Travis AFB and San Francisco VAMC (SFVAMC)

The 60 MDG, Travis AFB and the SFVAMC entered into a sharing agreement in August 2013 that provides guidance and authorization for the SFVAMC to incorporate an active duty Air Force CT surgeon into their facility as a full-time provider. The focus of this VA no-cost agreement is to ensure the surgeon has sufficient opportunity to develop and sustain specific skills in CT surgery not currently available within the CT program at the 60 MDG. These skills are necessary to maintain the proficiency and currency in CT surgery skills which are necessary to maintain readiness for deployment. Some of these skills include robotic surgery and trans-catheter aortic valve replacement. The CT surgeon will be integrated into the SFVAMC and receive any applicable training, provide clinical and surgical services for VA beneficiaries, and teach at the SFVAMC and its academic affiliate. TRICARE beneficiaries will also be seen by this provider at the SFVAMC at a reduced cost to DoD. This agreement is essential to the development and maintenance of critical skill sets not available at the MDG but often needed in the field of CT surgery.

59th Medical Wing (59 MDW), Lackland AFB and South Texas VHCS (STVHCS)

In June 2013, the 59 MDW and the STVHCS entered into a sharing agreement whereby the 59 MDW provides mammographic biopsy services for Veteran beneficiaries. The mammographic biopsy services include stereotactic breast biopsies and MRI breast biopsies. This agreement allows VA to enhance delivery of women's health care, reduce the impact on their purchased care budget, and keeps VA patients close to their homes.

Dwight David Eisenhower AMC (DDEAMC), Charlie Norwood VAMC (CNVAMC), and Carl Vinson VAMC (CVVAMC) Joint Venture

In June 2013, DDEAMC, CNVAMC, and CVVAMC were officially designated as a VA/DoD Joint Venture site by the HEC. This Joint Venture will accomplish MHS, Army Medicine, and VA goals through:

- Enhanced Veteran access to health care provided by DDEAMC, especially for those residing in rural areas. Both CVVAMC and CNVAMC serve Veterans in rural areas, serving a 52 county catchment area where access to specialty and subspecialty care is limited or non-existent.
- Enhanced provider readiness through increased volume and complexity of workload. The increased complexity and volume of workload will also contribute to the continued success of DDEAMC's five GME programs.
- Decreased costs for Federal partner facilities as compared to private sector care. A decreased per capita cost will incentivize the VA partners to choose DDEAMC as their prime referral facility versus higher cost civilian hospitals/ providers.
- Provision of Veteran and DoD beneficiary-centered care through coordination of care including referral management, transportation, clinical information exchange, and patient and staff education.
- Enhanced access to Population and Preventive Health services such as mammography, gastrointestinal and genitourinary services, vascular screenings, and reference lab tests for Veterans and DoD beneficiaries.

Effective October 1, 2013, a new Federal Resource Sharing (FRS) master sharing agreement between the three facilities will provide the framework for both long term and short term shared services that were previously covered by individual FRS agreements.

Pharmacy Ad Hoc Working Group

VA/DoD pharmacy programs explored eight joint initiatives with the goal of reducing redundancies, increasing efficiencies, and maximizing buying power. The table below outlines the status of the resulting seven active initiatives for FY 2013.

Initiative	Action	Status Of Action Update
VA prescriptions filled by TRICARE Retail Network Pharmacies	Approved for implementation by HEC/JEC	Given current priorities and funding, VA states that additional IT work on this project will take place in the next FY.
All VAMC pharmacies designated as TRICARE pharmacies	Approved for implementation by HEC/JEC	A survey of additional VA facilities with sufficient TRICARE workload to justify participation was completed and resulted in an additional 95 pharmacies being

Initiative	Action	Status Of Action Update
		added beginning in November 2012.
VA and DoD expand number of joint pharmacy procurement contracts when practicable	Reassigned	This initiative is ongoing. In February 2013, the HEC charged the A&MMMWWG to increase the pace of joint contracts to reduce the backlog.
DoD to make regulatory change to address coverage of newly approved drugs	HEC/JEC direction to pursue change.	Subject was not addressed by NDAA 2013. The draft will be resubmitted to the Regulatory Policy Office.
VA and DoD consolidate prime vendor contracts	Reassigned	Reassigned to the A&MMMWWG with pharmacy oversight
Harmonize Drug Formulary management processes	JEC approved a joint detailed analysis of therapeutic interchange opportunities, identify potential additional joint contracts; increase of pace of joint contracting, and DoD evaluate means to increase use of mail order	This item is considered closed.
Joint mail order prescription program	HEC/JEC directed a third party BCA	Based on results of the BCA report, DoD will continue to use the contractor to provide a national mail order program.

