VA/DoD Joint Executive Committee
Annual Joint Report
FISCAL YEAR 2015

VA/DoD Joint Executive Committee Membership List

(as of September 30, 2015)

Department of Veterans Affairs (9)	Department of Defense (9)
Deputy Secretary of Veterans Affairs	Under Secretary of Defense (Personnel and Readiness)
Under Secretary for Health	Assistant Secretary of Defense (Health Affairs)
Under Secretary for Benefits	Assistant Secretary of Defense (Manpower and Reserve Affairs)
Executive in Charge for Information and Technology	Principal Deputy Assistant Secretary of Defense (Health Affairs)
Assistant Secretary for Public and Intergovernmental Affairs	Director, VA/DoD Interagency Program Office
Assistant Secretary for Policy and Planning	Deputy Assistant Secretary of Defense (Warrior Care Policy)
Assistant Secretary for Congressional and Legislative Affairs	Assistant Secretary of the Army (Manpower and Reserve Affairs)
Assistant Secretary for Management & Chief Financial Officer	Assistant Secretary of the Navy (Manpower and Reserve Affairs)
Principal Executive Director, Office of Acquisition, Logistics & Construction	Assistant Secretary of the Air Force (Manpower and Reserve Affairs)

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Sloan D. Gibson
Deputy Secretary
Department of Veterans Affairs

Peter Levine
Acting Under Secretary of Defense
for Personnel and Readiness

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SECTION 1 – INTRODUCTION

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Joint Executive Committee (JEC) is pleased to submit this VA/DoD JEC Fiscal Year (FY) 2015 Annual Joint Report (AJR), for the period of October 1, 2014, to September 30, 2015, to Congress as required by law. The intent of the AJR is to provide Congress, with information about the collective accomplishments of the two Departments and highlight current efforts to improve 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 the JEC. 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 works to remove barriers and challenges that impede collaborative efforts, assert and support mutually beneficial opportunities to improve business practices, ensure high quality cost-effective services for VA and DoD beneficiaries, and facilitate opportunities to improve resource utilization. Through a joint strategic planning process, the JEC recommends to the Secretaries the strategic direction for joint coordination and sharing efforts between the two Departments and oversees the implementation of those efforts.

VA/DoD Health Executive Committee Reorganization

In 2015, the HEC was reorganized into five Business Lines (BLs): Clinical Care and Operations; Financial Operations and Business Operations; Health Data Sharing; Professional Development; and Research. As the result of the reorganization, all existing Work Groups (WGs) and Centers of Excellence (CoE) report to one of the five BLs. VA and DoD Senior Executive Service, Flag Officers, or appropriate senior personnel, co-lead the BLs while subordinate entities are co-chaired by VA/DoD senior leaders. The James A. Lovell Federal Health Care Center (FHCC) Advisory Board continues to report directly to the HEC.

The intent of this new structure is to help the HEC better define priorities, allocate resources, and increase overall efficiencies. The BL Co-Leads will also help shape initiatives and identify areas for the HEC Co-Chairs to apply their influence and remove barriers. They will also monitor milestone accomplishments through metrics, resolve conflicts, and raise issues to the HEC for direction or decision.

SECTION 2 – ACCOMPLISHMENTS

This section highlights the FY 2015 accomplishments of the HEC, BEC, IC3, IPO and Independent Working Groups (IWGs). These accomplishments reflect the efforts of VA and DoD to improve resource sharing between the Departments and further the mission to optimize the health and well-being of Service members, Veterans, and their eligible beneficiaries. The VA/DoD JEC FY 2015 AJR 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 to 2015. This approach clarifies the connection between strategic planning and outcomes achieved through VA and DoD 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 Communications of Benefits and Services Working Group (CBSWG) achieved many beneficial outcomes in FY 2015 through leveraging both VA and DoD communication outlets to share benefits information with beneficiaries. Primary among these outlets is eBenefits, a joint VA/DoD initiative, which serves as both a public website and a secure portal for Service members, Veterans, their beneficiaries, and/or other designees. eBenefits allows users both the ability to research and access available resources, as well as to self-manage their current VA and military benefits and personal information. New capabilities continue to be delivered each quarter. Focused marketing of the eBenefits portal contributed to the creation of 6 million Defense Self-Service (DS) Logon accounts prior to the end of FY 2015, greatly exceeding the VA's Agency Priority Goal (APG) of 5 million. eBenefits account users took advantage of the 58 features and hundreds of links available, resulting in a 6.4-percent increase in the use of the eBenefits letter generator, an online feature that allows Veterans to create VA letters for a variety of purposes, including Civil Service Preference, Commissary access (DoD Identification Card), Service Verification, and Benefit Verification.

VA and DoD expanded their marketing campaign by releasing 21 new videos in FY 2015, promoting both awareness of eBenefits and providing information on key features and benefit programs. Instructional topics included adding dependents through eBenefits, the benefits of using Disability Benefits Questionnaires (DBQs), and VA's new Centralized Mail Program. These newly released videos join a series of 26 internally and externally-facing educational and promotional videos related to eClaims

and the Fully Developed Claim (FDC) Program, developed in 2014. The step-by-step tutorial video from the first series, which explains how to file an eClaim for disability compensation through eBenefits, has reached over 100,000 views on YouTube through September 2015.

Additionally, during 2014 to 2015, the radio and television public service announcement (PSA) campaign promoting eBenefits and eClaims generated a combined total of over $7.2 million in earned media after a year in circulation. The PSAs, featuring actors and NASCAR personalities, were distributed to over 1,000 television media outlets and 4,000 radio outlets across the country. The PSAs are still in circulation and continue to receive airtime on media outlets nationwide.

VA's Veterans Benefits Administration (VBA) contracted with Duty First Consulting (DFC) to assist in the development of its marketing and strategic communications program to promote and encourage the use of eBenefits. In June 2015, a Silver Anvil Award was presented by the Public Relations Society of America (PRSA) to DFC in recognition of its successful collaboration with VBA in addressing a contemporary public relations issue with exemplary professional skill, creativity, and resourcefulness through its strategic marketing of eBenefits to Veterans, Service members, and their family members, by providing them the ability to access, research, and manage their VA and military benefits, and personal information. A 209-percent increase in eBenefits Premium Account users occurred from the first six months of VBA and DFC's collaboration in 2012 through September 30, 2015.

GOAL 2 - HEALTH CARE

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

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 2015, VA/DoD HEC Patient Safety WG (PSWG) continued to enhance the overall quality of care to Service members and Veterans through collaborative efforts in strengthening and coordinating safe patient care.

VA and DoD participated in a collaborative educational effort from March 10-12, 2015, hosted by the VA National Center for Patient Safety (NCPS); this is the second year in succession for this joint educational effort. Topics presented by both VA and DoD faculty included:

VA Presentations	DoD Presentations
Medication Safety	Operating Room Initiatives for Patient Safety – Aviano Air Force Base (AFB)
Hypoglycemic Risk	Actively Engaging Patients – Altus AFB
Medication Safety – What Have We Learned	Executive Leadership Rounds – Scott AFB
Clinical Team Training – Tools for High Reliability	Patient Safety in Deployed Setting – Air Force Medical Operations Agency
Medication Reconciliation	We are the Champions – Fall Prevention – Naval Medical Center San Diego
Health Literacy / Medication	Congestive Heart Failure – Tripler Army Medical Center (AMC)
Using Campaigns for Patient Safety Awareness	Improved Patient Outcomes / Teamwork – Fort Leonard Wood
Use of Future List to Prevent Missed Lab	Spotlight Safety Brief – Madigan AMC

Congress mandated a joint process for sharing information regarding error tracking (Public Law 106-398, Sec 742). The DoD purchased Patient Safety Reporting (PSR), an application to report patient safety events (PSE), accessible via Common Access Card/Personal Identity Verification (PIV).

The Joint PSR (JPSR) project was approved as a VA/DoD Joint Incentive Fund (JIF) initiative in March 2015. A project charter completed in June 2015 included a phased approach: comprehensive assessment of business concepts and processes; proof of concept/pilot; and a structured rollout. This initiative enables DoD and Veterans Health Administration (VHA) to utilize the same enterprise-level, commercial-off-the shelf (COTS) PSR System that DoD has successfully utilized since 2011. It will interface with the government-built Patient Safety Database, SPOT (not an acronym), that has been developed by VHA NCPS for capturing initial patient safety incidents as well as the root cause analysis process. This COTS product, which includes an analytics module for enhanced reporting capability, will allow ad hoc reporting without degrading system performance; both organizations will be able to leverage economies of scale and to prepare for the future. PSR provides the link to the continuum of safe care as the armed forces of today become the Veterans of tomorrow.

The importance of reporting PSEs in a secure, non-punitive environment has been emphasized over the last decade by experts in health care and patient safety. There are documented instances where reporting PSEs led to improvements in health care. Department of Health and Human Services (HHS) data show that quality improvements saved 15,000 lives and $4 billion in health spending from 2011 to 2012.

JPSR stakeholders include but are not limited to: patients, advocates, providers, HEC staff, families, DoD, VHA, and HHS.

The JPSR project was originally projected to be a 2-year effort including the following activities:

- DoD and VHA will conduct a comprehensive assessment and review of business requirements and processes for VHA medical centers and community based outpatient clinics (CBOCs). This assessment will consider the impact for both agencies regarding governance, organization levels, training and education, information technology (IT) network connectivity and system interfaces to the VHA SPOT database. There will be a proof of concept phase that will include 50 VHA pilot sites of varying complexity levels, combined with at least two VA/DoD integrated healthcare facilities.
- VA/DoD will evaluate the proof of concept pilot of 50 VHA sites and make modifications as needed, followed by the final phased rollout for the remaining 100+ VHA sites.

The original timeline of two years may be extended due to a delay in the contracting action, and is being closely monitored and tracked.

A Joint VA/DoD meeting occurred at the NCPS in Ann Arbor, Michigan, the week of September 13, 2015, and again during DoD Patient Safety Training, the week of October 26, 2015. The following points underscore the accomplishments of these meetings:

- Two demos of the current PSR system were provided for the “First Fifty” volunteer VA pilot sites. These sites include: Electronic Patient Event Report (ePER) users, non-ePER users, and joint DoD programs. Demonstrations were provided and a question and answer document was developed and provided to all participants. The JPSR team tested the capability of PIV access on a DoD system with success.
- A training plan was developed and includes test scripts to be provided to the pilot sites. DoD provided a test Uniform Resource Locator site for VA facilities to begin entering test cases. A feedback questionnaire will be developed to accompany the testing so that VA can begin evaluating configuration needs. DoD met with a VA analyst group to discuss a shared taxonomy for event reporting and commenced the mapping process to SPOT.
- DoD completed the certification process for the full JIF award, though only a portion of the award has been disbursed to both agencies. This will allow the funds to be transferred for the SPOT interface development and the purchase of VA licenses once the contract has been awarded.
- NCPS provided DoD a demonstration of the VA SPOT database test application to allow a greater understanding of the similarities and differences in the event reporting/Root Cause Analysis process for both agencies. In addition, VA personnel attended DoD patient safety training to gain knowledge of the DoD application and how it is used among the Services. A joint Memorandum of Agreement (MOA) is in the concurrence phase with both VA and DoD

simultaneously. Signatures from the VA Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs are anticipated in 2016.

- A joint MOA is nearing the final stages of review and will be forwarded through proper channels.

Both VA and DoD are signatories of a Data Use Agreement completed this year. Under this Agreement, the DoD Patient Safety Program shares information with NCPS event level patient safety data. There will be no use of the data except pursuant to the terms of this Agreement. Sharing of the following, if available, has been proposed: patient safely event reports, root cause analyses, proactive risk assessments, sentinel events, patient safety indicators, and the measures or analyses derived from patient safety data sources.

HEC Evidence-Based Practice Working Group

Clinical Practice Guidelines (CPGs) assist VA/DoD 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 the VA's Web site and the Army's Quality Management Web site. During FY 2015, the HEC Evidence-Based Practice Guidelines (EBPG) WG completed the annual target of four CPG updates in FY 2015. These updates included: Management of Chronic Kidney Disease, Management of Chronic Obstructive Pulmonary Disease, Management of Dyslipidemia, and Diagnosis and Management of Hypertension in the Primary Care Setting.

All completed CPGs submitted to the National Guideline Clearinghouse (NGC) have met their inclusion criteria. The NGC's mission is to provide an accessible mechanism for obtaining objective, detailed information on evidence-based CPGs to further disseminate, implement, and use. The EBPG WG is committed to educating healthcare teams. Due to budgetary constraints, the VA/DoD staff exhibited at a limited number of national and VA or DoD conferences. The staff presented multiple formal podium presentations in local VA and DoD educational settings on a variety of the 24 CPGs. In coordination with the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), 20 webinars were presented across the VA and DoD on a wide range of existing VA/DoD CPGs.

Six new CPG tools were developed during FY 2015. There are 173 different CPG tools now 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 are important decision support and educational tools. One CPG broadcast, "The Non-Surgical Management of Hip and Knee Osteoarthritis," was completed in March 2015.

The broadcast is available for on-demand viewing on the Quality Management Office and VA websites[1] and provides one-hour continuing education (CE) credit.

The EBPG WG continued to work jointly with the Guideline Development Collaborative, formerly known as the Inter-Organizational Guideline Forum, which includes the Agency for Healthcare Research and Quality, the Institute of Clinical System Improvement, and Kaiser Permanente. Continued collaboration will ultimately result in shared best practices and the ability to produce a greater number of CPGs while conserving valuable personnel and monetary resources inherent in CPG development.

The EBPG WG 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 ambulatory clinics, to include Patient-Centered Medical Homes (PCMHs). During this year, key recommendations from five VA/DoD CPGs were converted into AIM forms. Also, more than 31 million AIM forms were loaded across DoD to provide evidence-based care at the point of service, strong evidence that CPG implementation is growing across the DoD.

The following is included as part of the "Activities and Milestones" section of the AJR. During FY 2015, VA and DoD had 1.08 million internet requests as compared to 1.16 million in FY 2014. The decrease in numbers is most likely because DoD now has the ability to utilize VA/DoD CPGs through documentation tools and TSWF AIM forms, which are based on CPGs and facilitate implementation at the point of care. The TSWF AIM forms are used more than 800,000 times each week to document patient care. These data provide evidence that health care teams across the VA and DoD are successfully accessing CPG information via the internet or directly using AIM forms to enhance the delivery of quality health care. CPG tools are available in hard copy and electronically for medical facilities to provide health care teams with needed patient, family and provider support tools to assist with CPG implementation. During this FY, VA/DoD had 681,022 CPG tools ordered from the Army's Quality Management Web site and the VA's Talent Management System, compared to 674,870 in FY 2014. Despite fiscal constraints, the data show that health care teams across the VA and DoD are actively ordering and utilizing tools to assist with CPG implementation.

HEC Health Professions Education Working Group

The Health Professions Education (HPE) Ad Hoc Working Group (WG) remains committed to promoting accredited HPE training programs and resident trainee exchanges between VA and DoD. During Academic Year (AY) 2014 to 2015 (July 1, 2014 through June 30, 2015), the two agencies established six new VA and DoD Trainee Exchanges, for a total of 27. These 27 VA and DoD Trainee Exchanges enabled 185 VA resident trainees to receive part of their academic HPE training in a

[1] www.healthquality.va.gov and www.qmo.amedd.army.mil

DoD facility and 357 DoD resident trainees to receive part of their academic HPE training in a VA facility.

VA and DoD Resident Trainee Exchanges – AY 2014 to 2015
July 1, 2014 through June 30, 2015

VA Resident Trainees Rotating to a DoD Facility	
Dental Residents	3
Optometry Residents	4
Pharmacy Residents	9
Physician Residents	141
Podiatry Residents	28
TOTAL	**185**

DoD Resident Trainees Rotating to a VA Facility	
Dental Residents	15
Pharmacy Residents	4
Physician Residents	338
TOTAL	**357**

VA Office of Academic Affiliations Annual Report on Resident Training Positions (ARRTP), AY 2014 to 2015

The ability to provide quality health care is enhanced through these diverse trainee experiences. These exchanges provide trainees with exposure to a variety of patient populations and clinical presentations not possible in a single institution. For example, VA trainees rotating to DoD see a younger, healthier patient population, which includes both women and children, while military trainees rotating to VA 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.

There are now multiple VA and DoD sites with robust trainee exchange programs. To evaluate these programs, VA developed and piloted a new Trainee Exchange Short Survey specific for the VA and DoD trainees who have trained in both systems, with a goal of gaining insight into the perceived value of the training aspects within the other agency. This pilot study describes the development of a survey to identify trainees' perceived benefits of training in a site other than their sponsoring institution. This study, conducted April-June 2014, reports survey data from a multispecialty sample of VA and DoD trainees. Questions were framed to understand the benefits of having opportunities for clinical training in both agencies, rather than to compare experiences.

Analyses and results of the pilot study, provided to the HPE WG in December 2014, indicate a high percentage of trainees reported a positive experience for enhancing skills related to patient care. Trainees felt that the program was less beneficial for formal learning opportunities and research/quality improvement activities. Although a small pilot study, results indicate that the exchange program is highly valued by trainees in the two healthcare systems.

The HPE Ad Hoc WG continues to evaluate the challenges and barriers to successful interagency cooperation in HPE training programs. The HPE Ad Hoc WG remains committed to promoting HPE trainee programs and exchanges between VA and DoD and in AY 2014 to 2015, VA had three DoD Chief Residents from the Air Force participating in VA's Chief Resident in Quality and Safety training program.

In addition, VA implemented a contract with the National Board of Medical Examiners to develop and include questions related to military and Veteran health on the United States Medical Licensing Exam (USMLE), a pre-requisite for practice for all allopathic physicians in the United States. VA facilitated and included DoD experts on question-writing task forces, in addition to the representatives from VA and the academic community. The involvement of DoD experts has ensured that pertinent, high quality, and topical medical knowledge will be included on the USMLE, and this alone will drive curriculum development on military and Veteran health throughout the nation's medical schools and teaching hospitals.

HEC Deployment Health Working Group

The primary emphasis of VA/DoD/DoD Deployment Health WG (DHWG) is on Service members returning from Operation ENDURING FREEDOM (OEF), Operation IRAQI FREEDOM (OIF), and Operation NEW DAWN (OND). The DHWG also coordinates initiatives related to Veterans of all eras. Joint efforts continue to increase sharing of health surveillance information and review of relevant literature on hazardous environmental exposures, so that risky situations in theater are identified, and the Department's responses are appropriately coordinated. The DHWG analyzed complex clinical medicine, toxicology, and policy aspects to develop synchronized VA and DoD actions. In particular, the DHWG provided ongoing oversight of the development of the Individual Longitudinal Exposure Record (ILER). The DHWG organized twelve meetings in FY 2015 to coordinate VA and DoD responses to the potential health effects of five major environmental exposures in Iraq, Afghanistan, and the US, as described below:

- Exposure to burn pit smoke in OEF/OIF/OND.
- High ambient concentrations of particulate matter in OEF/OIF/OND.
- Chemical warfare agent exposure in OIF.
- Historical exposure to contaminated drinking water at Marine Corps Base Camp Lejeune.
- Exposure to Agent Orange during and after the Vietnam War.

- Exposures to Burn Pit Smoke and Particulate Matter in OEF/OIF/OND

The DHWG facilitated VA and DoD responses to airborne hazards in theater during every committee meeting in FY 2015. Exposure to smoke from the burn pits in OEF/OIF/OND could potentially impact hundreds of thousands of deployed Service members. VA funded an Institute of Medicine (IOM) study, entitled "Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan." The IOM recommendations, reported in the VA/DoD Joint Executive Council (JEC) Annual Report for FY 2014, were addressed by the DHWG in a comprehensive Joint Action Plan released in 2012, and are being updated again in 2016 to incorporate recent activities.

The Defense Health Board (DHB) published report, "Deployment Pulmonary Health," March 2015, focused on the potential health effects of airborne hazards in theater and had 17 recommendations to DoD. Some also impacted VA. The revised VA/DoD Airborne Hazards Joint Action Plan in 2015 included the responses to the DHB.

In 2015, the Borden Institute published the proceedings of the 2012 VA/DoD Airborne Hazards Symposium and several DHWG members authored chapters. Follow on symposiums took place in FY 2013 and FY 2015, to include epidemiology research, clinical research, and toxicology research; Veteran outreach; and clinician education. The DHWG continues to provide interagency coordination to implement VA's Airborne Hazards and Open Burn Pit Registry (required by Public Law (P.L.) 112-260 Section 201(a)). VA is using this Registry, in part, to provide outreach and information to Veterans and Service members about possible adverse health effects related to such exposures. Eligible Veterans include Veterans who served in: OEF/OIF/OND; Djibouti, Africa on or after September 11, 2001; Operations DESERT SHIELD or DESERT STORM; and the Southwest Asia theater of operations on or after August 2, 1990.

More specifically, in June 2014, VA launched the Airborne Hazards and Open Burn Pit Registry and opened registration (for participation) to the Veterans and Service members described above. These Veterans and Active-Duty personnel can use the registry questionnaire to report exposures to airborne hazards. More than 48,000 individuals signed up for the registry by September 2015, an increase of 33-percent from FY 2014. Approximately 65 percent of these individuals were Veterans and 35 percent were Active-Duty. VA analyzed registry data and published 3 reports on these analyses in FY 2015.

Section 201(b)(1)(A) of P.L. 112-260 mandated that VA enter into an agreement with an independent scientific organization that would be responsible for submitting an initial report, not later than two years after the establishment of the registry, in which it addresses the effectiveness of actions taken by the Secretaries of Defense and Veterans Affairs to collect and maintain information on the health effects of exposure to toxic airborne chemicals and fumes caused by open burn pits. This initial report would also need to include recommendations for the improvement of collection and maintenance of such information and recommendations on the most effective and prudent means of addressing the medical needs of eligible individuals with respect to

conditions that are likely to result from exposure to open burn pits. A follow-up report would be due five years after completion of its initial report. VA entered into such an agreement with the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (referred to here as "IOM"). The initial IOM study will be completed in July 2016. The first part of this study will focus on its analysis of early registry data. The second part will provide recommendations on how VA should respond to the findings of the registry data and how VA can improve registry procedures.