The Departments continued to pursue these active initiatives where appropriate and look for new opportunities to maximize efficiencies through joint efforts when possible. National contracts are at an all-time high with 108 existing contracts, of which 48 were new in FY 2013; there are currently 17 joint contracts pending at the NAC and 19 pending at DLA. The VA/DoD pharmacy team identified 28 commonly used pharmaceutical products and manufacturers for potential joint

contracting action and continued to seek new joint contracting opportunities where practicable. In FY 2013 through the third quarter, VA spent \$176 million on joint national contracts, and DoD spent \$50 million. In FY 2013 through the third quarter, VA joint national contract prime vendor purchases represented 5.81 percent of total prime vendor purchases; DoD purchases represented 1.85 percent. VA identified one drug within the top 25 drugs as measured by VA's acquisition dollar volume that lost patent exclusivity. VA identified 71 new molecular entities used in the ambulatory setting for contracting opportunities. All 71 have been reviewed or are currently under review. DoD performed 12 drug-class reviews representing \$464.7 million of the total spend with estimated cost avoidance and direct refunds of \$58.5 million. Eighty-three joint national contracts expired in FY 2013 and were reviewed for renewal, re-procurement, or termination.

HEC Contingency Planning Working Group

The Contingency Planning Working Group (CPWG) ensures that VA maintains a contingency capability to support DoD wartime bed requirements. In FY 2013, the CPWG completed a review of current and future DoD contingency requirements and proposed significant changes to the 2006 VA/DoD Contingency Plan. Key domestic assets that would support DoD future wartime requirements were identified, such as the VA Polytrauma Network Sites and civilian hospitals that are members of the National Disaster Medical System. The HEC approved a revised VA/DoD Contingency Plan in September 2013. Planning efforts will be complete in FY 2014 when these changes are incorporated into the U.S. Transportation Command's (USTRANSCOM) new Global Campaign Plan for Distribution.

Both Departments continued training and exercise programs geared to ensure preparedness of their contingency assets. Both VA and DoD oversee Federal Coordinating Centers (FCC) located in select cities throughout the country; during contingency operations these FCCs are responsible for receiving and transferring patients to participating civilian hospitals. In past years, providing initial and refresher training for FCC personnel posed a challenge. In FY 2013, the Defense Medical Readiness Training Institute (DMRTI) incorporated the basic and advanced FCC training courses into its curriculum, ensuring these courses will be available and regularly updated. The basic and advanced FCC training courses are taught by SMEs from both VA and DoD. In July 2013, DMRTI presented the basic FCC course to more than 50 VA and DoD participants. The advanced course was presented for the first time that same month to several hundred participants using video teleconferencing, which saved travel costs. Both VA and DoD require their FCCs to independently conduct periodic full-scale patient reception exercises. Four of these exercises occurred in FY 2013. In addition, VA and DoD participated in a national medical regulating exercise conducted by USTRANSCOM to ensure FCC readiness. All FCCs continue to conduct bi-monthly bed availability drills.

DoD recognizes VA as an essential partner in supporting its medical requirements during major wartime contingencies. Both Departments receive considerable benefit by planning, training, and exercising together to meet any potential contingency requirement.

HEC Credentialing and Privileging Working Group

The Credentialing and Privileging Working Group was chartered under the HEC on May 31, 2013, with the goal to evaluate VA and DoD policies, processes and systems improve existing processes and reduce the time and cost associated when staff move or are shared between VA and DoD.

The HEC directed the WG to expand the development of the DoD Centralized Credentials Quality Assurance System (CCQAS) to meet the needs of both VHA and DoD. This decision resulted in a JIF proposal to develop a Joint Centralized Credentials Quality Assurance System (JCCQAS) which builds on the existing DoD platform. The JCCQAS will integrate VA and DoD into one data system which contains all provider information across both Department. DoD CCQAS is comprised of separate modules for Credentialing, Privileging, Adverse Action, and Risk Management; however, as commonalities of processes currently exist in VA and DoD for provider credentialing, the initial work effort has been targeted on this credentialing functionality.

The WG has also tasked three sub-WGs to be formed allowing functional and technical representatives to champion changes within each organization. The Policy and Regulation sub-WG was charged to look at existing policies for similarities, differences and best practices. Once policy and regulatory differences are identified, this group will come to consensus on a path forward to unify Department-level policies where needed and possible. The Business Processes Standardization sub-WG was charged to look at the workflow mapping of existing processes. This group will identify differences in business practice and come to consensus on a path forward to unify Department-level business practices. The IT Assessment sub-WG was tasked to evaluate and move the VA and DoD systems (CCQAS for DoD and VetPro for VA) to a single credentialing technology platform. A taxonomy review is under way to define the data table changes and data migration relationships needed for system consolidation. Additionally, a draft project plan is being designed as the WG anticipates funding for the JIF proposal. This sub-WG is currently meeting twice per month in preparation of JIF proposal award.

SECTION 3 – NEXT STEPS

The accomplishments described in this year's *Department of Veterans Affairs (VA)/Department of Defense (DoD) Joint Executive Committee (JEC) Fiscal Year (FY) 2013 Annual Report* demonstrate concerted efforts within 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 Joint Strategic Plan (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 to successfully meet the needs of Service members and Veterans.

Appendix A

Memorandum of Understanding: VA/DoD Health Care Resources Sharing Guidelines, October 2008

MEMORANDUM OF UNDERSTANDING BETWEEN THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE HEALTH CARE RESOURCES SHARING GUIDELINES

This Memorandum of Understanding (MOU) rescinds and replaces the "VA/DoD Health Care Resources Sharing Guidelines" MOU between the Department of Veterans Affairs (VA) and the Department of Defense (DoD), dated July 29, 1983.

I. PURPOSE

The Secretary of Veterans Affairs and the Secretary of Defense shall enter into agreements for the mutually beneficial coordination, use, or exchange of use of the health care resources of VA and DoD. The goal is to improve the access, quality, and cost effectiveness of the health care provided by the Veterans Health Administration and the Military Health System to the beneficiaries of both Departments.

II. AUTHORITY

The Secretary of Veterans Affairs and the Secretary of Defense establish these guidelines pursuant to the authorities in and requirements of Title 38, United States Code, section 8111 (38 U.S.C. 5811 I), titled "Sharing of Department of Veterans Affairs and Department of Defense Health Care Resources," and the authorities contained under Title 10, United States Code, section 1104 (10 U.S.C. 1104), titled "Sharing of Resources with the Department of Veterans Affairs," which incorporates Title 31, United States Code, section 1535 (31 U.S.C. 51535), titled "Agency Agreements," also known as the "Economy Act." These guidelines assist in the implementation of these statutes.

III. JOINT EXECUTIVE COUNCIL (JEC)

A. Definition: In accordance with 38 U.S.C. 9320, the JEC is established as an interagency council co-chaired by the Under Secretary of Defense (Personnel and Readiness) and the Deputy Secretary of VA. Its members are composed of other designated officers and employees of both Departments.

B. Responsibilities: The JEC shall:

1. Establish and oversee the implementation of the strategic direction for the joint coordination and sharing efforts between the two Departments.

2. Oversee the activities of, and receive recommendations from, the Health and Benefits Executive Councils and all designated committees and working groups.
3. Submit an annual report to the Secretaries of Defense and Veterans Affairs and to the Congress.