Potential Health Effects of Chemical Warfare Agent (CWA) Exposure in OIF/OND

In October 2014, the US Army Public Health Center began an investigation of potential exposure to CWA among Service members in OIF/OND, after news articles were published about possible CWA exposures in Iraq during 2003 to 2011. A DHWG subcommittee started weekly meetings in February to coordinate the Army efforts with scientists in the Navy, Air Force, and VA. The four goals of the investigation are:

- Identify, contact, and evaluate Service members and Veterans for possible CWA exposure.
- Offer and provide a medical exam, if appropriate, to Service members and Veterans with likely or confirmed symptomatic CWA exposure.
- Document these efforts in the Defense Occupational and Environmental Health Readiness System (DOEHRS) and individual Service Treatment Records, and ensure the VA is informed of these findings.
- Consider appropriate recognition for Service members and Veterans with injuries resulting from likely or confirmed CWA exposure (potential consideration of Purple Heart award).

As of September 2015, approximately 7,000 Service members and Veterans have reported possible CWA exposures in Iraq. The confirmed exposures will be a much smaller number, based on the results to date. Four cohorts of Service members or Veterans potentially exposed to CWA included:

- Cohort 1: Individually identified in news articles (total 48).
- Cohort 2: Assigned to 4 Army units identified in news articles (total 226).
- Cohort 3: Identified based upon a review of DoD reports, to include Post Deployment Health Assessment (PDHA), Post Deployment Health Reassessment, and/or operational reports (total 5,884) (includes exposure to weaponized Toxic Industrial Chemicals, such as chlorine).
- Cohort 4: Self-identified using the DoD Hotline (total 845, numbers increase monthly).

As of September 2015, 651 structured interviews were completed, and 159 individuals were determined to have confirmed or likely symptomatic exposure to CWA and were referred for a medical exam. Nearly all of the confirmed or likely reports have been mild or moderate exposures to mustard agent. A few individuals reported mild exposure to sarin. The Army plans to complete the structured interviews by mid-2016. The Army is

documenting the results of the structured interviews in DOEHRS and the results of medical exams in individual Medical Treatment Records. The Army will provide VA the necessary records on exposed individuals to facilitate access to appropriate VA services and benefits.

Starting in February 2015, the DHWG has directed the effort to coordinate Army and VA interagency responses. In April 2015, the DHWG Co-Chairs provided a briefing to the HEC, entitled "Investigation of Potential Exposures to CWAs during OIF." In May, the Secretaries of the VA and DoD sent a joint memo to the President on the progress of the investigation, which included a summary of the coordination efforts. VA scientists reviewed Army's implementation guidance and the risk communication fact sheets for Veterans on the health effects of mustard agent and sarin. DHWG is developing a long-term follow-up policy that will be finalized in FY 2016 for the individuals with confirmed or likely CWA exposure who require long-term follow up.

The Army has shared information on the investigation with VA to determine whether the Service members and Veterans have enrolled for VA services. Of the first 1,400 individuals included in the investigation, 68 percent have already received VA health care or VA disability compensation. The Army will continue to work with VA on the long-term follow-up of this cohort and to ensure that those who have transitioned to Veteran status are informed and receive the VA benefits they have earned.

Potential health effects of exposure to contaminated drinking water at Marine Corps Base Camp Lejeune, NC

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, resulting in an estimated potential exposure of 630,000 Marines and sailors, civilians, and family members. Responses to the issue of exposures at Camp Lejeune continued in FY 2015. The DHWG enabled collaboration between VA and the U.S. Marine Corps (USMC) staff on VA programs that provide hospital care and medical services to eligible Veterans and family members for fifteen covered illnesses and conditions that may be attributed to Camp Lejeune exposure. Veterans who served on Active-Duty at Camp Lejeune for not fewer than 30 days during the period beginning on August 1, 1953, and ending on December 31, 1987, are eligible for enrollment in VA health care. Health care for the covered illness and conditions will be provided without any associated copayments, unless the illness or condition is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than the residence at Camp Lejeune. In 2014, VA published a final rule implementing its special treatment authority for these Camp Lejeune Veterans (effective September 24, 2014).

Under 38 U.S.C. § 1787, these Veterans' family members who resided at Camp Lejeune for not fewer than 30 days during the relevant period (August 1, 1953, to December 31, 1987) are eligible for payment, or for reimbursement for health-care provided by a non-VA provider, for any of the fifteen covered illnesses and conditions. However, VA is the payer of last resort for such expenses and will make payment once

all other reasonably available claims and remedies have been exhausted. Further, VA will not cover health care costs for any illness or condition found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than the residence at Camp Lejeune.

In 2014, VA published an interim final rule (effective October 24, 2014) implementing section 1787, permitting VA to provide payment or reimbursement of covered medical expenses to these Camp Lejeune families. Under that rule, VA provides reimbursement for hospital care and medical services provided to family members on or after March 26, 2013, and no earlier than two years prior to the date VA receives the application for benefits.

VA provided both of these regulations to the USMC to be uploaded onto the Camp Lejeune web site. This communication effort exemplifies the excellent cooperation between VA and the USMC.

In addition, the DHWG built consensus in planning scientific responses to complex, sensitive issues, despite different perspectives of the Services and VA. Several congressional briefings were provided in FY 2015, as well as the annual report on The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012.

VA also developed internal clinical guidelines, released in 2014, for VA physicians, which provide instructions to determine eligibility for hospital care and medical services, related to the 15 illnesses and conditions outlined in the law. IOM reviewed the guidelines to validate their scientific validity, with a particular focus on two broad categories: "neurobehavioral effects" and "kidney toxicity." In March 2015, IOM published a study titled "Review of VA Clinical Guidance for the Health Conditions Identified by the Camp Lejeune Legislation" and made clinical recommendations to VA on kidney toxicity, neurobehavioral effects, cancer, scleroderma, miscarriage, infertility, and hepatic steatosis. VA established a task force to respond to the IOM report, which evaluated whether or not to accept the IOM recommendations; their evaluation will be completed in late 2015. The task force is currently revising the VA Clinical Guidelines.

Personnel and housing records (1953-1987) of Marines and family members from Camp Lejeune require verification of residence on a case-by-case basis. The USMC worked with VA and identified DoD databases that could provide historical residence data at Camp Lejeune. The USMC kept attendance lists of names, called muster rolls, and has started digitizing the muster rolls for the period of 1940 to 2005. Almost 61 million pages of records will be digitized in December 2015 and will enable the USMC to perform searches for individual Veterans for VA.

The Agency for Toxic Substances and Disease Registry (ATSDR), which is a part of the Centers for Disease Control and Prevention, has been evaluating the health of the Camp Lejeune population since 1991. The Navy has provided more than $40 million to fund these ATSDR studies. In addition to three studies published previously, ATSDR recently published the results of two new Camp Lejeune studies in the Environmental

Health Journal: one focused on male breast cancer in Marines, and the other addressing infant health outcomes, including low birth weight. The OSD, Navy, USMC, and VA staff coordinated their agency responses to these two new studies. In 2014 and 2015, the USMC performed mass mailings in response to the five studies, using the Camp Lejeune notification database, which includes more than 238,000 individuals. The documents included the ATSDR fact sheets on these studies and the VA fact sheet for Veterans and family members who lived at Camp Lejeune. In 2015, VA announced that it is considering making a presumption of service-connection for some of the diseases in the ATSDR studies.

Potential health effects of Agent Orange exposure during and after the Vietnam War

In FY 2015, the DHWG analyzed extensive research literature on environmental exposures during military service, in order to mitigate the potential health effects of hazardous exposures. VA uses the conclusions of Congressionally-mandated IOM reports to determine if presumption of service connection is warranted for specific diseases in Vietnam Veterans. The next biennial published report from IOM will be in 2016.

VA also requested IOM evaluate a specific issue related to the potential long-term effects of residual exposure to Agent Orange in C-123 aircraft, used during the war for spraying herbicides. Following the Vietnam War, the Reserve Component flew the C-123 aircraft; the same aircraft used during the war to spray herbicides. Veterans raised concerns about long-term effects from possible residual contamination and requested a presumption of exposure of all aircrews and maintenance staff who worked on C-123 planes after the war—an estimated 2,000 Reserve members. IOM published its report in January 2015 and determined that reservists working inside C-123 aircraft between 1972 and 1982 would have experienced some exposure to dioxin. Overall, IOM concluded it was plausible that, at least in some cases, the reservists' exposure exceeded health guidelines for workers in enclosed settings. VA established an internal VA task force to respond to these findings and provided recommendations to the Secretary of VA. In June 2015, VA announced it would provide a presumption of exposure for Reservists who worked in C-123 aircraft during specified periods after the Vietnam War. The Air Force performed historical research to identify the military units that were included in the cohort and provided the unit data to VA. In June 2015, VBA instituted procedures to implement the new policy.

Individual Longitudinal Exposure Record

The DHWG provides ongoing oversight of the development of the ILER project, including briefings every two months. The goal of ILER is to create a complete record of every Service member's occupational and environmental exposures over the course of their career. ILER is a $19.1 million JIF pilot project and the goals are: demonstrate the feasibility of producing ILER, and develop a prototype that provides an Initial Operating Capacity (IOC). At IOC, VA and DoD will decide whether to proceed to Full Operating Capability, which would require considerable sustainment funding from both agencies in future years.

The ILER will mine several existing DoD data systems that contain in-garrison and deployment exposure-related information. It will link career location and year with exposure data and will be available to VA and DoD health care providers to inform diagnosis and treatment, and to help VBA claims adjudicators establish service connection. This will assist Veterans in establishing their individual exposures. Three major requirements documents were completed and validated in FY 2014: the Functional Concept of Operations, the Business Use Case, and Functional Requirements. In FY 2015, VA and DoD selected their respective Program Management Offices to manage ILER acquisition, development, and solution delivery activities. VA and DoD also initiated collaborative technical meetings; and completed a high-level conceptual ILER design and capability development approach for an ILER pilot. Additionally, VA and DoD completed design and development contract packages, with contract awards expected to begin in October 2015. Monitoring of acquisition and design/development activities is ongoing. Oversight will include joint VA/DoD ILER integrated project team meetings to coordinate and synchronize business processes, technical development and funding efforts towards building the ILER. The IOC milestone for the ILER pilot is October 2017.

HEC Psychological Health/Traumatic Brain Injury Working Group

In June 2015, the Psychological Health (PH) WG Co-Chairs, along with the Traumatic Brain Injury (TBI) Subgroup Leads, provided a briefing to the HEC Clinical Care and Operations Business Line (BL) Co-Leads, during which the group decided that the PH/TBI WG would no longer include a TBI component. This decision was made to reduce redundancy of efforts related to TBI activities, due to existing ongoing collaboration between the VA and DoD TBI subject matter experts. TBI issues and initiatives will continue to be reported to the HEC via the HEC Clinical Care and Operations BL. The TBI accomplishments in this report are divided between sub-goals 2.1 and 2.2.

HEC Psychological Health Working Group

The goal of the PHWG is to increase and sustain communication and collaboration between VA and DoD on issues related to PH, as well as to provide oversight of all joint PH initiatives.

The PHWG developed the VA/DoD Integrated Mental Health Strategy (IMHS) in 2010 to address the growing population of Service members and Veterans with PH and related needs. 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 (SAs), 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 Departments for Service members, Veterans, and their families.
- Advance care through community partnerships, education, and successful public communication.
- Promote resilience and build better behavioral health care systems for tomorrow.

At the start of FY 2015, 17 of the 28 IMHS SAs were complete. During FY 2015, six additional IMHS SAs fulfilled their originally planned milestones, including those addressing:

- Joint review of mental health screening policies and procedures (SA #01).
- Identifying rural mental health providers knowledgeable about military culture (SA #07).
- Promotion of effective family resilience programs (SA #16).
- Helping family members identify mental health needs of Service members and Veterans (SA #17).
- Military culture training (SA #25).
- Translation of mental health research into innovative programs (SA #26).

At the end of FY 2015, five SAs remain open. The PHWG is in the process of revising final reports and documentation for most of these SAs.

Four VA/DoD PH-related initiatives, that are direct follow-on projects to IMHS SAs, received 2-year JIF funding in FY 2013 and are approaching conclusion. These four projects 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 practice-based implementation (PBI) network across select VA and DoD facilities; and implementation of problem solving training (PST) in VA and DoD .

- The JIF project, addressing the role of chaplains in the provision of mental health services, held several Mental Health Integration for Chaplain Services (MHICS) training sessions this FY. Eighteen VA and 17 DoD chaplains completed training. Data from pre- and post-MHICS questionnaires are currently being analyzed. Post-collaborative interviews are complete and are currently being analyzed from face-to-face training. The training is conducted jointly for VA and DoD chaplains and mental health providers in seven DoD and seven VA sites. This analysis will permit comparisons in domains of screening, referrals, documentation, assessment, role clarification, and cross-disciplinary training.
- All JIF EBP pilot sites have a champion-consultant on site promoting awareness of EBP effectiveness. Baseline data regarding increased awareness of EBPs has been collected and comparison data will be collected in six-month increments.
- For more information on the PBI Network JIF, please see the Research Translation section of this report.

- In FY 2015, the JIF project on PST for VA and DoD clinicians conducted three Provider Training workshops and two Master Trainer workshops. One hundred eight clinicians (54 DoD, 54 VA) completed the initial training and 26 (12 DoD, 14 VA) completed the Master Trainer workshops. To be eligible to be trained as a Master Trainer, the clinician must have successfully completed the PST clinician training in FY 2014 or FY 2015. The next steps for this project are analysis of program evaluation data, refinement of training materials and dissemination of results, and providing lessons learned to VA and DoD stakeholders. Sustainment plans include use of the VA/DoD PBI Network MAX.gov site to ensure continuity of information exchange, and to establish a permanent location for supporting tools and documents. Completion of this project is expected in FY 2016.

Additionally, the PHWG has supported implementation of three major interagency initiatives:

- The Military and Veterans Mental Health Interagency Task Force was established by Section 6 of Executive Order 13625 (August 31, 2012). In FY 2015, this task force put forth eight recommendations to further enhance interagency activities addressing Service members' and Veterans' mental health. Results from these recommendations will be reported to the White House in FY 2016. The recommendations are:
    - Advance suicide prevention infrastructure and training across agencies to support Veterans, Service members, and their families.
    - Support and implement National Research Action Plan (NRAP) initiatives within HHS, DoD, and VA.
    - Initiate data collection for joint clinical outcome measures to track behavioral health service utilization and outcomes across agencies to support Veterans, Service members, and their families.
    - Build and enhance community partnerships to support military and Veteran families.
    - Implement and enhance policies and procedures to support full inclusion of lesbian, gay, bisexual, and transgender populations in Departmental programs.
    - Ensure effective policy and practice integration addressing substance use disorders in populations served by the Departments.
    - Advance policies and practices that address military sexual assault, military sexual harassment, and health concerns related to these experiences.
    - Advance workforce development models that support Service members, Veterans, and their families.

- The Cross-Agency Priority Goal (CAPG) on mental health was launched in March 2014 to accelerate progress on a select number of Presidential priorities where implementation requires active collaboration between multiple agencies.

CAPG includes three sub-goals with 11 priority actions. As of the end of FY 2015, two out of the 11 priority actions were considered complete:

- Evaluate/improve existing VA-community collaboration pilot programs and promote expansion of formal arrangements/collaborations with community providers.
- Standardize and integrate measurements for TBI, post-traumatic stress disorder (PTSD), and suicide prevention, across the research funded by DoD, VA, and HHS to advance research and health care.

- In August 2014, the President announced 19 Executive Actions (EA) that continue to build on actions that VA, DoD, and other Federal agencies have taken in response to the President's 2012 Executive Order and CAPG. As of the end of FY 2015, five have been completed. They are as follows:
  - Supporting Service members with mental health conditions in making the transition to VA care.
  - Ensuring continuity of mental health medications during the transition from DoD care to VA care.
  - Harnessing the efforts of researchers from DoD, VA, the National Institutes of Health (NIH), and Academia.
  - Advancing cutting-edge PTSD research.
  - Providing mental health awareness training more broadly.

CAPG and EA progress is reported to the White House quarterly and publicly available on performance.gov.

Common Standard of Care to Support PH

Evidence-Based Psychotherapies

In FY 2015, VA and DoD continued to expand efforts to provide consistent and coordinated training in EBP for PH conditions. As part of IMHS SA #9, VA and DoD implemented common and coordinated evidence-based training to increase 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 2015, VA provided training to more than 550 unique providers in the delivery of Cognitive Processing Therapy (CPT) and/or Prolonged Exposure Therapy; 99 percent of these providers are currently in consultation or have successfully completed VA's competency-based training process. VA has maintained a capacity of more than 145 trainers/consultants for these two training programs. VA continued to expand training efforts in Cognitive Behavioral Therapy for Depression, Cognitive Behavioral Therapy for Insomnia (CBTI), Cognitive Behavioral Therapy for Chronic Pain, and a number of other EBPs in FY 2015. VA provided training in one or more of these therapies to more than 1,400 unique providers, 96 percent of whom are currently in consultation or have successfully completed the competency-based training process. VA added 200

trainers/consultants in FY 2015 across all its 15 EBP training programs, creating a total capacity of more than 530 trainers/consultants.

In FY 2015, DoD provided training to more than 941 providers in EBPs for PTSD, depression, and other PH conditions. This includes 360 providers trained in PTSD EBPs and over 580 providers trained in EBPs for other PH conditions. DoD also trained 36 providers to be DoD trainers/consultants in EBPs for PTSD, depression, and other PH conditions in FY 2015, creating a capacity of more than 114 EBP trainers/consultants within DoD. In fulfillment of the final IMHS milestone related to EBP, consultation was provided to 474 DoD providers (130 providers for PTSD EBPs and 344 providers for other PH conditions).

Program evaluation results from VA EBP training programs have recently been published (or accepted for publication) in various high impact journals. These results have generally 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. The VA system for training, dissemination, and implementation of EBPs was lauded in the recent IOM report on Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-Based Standards (2015).

VA is developing alternative methods for EBP training informed by the literature on evidence-based practices for education and training with the goals of decreasing reliance on travel and increasing timely access to high quality EBP training. In FY 2015, VA piloted two EBP blended learning models that incorporate asynchronous learning strategies, such as web-based training courses for didactics, and synchronous learning strategies for interactive, experiential learning. VA is currently examining results from these pilots. Full results are expected in FY 2016 and 2017 as the EBP programs are in various stages of making these transitions. In addition, VA will be launching internet pages to provide EBP information to Veterans and families.

DoD continues to provide alternative methods for training to increase the pool of providers receiving training in EBPs as well as receiving follow-up consultation. These methods include providing training and consultation via online platforms such as Adobe Connect and Second Life. DoD is currently gathering preliminary program evaluation results regarding the effectiveness of such online training efforts. The VA/DoD JIF EBP project is evaluating the effectiveness of champion-consultants in training local providers and promoting use of EBPs at ten high-volume military treatment facilities (MTFs). In addition, VA and DoD have been working collaboratively to share insights and lessons learned on distance learning. EBP clinical information continues to be added and shared on the joint VA/DoD Provider Portal as a means of resourcing providers and ensuring comparable training and treatment information is shared and widely disseminated across both Departments.

Military Culture Training

In FY 2015, the VA/DoD IMHS SA #25 working group completed all action steps, milestones, and metrics in their implementation plan. The team remains active in the national dissemination of the four-module course, Military Cultural Competence for Healthcare Professionals.

To date, over 125 organizations within the Federal government and in the civilian community were contacted and have agreed to disseminate the course to their constituencies or members. Dissemination efforts have increased over the course of FY 2015 and will continue. Results of these dissemination efforts include a significant increase in the number of individuals accessing the military culture resource website pages developed by the IMHS SA #25 team (www.DeploymentPsych.org/military-culture), and an increase in the number of health care professionals completing at least one of the four course modules. For example, through September 30, 2015, FY 2015 saw the following activity with regard to military culture training:

- More than 11,200 CE credits have been awarded to over 2,625 health care learners who have completed the four-module Military Cultural Competence for Healthcare Professionals course.
- Over 3,850 providers have received CE credits for taking a two-credit military culture online course, Military Cultural Competence, offered directly by the Center for Deployment Psychology (CDP) and developed with content from the VA/DoD IMHS #25 working group.
- 2,100 providers have attended live military culture training through the CDP's one week, Addressing the Psychological Health Needs of Service members and Their Families regional workshops or STAR Behavioral Health Providers (SBHP – http://www.starproviders.org/) program supported by the CDP and the National Guard Bureau.

During FY 2015, more than 78,000 individuals visited the Military Culture for Healthcare Professionals resources page supporting providers working with Service members, Veterans, and their families (www.DeploymentPsych.org/Military-Culture). The CDP's Military Cultural Competence course is being updated and will pursue re-accreditation for two additional years. The four-module joint Military Cultural Competence for Healthcare Professionals course was recently re-accredited for three years. Additionally, evaluation surveys and follow up data are being collected and will be reported on in FY 2016.

The CDP is currently developing three complementary short courses on military cultural competence. These courses target specialized audiences such as, Military Cultural Competence for Primary Care Providers, and Military Cultural Competence for Chaplains and Non-healthcare Care Givers, and a course about the unique cultural aspects of National Guard and Reserve. These courses will all be available for free CEs by summer of 2016. Live military culture training through the CDP's one-week course and the SBHP program are funded and will continue through FY 2016.

Research Translation

In FY 2015, the IMHS SA #26 completed all action steps and milestones in their implementation plan. As a follow-on to IMHS SA #26, VA and DoD initiated a practice based implementation network; VA and DoD teams are in the process of completing a JIF-funded pilot to implement measurement-based care for PTSD. The pilot used an external facilitation model and a technical assistance model to increase implementation of outcomes monitoring to improve PTSD treatment outcomes. VA data indicates the PBI Network has been successful in achieving the desired results on several key outcomes.

In FY 2015, the DoD PBI Network also supported the pilot implementation of Screening Brief Intervention and Referral to Treatment (SBIRT) within the patient-centered medical home team, using the integrated behavioral health consultants to facilitate the process. SBIRT is an evidence-based practice, used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol. It is one practice that a primary care provider can use to quickly identify and refer to for brief intervention with Service members who indicate they may have problems with their alcohol use. The post-brief intervention screening consists of an interview and education about alcohol misuse and abuse. The SBIRT pilot is currently active at two Army medical treatment facilities, and efforts are underway to add two additional pilot sites, one Navy and one Air Force, in FY 2016.

Suicide Risk and Prevention Strategies

Extensive collaboration and cooperation between VA and DoD continued in FY 2015 related to Suicide Risk Awareness and Prevention Strategies. The Defense Suicide Prevention Office (DSPO) is well established in its role as the focal point for all DoD suicide prevention policy, training, and program oversight, and as the DoD lead for VA/DoD collaboration on suicide prevention. VA's Suicide Prevention Program also continued to expand, develop, and incorporate relevant information from its collaboration efforts with DoD.

Both Departments use proactive approaches in suicide prevention messaging. VA and DoD conduct bi-weekly conference calls to ensure the accuracy and consistency of joint messaging. DSPO and VA work together on joint messaging by leveraging the same campaign theme and applying it throughout the two Departments.

Veterans/Military Crisis Line

Overall, since its launch in 2007 through June 2015, the Veterans/Military Crisis Line (VCL/MCL; Veteranscrisisline.net) has received more than 1.86 million calls, more than 240,000 chats, more than 39,000 text messages, and has initiated more than 50,000 emergency interventions of suicidal callers. An emergency intervention occurs when a caller communicates an immediate suicidal intent or inability to remain safe. The crisis line respondent then contacts local emergency services to attend to the caller and ensure his or her safety. Through September 2015, the website has seen more than 899,000 visitors, a monthly average of more than 74,900.

VA and DoD have collaborated on marketing to ensure the widest dissemination of VCL/MCL. The messaging focuses on reaching two key audiences. The first is Veterans and Service members who may be in crisis; VA and DoD reach them primarily with confidential support through the VCL/MCL. The second audience is Veterans' and Service members' support networks, including family members, friends, health care providers, and community members. Individuals are encouraged to reach out and take that first step toward helping Veterans and Service members seek support, either by contacting the VCL/MCL themselves, or by sharing information and connecting Veterans and Service members to the VCL/MCL.

Suicide Prevention Month, in September of each year, is a prime opportunity for VA and DoD to raise public awareness of suicide risk and suicide prevention resources. The Power of 1 was the campaign theme for 2015. The "1" theme emphasized how a single act can give Service members and Veterans access to confidential support and resources through the VCL/MCL. By linking the number "1" to a variety of actions, the theme also underscores the numerous ways individuals can have an impact on Service members and Veterans in crisis. The "1" theme also reinforces the campaign brand by stressing the "Press 1" feature of the VCL/MCL, connecting callers directly with responders who are trained to support military/Veteran community.

To ensure that consistent continuity of care is being provided, VA and DoD standards of care are based on joint CPGs. Both Departments provide a continuum of care that includes referral from VCL/MCL to additional mental health resources. VCL/MCL responders are able to refer Veterans directly to the Suicide Prevention Coordinator at their local VA facility to facilitate entry into care or follow up care at their respective VA facilities or other community facilities, as appropriate. Similarly, VCL/MCL responders refer Service members to appropriate services, including Military OneSource and other resources.

Suicide Data Repository

The joint DoD and VA Suicide Data Repository (SDR) is a unique, collaborative effort to merge existing data from multiple federal agencies, such as the Centers for Disease Control and Prevention (CDC). The SDR stores mortality-related information to include suicide-related data for Service members and Veterans. The SDR supports researchers and decision makers from the DoD and VA by serving as the integrated mortality data repository from the DoD, VA, and the CDC. The SDR enables researchers to access this integrated data that was previously unavailable and thus, improves DoD and VA's ability to understand suicide behaviors, inform researchers, and evaluate suicide prevention programs. Since the SDR contains information on all causes and manners of death, it allows for comprehensive understanding of suicide prevalence, contributing factors to suicide-related events, and the identification of mortality control groups to enhance understanding about suicide in the military. This information also facilitates research of mortality for all who have a history of Military service and provides critical information to researchers beyond studies of suicide.

The SDR was created in 2013 and became operational in 2014. A joint Board of Governors (BoG) was chartered in February 2014, and serves as the SDR managing entity for approval of data requests. From February 2014 through September 2015, the Board of Governors for the SDR convened eight times and adjudicated a total of 102 requests for data from the SDR, typically data from the CDC's National Death Index Plus (NDI+). DoD has used the SDR to perform analysis on topics such as at-risk populations, understanding potential clusters, and analyzing the effect of different Military occupations on prevalence of suicide. VA has used the SDR to perform analysis on annual suicide rates and Standardized Mortality Analysis, which when combined, model the prediction of suicide risk. Principal Investigators (PIs) for DoD- or VA-sponsored research may request data from the SDR. There is no direct cost to the requestor for data provided by the SDR. Both Departments use SDR data to support Congressional and leadership inquiries on factors associated with suicide.

Joint VA and DoD Conference

In support of suicide prevention for FY 2015, VA and DoD conducted a joint conference in Dallas, Texas in January 2015. Over 425 participants attended the conference. Of the 182 participants who completed the satisfaction survey, 66 percent were from VA, 25 percent from DoD, 4 percent were from other Federal government organizations, and 5 percent were non-federal employees. Additionally, of those who completed the survey, 58 percent were licensed clinical social workers and 10 percent were clinical psychologists. Other categories of attendees included administrators, advanced practice nurses, associated/allied health professionals, licensed counselors, physicians, registered nurses, and other. Consistent with joint suicide prevention and outreach campaign messaging, the focus of this conference was on the joint message of "One Connection, One Conversation, One Small Act – It Matters" theme. This theme conveys that one small act can make a difference in the life of a Service member or Veteran in crisis. Topics included: suicide trends, research showcase, peer support programs, messaging and outreach, chaplaincy integration, therapeutic risk management, cognitive therapy, CPGs, intersection of domestic abuse and suicide prevention, transition periods and suicide risk, safety planning, suicide risk assessment, National Strategy for Suicide Prevention (NSSP), resilience, preservation of the force and family, and breakout sessions for the Military Services and VA Suicide Prevention Coordinators. Both Departments will continue collaboration of educational events via webinars and conferences.

The DSPO co-chairs the Military/Veterans Task Force in order to support implementation of the 2012 NSSP. The task force focuses on enhancing military and clinical competencies of community providers. This increases the community provider's ability to deliver effective suicide prevention services to Service members, Veterans, and their families. This task force is a sub-group of the National Action Alliance for Suicide Prevention, a public-private partnership dedicated to advancing the NSSP. DSPO and VA continue to participate in ongoing discussions and planning sessions through the Suicide Prevention and Risk Reduction Committee and the Military/Veterans Task Force.

Traumatic Brain Injury

Common Standards of Care to Support TBI

Training

VA and DoD clinicians receive training in evidence-based clinical practices covering the full spectrum of TBI care. Falls and motor vehicle crashes are the current primary focus of VA and DoD TBI training programs and exercises. The DVBIC offers online education for both civilian and military providers to learn about TBI, including two online courses. The first course provides an overview of concussion symptoms and elicits useful diagnostic information to assist providers who also receive tips and links to relevant resources. The second assists Service members or Veterans with ongoing post-concussion symptoms and helps clinicians identify and treat the side effects of a concussion.

The quarterly VA and DVBIC TBI Clinical Grand Rounds provide an opportunity for health care providers to discuss TBI hot topics. Topics include multi-dimensional approaches to sports-concussion evaluation and management, and associated issues such as sexuality, pain, and visual dysfunction. Presenters from across the VA, military health system (MHS), civilian sector, and academia describe evidence-based research and case studies to facilitate discussion on best practices in treatment and care. In FY 2015, 450 participants from the VA and DoD received CE credit from these Grand Rounds.

DVBIC educators trained 47 providers on Sleep Clinical Recommendation Guidelines in May 2015, at the Fort Belvoir Community Hospital. DVBIC education staff also held 1-2 day training courses for TBI to 99 Alaskan VA and DoD primary care providers in June 2015. Remote VA/DoD provider training is also facilitated through the DCoE/DVBIC website with extensive information and training materials.

The 2015 DCoE PH and TBI Summit was held at the Defense Health Agency (DHA) Headquarters from September 9-11, 2015. The theme for this year's Summit was, "Continuum of Care and Care Transitions in the Military Health System." The training provided VA and DoD health care practitioners and MHS leaders an opportunity to learn more about factors that challenge and facilitate quality healthcare services for PH and TBI conditions. More than 1,000 health care providers, researchers, and administrators registered for the Summit.

The VA Polytrauma System of Care offered a 2-day face-to-face conference for 251 providers from May 5-6, 2015 to optimize recovery and community re-integration after complex TBI and associated co-morbidities. The program included evidence-based training to advance providers' competence, practice performance, and to improve healthcare management and outcomes.

The Secretary of VA requested that the VA hold a TBI State of the Art summit of leaders from the VA, DoD, and the private sector for the purpose of highlighting advances that

have been achieved since the previous TBI State of the Art summit in 2008, and to discuss future research and clinical directions in TBI. Over 200 scientific experts from VA and DoD, as well as Veteran Service Organization representatives and caregivers of Veterans with TBI met from August 24-25, 2015, to discuss gaps and challenges in TBI research and the need to maintain collaborative efforts to enhance and standardize TBI care.

DCoE conducts monthly webinars to provide information and facilitate discussion topics related to PH and TBI. FY 2015 webinars covered topics including sleep, nutrition, stress, and prevention. Typically, 300-500 providers and researchers attend these webinars each month.

Research Translation

During FY 2015, patient enrollment was completed for the two translational clinical studies described in the FY 2014 Report -The Neurocognitive Assessment Tool (NCAT) "Head-to-Head" Validity Study, and the Study of Cognitive Rehabilitation Effectiveness (SCORE!) in mild TBI (mTBI).

- The second phase of the Head-to-Head Validity Study of four computerized NCATs (ANAM4, CNS-Vital Signs, CogState, and ImPACT) comparing those tools to each other and to traditional neuropsychological tests in a group of healthy control Service members was completed. All four computerized NCATs performed similarly to each other; traditional neuropsychological tests and results showed that NCATs could be used as a targeted cognitive screening tool for following acute TBI, but are not a substitute for a full neuropsychological assessment of cognitive deficits. NCATs are one piece of a multi-disciplinary system post-TBI assessment, but alone NCATs cannot be used to diagnose concussion. The computerized NCATs should not be used as a population screening tool for cognitive deficits.
- The SCORE! Study was conducted by DVBIC to evaluate the efficacy of cognitive rehabilitation therapy of patients with mTBI with persistent cognitive deficits. The study found clinically improved perceived cognitive functioning (i.e., memory, attention, social communication, and executive function), and reduced anxiety in Service members receiving cognitive therapy, compared to the control group. Further analyses are ongoing to identify ways to best apply treatments, and possibly identify individuals for whom these interventions are most effective. A study treatment manual was published during FY 2015 and is available on the DVBIC website.

An update to the 2009 VA/DoD CPG on the Management of Concussion/mTBI was started in FY 2015 and includes TBI subject matter experts from policy and healthcare. Evidence-based clinical recommendation documents were developed for health care providers in FY 2015 on the management of headaches following mTBI. The clinical recommendation is currently being piloted at MTFs and VA facilities. The electronic release of this CR is scheduled for February 2016. The collaborative process for reviewing the literature and gathering subject matter experts within the DoD, VA, civilian

and academic communities has produced 11 evidence-based clinical recommendations on medical topics directly related to the diagnosis and management of Service members and Veterans with concussion and associated symptoms. The suite of products for each CR can be found on and downloaded from the DVBIC website.

The VA's Polytrauma and Blast-Related Injuries Quality Enhancement Research Initiative (QUERI) continued to drive enhancement of current clinical care. The focus of the QUERI through FY 2015 was implementation of evidence-based integrated, patient-centered care for TBI and associated comorbidities, improving symptoms, impairments, and optimizing Veterans' support system. The QUERI portfolio includes 18 studies and 19 publications in FY 2015. VA's TBI screening and evaluation program practices and metrics continue to be refined and validated, and shared monthly with senior leadership as well as providers across the VA.

Outcome Measures

In 2015, the individual Services agreed to use the following outcome assessment tools for patients with TBI: the Neurobehavioral Symptom Inventory and a modified version of the Patient's Global Impression of Change. Currently, the Readiness Division of the DHA is coordinating with the TAC to codify standardization of the outcome measures for TBI.

Ongoing Research

A major focus for both the VA and DoD continues to be improving understanding of the chronic effects of mild to severe TBI. Through June 2015, the VA TBI Model Systems Study (TBIMS) has enrolled 712 participants across the five Polytrauma Rehabilitation Centers. This study utilizes demographics and common data elements to establish a longitudinal database of Active-Duty military and Veteran rehabilitation outcomes during acute and chronic stages of recovery from TBI.

A 5-year prospective, VA/DoD multi-center study on Improved Understanding of Medical and Psychological Needs in patients with chronic TBI (the iMAP Study) began at the Tampa VA. The study will capitalize on the existing infrastructure of the VA TBIMS Program and the DVBIC 15-year longitudinal studies through addition of new study measures, interviews and focus groups, and provider surveys to address: long-term health effects, rehabilitation needs and programs after inpatient treatment, and the effect on family members.

HEC Vision Center of Excellence

The Vision Center of Excellence (VCE) seeks to improve vision health and quality of life for Service members, Veterans, and their families by delivering evidence-based solutions and best practices that promote military readiness and improve care delivery. VCE provides clinical support, facilitates research, and conducts education and outreach on the prevention, diagnosis, mitigation, treatment, and rehabilitation of

military vision and eye injuries. Administratively, the VCE works closely with the VA to establish sustainable inter-agency support for VCE programs and initiatives.

Clinical Support

Trauma associated ocular injuries, diseases, and visual dysfunctions impact military readiness and can have life-long impact on quality of life for Service members, Veterans, and their families. The VCE improves clinical care at the systems- and individual-levels by developing and disseminating evidence-based best practices, working to identify optimal pathways of vison care, and improving coordination of care between and among DoD, VA, and civilian resources. VCE also actively collaborates with academia and professional organizations to ensure translation of military combat lessons learned into civilian practice, enhancing the nation's readiness posture for catastrophic events.

VCE reviews and updates the DoD Joint Trauma System's (JTS's) CPG for Initial Care of Ocular and Adnexal Injuries at Role I, Role II, and Non-ophthalmic Role III Facilities annually. The CPG forms the fundamental basis for the companion Tactical Combat Casualty Care (TCCC) guidelines on combat ocular care, which in turn are also recognized by national emergency medical services as pre-hospital trauma care standards and serve as the basis for both communities' educational curricula. The CPG underwent a major revision in FY 2015, and a manuscript version has been prepared for submission to a peer-reviewed medical journal in 2016.

During FY 2015, VCE developed a clinical recommendation on Eye & Vision Care Following Blast Exposure and/or Possible TBI. Two additional clinical recommendations that address vision issues associated with TBI are in development and VCE anticipates publishing in FY 2016.

VCE produced an instructional video on the proper use of the rigid eye shield that was co-authored and produced with the JTS Committee on TCCC, which fully endorsed it and immediately incorporated it into their TCCC national curricula. The video is now an integral component of both the TCCC for Medical Providers and TCCC for All Providers courses. VCE also collaborated with the Committee on TCCC and DHA-Medical Logistics to ensure documentation of protective eye shield use was included on the newly approved DD Form 1380, TCCC card. In addition, VCE was a key collaborator in efforts that resulted in an Assistant Secretary of Defense for Health Affairs memorandum directing the Services to update doctrine and training to include provision and use of rigid eye shields in DoD Individual and Joint First Aid Kits. VCE also influenced development of a new federally recognized, commercially available, eye shield embossed with instructions for use.

In FY 2015, VCE continued its monthly worldwide ocular trauma call for providers caring for Service members and Veterans with eye trauma. Now in its 5th year, this successful effort has been a key platform for providing feedback and follow-up to deployed providers, developing and disseminating best practices and clinical lessons learned, and identifying and addressing clinical- and systems-level process improvement

opportunities. The worldwide ocular trauma call documents and evaluates occurrences of ocular trauma in the MHS to recommend process improvements in vision care and vision care coordination. The addition in January 2015 of a monthly didactic presentation on ocular trauma management, focused particularly on damage control ophthalmology principles, further complements the VCE's active role in maintaining provider readiness.

To meet Joint Strategic Plan (JSP) milestones for advancement of simulation, the VCE team continues to identify, validate, and address requirements for new VA/DoD ocular simulation capabilities. In FY 2015 VCE worked in close collaboration with U.S. Army Medical Research and Materiel Command's (MRMC's) Joint Program Committee-1 (JPC-1), to update the Roadmap for Simulation in Eye Care report. VCE is a participant in a major ocular trauma simulation validation study currently underway at Walter Reed National Military Medical Center (WRNMMC) and Uniformed Services University of the Health Sciences (USUHS). VCE is also involved in other simulation studies underway at other medical facilities, such as Madigan AMC's evaluation of a virtual reality direct ophthalmoscopy simulator for training primary care providers. Additionally, VCE is directly involved in the design and development of an advanced ocular trauma mannequin in collaboration with Massachusetts General Hospital.

Similarly, VCE worked closely with the U.S. Army Medical Department Center and School and U.S. Army Research, Development, and Engineering Command to develop requirements for a canthotomy/cantholysis simulator, which will provide training for a vision-sparing procedure. Selected as a 2015 U.S. Army Small Business Innovative Research (SBIR) topic, this simulator is in the Phase I award cycle along with a separate VCE-authored SBIR topic, Novel Intraocular Visualization Tool. VCE will remain intimately involved in the technical evaluation of competing products as these and prior VCE-sponsored SBIRs progress.

Separately, VCE actively advises the computational modeling and simulation communities in the development of advanced high-fidelity ocular trauma models. Sophisticated mathematical simulations of the eye and orbit will allow a greater understanding of blast phenomena and ocular interactions and effects, leading to improved prevention, protection, and mitigation strategies. VCE expertise directly informed recent publications and presentations from Johns Hopkins University, the U.S. Army Aeromedical Research Laboratory, and the Institute of Surgical Research.

VCE provides clinical care coordination support through staff embedded at WRNMMC and Madigan AMC. The objective of vision care coordination is to improve efficiency and outcomes for casualties with ocular injuries who are transferred from overseas to state-side military health facilities and VA medical centers. The VCE Vision Care Services Coordinator coordinates patient transfers to ensure available ocular sub-specialty capabilities at MTF and VA medical centers are matched to patients' clinical care needs. During FY 2015, VCE reviewed existing military eye injury care coordination guidance, and interviewed VA/DoD case managers and care coordinators

to document best practices, identify gaps or needs, and formalize training and educational requirements.

VCE actively engages the pre-hospital and combat casualty care communities by participating in conferences and symposia, and communicating and collaborating with the Emergency Medical System (EMS) and primary-responder communities. As examples, VCE participates in the weekly JTS worldwide trauma call and quarterly Committee on TCCC symposia, has provided educational material on eye shields and proper first response to the National Association of EMS Physicians, and presented at multiple primary trauma conferences in FY 2015.

VCE plays an active role in national patient clinical care and safety initiatives as well. In FY 2015 VCE represented DoD ophthalmology as an invited charter member of the American Board of Ophthalmology's and American Academy of Ophthalmology's (AAO) Joint Working Group on Patient Safety.

Research

Military eye injury, vision loss, and vision dysfunction can result from multiple interrelated causes. During FY 2015, VCE worked in collaboration with a wide variety of government and private sector partners to identify emerging clinical needs and address these needs through directed research efforts. VCE maintained its lead role in the development of the DoD vision research portfolio by participating in the MRMC's Congressionally Directed Medical Research Program Vision Research Program under the Clinical and Rehabilitation Medicine Research Program (CRMRP) and JPC-8 steering committees. Additional activities include participation in the CRMRP Neurosensory Systems Scientific Working Group as well as working with the Military Operational Medicine Research Program and the Combat Casualty Care Research Program JPC-5 and JPC-6, respectively. VCE also maintains close alliances and partnerships with the MRMC Blast Injury Research Program Coordinating Office and other Army research labs. Activities include identifying and updating vision research gaps, developing research program announcements, participating in steering and symposium planning committees, and reviewing scientific proposals.

VCE worked closely with CRMRP's JPC-8 to review and revalidate vision research gaps as well as to participate in both scientific- and programmatic-level reviews of the Vision Research Program. VCE also participated in a grant review to evaluate VA research proposals. These activities resulted in validated research gaps and selection of grant awardees.

Additionally, VCE played a pivotal role in the initiation of MRMC's Medical Technology Enterprise Consortium's (MTEC) Horus Vision Restoration Project, a public-private initiative to significantly advance vision restoration for blinded casualties within 5 years. The grant to establish MTEC was awarded in late FY 2015.

During FY 2015, VCE conducted a systematic review and analysis of blast-related ocular trauma literature, and a manuscript on this topic is in development. VCE also

began interviewing a sample of returning OEF/OIF ophthalmologists and optometrists to capture lessons learned in order to improve care and ensure readiness for future operational deployments; a report is in development.

To foster a continuous dialogue in vision research, VCE maintains direct communications with international civilian and military academic researchers such as the Hopkins Extreme Materials Institute at Johns Hopkins University, the Schepens Eye Research Institute and Massachusetts Eye and Ear Infirmary at Harvard University, Vanderbilt University, and the Royal Centre for Defence Medicine in Birmingham, UK. Additionally, VCE publishes a quarterly research review newsletter called Frontlines of Eye Care that shares recent, note-worthy research findings from diverse fields within vision research.

Education and Outreach

VCE supported the curriculum development and execution of the annual DoD Tri-Service Ocular Trauma Course at USUHS. This course, attended by tri-Service ophthalmology residents and taught by military faculty, is the only ocular trauma readiness course in existence.

The VCE monthly worldwide ocular trauma call format was expanded to include a didactic educational portion on ocular trauma care principles, providing continuing medical education credits (CMEs) for physicians, nurses (CNEs), and optometrists (COPEs). During this period, VCE also conducted a review of the use of ultrasound in ocular trauma and prepared an article on the topic published in the JTS newsletter, as well as an article on ocular prosthetics.

In coordination with the VA Blind Rehabilitation Service and the VA Polytrauma Nursing Field Advisory Committee, VCE produced two fact sheets to improve care of visually impaired patients, Caring for Patients who are Blind or Visually Impaired: A Fact Sheet for the Outpatient Care Team (2015) and the companion fact sheet for inpatient care teams (2014). The fact sheets were distributed in 2015 to all Veterans Integrated Service Networks (VISNs), the TRICARE Beneficiary Education Communication Division, the three DoD Managed Care Support Contractors, all TRICARE Regional Offices, MTFs, and participants at the 2015 VA Blind Rehabilitation National Conference. The information was accepted for international presentation at both the 2015 (FY 2016) American Society of Ophthalmic Registered Nurses scientific symposium as well as 2015 (FY 2016) Association of Military Surgeons of the United States, and was submitted for journal publication (publication forecast for 2016). Additionally, a published article on Health.mil, Vision Center of Excellence Opens Eyes on Best Care Practices, March 26, 2015, highlights suggestions from the fact sheets. VCE also finalized development of the patient brochure Vision Problems Associated with TBI, a Visual Field Loss Fact Sheet and an Oculomotor Dysfunction Fact Sheet; these products are published on vce.health.mil and will be promoted during FY 2016.