IV. SHARING AGREEMENTS

A. Policy: The head of a medical facility or organization of either Department shall agree to enter into a proposed sharing agreement with the head of a medical facility or organization of the other Department in accordance with the guidelines in this MOU, including without limitations section IV.D.I., below. The VA Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs or the Secretaries of the Military Departments may authorize regional or national sharing agreements, subject to the approval process stated in this MOU. Such sharing shall not affect adversely the range of services, the quality of care, the established priorities for care, or result in delay or denial of services to primary beneficiaries of the providing Department. Additionally, sharing agreements shall not adversely affect readiness or the deployment capability requirement of DoD personnel. Facilities must base sharing agreements on jointly conducted business case analyses demonstrating mutual benefit to both parties and using analysis templates prescribed by both Departments.

B. Eligibility: Military Treatment Facilities (MTFs) and other DoD organizational components may provide health care to VA beneficiaries eligible for care under 38 U.S.C. §101 *et seq.* on a referral basis under the auspices of a sharing agreement. VA facilities may provide health care to DoD beneficiaries eligible for care under 10 U.S.C. §1071 *et seq.* on a referral basis under the auspices of a sharing agreement.

C. Reimbursement and Rate Setting: The authority of the Secretaries of the two Departments to establish and modify mutually beneficial, uniform payment and reimbursement schedules for VA/DoD sharing agreements is delegated to the VA-DoD Health Executive Council (HEC). Although most sharing agreements will use the reimbursement methodology outlined in the VA/DoD Outpatient and Inpatient guidance agreed to by the Departments, DoD and VA facilities are authorized to provide services in kind provided the exchange is clearly documented in the sharing agreement and can be expressed by a monetary value.

D. Scope of Agreements:

1. Sharing agreements include agreements between the two Departments; between Service regions of each Department; or between the heads of individual DoD and VA medical facilities where health care resources are acquired or exchanged between VA and DoD. A Memorandum of Agreement (MOA) shall accompany each VA Form 10-1245c and identify the health care or other health-related resources to be shared and demonstrate that the agreement is in the best interest of both Departments' beneficiaries and mission. In general, health care resources covered under these agreements include hospital care, medical services, rehabilitative services, and any other health care services including health care education, training, and research as the providing Department has authority to conduct; and any health care support or administrative resource or service in support of VA medical facilities or Service MTFs.

2. Joint ventures are characterized by specific resource sharing agreements encompassing multiple services resulting in joint operations. These arrangements resemble strategic alliances between DoD and VA for the purposes of longer term commitments of more than 5 years to facilitate comprehensive cooperation, shared risk, and mutual benefit. Joint ventures may or may not involve joint capital planning and coordinated use of existing or planned facilities. Joint ventures exist along a continuum in which the medical facility missions and operations are connected, integrated or consolidated. Joint ventures are characterized by regular and ongoing interaction in one or more of the following areas: staffing, clinical workload, business processes, management, information technology, logistics, education and training, and research capabilities. Joint ventures are established in accordance with DoD Instruction 6010.23 and VA policy.

3. In accordance with 38 USC §8111(e)(3), all sharing agreements shall include, at a minimum, the following information if an individual is a primary beneficiary of one Department and is to be provided health care at a facility or service region of the other Department:

- a. a statement that the provision of this care is on a referral basis;
- b. a statement that the provision of this care will not affect adversely the range of services, the quality of care or the established priorities for the care provided to the primary beneficiaries of the providing Department;
- c. a complete statement of the specific health care resources to be shared under the agreement and,
- d. the reimbursement rate or mechanism previously approved by the HEC for the cost of the health care resources provided under the agreement.

E. Dual Eligibility: VA/DoD beneficiaries provided care under a VA/DoD sharing agreement will be the responsibility of the party to the agreement that is making the referral of the patient to the other party. All questions regarding financial responsibility for care provided to these beneficiaries may be referred to and resolved by the designated officials of the parties to the agreement under which the care is being provided.

F. Approval Process: VA and DoD shall concurrently submit proposed sharing agreements to the respective approval authorities. The authority to approve/disapprove VA/DoD resource sharing agreements and joint ventures is delegated to the Secretaries of the Military Departments (or their designees) for DoD and to the appropriate VA Central Office designees for VA. The designated approval authority for both DoD and VA must approve or disapprove a proposed agreement within 45 days of receipt. If action is not communicated to both signatories to the agreement at the end of the 45-day period, the agreement is considered as approved on the 46th day.