To support development of future education modules for the VA Employee Education System as well as development of patient educational materials, VCE conducted reviews on assistive technology and psychological health.

Throughout FY 2015, VCE was an active participant in national and international educational symposia. International presentations were delivered at the American Academy of Ophthalmology and the Association for Research in Vision and Ophthalmology annual scientific symposia, the University of Pittsburgh's 5th International Conference on Regenerative Medicine, Virginia Commonwealth University's Symposium on Military and Veterans Health, and the DoD's Military Health System Research Symposium. Presentations by VCE included two lectures and a poster. National presentations and webinars included lectures at the American Optometric Association annual symposium and the MHS Speaker Series. VCE also worked with the VA Employee Education System to develop and deliver a webinar series describing co-morbidities of Visual Dysfunction and Psychological Health. The first two webinars were conducted in September 2015, and were open to all VA, DoD, and non-governmental providers, including eye care, mental health, primary care, rehabilitation, and nursing practitioners. A third webinar developed and delivered through the VA Employee Education System in September 2015, Testing and Reliability of Afferent Visual Function in Blast Neurotrauma, was attended by a broad audience of providers and researchers from across the DoD, VA, and civilian sectors.

VCE partnered with the Hearing Center of Excellence (HCE), USUHS, and the University of Pittsburgh, on April 17, 2015, to present Caring for Wounded Warriors with Vision and Hearing Impairments – Impact on Rehabilitation. Further, VCE presented Combat Eye Injury and Visual Dysfunction-Association with TBI and PH at the Defense Centers of Excellence for PH and TBI Summit on the Continuum of Care and Care Transitions in the MHS, on September 9, 2015, in collaboration with WRNMMC departments of Ophthalmology and Optometry.

Additionally, VCE finalized development of four new audio learning modules on the following topics: Antibiotic Resistance in Acute Postoperative Endophthalmitis; Vision Concerns Post mTBI; Visual System Biomarkers for mTBI; and, Adult Onset Convergence Insufficiency. These audio learning modules will be released and promoted throughout FY 2016.

VCE continued its commitment to increase awareness of vision health topics and build relationships with military and Veteran health programs. VCE promoted awareness campaigns highlighting key observances such as National Eye Injury Prevention Month, Save Your Vision Month, and worked collaboratively with the HCE in support of Vision and Hearing Month. In July, VCE launched the third in a series of Shields Save Sight advocacy campaigns to target increased use of eye protection and encouraging proper response techniques to eye injuries. As part of this month-long targeted outreach effort, VCE secured placements in military press and blogs; produced public service announcements aired on the Armed Forces Network and liquid crystal display screens at DoD installations; and further strengthened strong working relationships with

organizations, including DHA, MHS, US Navy Bureau of Medicine and Surgery, Navy Installation Management Command, and Naval Safety Center, to expand access to target audiences.

VCE continued collaboration with the HCE as a sponsoring organization for Salus University's Veterans Readiness Initiative: Multisensory Screening and Care for Post 9/11 Veterans. This program, jointly conducted by the Optometry and Audiology programs of the University, together with the Philadelphia Veterans Affairs Medical Center (VAMC), and the two largest community colleges in the Philadelphia area, provided Veterans with onsite screening for vision, hearing and/or balance issues that may have the potential to interfere with meeting academic and reintegration goals. VCE also consulted and collaborated with Veterans service organizations (VSOs), including the Blinded Veterans Association (BVA). In FY 2015, VCE hosted an industry day on assistive technology, providing an opportunity for BVA members to share their perspectives on current technology as well as new technologies presented by several industry participants. The forum also provided a launching point for future VCE investigations into emerging assistive technology. Additionally, VCE presented to the Educational Working Group on assistive technology at the BVA National Convention in August 2015.

VCE strengthened its online presence by redesigning its website (vce.health.mil) to enhance the user experience, accessibility, and message retention. The website includes VCE-developed educational audio learning modules on the following topics: Applying Eye Shields; Talking to Patients about Vision Loss; Concomitant Cranial Injury; TBI and Visual Dysfunction; Depression and Vision Loss; and Keratoconus.

The Defense Veterans Eye Injury and Vision Registry (DVEIVR) supports the mission of guiding research and treatment for improved vision care and restorative innovations for those injured in battle. It provides a repository of Service members' and Veterans' longitudinal eye care data to aid in this effort. With DVEIVR, VA and DoD 's vision community has access to computable, aggregated data for fact-based evidence to guide care for injured Service members and Veterans.

DVEIVR met acquisition requirements and achieved full operational capability in second quarter FY 2015. Additionally, implementation of the registry's data management informatics governance was completed and VCE established membership on the CoE's Health Registry Governance Board.

In FY 2015, abstraction of DoD vision and related data into the Vision Registry was achieved with data abstraction quality consistently at 98 percent accuracy, exceeding the 96 percent requirement. VCE has developed three clinical practice ontology models: intraocular foreign bodies; TBI with vision dysfunction and traumatic limb injury; and vision trauma and dysfunction. The clinical practice ontology models present a structured representation of associated data relationships and samples of DVEIVR data. These practice models have been presented to internal and external stakeholder workgroups.

VCE develops DVEIVR management and data related reports on clinical conditions to support early identification of Service members this may need support or care coordination services. The DVEIVR VA and DoD Stakeholder Workgroup meets monthly to guide decisions related to DVEIVR data definitions, requirements, and standards including development of the low vision and blind rehabilitation data values.

VCE is collaborating with the Wilmer Eye Institute at Johns Hopkins Medical Center to provide DVEIVR data in support of a research project on indirect traumatic optic neuropathy. Initial data release for the project was August 2015. VCE also was a contributing author on a review of the literature titled, "Indirect Traumatic Optic Neuropathy," which was accepted for publication in the Military Medical Research (2016).

VCE, in compliance with the NDAA 2008, developed for distribution to Veterans Administration the "Coordination of Care and Benefits Per NDAA 2008," a list of DVEIVR enrollees and identified Service members with a visual acuity of 20/200 or less and/or peripheral vision of 20 degrees or less. The report will be provided to VA in the first quarter of FY 2016 and quarterly thereafter.

VCE continues collaboration with the Information Delivery Division, Health Information Technology (HIT) Directorate, DHA, on governance of data management at the enterprise level to ensure that data standards established by the ocular community are transitioned/leveraged with the new DoD electronic health record. Efforts to expand and refine the data mapping between VA and DoD clinical ocular and related data for use in other health registries and the Optimal Vision Care application are ongoing.

HEC Hearing Center of Excellence

DoD Hearing Center of Excellence (HCE) continued to advocate for the hearing health of Service members and Veterans by delivering solutions that promote prevention, improve delivery and transition of care, and coordinate the translation of research. The HCE is organized into five directorates to conduct its mission: Operations; Information Management; Prevention; Clinical Care, Rehabilitation, and Restoration; and Research Coordination.

Operations

U.S. Air Force (USAF) and VA civil service personnel, contract support, and leveraged staff actively collaborated to conduct operations. Five civil service positions replaced contractors, bringing the number of government staff to eight. Three VA positions remain unfilled due to VA hiring restrictions. Army, Navy, and Air Force audiology liaison officers are assigned and working with HCE staff.

Information Management

The HCE developed a problem statement, including the Joint Hearing Loss and Auditory System Injury Registry (JHASIR) as a component (data mart) of the Clinical Enterprise Intelligence Program (CEIP). The problem statement was approved by the

DoD Office of the Deputy Chief Management Office (DCMO) Investment Review Board and a contract was awarded, September 2015, to begin the registry build. When fully functional, JHASIR will have longitudinal functionality and share hearing loss and auditory-vestibular system injury data across VA and DoD. A JHASIR work group was charged to review current International Classification of Disease of the World Health Organization and Current Procedural Terminology coding practices for auditory-vestibular services across DoD. Outcomes from consistent coding practices will support the integrity of JHASIR data.

The HCE continued deployment of the Enterprise Clinical Audiology Application (ECAA), an important source of hearing data for JHASIR that will standardize hearing metrics, and is available at most DoD testing sites with the remaining sites to be completed in FY 2016. The HCE worked with DHA toward ECAA server consolidation into the MHS Application Access Gateway (MAAG), a virtual hosting environment, allowing tri-service cross connectivity of ECAA data throughout DHA with implementation expected early FY 2016.

The HCE established new, annual, data use-, data transfer-, and data sharing agreements (DUAs, DTAs, DSAs), and data extract processes with a variety of clinical data sources that will eventually feed into JHASIR. Further, HCE established a MOA with DoD, Air Force Medical Service and Army Institute of Surgical Research/Joint Trauma System (JTS), which outlines the activities and collaborative partnership to collect and disseminate patient-related data from the DoD Trauma Registry (DODTR). These patient data support VA and DoD efforts to understand trauma-related hearing and balance injuries in the tertiary care arena, key to improving acute management of overt polytraumatic injury. The HCE completed data extraction for 857 of the 3,000 patient records.

The HCE provided analytical and expert support for over 32 external data requests and received de-identified patient level data from other DoD agencies to support HCE DoD Epidemiologic and Economic Burden of Hearing Loss study. The HCE requested and received an extensive VBA data set that includes patient level data from 2003 to 2013. The aim of studying these data is to improve providers' clinical practices, and ultimately hearing health of the Service member and Veteran through understanding historical data.

<u>Hearing Loss Prevention and Surveillance</u>

HCE continued implementation of the Comprehensive Hearing Health Program (CHHP), designed to prevent, and ultimately eliminate, noise-induced hearing loss through effective and consistently delivered education, monitoring of hearing, and proper fitting and use of hearing protection, on and off duty. The HCE prepared a pilot study to assess CHHP materials to launch in FY 2016. Further, HCE continued collaboration with the DoD Hearing Conservation Working Group to update DoD Instruction 6055.12 "Hearing Conservation Program (HCP)," including all elements of the CHHP.

The VA collaborated with HCE to develop an additional pilot program plan to enhance implementation of CHHP in VA clinics, improving Veteran hearing health through prevention of noise induced hearing loss (NIHL). The aim is to integrate hearing loss prevention practices into the audiology clinical encounter. The HCE held a webinar on CHHP for 52 Audiologists and provided counseling tools at no cost. Clinicians will review and assess CHHP practices to determine program effectiveness. These efforts will continue in FY16.

An important front gate to hearing health surveillance is a baseline hearing test at military accession and prior to subsequent noise exposure. Air Force leadership initiated a baseline hearing testing for all Airmen, enlisted and officers. Recruits across all Services now receive baseline hearing tests. There were 16,514 Air Force baseline hearing tests conducted in the first 6 months of the program with 0.22 percent identified with hearing loss exceeding accession standards, thus requiring removal from military service. Cost avoidance in disability and treatment for these Service members exceeds $1 million. Such baseline hearing tests also provide the historical auditory data that impact VA disability evaluations and decisions related to clinical care.

The HCE developed four Public Service Announcements (PSAs) for use in hearing health improvement training, education, and outreach that are available for use by VA and DoD hearing health providers. Armed Forces Radio and Television Network air the PSAs throughout the world. The HCE received the National Hearing Conservation Association 2015 Media Award for its exceptional outreach and multimedia work.

The HCE provided five Exercise in Communication and Hearing Operation (ECHO) training sessions for both medical and tactical audiences of over 90 attendees. The aim of ECHO is to teach participants how hearing capabilities enhance unity of effort or unity of command and how hearing loss degrades military operations through dismounted military operation scenarios. Post-event survey results show positive educational outcomes indicating participants gained an increased awareness and understanding of the importance of hearing and effective communication in operational settings.

The HCE conducted key prevention outreach initiatives with Audiology Now, DiscovEarY Zone (a Vision Center of Excellence (VCE)/HCE hearing and vision health campaign for Service members and Veterans), and the Songs for Sound (a 501(c)(3) charitable organization supporting people with hearing loss) hEARoes Tour (large airshows in military dense communities focused on mobile health outreach providing hearing healthcare through music experiences). Thousands of Service members and Veterans received hearing health education at these evidence-based education events. The HCE collected metrics to assess outcomes related to change in participant knowledge, behaviors, and attitudes in response to education efforts. The data show positive results.

The HCE website revision is complete and includes new content on the developmental website (hearing.health.mil). Website management is currently in transition to DHA.

The HCE's efforts to monitor social media trends was truncated due to the website transition to DHA and will be routinely reported once the transition is complete.

Auditory-vestibular Clinical Care, Rehabilitation, and Restoration

The HCE is putting its clinical care, rehabilitation, and restoration outcomes into the hands of providers to enhance the hearing health of Service members and Veterans. Starting in January 2015, HCE initiated no-cost, monthly, continuing education events for VA and DoD providers. There were 245 unique providers (audiologists and physicians) that participated. The HCE provided 529 continuing education units (CEUs) with cost avoidance of $12,410 for just the cost of CEUs.

The HCE provided critical peer review to the Agency for Healthcare Research and Quality Clinical Evidence Review of the Evaluation and Treatment of Tinnitus (the most common VA service-connected disability), as well as the American Academy of Otolaryngology Clinical Practice Guideline for Adult Tinnitus Management. The HCE produced a webinar in collaboration with the VA National Center for Rehabilitative Auditory Research (NCRAR) to train VA and DoD audiologists and ENT physicians on best practices of the Progressive Tinnitus Management (PTM) program. The HCE sponsored PTM program materials at no cost to VA and DoD providers.

The HCE collaborated with Walter Reed National Military Medical Center and established partnerships with the Defense and Veterans Brain Injury Center to augment the Military Vestibular Assessment and Rehabilitation (MVAR) course with new curriculum on traumatic brain injury. The partnership and extended hands-on content for the biennial course provides holistic management and develops networking between physical therapists and hearing health clinicians.

The HCE updated the Acoustic Trauma and Hearing Loss section of the Joint Trauma System Clinical Practice Guidelines with up-to-date evidence-based practices. The updates include placing boothless diagnostic audiometry with tele-health capability at concussion care centers to augment echelon 3 level hearing health care, and preventing overuse of costly AIREVAC resources for Service members who could be screened and managed on site.

Efforts with the Denver Acquisitions and Logistics Center's (DALC) VA Remote Ordering Entry System (ROES) resulted in further cost savings for the DoD through purchase of hearing aids, accessories, and cochlear implants on VA contracts. All 77 DoD sites with audiology services now use VA ROES and had a cost avoidance of $9.83 million, when comparing network costs versus ROES.

The HCE has identified $10 million cost avoidance by using the same ROES process to order hearing prosthetic devices for beneficiaries currently outsourced through Tricare. HCE delivered a business case showing return on investment and is awaiting Medical Operating Group Decision on program funding.

The MHS implanted its first middle ear implantable devices made possible by HCE validation and training of DoD surgeons. The HCE is facilitating translation of hybrid cochlear implants, and assessment of traumatic hearing preservation techniques for devices designed to accommodate hearing loss profiles consistent with significant NIHL.

Research Coordination

The HCE Collaborative Auditory/Vestibular Research Network (CAVRN) continued working across the VA and DoD research communities with a 15 percent participation growth rate from FY14. The CAVRN executed formal relationships via MOA among seven DoD sites and one VA site, to collaborate and share program information. The CAVRN Scientific Advisory Board filled advisory capabilities for DHP programmatic research, review, and development of research gaps and priorities for Military Operational Medicine and Chronic Rehabilitative Medicine research directorates. Proposal awards for funding in FY15 increased 560 percent for hearing, balance/vestibular, and tinnitus research, and accounted for 50 percent of funds available to all Joint Program Committee-8 (JPC-8) focus areas.

The HCE Auditory Fitness For Duty WG initiated development of auditory standards for Service members to confirm necessary hearing function to meet critical job and mission requirements. The HCE also contributed to an analysis, which showed that recruits entering Service with elevated high frequency hearing thresholds (at 3,000 and 4,000 Hz) showing moderate high frequency hearing losses, had a 60 percent increased risk of experiencing a disqualifying H-3 profile hearing loss within 6 years of service. This strengthened a tri-Service recommendation to the Accession Medical Standards working group to tighten accession hearing standards.

The HCE developed and populated the Research Coordination (ReCoord) Projects Database with research project details across labs and MTFs. ReCoord facilitates research efficiencies and productivity across VA and DoD through tracking and quantifying research proposals and awards and information research processes/status.

The HCE-chartered Pharmaceutical Interventions for Hearing Loss (PIHL) WG standardized research methods and reporting standards, while coordinating VA and DoD interests related to drug developmental strategies. PIHL members submitted nine peer-reviewed journal articles to comprise a special edition in Otology & Neurotology, a respected international journal. The articles are guidance documents for researchers, funding sponsors, and FDA reviewers for PIHL related work.

HCE members finalized North Atlantic Treaty Organization (NATO) work for the Human Factors in Medicine Research Technical Group 229, “Optimizing Hearing Loss Prevention and Treatment, Rehabilitation and Reintegration of Soldiers with Hearing Impairment.” The final report recommended common database methodologies for hearing surveillance to foster international comparability and improvement of hearing health practices.

Activities that enhance hearing readiness, prevent hearing loss, and improve the hearing health and quality of life for Service members and Veterans are HCE's ultimate measures of effectiveness. The growth HCE has seen in activity and prominence throughout FY 2015, and the impact on Service members' and Veterans' hearing health will continue to guide HCE objectives.

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. VA's long standing, broadly based research program in prosthetics, orthotics, and rehabilitation engineering continues to improve the quality of life and functional status of both Veterans who are at risk for lower extremity amputation and Veterans and Service members who have undergone lower extremity amputation, as typified by VA's Center of Excellence for Limb Loss Prevention and Prosthetic Engineering at the Seattle VAMC.

EACE advocates for advancement in clinical care, research, and collaboration around the world to share lessons learned in delivering complex rehabilitation care for those who have sustained severe extremity trauma and limb loss.

At full operating capability since October 2014, including four VA staff members, the EACE is better able to focus and refine its mission execution. The documentation of 37 Department of the Army civilian requirements on an Army Medical Command Table of Distribution and Allowances provides the EACE long-term organizational stability.

<u>Highlights of EACE initiatives during FY 2015</u>
The second annual Federal Advanced Amputation Skills Training (FAAST) Symposium was held May 19-21, 2015, and the theme was "Clinically Relevant Lessons Learned." Co-sponsored by the EACE and VA Amputation System of Care (ASoC), and supported by the VA Employee Education System, the FAAST was attended by more than 120 VA and DoD clinicians and researchers. Post conference evaluations revealed 86 percent of respondents were satisfied with the training and 88 percent stated they had gained new knowledge and would be able to apply that knowledge in their clinic.

The EACE collaborates with the VA ASoC to deliver bi-monthly virtual grand rounds presentations to provide medical education on state-of-the-art amputation related topics for VA and DoD clinical providers. This program averages 150 attendees per session and provides CE credits for VA and DoD attendees. The overall FY 2015 survey satisfaction of attendees for this offering is over 90 percent.

The Federal Amputation Interest Group is a joint agency email group for over 650 members including clinical providers, researchers, and administrators. The Federal Amputation Interest Group was introduced in mid-2014, and evolved in 2015, as a

valued communications platform for clinical and research topics to be discussed among professionals to enhance sharing of expertise.

VA and DoD continue to pursue development of an expedited prosthetic component purchasing process to be done in partnership with the VA Denver Acquisition and Logistics Center. This e-commerce joint project is on target for creation of a remote order entry system with contract awards anticipated in FY 2016.
The Advanced Orthotics Initiative is a comprehensive translational (research to clinical care to policy) project, providing advanced hands-on training. The program was developed and conducted by EACE personnel at the VA New York Harbor Healthcare System-Manhattan Campus. The Advanced Orthotics Initiative trained VA's senior orthotists to fabricate and fit advanced lower extremity orthoses, including the Intrepid Dynamic Exoskeleton Orthosis.

The EACE continues to assist VA's ASoC in setting up new, specialized advanced orthotic clinics and to expand existing clinics to accept patients with complex amputee needs. EACE researchers are conducting a systematic review of the literature regarding clinical efficacy, to guide prescription of these advanced orthotic devices. Finally, EACE personnel developed a clinical prescription/instruction document to guide clinical prescription within VA and DoD.

VA has implemented a Step Activity Monitoring Program focusing on Veterans with an amputation. EACE staff collaborated on the project to ensure vital outcome measures are captured in reports to promote improved metrics for efficacy and utilization of VA provided interventions.

EACE personnel contributed extensively to the DoD-VA Upper Extremity Amputee Patient Handbook by authoring numerous chapters, leading the development of the visual portion (illustrations/pictures) of the production, and editing. This manual will serve Service members, Veterans, and U.S. citizens with an upper extremity amputation. The handbook will be available in the future for patients with upper limb amputation.

VA patient satisfaction with amputation care data was collected and reported on a quarterly basis and it captured perception of the quality of services as well as the level of patient satisfaction during hospitalization. Overall satisfaction for the three quarters currently available for FY 2015 ranged from 96-98 percent. These ratings have consistently remained at or above the national average for Veterans with other diagnoses.

Multiple areas of investigation have continued to mature and produce scholarly work in the EACE research focus areas of epidemiology; medical/surgical innovation; advanced rehabilitation sciences; and advanced prosthetics/orthotics. In FY 2015, EACE supported 98 ongoing active research initiatives, to include nine new Institutional Review Board approved research studies. There were 23 scientific peer-reviewed journal publications and 80 presentations at national and international conferences.

Epidemiologic Research

EACE Research and Surveillance Division initiated an epidemiology research program in FY 2015. There is great value in defining and understanding the clinical populations of interest. Two epidemiology efforts represent major strategic initiatives for the EACE. One is defining and describing the population of Wounded Warriors with extremity trauma without amputation, but with permanent loss of limb function. There is a known clinical knowledge gap for this population. The EACE epidemiology team is diligently working to define the population, and to develop and validate a corresponding medical code algorithm, which will help to accurately quantify this population.

The second major epidemiology effort is developing a research method to assess the quality of life of the EACE population of interest. This endeavor is in its infancy, but may impact future research, acute care and rehabilitative interventions, and policy initiatives, based on findings in the study.

Medical/Surgical Innovation Research

The medical/surgical innovation pillar of the EACE research program was established in FY 2015. This expansion of EACE research capability is based out of WRNMMC and USUHS. Efforts are underway in the area of regenerative medicine/tissue engineering. A promising area of research focuses on the use of biologic scaffold materials to aid in the restoration of tissue structure and function following injury. This is particularly relevant for Service members and Veterans with extremity trauma and/or amputation.

The EACE fully supports research efforts into the emerging technology known as osseointegration. The concept of attaching prostheses directly to the skeleton of a patient with an amputation is becoming a reality in the United States. The EACE is facilitating efforts for the formalization of a DoD osseointegration research initiative, led by clinicians and researchers at WRNMMC, to optimize the surgical techniques, componentry, associated rehabilitation, and to identify ways to reduce the risk of secondary infection. Also, after years of preliminary preclinical trials, a team of researchers and surgeons from the George E. Wahlen VA Medical Center, Salt Lake City, and the University of Utah, hope to provide an alternative solution to prostheses with socket-type attachments via osseointegrated prosthetic limbs; an FDA-approved clinical trial is underway for up to 10 research subjects.

Advanced Rehabilitation Science Research

The EACE research area of advanced rehabilitation science is a well-developed program within VA and DoD. EACE continues the following research efforts:

- Safely return patients with amputation to high-level athletic activities.
- Safely return patients to run, jump, and agility activities following limb reconstruction.
- Optimize gait patterns for patients with amputation.
- Prevent and treat secondary health effects that can develop after primary neuro-musculoskeletal injury.

- Define optimal treatment strategies and sequencing of progression throughout the rehabilitation process.
- Facilitate optimal reintegration into the military or civilian communities.

Advanced Prosthetics/Orthotics Research

The EACE research area of advanced prosthetics/orthotics is also a well-developed program at each of the DoD Advanced Rehabilitation Centers and in VA. Numerous study efforts are underway to discover and improve prosthetic solutions and functional outcomes. Examples include:

- Developing criteria for prescription of advanced prosthetic feet.
- Measuring sustainable benefits of powered ankle prostheses.
- Developing orthotic intervention prescription criteria.
- Measuring functional outcomes and differences between conventional and advanced orthotic interventions.
- Evaluating biomechanical and physiological responses to use of a running prosthesis with and without a heel.

EACE personnel influence research priorities and funding by serving on multiple scientific and merit review panels for VA and DoD, as well as participating in the DoD Joint Programmatic Committees. As part of the programmatic review panels for DoD, EACE personnel assist in framing clinical gap analysis and guiding research program announcements to ensure that research goals within request for proposals are well defined. This promotes higher levels of translation into clinical practice from DoD funded research.

The EACE will continue to demonstrate and track progress toward distinct goals, objectives, and end-states. It will continue to aggressively pursue promising opportunities that will advance the science surrounding extremity trauma and amputation to improve outcomes for both VA and DoD patients.

HEC Medical Research Working Group

Established in 2012, the overall goal is to ensure coordination through identification of new research directions and approaches, and identification of gaps in scientific knowledge. DoD-funded projects, performed by VA scientists, cover several high-priority topics, including: PTSD, alcohol abuse, post-deployment health, treatment of TBI, spinal cord injuries, treatment of amputations and improved prosthetics, visual and hearing impairments, and rehabilitation.

In FY 2015, VA and DoD collaborated in seven joint comprehensive program reviews, each included hundreds of projects topics (e.g., treatment of acute traumatic injuries; rehabilitation medicine and orthopedics; PTSD, suicide prevention, and other psychological conditions; TBI; infectious diseases; operational medicine; and health IT and medical simulation). Comprehensive reports on the program reviews were written

for each of the seven reviews and distributed to the hundreds of VA and DoD scientists who participated in each of the reviews. These reviews identified complementary research projects, new research approaches, and gaps in scientific knowledge, while contributing to improved coordination through the linkage of VA and DoD scientists in the same medical specialty.

A monthly bibliography update of medical articles related to Service members and Veterans deployed to OEF, OIF, and OND is distributed to senior VA and DoD research managers and scientists. These updates included 2,810 articles during FY 2015, more than 460 percent over the annual metric set in the VA/DoD JEC JSP. Response times of senior research leaders to new findings were shortened, as a result of this continuous information flow.

Scientists in DoD Health Affairs and the VA Office of Research and Development (ORD) directed the planning and funding of two jointly-funded Consortia. These Consortia represent an unprecedented collaboration by VA and DoD, in terms of joint oversight and total funding of $107 million during a 5-year period. Virginia Commonwealth University, the Richmond VAMC, and the USUHS received the award for the Chronic Effects of Neurotrauma Consortium. Its goals are to investigate the long-term effects of mTBI and to develop biomarkers, such as blood and neuroimaging. The University of Texas at San Antonio and the Boston VAMC received the award for the Consortium to Alleviate PTSD. Its goals are to develop improved treatments for PTSD and to develop biomarkers for PTSD. Senior VA and DoD research managers serve on a Government Steering Committee to provide ongoing oversight of the two Consortia.

The Millennium Cohort Study (MCS) includes more than 200,000 Service members, who started enrollment in 2001. The health of the cohort will be evaluated every three years until 2022, to determine the impact of military service on health 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; and the Naval Health Research Center in San Diego performs the research. In 2015, VA ORD and the VA Office of Public Health collaborated with DoD in the MCS, through the provision of substantial VA funding and dedicated VA research staff, who work on-site in San Diego.

In early 2015, President Obama and the Director of the NIH announced the Precision Medicine Initiative. NIH is planning a national genetics study to enroll one million Americans. VA and DoD scientists plan to leverage the Million Veteran Program of the VA, which already includes more than 400,000 Veterans. DoD staff is working with VA to plan the recruitment of more than 200,000 individuals, who are enrolled in the MCS. This national effort will lead to advances in diagnosis and treatment tailored to individual Service members and Veterans. VA and DoD scientists have been critical to planning this national interagency program.

In 2012, President Obama issued Executive Order 13625, entitled “Improving Access to Mental Health Services for Veterans, Service members, and Military Families.” This order focused on PTSD, TBI, and suicide prevention. Section 5 of the Executive Order

required VA and DoD to develop a NRAP, a 10-year blueprint for interagency research to enhance the diagnosis and treatment of PTSD and TBI and to improve suicide prevention. 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 of Drug Abuse, National Institute of Alcohol Abuse and Alcoholism, and the Department of Education. The NRAP outlines coordinated research efforts to accelerate discovery of the causes and mechanisms underlying PTSD, TBI, and other comorbid conditions, including suicide, depression, and substance abuse disorders. The NRAP also includes research to accelerate the implementation of effective treatments, through the rapid translation of new findings into effective prevention strategies and clinical innovations in the VA and DoD medical systems.

An executive review was organized for the senior research leaders in July 2015, which included a two-year progress report on the 70 initiatives. In May 2015, the White House asked the agencies to organize a conference to showcase NRAP progress, which featured the senior research leaders in DoD, VA, and NIH. In July 2015, the White House Office of Science and Technology Policy highlighted the NRAP and the Precision Medicine Initiative as two of the highest national research priorities in 2015.

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 Working Group

Improve Access to and Reduce the Stigma Associated with Seeking Mental Health Care
Facilitating Connections with Care
The inTransition program is a voluntary and confidential program designed to ensure continuity of care, as Service members and Veterans with psychological health needs, move between VA and DoD health care systems. Personal coaches facilitate and encourage making behavioral health connections during transitions via telephonic behavioral health care support and guidance with motivational coaching, resources, and tools. inTransition coaches ultimately empower Service members and Veterans to make healthy life choices during their transitional period.

In FY 2015, as directed by the 2014 Presidential EAs, inTransition completed updates to DoD Instruction (DoDI) 4690.10 to make it mandatory for all transitioning Service members receiving mental health treatment to be automatically enrolled in the program unless they specifically opt out. Additionally in FY 2015, a contract modification incorporated the out-bound call process to Service members who were recently separated from the Service.

The inTransition program has opened 13,268 coaching cases. The monthly average of new cases quadrupled to 799.5 between April 1 and October 31, 2015, due to newly placed outgoing calls to recently separated Service members.

The inTransition program provided 61 presentations to more than 300 different locations consisting of: DoD leadership, MTFs, VAMCs, and VSOs. Additionally, the program attended 22 conference exhibits and 36 DoD Yellow Ribbon Reintegration Program event briefings.

Program satisfaction of Service members enrolled in the inTransition program is measured annually by monitoring responses on the Interactive Customer Evaluation surveys. This FY, surveys were sent out October 2014 through September 2015 and received a 20 percent response rate. Target metrics (more than 90 percent satisfaction rate) were exceeded as outlined below:

- Ninety-seven percent agreed the assistance received from the inTransition Program increased the likelihood they would continue treatment at a new location.
- Ninety-seven percent of Service members were satisfied with the experience.
- Ninety-six percent of Service members agreed the product or service met their needs.

National Efforts to Reduce Mental Health Stigma
VA and DoD have launched successful national public awareness campaigns. VA's Make the Connection and DoD's Real Warriors Campaign, are separate campaigns, but are complementary to one another with ongoing coordination between the VA and DoD teams.

The Real Warriors Campaign (realwarriors.net) is a multimedia public health awareness campaign designed to encourage Service members, Veterans, and military families to seek care and promote psychological health tools and resources.

The campaign employs a variety of strategies expanding its reach to the broadest target audience possible including: event outreach and partnership engagement, print materials development and dissemination, media outreach, an interactive website and mobile application, and social media interaction. Engagement is intentionally designed to be anonymous, per efforts not to make target audiences feel tracked or stigmatized. This approach limits certain evaluation and impact metrics. We are, however, able to track the reach of the campaign in a variety of ways.

For example, 179,266 pieces of material have been distributed at 212 events nationwide; video downloads (profile videos and public service announcements) increased by 15 percent in FY 2015 as compared to FY 2014; and VA and DoD websites make up 40 percent of the referrals to the campaign site. Future program evaluation efforts will capture qualitative feedback from Active-Duty Service members and military health care providers, including information about barriers to seeking

psychological care as well as opinions on the effectiveness and appeal of Real Warriors Campaign tools and tactics.

Other accomplishments for FY 2015 include:

- The Real Warriors Campaign has reached more than 1.1 million unique individuals on Facebook, Twitter, YouTube, and Scribd (a tool used to upload and host 508-compliant PDFs to direct audiences to content and track the number of reads for each document).
- As of September 30, 2015, the campaign has published 2,452 posts on Facebook and Twitter, resulting in 314,887 interactions (i.e., Likes, comments, shares, retweets). In the past year, interactions increased by 86-percent, and online audiences engaged with the campaign an average of 796 times every day.
- The campaign had 219,497 cumulative social media mentions as of September 30, 2015, which is more than a 112-percent increase from the previous year. By targeting returning and deploying audiences and engaging with international DoD organizations, the campaign's social media channels reach audiences around the world.
- The Real Warriors mobile application, launched on September 4, 2014, has been downloaded 1,649 times. Visitors to the mobile app's complementary website increased by 19-percent.
- The campaign has achieved the following cumulative metrics as of September 30, 2015:
    - 96,141 earned media clips garnering more than 3.8 billion media impressions, which are all positive or neutral in tone.
    - 21,839 direct interactions with unique individuals.
    - 179,266 pieces of material distributed at 212 events nationwide.

In FY 2015, there was an average of 25,144 visits per month to the website. This reflects a six-percent decrease in visits from the previous year. Changes in search engine favoring certain types of websites, and the focus of the campaign on social media likely account for these decreases. Recent development of a mobile version of the website and a Google marketing campaign are expected to mitigate these declines.

Make the Connection.net is VA's award-winning, national public awareness campaign that connects Veterans and their families with information and services about mental health resources to discover ways to live more fulfilling lives. Videos from Veterans of all eras, genders, and backgrounds are at the heart of the campaign. FY 2015, accomplishments include:

- Over 3.3 million visitors for a monthly average of 279,242 – a 17-percent increase over FY 2014.
- Videos have been viewed over 3.2 million times for a campaign total of 12,493,255 views.
- 5,639 viewers subscribed to the campaign's YouTube channel for a campaign total of 16,636.

- Experienced over 18.5 million Facebook interactions (i.e., Likes, comments, shares). The Facebook page has achieved more than 1.2 billion total impressions from organic, viral, and paid advertisements.
- Launched two Public Service Announcements (PSAs) in FY 2015: When the Welcome Home Fades and Transitioning from Service. Both have been ranked by Nielsen in the top seven percent of all PSAs distributed and combined, achieved over 252 million impressions for a media value of over $4 million.
- Placed over 29,571 unique outreach materials at more than 33 events or conferences.
- Garnered over 60 awards from many notable organizations and associations.

Technological Innovations to Reduce Barriers to Care

VA and the National Center for National Center for Telehealth & Technology (T2) have collaborated on the development of the following websites: AfterDeployment.dcoe.mil, StartMovingForward.dcoe.mil, and MilitaryParenting.dcoe.mil. Both Start Moving Forward and Parenting for Service members and Veterans were jointly developed within IMHS.

Collaboration has also resulted in the development of several mobile applications and has positively impacted potential barriers to seeking face-to-face care (e.g., scheduling, time off work, transportation, and privacy). AfterDeployment.dcoe.mil, includes a specific module that addresses stigma.

T2 has developed a training program to assist VA and DoD providers with understanding web and mobile health resources, and with approaches for including those resources in clinical practice settings. In FY 2015, 1,635 individuals accessed eight webinars, 230 individuals accessed four community-of-practice sessions, and 186 individuals attended six face-to-face workshops.

T2 has developed a social media campaign (Facebook, Twitter, YouTube, LinkedIn, and Google+). Social media for the joint VA/DoD websites showed a positive trend in FY 2015 compared to FY 2014: Facebook Likes were 41-percent higher and the Twitter account followers increased 131 percent. T2 also collaborates with the National Center for PTSD on social media communications during PTSD Awareness Month.

December 2014, marked the implementation of the government's Digital Analytics Program which allows ongoing monitoring of usage metrics for the VA/DoD websites identified in the following table. The table indicates the number of website visits during FY 2015. On average, there were 10,418 visits to the site per month, resulting in 562,528 lifetime visits to the sites.

The following table indicates the total number of downloads for the 12 mobile applications that have involved VA/DoD collaborative efforts. There have been just under a half-million lifetime downloads of these 12 apps (483,505).

The number of downloads for Prolonged Exposure (PE) Coach and Stay Quit Coach decreased slightly. These small decreases might be a reflection of the user's interests from one year to the next, or the availability of other VA/DoD and public market resources.

While total downloads is a significant indicator of the degree to which an app has been adopted by users, user-ratings can indicate a user's subjective experience and overall satisfaction with an app. The table indicates that the apps have received generally positive ratings. Concussion Coach is the one exception, although the number of ratings for this app is quite small. Ratings data have been compiled as of December 31, 2015, and combine ratings from iTunes and GooglePlay. Higher ratings, approaching a 5, indicate greater satisfaction.

Application	Launch Date	FY 2013 Downloads	FY 2014 Downloads	FY 2015 Downloads	FY2014 - FY2015 % +/-	Total Downloads	# of Marketplace Ratings	Overall Marketplace Star Rating
ACT Coach	Feb-14	NA	2,895	13,676	**372%**	16,571	0	NA
CBT-i Coach	Jun-13	4,496	25,348	34,035	**34%**	63,879	22	4.0
Concussion Coach	Nov-13	NA	3,079	3,219	**5%**	6,298	1	1.0
CPT Coach	Feb-14	NA	3,390	4,144	**22%**	7,534	6	3.0
Mindfulness Coach	Jan-14	NA	7,873	15,749	**100%**	23,622	7	4.5
Moving Forward	Jan-14	NA	1,663	2,170	**30%**	3,833	0	NA
Parenting2Go	Jan-14	NA	765	1,277	**67%**	2,042	0	NA
PE Coach	Mar-12	11,031	11,259	10,513	**-7%**	38,042	103	3.8
PFA Mobile	Aug-12	5,512	3,946	4,334	**10%**	15,084	10	5.0
PTSD Coach	Apr-11	53,357	44,205	45,342	**3%**	221,834	111	4.0
Stay Quit Coach	May-13	1,110	2,364	2,301	**-3%**	5,775	9	5.0
Virtual Hope Box	Feb-14	NA	11,719	45,981	**292%**	57,700	378	4.4

Acceptance and Commitment Therapy (ACT)
Psychological First Aid (PFA)

Providing Care in Alternative Settings

DoDI 6490.14 outlines the minimum staffing requirements for DoD, and per these staffing requirements, 312 DoD primary care clinics will be staffed as of September 30 2015; 80 percent of clinics are staffed with 254 full-time behavioral health providers and 106 behavioral health care facilitators, an increase of 31 full-time behavioral health staff from June 2014. Ninety percent of clinics are expected to be staffed by June 2016. In the first quarter of FY 2015, patients with two or more appointments with an Integrated Behavioral Health Consultant (IBHC) reported a statistically significant improvement on the Behavioral Health Monitor (a 20 item scale). IBHCs saw 1.66 percent (23,068) of all patients seen in primary care. Additionally, the staffing percentage of IBHCs increased 15-percent by the fourth quarter of FY 2015. Finally, in an aim to increase the involvement of IBHCs in patient care, the PCMH Tri-Service Workflow updates will remind PCMH and support staff to include IBHCs in patient care within the electronic health record. These updates are expected to be deployed enterprise-wide in FY 2016.

In primary care settings, VA's Primary Care-Mental Health Integration Programs combine co-located collaborative care and care management functions to support

providers within the Patient Aligned Care Teams in treating common mental health conditions. Through September 2015, 355 (96 percent) of the 370 VAMCs and CBOCs classified as large, or very large, have integrated behavioral health programs, an increase of two percent since the end of FY 2014. Seven percent of all primary care patients at these sites were directly served by the program.

Traumatic Brain Injury

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

The DoDI 6490.11, "DoD Policy Guidance for Management of mTBI/Concussion in the Deployed Setting," remains the important, "incident-based" mandate requiring screening and prompt treatment of individuals with a potentially concussive event. The number of Service members sustaining a TBI has declined from a high of 32,907 in Calendar Year (CY) 2011 to 25,044 in CY 2014. During the first two quarters of CY 2015 there were 11,715 new TBIs. Most TBIs are concussions (82.4 percent), 8.5 percent are moderate TBIs, and only 1-1.5 percent are penetrating or severe injuries (6.6 percent are not classifiable). Based on data from Theater, an estimated 17.3 percent of those identified through the incident based reporting mechanisms (Blast Exposure and Concussion Incident Report) are diagnosed with a concussion and 81.6 percent of those were within 20 meters of a blast.

The PDHA continues to be an important tool for screening Service members who may have sustained a concussion while deployed. During the third quarter of FY 2014 a total of 34,597 Service members returning from deployment completed the PDHA. Of those, 432 Service members (1.2 percent) reported being exposed to potentially concussive events, loss of consciousness, or loss of memory related to the exposure event. Of those 432 Service members who screened positive, 82 (19.0 percent) were referred for concussion evaluation.

In FY 2015, the VA completed screening for possible mTBI on 96 percent of all OEF/OIF/OND Veterans who received healthcare services within VHA. From April 2007 through September 2015, the VA screened 984,044 Veterans from OEF/OIF/OND for possible mTBI with a resultant 185,934 positive screens requiring further evaluation. Of the 136,571 Veterans who consented and completed follow-up comprehensive evaluations, a total of 82,468 were confirmed to have incurred an mTBI. The time between the initial positive screen and completion of the comprehensive evaluation averaged 23 days, well below the 30-day target.

The Comprehensive TBI Evaluations (CTBIE) pilot FY 2015 results indicated providers felt that they were able to complete all aspects of the CTBIE during the telehealth evaluation 94 percent of the time. Through September 2015, 1,678 initial visits and 685 follow-up visits were achieved through this tele-rehabilitation program. Teleconsultation for CTBIE completion has now become standard of practice at many VA facilities. On-line training and virtual training is available when establishing new Teleconsultation

clinics. Use of a common definition of TBI, updated by DoD in collaboration and coordination with VA in FY 2015, ensures continued appropriate identification, screening, and evaluation of mTBI.

The Assisted Living Pilot Program for Veterans with TBI is a 5-year pilot program that ends on October 6, 2017 (See Section 501 of the Veterans Access, Choice, and Accountability Act of 2014, Public Law 113-146 (2014)). Through September 2015, 221 Veterans have been admitted into the pilot. Currently, there are 87 Veterans participating thus far, and over 90 percent of Veterans who complete this program are discharged to home.

Service members and Veterans living in remote regions who remain symptomatic following a TBI have their follow up care facilitated by the DVBIC TBI Recovery Support Program. The program's 13 Recovery Support Specialists, located at four VA Health Care Centers and nine DoD Military Health Care Centers, establish ongoing relationships with clients by providing resources to advance their care and understanding of TBI during their transition to civilian life. Recovery Support Specialists are currently providing services to more than 967 Service members, Veterans, and their family members, and in 2015 completed 500 intakes and 972 follow-ups.

The DVBIC Regional Education Coordinator (REC) network facilitates scientific TBI education and training. RECs conduct outreach, facilitate face-to-face and virtual presentations, and distribute education materials to Service members, Veterans, family members, and caregivers, line leaders and supervisors, providers, and other military stakeholders. During FY 2015, the DVBIC REC network facilitated a total of 4,793 education outreach and training events related to TBI, and reached an audience total of 286,552, which included Service members, Veterans, families, providers, and community members. This is an increase from the events and audience seen during FY 2014, during which the DVBIC network facilitated 1,830 events and saw 189,844 Service members, Veterans, families, providers, and community members (262-percent increase in events, 151-percent increase in audience). From July through September, 2015, 1,232 education, outreach and training events related to TBI reached an audience total of 63,754, which included Service members, Veterans, families, providers and community members.

The VA/DoD Interagency Care Coordination Committee (IC3), represented by VA and DoD leadership from all Services, launched the Lead Coordinator (LC) initiative in FY 2013 to improve the way VA and DoD care coordinators collaborate to provide more synchronized care, benefits, and services to Service members and Veterans with TBI who require complex care coordination. In July 2015, the IC3 rolled out the national LC comprehensive training package for face-to-face and virtual training of all VA and DoD case managers by regions. More than 60-percent of VA/DoD case managers have completed training to date. The IC3 expects to complete the initial LC training for VA and DoD care managers across the country by early FY 2016.