G. Modification, Termination, and Renewal: Except as noted in section D2 above, relating to joint ventures, sharing agreements may be written for a period of up to 5 years. Each sharing agreement and joint venture shall include a statement on how the agreement may be modified or terminated. Either party may terminate a sharing agreement with a minimum of 30 days written notice to the other party. For joint ventures, the agreement must set forth the terms and conditions for dissolution of the joint venture in the event of unforeseen exigencies that require the agreement to be rescinded, with a minimum of 180 days written notice to the other party from the original approving authority. Examples would include Base Realignment and Closure (BRAC) or VA Capital Assets Realignment for

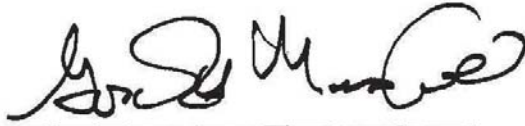
Enhanced Services (VA CARES) decisions or significant demographic changes. Sharing agreements shall provide for modification or termination in the event of war or national emergency, as necessary. Annual reviews of sharing agreements are required by all involved agencies for VA/DoD health care ensure that decisive action is taken to approve or disapprove requests for renewal of sharing agreements prior to the expiration of the sharing agreement. In the event the renewed or amended agreement is not completed prior to the expiration date, written requests for extension of the agreement must be forwarded to the Military Departments' approval authority. Renewals may be written for up to 5 years. Amendments that are required prior to the renewal of an agreement must last only as long as the agreement upon which it is based.

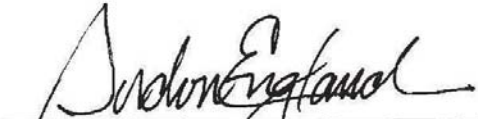
V. EFFECTIVE DATE AND MODIFICATION OF GUIDELINES

A. Duration: This memorandum becomes effective on the date of the last signature and remains in effect until either terminated by either party upon 180 days written notice to the other party or amended by mutual agreement of both parties.

B. Review Authority: These guidelines shall be reviewed every 5 years to determine continued applicability or need for modification.

C. Departmental Policies: For VA: VHA Handbook 1660.4, VA-DoD Direct Sharing Agreements Handbook: <http://www1.va.gov/vapubs/>. For DoD: DoD Instruction 6010.23, DoD and VA Health Care Resource Sharing Program: <http://www.tricare.osd.mil/DVPCOldefault.cfm>


Gordon H. Mansfield *G.H.M.* (date)
Deputy Secretary of Veterans Affairs


Gordon England (date)
Deputy Secretary of Defense OCT 31 2008

Appendix B

Cost Estimate to Prepare Congressionally-Mandated Report

Title of Report: VA/DoD JEC FY 2013 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	\$	60,383
Contract(s) Cost	\$	0
Production and Printing Cost	\$	TBD
Total Estimated Cost to Prepare Report	\$	TBD

Brief explanation of the methodology used to project cost estimate:

The estimated number of total direct labor hours expended was multiplied by the U.S. Office of Personnel Management's calendar year 2013 hourly rate structure for the metropolitan Washington, DC area. The calculated net labor costs were multiplied by the fiscal year 2013 fringe benefit amount of 36.25 percent. The reported information in the cost statement reflects the sum of direct labor hour costs and fringe benefits.

Glossary of Abbreviations and Terms

A&I – Artifacts and Images
A&MMMWG – Acquisition and Medical Material Management Working Group
AC – Access Control
ACO – Auditory Care Optimization
ADC – Active Dual Consumer
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
AMC – Army Medical Center
AMSWG – Accessions Medical Standards Working Group
ANRs – Audio News Releases
APPs – Applications
AR – VA/DoD JEC Fiscal Year 2012 Annual Report
ARCs – Advanced Rehabilitation Centers (ARCs)
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 Council
BHIE – Bidirectional Health Information Exchange
BI – Business Intelligence
BJPs – Business Justification Packages
BOG – Board of Governors
BRAC – Base Realignment and Closure
BRD – Business Requirements Document
CAC – Common Access Card
CAPC – Capital Asset Planning Committee
CAREN – Computer Assisted Rehabilitation Environment
CARF – Commission on Accreditation of Rehabilitation Facilities
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
CCQAS – Centralized Credentials Quality Assurance System
CDC – Centers for Disease Control and Prevention