In FY 2014, a web-based tool for promoting TBI awareness, education and prevention entitled “A Head for the Future,” was created by DVBIC. The objectives of the program are identifying, reporting, and treating possible TBI Diagnoses. This initiative raises awareness of signs, symptoms, and treatment of TBIs diagnosed in non-deployed settings and educates about the importance of preventing brain injuries. On March 23, 2015, “A Head for the Future” unveiled its new website (http://dvbic.dcoe.mil/aheadforthefuture/) containing a wealth of information about TBI. In addition, the “A Head for the Future” campaign has increased media activity 99 percent March through September of 2015 (press releases and placements, blogs, etc.), fully-integrated itself into the DVBIC Facebook page by developing 100 posts from March to September 2015, (DVBIC’s Facebook presence increased 13.58 percent its number of ‘likes’ and achieved 55,888 total daily organic reach of posts during this time period), produced a variety of products for distribution to assist in raising awareness (posters, postcards, etc.), and attended multiple outreach events. By December 31, 2015, the website will expand to include new state-of-the-art digital resources (including four “cause of injury” prevention fact sheets) and videos featuring compelling stories of recovery and hope from Service members and Veterans who have sustained a TBI.

The Concussion Coach Smartphone application has been designed for individuals who experience physical, cognitive, and emotional symptoms that may be related to mild to moderate TBI. It provides users with information about concussion, tools to build resilience and manage symptoms, and recommendations for resources and support. Launched in November 2013, this app has been downloaded 6,720 times in 69 countries through November 2015.

HEC Pain Management Working Group

The HEC Pain Management WG (PMWG) continued to focus on major lines of effort to improve pain management for federal medicine beneficiaries in FY 2015. Of note, these lines of effort are consistent with recent actions called for by the National Pain Strategy document released for comment this year in response to the IOM report on pain. Activities remain centered on developing pain support tools and educational products to support pain management with a focus on primary care.

Standardized Pain Screening and Assessment

The VA/DoD Center for Integrated Pain Management (DVCIPM) has recently operationalized the Pain Assessment Screening Tool and Outcomes Registry (PASTOR) as a pain research standard by adapting the tool to the Research Electronic Data Capture (REDCap) (http://project-redcap.org/) research electronic data capture consortium (1,595 active institutional partners in 92 countries who utilize and support REDCap in various ways). PASTOR Research provides open access to the PASTOR construct by civilian and federal researchers using an international standard in data collection. PASTOR Research will enhance opportunities for public and federal collaborations in pain research. Results have been encouraging, and will be presented

at the American Academy of Pain Medicine in 2016. Peer reviewed publications on this effort began appearing in MEDLINE journals in 2015, and are expected to continue.

In FY 2015, the Patient Reported Outcomes and Clinical Registry Steering Committee charter was established and approved by DHA with DVCIPM serving as chair. This committee will oversee the expanded rollout of PASTOR within DoD.

Defense and Veterans Pain Rating Scale

Two additional validation studies of the new Defense and Veterans Pain Rating Scale (DVPRS) were completed in both VHA and DoD hospital systems in FY 2015. The DVPRS consistently demonstrates value as a pain assessment tool in a variety of patient cohorts. The DVPRS is also integral to the PASTOR program and is being validated with Patient Reported Outcomes Measurement Information System PROMIS standards in the ongoing PASTOR research program. The tool continues to be adopted independently by civilian and federal healthcare systems at the local level. DVCIPM continues to work through the DoD Tri-Service Pain Management WG to establish the DVPRS as the standard pain screening and assessment tool for the MHS as required by the Joint Commission.

Joint Pain Education Project (JPEP)

Under the auspices of a DoD/VHA JIF Project, JPEP developed a standardized VA and DoD pain management curriculum for widespread use in education and training programs. JPEP focuses on the needs of providers and patients in primary care, and provides a holistic, multi-modal, and multi-disciplinary care model that supports the balanced use of medications, procedures, behavioral treatment, integrative health, specialty care, rehabilitation, and self-care approaches for pain management. The JPEP also provides education outcome and effectiveness data to the MHS and VHA.

JPEP curriculum was developed to include course content for 60 distinct modules categorized into four courses: Pain Management for Primary Care; Pain Management for Subspecialty Care; Pain Care Transitions; and Patient Education.

In 2015, JPEP completed pain modules that are integrated into the VA mini-residency program and the pain tele-mentoring initiatives in the VA (SCAN ECHO) and in the Army and Navy (ECHO). For each of the pain management modules, several key constructs are communicated to the provider:

- Anatomy and physiology
- How to perform an assessment
- How to treat
- When to refer

Integrative Medicine

The JIF Project, Acupuncture Training Across Clinical Settings (ATACS) is developing, piloting, evaluating, and implementing a uniform tiered acupuncture education and training program to implement across MHS and VA treatment facilities. ATACS also

provides an alternative in cases where opioid analgesic therapies cannot be used due to contraindications of current medications therapies, existence of potential for substance misuse or addiction, or tolerance issues.

Since the start of the project in July 2013, ATACS project has trained over 1,700 providers in Battlefield Acupuncture (BFA), a rapid and effective auricular pain relief technique, at over 100 training sites, including many CONUS and OCONUS military facilities and VA medical centers. BFA training recently has been included in VHA's Pain Mini-residency Program, which is being developed across VHA to improve the pain management skills of primary care physicians. BFA training with JIF funding is still ongoing at more MTFs and VA medical facilities. Preliminary data is promising and appears to indicate that providers integrating BFA into their clinical practice seem to be prescribing fewer opioids than before they had access to this modality. In 2016, the ATACS project will continue data analysis with the development of a joint policy for acupuncture utilization, credentialing, and training.

Between May 1, 2014, and July 31, 2015, 1,494 trainees were entered into the REDCap ATACS site. Trainee demographics May 1, 2014, through July 31, 2015, are shown below:

Air Force	Navy	Veterans Affairs	Army	Civilian (NOS)	Public Health Svc.	Coast Guard
27 percent	23 percent	21 percent	15 percent	13 percent	1 percent	0 percent

- Over time, the percentage of respondents who report that they are using BFA in their clinical practice has increased from 36-percent in the first month, 61-percent at 6 months, and 89-percent at 1 year.
- Principle conditions for which respondents report using BFA are consistently: headache, neck and shoulder pain, back pain, and joint pain. Use for neuropathic pain is consistently less and less evident in later surveys (52 percent at 1 month; 25 percent at 6 month).
- Respondent impressions of patient satisfaction with BFA treatment are high ("very satisfied" ranges from 33-45 percent, while "mostly satisfied" ranges from 50-60 percent for a total positive rating of 83-96 percent). Similarly, provider satisfaction is in the 83-96 percent range.
- Changes in prescribing habits attributed to use of BFA are reported as well, with 21 percent to 39 percent of respondents reporting it has "greatly reduced" or "slightly reduced" their rate of prescribing opioids.

HEC Telehealth Working Group

The mission of the Telehealth WG (THWG) is to identify opportunities to expand the joint telehealth program and optimize joint capabilities between VA and DoD. During FY 2015, the THWG began to pursue a HEC-approved shift in focus from developing pilot programs based on marginal capacity and locally identified needs to designing

enterprise-wide programs based on identified needs paired with resources. The THWG initiated an investigation of geo-mapping for this purpose, which compares geographic analysis of beneficiary location and clinical facility distribution across Departments to identify possible opportunities for inter-agency care collaboration. The THWG engaged with representatives of DoD's Health Affairs and the VA's Planning Systems Support Group to discuss the applicability of geo-mapping to development of TH pilots and programs in the 1st and 2nd Quarters of FY 2015. Discussions between VA and DoD neurosurgery leadership regarding potential geo-mapping to inform cross-agency tele-neurosurgery programs were also initiated during that time.

The THWG made a decision to pause its work in the 3rd quarter of FY 2015 to allow the DoD to focus on completion of the MHS THWG Strategic Plan. The Strategic Plan will inform future interagency collaboration. The THWG is also in the process of drafting an updated charter and will draft new goals for presentation to the HEC in FY 2016. While not directly part of the HEC Telehealth WG, the IMHS Telemental Health Team (IMHS Strategic Action (SA #6) has continued to foster inter-agency Telehealth initiatives. Over the course of FY 2015, the IMHS SA #6 team oversaw the completion of the first two VA and DoD tele-mental health pilots. These pilot projects provided real time tele-care from VA expert clinicians (through VA's National Telemental Health Center) to Active-Duty DoD personnel at Canon AFB (tele-pain management assessment) and Camp Lejeune Marine Base (tele-insomnia treatment). Through FY 2015, a total of 4 airmen had been seen for a total of 12 tele-pain assessment sessions, while a total of 58 Marines had been seen for a total of 236 tele-insomnia treatment sessions. In addition to the direct services provided, these pilot projects have been critical to developing technical, business and clinical procedures necessary to enable future VA/DoD real-time telehealth collaborations. The FY concluded with the work on the development of a jointly authored summary that will document lessons learned and provided recommendations for future initiatives.

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 Health Data Sharing Business Line

The Health Data Sharing BL accomplishments for FY 2015 are detailed below:

- Validated the specific health data domains required for mapping and sharing in order to meet NDAA 2014 requirements: In May 2015, the HDS BL Co-Chairs approved the VA/DoD Interagency Clinical Informatics Board (ICIB) recommendation to prioritize 25 data domains to support continuity of care and Veterans benefits adjudication. The VA and DoD mapping and development efforts leveraged national standards associated with each domain identified by HHS Office of the National Coordinator for Health IT (ONC).

In FY 2015, the Departments completed mapping the majority of the 25 ICIB identified data domains that can be mapped from their current electronic health record (EHR) systems to the ONC identified data standards. These data domains include: ethnicity, preferred language, medications, medication allergies, problems, laboratory tests, procedures, smoking status, encounter diagnoses, and immunizations.

- Approved VA/DoD Joint Legacy Viewer (JLV) Implementation Strategy: In June 2015, the HDS BL Co-Chairs approved a joint implementation strategy for JLV that removed the limit on the number of JLV users, and accelerated user access to interagency health information. The Departments will continue to monitor system performance and develop a plan to accommodate anticipated capacity levels for full JLV implementation across both Departments. This enabled a dramatic increase in JLV users, from 1,300 early in the FY to 26,445, as of September 30, 2015.
- HDS BL Charter submitted to HEC for approval August 2015: The HDS BL is focused on driving continuous integrative progress for VA/DoD and private sector partner health data sharing that addresses HEC approved priorities, needs, and issues.
- Developed specific, measurable FY 2016 milestone driven deliverables that address HEC priorities: The HDS BL deliverables for FY 2016 include the following:

    - Specify the data elements currently shared or accessible by VA/DoD in support of the Joint Interoperability Plan (JIP) Use Cases.
    - Specify the additional data elements that are required to meet all use case interoperability requirements.
    - Identify additional non-data element refinements required and/or recommended.

VA/DoD Interagency Program Office

The Department of Defense/Veterans Affairs (VA/DoD) Interagency Program Office (IPO) is chartered to "oversee and approve VA and DoD adoption of and mapping to national and international health standards, an essential step toward interoperability, that (a) require the Departments to express the content and format of health data using a common language to improve the exchange of data with each other and the private sector; and that (b) ensure Department clinicians have an integrated, computable view of a patient's comprehensive health record, which can be trended to show health care information about a patient over time and provide expedient, improved healthcare treatment."

The IPO is also chartered to "monitor and report on (a) the Departments' use of IPO approved national and international health standards; (b) the Departments' compliance with the IPO's identification of data domain and messaging standards for department information technology (IT) solutions necessary to

create a seamless integration of VA and DoD health care record [EHR] data."

The IPO's goal is to support the interoperability of clinically relevant health data in accordance with the FY 2014 National Defense Authorization Act, and is in compliance with the Office of the National Coordinator for Health Information Technology (ONC) guidance regarding standards and interoperability for clinical records. Throughout FY 2015, the IPO worked with the Departments in the pursuit of standards-based data interoperability between the Departments' EHR systems.

Progress on Goal of Standards-Based Data Interoperability

Throughout FY 2015, the IPO collaborated with VA and DoD to improve upon the more than 1.5 million elements of data exchanged between the Departments daily by:

- Reviewing and analyzing 58 data maps delivered by both Departments;

- Developing and publishing Consolidated-Clinical Document Architecture (C-CDA) Release 2.1, improving the framework for care summaries while introducing compatibility issues with implementers who followed earlier versions of the standard;

- Continuing to collaborate with the ONC and standards organizations by serving as active member of the ONC Interoperability Standards Advisory (ISA) and contributing to ONC's 10-Year Vision to Achieve an Interoperable Health IT Infrastructure, ONC's Interoperability Roadmap, The Strategic Plan for Federal Health IT for 2015 to 2020, and The Federal Health Architecture (FHA) Strategic Plan for 2013 to 2015;

- Updating and issuing technical and governance guidance for the Departments, as well as a Joint Interoperability Plan (JIP) that defines short- and long-term visions for interoperability between the Departments;

- Chartering the Health Interoperability Enterprise Architecture Workgroup (HIEA WG) to operationalize the suite of standards, services, and policies necessary to achieve interoperability between the Departments, including the development and maintenance of implementation guidance, and hosting several Technical forums to discuss data standards interoperability, among other topics; and

- Improving upon baseline Health Data Interoperability (HDI) metrics and definitions, and creating a dashboard to track the health data sharing progress of both Departments as they advance toward modernization and enhanced interoperability; hosting several metrics summits with the Departments and ONC.

Progress on Objective 1: Oversee and approve VA and DoD adoption of and mapping to health standards

Engagement with ONC and Standards Organizations

Throughout FY 2015, the IPO, the Departments, ONC, and other external stakeholders continued to collaborate as the standards for interoperability were developed and adopted. This has played an integral role as the Defense Healthcare Management Systems Modernization (DHMSM) and VistA Evolution program offices have adopted national standards. Specifically, the IPO has continued to participate in the FHA, Health IT Standards Committee Task Forces, and the ONC Interoperability Roadmap Workgroup, as well as many other collaboration forums. The IPO has a representative embedded as an on-site liaison at the ONC office in Washington, D.C. This has resulted in increased communications and synchronized efforts to improve the Departments' influence and awareness as national standards are developed and adopted. The IPO has contributed to ONC's 10-Year Vision to Achieve an Interoperable Health IT Infrastructure, ONC's Interoperability Roadmap, The Strategic Plan for Federal Health IT for 2015 to 2020, and The Federal Health Architecture (FHA) Strategic Plan for 2013 to 2015. Additionally, the IPO has hosted monthly ONC technical discussions throughout the year on topics such as the International Classification of Diseases – 10th Revision (ICD-10), C-CDA, and Patient Identity Management, as well as ONC-sponsored Standards and Interoperability initiatives such as Data Access Framework and the Health Level 7 (HL7) voting process. These discussions, which include representatives from both Departments as well as ONC, provide a unique opportunity for collaboration outside the Departments and demonstrate the importance of external engagement to the IPO's mission and to the future of interoperability in the public and private sectors.

In addition to these engagements, the IPO also collaborated with the Departments to develop C-CDA Release 2.1, which was subsequently submitted to HL7 for ballot and approved as a national standard. ONC's Certification requires C-CDA for exchanging patient care summaries to support the Centers for Medicare & Medicaid Services' (CMS) Meaningful Use program. HL7 developed C-CDA Version 2.0 last year, improving the framework for care summaries, while introducing compatibility issues with implementers who followed earlier versions of the standard. Given that the Departments share care summaries with over 85 exchange partners on different upgrade timelines, these compatibility issues could have a significant impact on interoperability in support of the patients we serve. The IPO recognized this was an interoperability issue for the Departments, as well for the national level. With broad industry support, the IPO coordinated an effort to resolve the compatibility issues and developed version 2.1, which has been adopted as a national standard. The resulting standard was adopted in the ONC 2015 Edition Health IT Certification Criteria.

Technical Governance Guidance

The three IPO core technical guidance documents are updated annually and include the Healthcare Information Interoperability Technical Package (I2TP), the Health Data Interoperability Management Plan (HDIMP), and the VA and DoD Joint Interoperability

Plan (JIP). The I2TP serves as an implementation guide with IPO required, interim, and emerging national HDI standards. The HDIMP documents the IPO's role in supporting interoperability management and outlines necessary governance to support health data exchange and terminology standardization. The JIP guides the Departments' technical vision for interoperability and outlines plans for achieving seamless data integration. These documents provide key strategic and technical guidance to the Departments, the IPO, and its stakeholders. The I2TP Version 4 was released on June 25, 2015. The most recent version of the I2TP realigned language with the HDIMP, JIP, and ONC's A Shared Nationwide Interoperability Roadmap to improve the consistency of the IPO's technical standards documents. Updates to the HDIMP and JIP were finalized in the fourth quarter of FY 2015.

Data Mapping

At the beginning of FY 2015, the VA/DoD Interagency Clinical Informatics Board (ICIB) approved the restructure of the 28 initial clinical domain areas into 25 domains to support continuity of care and Veterans benefits adjudication. The IPO worked with the Departments to identify the appropriate national standards associated with each domain, which is documented in the IPO's HDIMP and I2TP. Of the three domains removed, (1) "other Past Medical History" and (2) "Pre-and Post-Deployment Assessments" are reported under other domains; (3) "Additional CCDA Clinical Data Elements" was a placeholder for undefined exchanges. For the domains that do not have structured data, the information is currently captured in the clinical notes in the Departments legacy EHR systems (shared as part of other domains) and will be included as part of the Departments' modernization efforts.

In FY 2015, the Departments submitted early Plans of Actions and Milestones (POA&Ms) to the IPO detailing their respective plans and schedules for meeting data mapping requirements. Additionally, the VA and DoD continued to improve baseline mapping from initial efforts focusing on terms used most frequently, while addressing maps with the lowest usage thereafter. As of the fourth quarter, the IPO received and reviewed 58 data maps from the Departments. DoD submitted 35 data maps, 26 of which were approved, and 9 were returned for further analysis. The VA submitted 23 data maps, 10 of which were approved, and 13 were returned for further analysis.

Progress on Objective 2: Monitor and report on the Departments' use of IPO approved health standards and compliance with data domain and messaging standards necessary to create a seamless integration of VA and DoD health care record data

Data Sharing Statistics

A key component of the IPO's mission is ensuring VA and DoD EHR data are interoperable with each other and with the private sector, meaning the Departments are able to exchange information and use the information that has been exchanged. The Departments already share a tremendous amount of clinically relevant health information, much of which is interoperable. VA and DoD clinicians can currently view records in real time on more than 7.4 million patients who have received care from both

Departments through existing software applications, and DoD and VA providers generate data queries through their current tools nearly a quarter of a million times per week. The Departments currently use several tools to support EHR data interoperability:

- Bidirectional Health Information Exchange: The Bidirectional Health Information Exchange (BHIE) was initiated in 2004 and gives VA and DoD providers the ability to view inpatient and outpatient clinical data on shared patients to improve the continuity of care. BHIE data can be accessed through AHLTA for DoD providers, VistA for VA providers, and Compensation and Pension Record Interchange (CAPRI) for Veterans Benefits Administration examiners. Additionally, the DoD has implemented a BHIE DoD Adaptor, which contains data feeds from previously used legacy data systems.
- Clinical Data Repository-Healthcare Data Repository: Since 2006, VA and DoD have been sharing computable outpatient pharmacy and medication allergy data through the interface between the Clinical Data Repository (CDR) of AHLTA, DoD's EHR and VA's Health Data Repository (HDR). This initiative, called "CHDR," exchanges medication and medication allergy data that include the translation of one system's clinical vocabularies into the other system's vocabularies for a subset of shared patients known as "Active Dual Consumers." The exchanged translated data can be used subsequently in each Department's clinical decision support for drug-drug and drug-allergy interactions.
- Joint Legacy Viewer: In April 2015, the Departments agreed to continue to expand usage according to their internal needs and to monitor infrastructure performance. Moving forward, the Departments will no longer target specific numbers of users for deployment but instead, will provide the capability to users based on the existing data-driven approach and report status of this approach to the HEC as requested. The Departments have continued to improve infrastructure to support expanded usage of JLV. As of the fourth quarter of FY 2015, there were 8,480 DoD and 17,965 VA JLV users.

Metrics Development

Throughout the third and fourth quarters of FY 2015, the IPO and both Departments collaborated to improve baseline HDI metrics, definitions, and a dashboard to track the health data sharing progress of both Departments as they advance towards modernization and enhanced interoperability. Specifically, these products were developed to gauge the progress of national standards adoption, private partner interoperability, systems readiness and availability, and efforts to improve clinical care transition. On 25 August, the IPO presented these items to the IPO Executive Committee, who approved the metrics, definitions, and dashboard.

Moving Forward

The Departments remain fully committed to advancing health data interoperability between the EHR systems of the two Departments and the private sector. Looking ahead to FY 2016, the Departments are poised to improve delivery capabilities as EHR standards continue to mature and are incorporated into their systems. Health

information exchange between EHR systems in the DoD, VA, and the private sector will serve as the foundation for a patient-centric health care experience, seamless care transitions, and improved care for our Service members, their families, and our Veterans.

The IPO will continue to facilitate and measure the Departments' interoperability. Additionally, the IPO will seek approval of FY 2016 priorities, which include developing outcome-oriented interoperability metrics, expanding collaboration with ONC and other standards development organizations, and enhancing standards with ICIB-approved use cases.

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 to 2011. As of January 2012, when the SOC was consolidated into the Joint Executive Committee (JEC), the JEC and subordinate Benefits Executive Committee (BEC) began overseeing the DES. The BEC DES Working Group, an action officer-level joint oversight body officially chartered on August 24, 2012, provides briefings as required to the BEC, which in turn informs the JEC.

In July 2010, the Co-Chairs of the SOC agreed to expand the DES Pilot program in the National Capital Region and rename it the Integrated Disability Evaluation System (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 in September 2011. Currently, there are 139 IDES sites operational worldwide, including the original DES pilot sites.

The IDES, compared to the previous VA and DoD disability evaluation processes, provides a more streamlined, transparent, and efficient process for making disability determinations for wounded, ill or injured Service members who no longer meet their respective Services' medical retention standards. Service members in IDES undergo a single disability examination and are provided a proposed VA disability rating. They receive more consistent VA and DoD disability ratings and anticipated benefits information simultaneously, prior to separation, which enables them to make better

informed decisions about their future. The pay gap that previously existed between separation from Service and receipt of VA benefits has been significantly reduced.

Between November 26, 2007, and September 30, 2015, DoD has enrolled 153,797 Service members in IDES. A total of 125,240 Service members completed IDES by either returning to duty or being medically separated or retired and receiving VA benefits. Another 7,542 were removed for other reasons (e.g., additional medical treatment, administrative discharge). As of September 30, 2015, there were 20,705 Service members enrolled in IDES.

Active Component Service members who completed IDES in September 2015, by returning to duty or receiving VA benefits, averaged 219 days to complete the process. This 219-day average is 26 percent faster than the IDES goal of 295 days established for Active Component Service members. Reserve Component and National Guard Service members who completed IDES averaged 279 days from entry to receipt of VA benefits, which is nine percent faster than the IDES goal of 305 days. Overall, IDES has been 50 percent faster in FY 2015 compared to the 540-day benchmark for the sequential pre-IDES VA and DoD disability evaluation processes. As of September 30, 2015, 85 percent of Active Service members and 69 percent of Reserve Service members met the overall timeliness goal.

VA completed the following in the four core areas of responsibility in FY 2015:

- Claims Development – 29,014 (cases developed)
- Medical Exams – 28,083 (exams)
- Proposed Ratings – 28,699 (ratings)
- Final Ratings & Benefit Notifications to Veterans – 33,016 (benefits letters)

In April 2015, VA met the 100 day timeliness goal for the very first time, averaging 90 days for the four core process steps. The extraordinary efforts of the VA and DoD IDES team have resulted in 86 percent of Service members receiving their benefits notification letter within 30 days of separation from their respective Military Service.

As of September 2015, overall DoD IDES timeliness continued to improve for all portions of the DoD core process steps: referral, Medical Evaluation Board (MEB), Informal Physical Evaluation Board (IPEB), and transition. DoD met the 105-day average Active Component core processing timeliness standard and the 125-day average Reserve Component standard. As of September 30, 2015, 70 percent of Service members completed the DoD core process steps within the established timeliness goals.

The Departments continue to refine and improve IDES with numerous efforts, both independently and in close collaboration. In FY 2015, major efforts in this area included:

- VA IDES Program Office continued to conduct monthly internal video teleconferences with all VA stakeholders involved in the execution of IDES. VA also conducted biweekly teleconferences with DoD and the Military Departments to monitor performance, resolve problems, and collaborate on improvement strategies.
- VA used a phased approach to eliminate excess inventory and improve overall IDES timeliness. The first phase was achieved, meeting the benefit notification timeliness standard in April 2015, when average days to complete dropped below the 30-day standard to 21-days. The second phase was to meet the timeliness standard for proposed rating and was achieved in June 2015, with average days to complete falling below the 15 day standard to 14 days. Meeting the timeliness standards has been commensurate with the elimination of excess inventory. Inventory has been reduced by 60-percent this fiscal year arriving at a functionally minimum work load of 3,000 cases per month in April 2015.
- VA continues to glean more efficiencies in the IDES process: a paperless work environment exists as claims folders are now sent to scanning vendors and uploaded into the Veterans Benefits Management System (VBMS); automated benefits letters further save time; collaboration with the Army's Medical Evaluation Board Tracking Office (MEBTO), and development of initiatives to improve processing of Reserve Component cases are all examples of continued efforts to improve the IDES process.
- VA continued to enhance Disability Benefits Questionnaires (DBQs), which are streamlined medical examination forms used to capture Veterans and Service members' essential medical information. The enhancements have decreased the number of medical examination reports that are insufficient for rating purposes, and allow VA to produce digital images of exams for input to VBMS. Also, deep-dive analyses of exam sufficiency, improvements in exam provider training, and 11 improved templates have helped improve the quality of the exams. Because of the efforts of the VA IDES Team, the rate of insufficient exams decreased from 16-percent in August 2014 to eight-percent in September 2015.
- VA implemented the automated decision letter (ADL) in the VBMS in December 2014. IDES case information in VBMS allows the system to generate Service member's award notification letters with minimal input from the Disability Rating Activity Site (DRAS) personnel. ADLs have decreased the time and effort required for a case to complete the VA Benefits Notification stage.
- VA implemented Digital IDES case file documents at Joint Base Lewis-McChord (JBLM) in January 2015. Digital IDES case file documents have reduced the transit time between VA process steps and reduced the use of paper documents. VA and JBLM are currently discussing implementation at other large high volume IDES sites with DoD.
- The Office of Warrior Care Policy, in collaboration with the DHA and the Military Departments, began developing business and functional requirements for a DoD DES IT solution, with a targeted initial operating capability in 2017. The DoD DES IT solution will enable the Department to leverage existing IT capabilities where appropriate, and include new capabilities to support end-to-end case

management: tracking, reporting, and electronic IDES case file transfer between the Services and Departments. The electronic case file transfer capability will be included in Phase 1 of the DoD DES IT implementation.

- DoD IDES Service member satisfaction surveys identify potential portions of the process or physical locations that require senior leadership involvement to provide actionable results. Eighty-seven percent of all Service members surveyed during January 2015 to June 2015 expressed overall satisfaction with the IDES process. Generally, Service members expressed greatest satisfaction with customer service, both from Physical Evaluation Board Liaison Officers (PEBLO) and VA Military Services Coordinators (MSCs).
- DoD continued downloading DD Form 214s from the Defense Personnel Records Information Retrieval System (DPRIS) and uploading them into Virtual VA to assist VA in completing IDES final benefit determinations. From October 1, 2014, to September 30, 2015, DoD submitted 4,416 DD Form 214 requests, entered 1,671 dates of separation into VTA, and uploaded 1,895 separation documents to Virtual VA, enabling VA to complete its disability benefit notifications for those cases sooner.
- DoD established policy for Service-specific ratios of PEBLOs-to-cases for the IDES (tailored for each Military Department) based on their unique IDES case load, case complexity, and staffing requirements. This improved case management for IDES helps ensure Service members, their families, and caregivers receive more consistent and meaningful communication about IDES and gain awareness of where they are in the process at any given point. This eases the significant life event of transitioning to Veteran status.
- DoD continued implementation and refinement of a DES Quality Assurance Program (QAP) that standardizes the way DoD compares and reports on the accuracy and consistency of DoD disability determinations. In November 2014, DoD published DoD Manual 1332.18, Volume 3, “Disability Evaluation System (DES) Manual: Quality Assurance Program (QAP).” The DES QAP enables DoD and the Military Departments to monitor the performance of Medical and PEBLOs by using in-process, post-process, and constructed case reviews, as well as data on timeliness, Service member satisfaction, surveys, and site visits. This analysis enables DoD to identify best practices as well as areas needing improvement.
- DoD continued development of the Warrior Care Training Standards and Performance Objectives Guidebook, and updated existing standards to conform to new policy and issuances that were published during FY 2015. Well-defined training standards are an essential component to the Department achieving better performance of MEBs, PEBs, and PEBLOs in the execution of their duties and reducing variance of MEB and PEB disability determinations.
- The Departments collaborated to implement IDES case file content guidance to ensure all medical information is available to conduct Medical Evaluation and Physical Evaluation Boards and provide proposed disability ratings. This collaboration enabled both Departments to deliver timely disability determinations without delaying the IDES process due to missing medical documents.

- VA and DoD collaborated to provide Army Reservists' support to VA's Seattle Disability Rating Activity Site (through the end of FY 2015) to help expedite the delivery of VA disability benefits to discharged Service members, reducing the time these Service members waited to receive their VA final disability benefits determination.
- DoD collaborated with VA to improve the authoritative tracking system for IDES, the Veterans Tracking Application (VTA). Improvements include the automatic population of data to alleviate manual data entry; the capability to flag cases as "deferred," providing the Departments the ability to track activities outside of the IDES that prolong the length of the process; and the capability to track "duty status" to identify those IDES participants whose process and benefits eligibility differ from the traditional population.

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) oversees the entire lifecycle of the military STR, ensuring VA and DoD benefit adjudicators have accurate and complete STR information for all Service members. In FY 2015, the MRWG improved management of STRs needed in support of Veterans' disability claims, and it continues to oversee the digitizing of STRs available to VBA through the Healthcare Artifact and Image Management Solution (HAIMS).

In FY 2015, the MRWG centralized requests for STRs of current Reserve and National Guard members, or those separated from the Reserves/National Guard within one year. VBA piloted the centralized process, which allows for better tracking and managing of the requests, at the San Diego and Des Moines Regional Offices (ROs) and then deployed it nationally on March 23, 2015. Between March 23, 2015, and September 30, 2015, the 56 VA ROs submitted 27,823 requests for Reserve/National Guard STRs. Out of that number, 23,342 requests (84 percent) were completed by the end of the fiscal year with 4,481 requests still pending. The average turnaround time for these requests increased from 27 days during the pilot to 42 days after national deployment, which is below the timeliness standard of 45 days. VA and DoD continue to collaborate to return the turnaround time to 27 days or better.

The MRWG continues to collaborate with the DoD Health Records Working Group to ensure consistent and appropriate use of HAIMS at the field sites digitizing the STRs. The Services uploaded 375,886 STRs to HAIMS during FY 2015 and successfully completed and certified 102,719 STR requests for VBA out of the 106,754 STRs (96 percent) requested from HAIMS to support Veterans' claims. Of the 102,719 completed STR requests, 80 percent were provided to VBA within the 45-calendar-day timeframe, compared to 27 percent in FY 2014. VA and DoD continue to improve the timeliness of

STR transfers, helping reduce VBA's claims backlog with the aim of increasing Veteran satisfaction.

Finally, the MRWG worked with the United States Coast Guard (USGC) to end its transmission of paper STRs to VA. On September 1, 2014, the USCG started digitizing its STRs and stopped sending paper STRs to the VA Records Management Center (VA RMC). On June 1, 2015, the USCG began uploading its digitized STRs into HAIMS directly, and VA began receiving the STRs via an interface from HAIMS to VBMS. All five military services are now transmitting their STRs electronically to VA.

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 IS/IT WG is to facilitate the electronic exchange of personnel and benefits data between VA and DoD. The BEC IS/IT WG 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.

<u>DoD Self-Service (DS) Logon</u>
DS Logon is a secure identity (username and password) that is used by eBenefits and various VA and DoD websites. The BEC IS/IT WG successfully implemented 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 and transitioning to civilian life. As of September 30, 2015, there were over 5 million registered eBenefits users in over 180 countries, and that number continues to grow. This growth of registered users represents a growth rate of over 20-percent in FY 2015, as compared to the previous fiscal year.

<u>eBenefits</u>
eBenefits, a joint VA/DoD initiative, serves as both a public website and a secure portal for Service members, Veterans, their beneficiaries, and/or other designees. eBenefits allows users both the ability to research and access available resources, as well as to self-manage their current VA and military benefits and personal information. New capabilities continue to be delivered each quarter. Focused marketing of the eBenefits portal contributed to the creation of 6 million Defense Self-Service (DS) Logon accounts prior to the end of FY 2015, greatly exceeding the VA's Agency Priority Goal (APG) of 5 million.

Coordinated efforts between DoD, VA, and Duty First Consulting (DFC), a consulting firm contracted by VBA, were recognized by the Public Relations Society of America (PRSA) with a Silver Anvil Award for their extraordinary success in gaining a 209-percent increase in eBenefits Premium Account users within the first six months of the deployment of eBenefits.

In FY 2015, the working group deployed additional eBenefits self-service features and major enhancements, bringing the total number of self-service capabilities to 58. The BEC IS/IT WG developed the fourth consecutive yearly eBenefits Roadmap for calendar year 2015, showing the scheduled releases of enhancements and new capabilities for each quarter. The quarterly releases in FY 2015 provided users with new or improved access to information and resources as follows:

Features for the Winter - released on January 25, 2015.

- eBenefits Site Redesign – Includes dynamically editable content and improved site performance.
- Edit Basic Personal Data – Allows user to edit basic information, such as gender, when completing an online application.
- Rules-Based Processing System (RBPS) Off-Ramp Messaging – Generates a message to the user and generates a note in the Modern Awards Processing – Development (MAP-D) system when a dependency claim is to be processed manually instead of electronically.
- Claim Status Redesign (Part B) – Updates the end-product (EP) codes that drive what information should or should not be displayed to provide more consistent and accurate information in Claim Status.
- Authenticated Live Chat Pilot – Allows authenticated users to communicate directly with the national call center (NCC) agents by means of an authenticated chat window. This feature enables an agent to assist a caller in using the system and allows the exchange of personal information with the user.
- Improved Display of Uploaded Documents in Claim Status – When viewing Claim Status informs users that their document was received after it was uploaded.

Features for the Spring – released on March 20, 2015.

- Intent to File (Form 21-9066 Intent to File (I2F)) – Provides paper claimants the same opportunity as electronic claimants to receive benefits back to the time when they initiated the claim process. Users can create an “intent to file” for compensation, pension, and dependency benefits.
- Veteran Profile – Provides Veterans, dependents, and Service members a single location to view their information in VA systems. The initial phase provides users easy access to a Veteran Profile dashboard, allowing them to view information such as disabilities, benefits, and their appointed power of attorney (POA).
- Claim Status Redesign – Enhances user experience for Claim Status display for disability compensation, pension, and survivor benefits.

- Vocational Rehabilitation and Employment (VR&E) Landing Page (homepage) – Provides users a variety of options, including links to information regarding eligibility, training, and transitioning from Active-Duty to civilian employment.
- Google Analytics Implementation for Authenticated Chat – Provides metrics on the number of times a user has used the chat option to communicate with VA.

Features for the Summer – released on July 19, 2015.

- Improved Error Messages in Claim Status and Letter Generator – Provides more useful messages to the end user and help desk agent.
- Claim Status – Allows users the ability to view their online applications alongside their other "work in progress" in their personal profile. Allows users to upload documentation to support a claim. Increased file upload size to 10MB.
- Veteran Profile – Allows users to view dependency and ancillary information and payment history in one centralized location.
- Online VHA Enrollment Application (without 10-10EZ) – Allows users to auto enroll for VA healthcare when applying for a disability claim.
- Private Medical Records (PMR) Integration (VA Form 21-4142 Phase 1) – Allows Veterans to submit authorization for VA to obtain health records from private providers.
- National Resource Directory Enhancements – Adds a new category called “Community of Care” and moves the IC3 folder and resources from a sub-category under the ‘Other Services and Resources’ category to a main category of the ‘Find Resources For’ search.
- 3rd Digit EP Modifier – Applies the proper EP code for foreign claims.

Features for the Fall – released on September 27, 2015.

- File Upload – Increases file upload size in claim status (10MB) and Veterans Online Application (VONAPP) Direct Connect (VDC) from 5MB to 25MB.
- Integrate Vocational Rehabilitation and Employment (VR&E) Forms – Allows Veterans to apply for VR&E benefits via VDC, using VA Forms 28-8832 for educational/vocational counseling, and 28-1900 for vocational rehabilitation.
- Appeals Status Redesign – Allows users to view open and historical appeal status information, as well as real-time notifications in Veteran Profile.
- Chapter 33 Fraud Indicator – Blocks routing numbers (RTN) that are associated with a high rate of fraudulent activity. When an RTN is blocked for fraud and used in an attempt to change existing payment information, a message is displayed notifying the user that the RTN is blocked and cannot be used to make the change. The message instructs the user to contact the National Call Center to set up or change his or her direct deposit account information.
- Improve Error Messages (Phase II) – Provides more meaningful messages to the end user and help desk.
- Various Updates to the VA Form 21-22 – Appointment of a Veteran Service Organization as claimant’s representative is now available online.

VA and DoD deployed “Early Communications Messages” based on anticipated or actual “life-changing” events. “Early Communications Messages” are sent via eBenefits email to notify Service members and Veterans of potential eligibility for health, education, and disability benefits. This proactive approach encourages the use of 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). Since the inception of this feature in October 2013, millions of e-mails have been sent.

The frequency of logged-in users for specific key features from October 1, 2013, through September 30, 2015, is as follows:

- Compensation and Pension Claims Status Views – 2.63 million
- VA Home Loan Certificates of Eligibility – 841,874
- Official Military Personnel File – 945,403
- Chapter 33 Post 9/11 GI Bill Enrollment – 3.29 million
- Payment History – 1.56 million
- Appeals Status – 5.86 million
- Letter Generator – 5.45 million

Servicemembers’ Group Life Insurance (SGLI) Online Enrollment System (SOES)
SOES is a web-based application that allows all Service members to view and update their SGLI and Family SGLI coverage online. Service members will access SOES via eBenefits using a DS Logon or Common Access Card (CAC). SOES is being designed, built, and deployed through a collaborative effort between VA, the Defense Manpower Data Center (DMDC), and the Services.

The following accomplishments were made in FY 2015:

- Navy review of SOES applications (June 21 – July 26, 2015) identified future enhancements and issues that need to be fixed prior to implementation.
- DMDC and Defense Finance & Accounting Service (DFAS) completed testing of premium transactions with Active and Reserve Component pay files.
- DMDC began sending Family SGLI files in new format.
- Developed requirements for SOES access via eBenefits.

Interagency Paperless DD Form 214
The Interagency Paperless DD Form 214 project is focused on executing an implementation strategy to eliminate mailing DD Forms 214/215, while satisfying the business requirements of its stakeholders. A detailed report, published in August 2013, identified a potential cost avoidance of $58 million per year amongst all interagency stakeholders when the new distribution process is operational.

The following accomplishments were made in FY 2015:

- VA completed transition from manual processing of paper DD Forms 214 Copy 3, to an automatic feed of paperless Military Service information in support of outreach and benefits delivery processes.
- VA and DoD completed solution design for joint management of electronic DD Form 214 separation information, to include allowing Veterans to request research and verification of service record accuracy, submit evidence of service information that is missing for addition to their official record, and for VA to receive automatic notification when a Veteran's official service record is corrected.
- VA completed functional and technical discussions with the Veterans Health Administration for use of electronic DD Form 214 information to enable automatic enrollment in VA healthcare, and suspend requirement for Veterans to attach a copy of the paper DD Form 214 with the 1010ez – Request for Enrollment in VA Healthcare.

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 2015, the WG coordinated and/or managed the sharing of 302 clinical or clinically related programs between VHA and DoD: 176 trainings from VHA and 126 from DoD. These shared programs offered over 680 Continuing Medical Education (CME) hours of learning with a focused outreach to physicians, nurses, dentists, social workers, psychologists, occupational therapists, and counselors.

The WG continued to utilize enhanced Learning Management capabilities in VHA and DoD to optimize resources with archived e-learning programs. Training programs developed by the Federal Healthcare Consortium are available on the MHS and DHA websites for DoD personnel training.[2] In FY 2015, Health.mil reports 17 contributing partners and 519 archived training programs.

In April 2015, VA became an affiliate of the Public Health Foundation TrainingFinder Real-time Affiliated Integrated Network (TRAIN) and established VHA TRAIN. VHA TRAIN is an external learning management system to provide valuable, Veteran-focused, accredited, continuing education in the health professions at no cost to community health care providers. VHA TRAIN reports 279 DoD completions with 494 hours of CME awarded.

[2] http://www.health.mil

In an effort to leverage special initiatives to develop and deploy training programs, the WG ensured the coordination of technical upgrades to the VA Knowledge Network, the Content Distribution Network, and across DoD Service facilities for the Medical Interagency Satellite Training-Next Generation (MIST-NG) program. During FY 2015, 69 MIST-NG programs were shared: 22 programs from VHA and 47 programs from DoD. These were completed by 6,070 personnel with over 81 hours of training.

In FY 2015, the WG deployed 82 virtual clinical grand rounds training programs to providers with more than 6,240 staff participations. More than 5,035 completions were recorded whereby health care providers received continuing education credits to support licensure and certification requirements. The WG continued to support the continuing education and in-service training deployed at the Captain James A. Lovell Federal Health Care Center (FHCC) and joint venture sites in FY 2015. The continuing education and in-service training at FHCC included 35 courses and over 97,700 course completions for FY 2015.

Following the HEC restructure to include Business Lines, the WG has increased knowledge of each Department's training products and is investigating a number of opportunities for sharing and consolidation of products to include: piloting the Virtual Medical Center with the DoD, simplifying visibility, and access to online training programs.

HEC Acquisition and Medical Materiel Management Working Group

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

Identifying and Leveraging Joint Requirements

During FY 2015, VA and DoD worked on solicitations for the next generation of joint radiology and imaging systems contracts and Digital Imaging Network-Picture Archiving Communication Systems (DIN-PACS) contracts. Defense Logistics Agency (DLA) Troop Support is the responsible contracting office for both solicitations. There are currently 37 radiology and 10 DIN-PACS contracts in place. VA and DoD are jointly evaluating the 27 current proposals for the next generation radiology program, which will expand the vendor base and product offerings for all VA and DoD customers. VA and DoD are currently evaluating two DIN-PACS proposals. In the pharmaceutical commodity area, both the VA National Acquisition Center and DoD DLA Troop Support are awarding joint national contracts for pharmaceuticals. During FY 2015, a total of 50 joint national contracts were awarded, an increase of 46-percent from FY 2014. These contracts enable both VA and DoD customers to purchase generic pharmaceuticals at substantially lower costs.

As evidenced in the chart below, total joint pharmaceutical sales showed an increase from FY 2014 to FY 2015, while joint equipment sales have decreased. The decrease in joint equipment sales is due to a large increase in VA sales in FY 2014 that were not sustainable in FY 2015. However, the total joint sales increased by 15.2-percent, an overall good performance.

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

Commodity	FY 2014	FY 2015	Change
Pharmaceuticals	$2,145.95	$2,612.42	+ 21.7 percent
Equipment	$ 485.60	$ 419.07	- 13.7 percent
Total	$2,631.55	$3,031.48	+ 15.2 percent

VA and DoD cost avoidance from using acquisition programs with joint requirements approached $37.5 million for VA in high tech medical equipment and exceeded $666.2 million in pharmaceuticals.

Medical Surgical Business Intelligence

In 2015, the joint VA/DoD data synchronization program accelerated the integration of the Product Data Bank (PDB) business intelligence data into enterprise processes to broaden the benefit of synchronized product data within the DLA and VA. The PDB continued to serve as a source repository for reports to support management and monitoring of program spend data and enabled prompt responses to numerous Freedom of Information Act inquiries.

The joint VA/DoD data synchronization program worked with DLA leadership to define and provide an enterprise pricing effectiveness metric that compares DoD pricing to industry/local purchase benchmarks, enabling the DLA Troop Support Medical and the VA Program Management Office to improve their understanding of pricing competitiveness. This business intelligence enables best-value product sourcing decisions, and reduces delivered costs of medical material purchased by customers.

The DLA Troop Support Medical operations benefited from improvements in provision of data to PDB and corresponding integration of PDB with key Defense Medical Logistics Standard Support (DMLSS) applications. The Medical Master Catalog (MMC) application team is reviewing a data extraction format that will allow MMC to integrate on-demand company name and item identification research to replace current monthly feeds. In addition, MMC is currently accessing usage data from PDB and is moving towards accessing usage data from the on-demand feed. The joint VA/DoD data synchronization program improved integration with DMLSS Electronic Catalog and Medlife by streamlining and automating First Data Bank, SupplyLine and the DLA Troop Support Medical's Medical Supplier Directory manual processes.