CDN – Content Delivery Network
CDP – Center for Deployment Psychology
CDR – Clinical Data Repository
CFI – Department of Defense Center for the Intrepid
CHDR – Clinical Health Data Repository
CHHP – Comprehensive Hearing Health Program
CIRD – Clinical Informatics Research and Development
C-IPT – Capability-Integrated Product Team
CM – Context Management
CMI – Chronic Multi-symptom Illness
CNVAMC – Charlie Norwood VA Medical Center
CoE – Center of Excellence
CoEPE – Centers of Excellence in Pain Education
C&P – Compensation and Pension
CONOPS - Concept of Operations
CPC – Construction Planning Committee
CPE – Clinical Pastoral Education
CPG – Clinical Practice Guideline
CPT – Cognitive Processing Therapy
C-STARS – Center for Sustainment of Trauma and Readiness Skills
CT – Cardiothoracic
CVVAMC – Carl Vinson VA Medical Center
CY – Calendar Year
DBQ – Disability Benefits Questionnaire
DCoE – Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DD – Department of Defense Forms 214, 2807, and 2808
DDEAMC – Dwight David Eisenhower Army Medical Center
DEERS – Defense Enrollment Eligibility Reporting System
DES – Disability Evaluation System
DHA – Defense Health Agency
DHMSM – DoD Healthcare Management System Modernization
DHWG – Deployment Health Working Group
DIN-PACS – Digital Image Network – Picture Archive and Communications System
DMA – Disability and Medical Assessments
DMDC – Defense Manpower and Data Center
DMRTI – Defense Medical Readiness Training Institute
DoD – Department of Defense
DOEHRS - Defense Occupational and Environmental Health Readiness System
DOEHRS-HC - Defense Occupational and Environmental Health Readiness System for Hearing Conservation
DoDI – Department of Defense Instruction
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
DVEIVR – Defense and Veterans Eye Injury and Vision Registry
DVPRS – Defense and Veterans Pain Rating Scale
EACE – Traumatic Extremity Injuries and Amputations Center of Excellence
EBP – Evidence Based Psychotherapy
EBPWG – Evidence Based Practice Working Group
eCFT – electronic Case File Transfer
ED – Department of Education
eDR – Enhanced Document Referral
EHR – Electronic Health Record
EPA – Environmental Protection Agency
ESB – Enterprise Service Bus
FCC – Federal Coordinating Center
FCG – Functional Capabilities Group
FHCC – Federal Health Care Center
FHIR – Fast Healthcare Interoperability Resources
FHP&R – Force Health Protection and Readiness
FMWG – Financial Management Working Group
FOC – Full Operating Capability
FRC – Federal Recovery Coordinator
FRCP – Federal Recovery Coordination Program
FRS – Federal Resource Sharing
FTE – Full-Time Equivalents
FY – Fiscal Year
GAO – Government Accountability Office
GFHEC – Georgia Federal Healthcare Executive Council
GME – Graduate Medical Education
HACs – Hospital Acquired Conditions
HAIG – Health Architecture Interagency Group
HAIMS – Healthcare Artifact and Image Management Solution
HARB – Health Architecture Review Board
HCE – Hearing Center of Excellence
HCS – Health Care System
HCWG – Hearing Conservation Work Group
HDD – Healthcare Data Dictionary
HDR – Health Data Repository
HEC – Health Executive Council
HHS – Department of Health and Human Services

HIE – Health Information Exchange
HIT – Health Information Technology
HIPPA – Health Insurance Portability and Accountability Act
HL7 – Health Level 7
HPE – Health Professions Education
iBPR – Integrated Business Process Reengineering
iBRD – Integrated Business Requirements Document
iBRM – Integrated Business Requirements Model
IC3 – DoD/VA Interagency Care Coordination Committee
ICE – Interactive Customer Evaluation
ICIB – VA/DoD Interagency Clinical Informatics Board
IDES – Integrated Disability Evaluation System
IE – Information Exchange
IE-IPT-Information Exchange Integrated Product Team
iEHR – integrated Electronic Health Record
ILER – Individual Longitudinal Exposure Record
JCCQAS – Joint Centralized Credentials Quality Assurance System
IMHS – Integrated Mental Health Strategy
IM/IT – Information Management/Information Technology
IOC – Initial Operating Capability
IOGF – Inter-organizational Guideline Forum
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
IT – Information Technology
IWG – Independent Working Groups
JAL FHCC – James A. Lovell Federal Health Care Center
JACC – Joint Ambulatory Care Center
JEC – Joint Executive Council
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
JSP – VA/DoD JEC Joint Strategic Plan
JTTR – Joint Theater Trauma Registry
JV/RS WG – Joint Venture and Resource Sharing Working Group
Lab/AP – Laboratory/Anatomic Pathology
LINAC – Linear Accelerator
LUT – Limited User Testing
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
MedPDB – Medical Surgical Product Data Bank
MHS – Military Health System
MHS Learn – Military Health System Learning Portal
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
MTF – Military Treatment Facility
NATO – North Atlantic Treaty Organization
NCAT – NeuroCognitive Assessment Tool
NCC – National Capital Consortium
NCPS – National Center for Patient Safety
NCR – National Capital Region
NDAA – National Defense Authorization Act
NGC – National Guideline Clearinghouse
NH – Naval Hospital
NHCC – Naval Health Clinic Charleston
NIH – National Institutes of Health
NMCSO – Naval Medical Center San Diego
NMVAHCS – New Mexico Veterans Affairs Health Care System
NRAP – National Research Action Plan
NRD – National Resource Directory
(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
PBM – VA Pharmacy Benefit Management
PBRN – Practice-Based Research Network
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
PMO – Program Management Office
PMWG – Pain Management Working Group
PPDHA – Pre- and Post-Deployment Health Assessment
PSA – Public Service Announcements
PSC – Polytrauma System of Care
PSWG – Patient Safety Working Group
PT/BRI – Polytrauma/Blast-Related Injuries
PTSD – Post Traumatic Stress Disorder
QMO – Quality Management Office
QUERI – Quality Enhancement Research Initiative
RAC – Regional Amputation Centers (RAC)
RACH – Reynolds Army Community Hospital
RCA – Root Cause Analysis
RCP – Recovery Coordination Program
RHJVAMC – Ralph H. Johnson VAMC
RoG – Republic of Georgia
RTO – Research and Technology Organization
SA – Strategic Actions
SAB – Scientific Advisory Board
SCAN-ECHO™ – Specialty Care Access Networks-Extension for Community
Healthcare Outcomes
SCORE! – Study for Cognitive Rehabilitation Effectiveness
SCWG – JEC Strategic Communications Working Group
SDSU – Same Day Surgery Unit
SGLI – Service Members Group Life Insurance
SHAWG – Separation Health Assessment Working Group
SMMAC – Senior Military Medical Advisory Council
SME – Subject Matter Expert
SOA – Service Oriented Architecture
SOC – Senior Oversight Committee
SOES – SGLI Online Enrollment System
SPARRC – Suicide Prevention and Risk Reduction Committee

SPC – Suicide Prevention Conference
SSA – Social Security Administration
SSO – Single Sign-On
STAR – Service members Transitional Advanced Rehabilitation (STAR)
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
TAMC – Tripler Army Medical Center
TAP – Transition Assistance Program
TATRC – Telemedicine and Advanced Technology Research Center
TBI – Traumatic Brain Injury
TED-I/NI – TRICARE Encounter Data – Institutional/Non-Institutional
TFMO – Theater Functional Management Office
THSP – Target Health Standards Profile
TMA – TRICARE Management Activity
TMS – Talent Management System
TSWF – Tri-Service Work Flow
USMC – United States Marine Corps
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
VAS – Visual Analog Scale
VASDHCS – Veterans Affairs San Diego Health Care System
VBA – Veterans Benefits Administration
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
VSO – Veterans Service Organization
VTA – Veterans Tracking Application
VTA IDES – Veterans Tracking Application for the Integrated Disability Evaluation System
WG – Working Group