The joint VA/DoD Data Synchronization Program provided reports to senior management to manage and monitor dollars spent including identification of Decentralized Blanket Purchase Agreement purchases and contract vehicles. In

addition, reports were provided to enable monitoring of DoD spend migration to new Electronic Catalog contracts replacing direct only orthopedic items.

VA and DoD users accepted purchase recommendations in FY 2015 that could reduce medical/surgical product costs by $5.7 million, meeting the annual target set by the A&MMM WG in the FY 2013 to 2015 VA/DoD JSP despite a 4-month period without VA access to program resources due to funding delays. The total potential amount of product price reductions achieved as a result of using the business intelligence tool between FY 2013 to 2015 was $27 million, exceeding the JSP goal by 180 percent.

HEC Financial Management Working Group

The Financial Management WG (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, to include shared oversight of the VA/DoD JIF.

VA/DoD JIF
The JIF provides "seed" money to support shared VA/DoD initiatives. In 2014, the FMWG Co-Chairs performed a comprehensive review of JIF that identified numerous opportunities for improvement to the program. FY 2015 was dedicated to capitalizing on these opportunities to make substantial improvements in the JIF program, including:

- Revamped JIF Policy, Guidance, and Approvals – Key clinical, IT, and program management requirements were outlined upfront in the JIF guidance to ensure submissions addressed minimum standards. In addition, the JIF submission voting and scoring board was restructured to include neutral IT and clinical subject matter experts.
- Implemented a More Disciplined Planning, Programming, Budgeting, and Execution Process – JIF submissions must now directly support both agencies' most important goals and offer the greatest system-wide return on investment. In-depth assessments are performed quarterly and unsuccessful projects are shutdown. Successful projects are identified for rapid deployment at other locations.
- Improved JIF Website – The WG overhauled and enhanced a JIF website to include JIF templates, training materials, electronic proposal submission, guidance, resources, etc.; and began developing an OMB MAX.gov website for "next generation" JIF management.
- Developed and Implemented JIF Program Management Training for Approved Initiatives – The WG developed and provides training for best practice Project Management Professional-based program management, with easy-to-use managerial and reporting templates and resources to guide JIF program managers.
- Re-engineered Standard Operating Procedures – To achieve better financial and project management, project scope changes and additional funding requests will

only be considered with a full impact assessment, including a revised business case assessment and updated project timeline that meet approval thresholds.

- Improved Financial Management – Worked with finance and accounting staff to implement a new, monthly-financial report for JIF that mirrors the DoD's 1002 report, with individual JIF project codes to track funding, obligations, and disbursement.

The National Reimbursable Sharing Agreement and Streamlined Billing Practice

FY 2015 was a hallmark year in the DoD/VA journey towards a more effective and efficient business relationship. The year started with amounts owed in arrears by both Departments dating back to 2011 and a general concept of how to improve the process to ensure both seamless patient management and prompt payment.

FMWG members devised a plan to eliminate all amounts in arrears. Amounts owed by location and by year were identified and supporting documentation was prepared for payment. In August 2015, the VA paid DoD $23.5 million, effectively eliminating all amounts in arrears from FYs 2011 to 2014. In a reciprocal action, DoD processed delinquent payments to VA for Integrated Disability Evaluation System Compensation and Pension exams. Results achieved in FY 2015 are the most transformative in at least ten years.

Concurrent with the elimination of amounts in arrears, a grass-roots team led by the FMWG Co-Chairs began flow-charting and documenting patient management and payment processes at a number of locations, both effective and ineffective. The purpose was to form a basis of understanding for a pilot project that would streamline business processes. The team developed the pilot attributes by working with subject matter experts at all levels, and deployed the pilot at the Naval Medical Center Portsmouth-Hampton Roads, VA in the first quarter of FY 2016. The pilot will provide tools and solutions to assist facilities to focus on patient management and enhance the patient experience. In addition, the Departments reached an agreement to stop individual claim preparation, submission, and adjudication between the two Departments as of April 1, 2016. In lieu of this, the VA and DoD will pay each other prospectively and reconcile based upon workload/documentation that VA and DoD capture.

In FY 2016, a defined path forward was established to achieve a more sophisticated VA/DoD business and patient care relationship. A formal workgroup will be chartered to the HEC and will work to:

- Ensure a smooth transition away from individual billing/collections and to more effective patient management;
- Identify locations where the opportunity exists to increase services provided by DoD to VA and vice versa; and
- Adopt a long-term strategy to identify opportunities, by market, where VA and DoD agree to a consolidated approach to delivering or purchasing a clinical

service vice each pursuing a separate strategy or each providing the same service.

HEC Joint Venture & Resource Sharing Working Group

The mission of the Shared Resources WG (SRWG), formerly the Joint Venture/Resource Sharing WG, is to explore and identify opportunities for increased collaboration between VA and DoD to improve and maximize access, quality, safety, and clinical readiness of providers, and to promote cost effective care. The renaming of the work group and revisions made to its charter were approved by the HEC in May 2015.

The key initiative and focus of the SRWG is the development of data-driven VA-DoD resource sharing site selection criteria and performance evaluation metrics addressed in the work group's draft FY 2016 to 2018 Joint Strategic Plan.

The Comparative Analysis Study, which was directed by the 2014 OMB Passback to identify healthcare efficiency opportunities between VA and DoD, is near completion. A closeout report will be presented, by VHA Office of Policy and Planning and Health Affairs Health Readiness Policy and Oversight to OMB, in FY 2016. The SRWG has conducted and monitored the in-progress reviews of the comparative study pilot sites, and is analyzing and verifying the validity of the resource sharing site selection process and performance evaluation tools used in the study for potential replication and operational use.

The SRWG has teamed with OMB-Budget Systems Branch, MAX.gov, to enhance its Resource Sharing Database through a web-based, cloud-service architecture. The database requirements are under development and will be placed in a test environment by, and tested in, MAX.gov.

The DoD Physical Security Program and Policy Branch are revising DoDI 5200.08, Security of DoD Installations and Resources. The Access Control Standards and Policy/Procedures Working Group are tasked with developing the new DoD installation access language. VA and DoD representatives from the SRWG are invited members to the working group and are involved to ensure that DoD installation access for VA and DoD healthcare beneficiaries is properly and uniformly addressed. Review of the revised DoDI is to begin the first quarter FY 2016.

Because of the VA Choice Act initiative and implementation, the SRWG is involved with the future development, execution, and evolution of the VA-DoD resource-sharing program. Enactment of VA Choice may potentially require policy and program changes on how VA and DoD conduct and support resource sharing between the departments, beginning in FY 2016.

James A. Lovell Federal Health Care Center Advisory Board

James A. Lovell FHCC Advisory Board, which met four times in 2015, continues to function as the link between the James A. Lovell FHCC and the JEC/HEC, and serve as the Board of Directors for strategic and operational decision-making. The James A. Lovell FHCC Stakeholder Advisory Committee met monthly to advise the Director and Commanding Officer on the effectiveness of this collaboration.

In January 2013, a JIF project was approved for a contract to perform an enterprise evaluation of the James A. Lovell FHCC 5-year demonstration, as required by the NDAA 2010. The contract evaluation of the James A. Lovell FHCC began in FY 2014 and a first draft was presented to the James A. Lovell FHCC Advisory Board in April 2015. The VA's Product Effectiveness team also conducted an independent evaluation of James A. Lovell FHCC Information Management/Information Technology (IM/IT) systems. VHA, DoD, Advisory Board members, and the FHCC were given the opportunity to comment on the contractor report prior to the final report being sent to both agencies. The Departments are currently determining their joint recommendation for the way forward. The final Report to Congress is due March 2016.

Organizational Structure

In FY 2015, the FHCC leadership team, composed of a VA Director, DoD Deputy Director, six VA Associate Directors, and five DoD Associate Directors, began their first full FY of operations as an Executive Team. The new Deputy Director/Commanding Officer of the FHCC began his tour in September 2014, and the first new Director since integration in 2010 started at the FHCC in October 2014. Over the course of FY 2015, the new Leadership team operating under the new structure made substantial progress in taking the FHCC out of a demonstration phase and into sustainment.

The James A. Lovell FHCC is in the process of closing out a roughly $428 million budget for FY 2015 with a projected execution rate of 99.9 percent. Despite a permanent $12.9 million funding base reduction, the FHCC continues to meet the mission. Funds were shifted throughout the year to adjust for emerging needs through prioritization and budget reviews. The FHCC satisfied the increasing demand for care in the community, costly Hepatitis C drug therapy, implementation of the Choice Program; and addressed potential budget shortfalls through internal funding adjustments.

Strategic Plan 2015 to 2016

The FHCC conducted its first Strategic Planning session in the fall of 2011. The result was a 3-year plan, with 17 initiatives to be carried out from 2012 to 2015. A refresh of the current plan in FY 2015 created a crosswalk between the Veterans Affairs Strategic Plan, the Navy Medicine Strategic Map, and the Blueprint for Excellence. Defining themes and goals of these three documents led the FHCC leadership team to develop the following strategic initiatives and goals for FY 2015:

- Integration

  Using lessons learned from the first three years' Integration Award Winners, this team has been tasked with creating an integration tool to measure the integration

level of individual departments. The next task for this team is to create a staffing model for optimal 24/7 Active-Duty presence to better serve the acute inpatient care areas.

· Patient-Centered Care (PCC)

To better quantify the patient experience, the PCC initiative aimed to improve the Press Ganey Patient Satisfaction survey results. The team worked on educating staff on how to use the Press Ganey results to improve the patient experience. Working with staff, the team learned that there was a gap in customer service training, and began work on initiating the StuderGroup's AIDET training to the FHCC. AIDET or "Acknowledge, Introduce, Duration, Explanation and Thank You," is a tool for organizing patient communication, and providing patients with the information and caring relationship that they desire. Training will roll out at the FHCC in FY 2016. Through the efforts of the PCC team, the FHCC saw slight improvements in overall patient satisfaction in FY 2015:

Press Ganey Metrics	CY 2014	CY 2015
Inpatient	85.9	87.5
Inpatient Mental Health	76.0	79.9
Outpatient	87.3	88.8
Emergency Department	85.2	85.7
Ambulatory Surgery	91.0	90.4
Community Living Center	79.1	87.5

· Workforce Development

The Workforce Development team was tasked with advancing educational opportunities, as well as using best practices. The Workforce Development team created a career development questionnaire to use for the civilian workforce. Roll-out of this tool is planned for FY 2016, beginning with employees who are designated as Certified Mentors. Working with human resources, the team promoted enhanced training for supervisors, which began in October 2015. The focus of the initial training was employee and labor relations. Topics will continue to be added for supervisors throughout FY 2016.

· Optimization & Expansion

The Optimization and Expansion team chose two pilot sites, Housekeeping and Podiatry, to represent operations for administrative and clinical components of the organizations. The team sent in a tiger team to analyze workflow, staffing, and efficiency of operations within these two areas. The tiger team was able to develop respective Department business rules focusing on staffing, access, productivity, budgetary, and utilization practices based on the sum of variables. The Tiger Teams will use the product developed in FY 2015 to apply to additional administrative and clinical areas in FY 2016.

· Organizational Stewardship

The Organizational Stewardship team most closely aligns with Blueprint Strategy #9. Blueprint Strategy #9 encourages VA facilities to "operate and communicate with integrity, transparency, and accountability that earns and maintains the trust of Veterans, stewards of the system (Congress, Veterans Service Organizations), and the public." This team worked on leveraging current resources to increase available appointments and ensure financial stewardship of appropriated funding. The team worked to increase the number of specialty clinical areas compliant with established productivity benchmarks from 62.5-percent of clinics within compliance in March 2015, to 90-percent compliant by September 30, 2015. The team was able to reach 76 percent compliance. By FY 2016, the team will expand efforts to the CBOCs, BHCs, Primary Care (PACT & MedHome), and mental health to establish productivity metrics to measure efficiency. Productivity metrics of providers will be incorporated into a public source of quality, performance, and productivity indicators that promote the FHCC as a provider of high quality, efficient, and conscientious healthcare by December 31, 2015. The public scorecard was developed with input from the Patient Advisory Council, Veteran volunteers, and ombudsman representatives.

· Quality

Throughout the course of the demonstration project, the FHCC collected and reported on duplicate metrics for measuring the quality of care provided. The Quality initiative is designed to create one dashboard to capture key quality and safety indicators that meet or exceed agency and/or national benchmarks to propel the journey towards a high reliability organization by December 2015. A public dashboard was created in conjunction with the Organizational Stewardship team, and will be available to view on the FHCC Internet site early in 2016. This will be the one-stop shop for patients seeking care at the facility to view the most up to date quality metrics.

Clinical Care

The James A. Lovell FHCC provides care to over 101,000 individuals per year, including Veterans, Active-Duty Service members, students, and their families, and over 37,000 new Navy recruits. As of September 2015, the James A. Lovell FHCC processed 176 Medical Evaluation Boards, with an average processing time of 68 days – DoD standard is 120-days. The 176 cases to date represent an increase of 22-cases over FY 2014, and were accomplished with no increase in staff. The Veterans' Choice Program was implemented in FY 2015. In FY 2015, 611 Veterans were eligible for Choice based on wait times, with 23 of those Veterans subsequently electing to receive care in the community through Choice.

In July 2015, the Gastroenterology (GI) Service began 24/7 endoscopy coverage at the FHCC to provide a more seamless continuity of care for patients. Leadership recognized the opportunity to reduce the number of patients transferred to outside facilities when requiring urgent or emergent GI services, and prevent a breakdown in communication/care with multiple facilities involved in patient care. In planning and preparing to expand this service, the GI section worked in collaboration with the FHCC

Lean 6 Sigma team and simulation specialists to develop best practices for providing excellent patient care outside of the GI department. The FHCC conducted simulation exercises that included all GI staff, the emergency department, Intensive Care Unit, and general medical/surgical floor. These simulation exercises helped to identify the need to provide services on off-hours and outside of the normal circumstances of the GI department and develop and implement processes. Since implementation, the GI section saw six patients requiring emergent care outside of normal clinic hours and met the needs of the patients in these critical situations with positive outcomes for all. Primary care at the FHCC is organized as two separate entities, the VA Patient Aligned Care Teams for Veterans and the Medical Home Port for Active-Duty and family members. As of July 2013, the FHCC closed to new Tricare for Life (TFL) patients, but previously enrolled patients were accommodated as space was available (EA Priority 5). Approximately 100 TFL beneficiaries were empaneled to third year internal medicine residents within the Medical Home Port to support continuity clinics required by graduate medical education. In the summer of 2015, the third year residents graduated, leaving those 100 TFL beneficiaries without a Primary Care Manager. The Medical Home Port did not have capacity to re-empanel these patients and maintain access standards for TRICARE Prime beneficiaries. To provide continued care for this group of beneficiaries, they were empaneled in the VA Primary Care clinic. This is the first integrated panel in the history of the FHCC in which a primary care provider has a mixed panel of Veterans and DoD retirees over the age of 65, and their family members. A benefit of this model is that is creates a one stop shop for dual eligible patients. A single provider can address all TRICARE and VA benefits for the patient in a single visit, eliminating the need for repeat visits. The integrated panel also means the elimination of requirement for two primary care providers, one VA and one DoD. With the elimination of a provider under an Agency, the patient benefits from a single health record, a single secure messaging system, and the opportunity to belong to ONE, a single, comprehensive patient-centered model of care.

Patient-Centered Care

The James A. Lovell FHCC has been working towards transforming Patient-Centered Care to improve practices, and educating staff on the best techniques and processes to achieve quality, patient-centered care for every patient, every time.

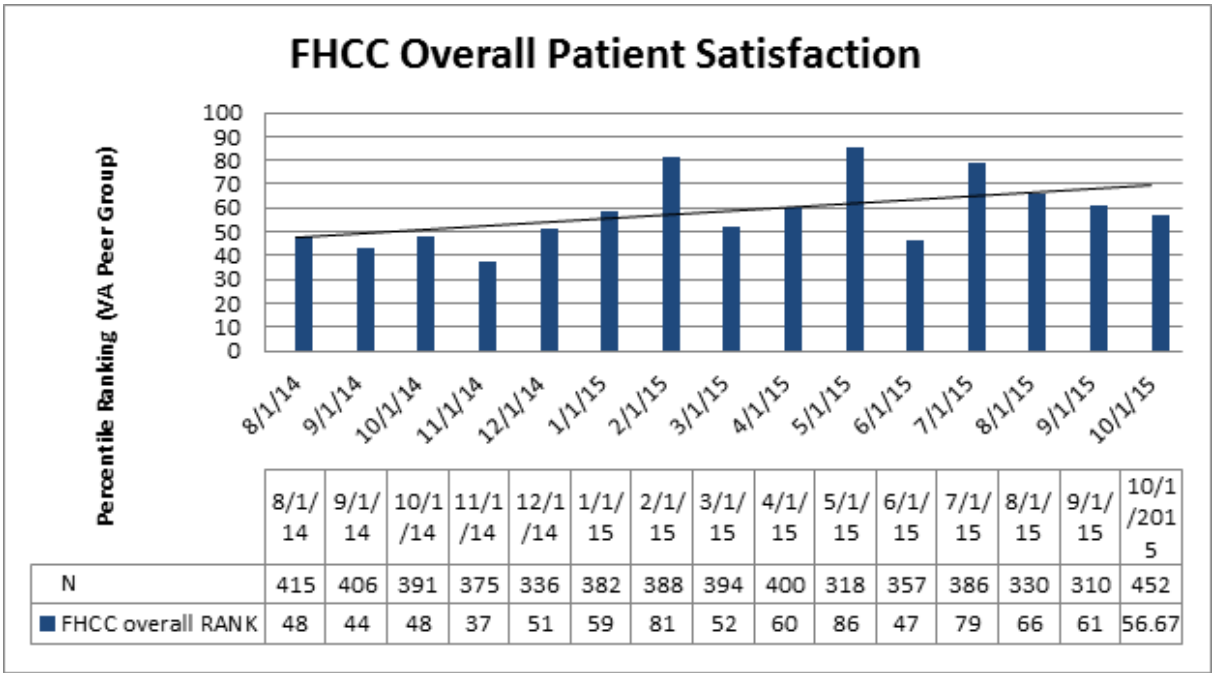
GetWellNetwork

The GetWellNetwork, an interactive patient engagement solution, was implemented as a patient engagement tool. The GetWellNetwork operates as part of the patient's television, and offers interactive patient care allowing for real time customer feedback; hospital information; over 400 health education videos available on the patient's television; as well as enhanced entertainment options such as internet, and on-demand movies. The GetWellNetwork is currently in over 200 James A. Lovell FHCC beds. The VA signed in FY 2015 the Authority to Operate agreement with the GetWellNetwork, and integration with Vista/Computerized Patient Record System will begin in the winter of 2016. Integration with the medical record will allow staff to prescribe education to patients from their desktop, and the system will auto-populate the medical record when the patient has completed the education. Integration will also give the FHCC the ability

to use care pathways to improve outcomes in areas such as pain management, discharge planning, and falls.

Patient Satisfaction

The FHCC is working to integrate patient satisfaction data through a contract to survey the FHCC beneficiaries (DoD and Veterans) on their patient experience. The FHCC currently uses six different surveys (e.g., inpatient, outpatient, behavioral health, and community living center), and survey data are updated daily, providing for regular patient feedback. Reports can be automated and emailed to leadership and staff weekly, monthly, or quarterly. These reports also provide comparison data by geographic location and hospital type (including other VAs). This not only assists the FHCC with their Magnet Journey but also informs the FHCC on where patient satisfaction ranks compared to the community. Using Press Ganey, the FHCC has targeted several priorities for improvement and has easily shared monthly data with stakeholders. Since Aug 2014, the FHCC has seen a positive trend in the overall patient satisfaction as compared to the VA Peer Group (graph below). In FY 2016, the FHCC is looking to expand Press Ganey by including other areas of the hospital, including DoD clinics.



	8/1/14	9/1/14	10/1/14	11/1/14	12/1/14	1/1/15	2/1/15	3/1/15	4/1/15	5/1/15	6/1/15	7/1/15	8/1/15	9/1/15	10/1/2015
N	415	406	391	375	336	382	388	394	400	318	357	386	330	310	452
FHCC overall RANK	48	44	48	37	51	59	81	52	60	86	47	79	66	61	56.67

Fisher House

In FY 2015, James A. Lovell FHCC was approved for a Fisher House, to be built in 2017. It will be a 16-bed facility to help families of wounded warriors and Veterans stay free of charge. In limited circumstances of immediate need and no alternative temporary lodging, the Wounded Warrior or Veteran with one of more accompanying individual(s) may be provided temporary lodging based on space or resource limitations.

Education & Training

In FY 2015 the FHCC provided a structured framework for the Cook County Hospital Trauma & Burn Experience program that was piloted in FY 2014. This program offers a unique, fast-paced learning environment for FHCC Corpsmen, nurses, and physicians to evaluate, triage, and treat acute traumatic injuries in real time. This program augments complex medical skills and builds teamwork necessary for deployments. Participants work hand-in-hand with the attending surgeons, residents, and nurses to gain a multi-faceted experience aimed at management of the acutely injured patient. Cook County serves approximately 8,000 trauma patients per year, roughly 20 per day. Surgeons perform about 800-850 trauma laparotomies each year and treat, at any given time, roughly 10-12 patients in the Intensive Care Unit.

The Navy Hospital Corpsmen also gain tremendous value in their trauma rotations. In their average rotation, the Corpsmen will see 40-50 blunt head traumas, 30-40 gunshot wounds, 20 plus laceration repairs, 10-20 burn wounds, 3-5 traumatic amputations, and 150+ IV starts.

Lean Six Sigma

At the end of FY 2014, the Lean Steering Committee participated in its FY 2015 Transformational Plan of Care. The outpatient value stream was put into Model for Daily Improvement, which puts its successes into sustainment mode. The Inpatient Value Stream was successful in reducing average Length of Stay on the medicine unit from 4.3 to 3.3 days and decreasing hours on diversion by 90 percent. Other highlights include improving the number of patients meeting continued stay criteria and patient satisfaction regarding discharge. During FY 2015, an access value stream was opened focusing on the access from the patient's perspective. The events and projects from this value stream are still in progress. The FY 2016 Transformational Plan of Care was finalized in August, opening a new value stream focusing on improving internal administration processes that will strengthen the FHCC's foundation to continue to support patient-centered care.

Business Operations

VA/DoD Interagency Program Office (IPO)

Throughout FY 2015, the VA/DoD IPO, VA/DoD Joint Development Teams, and the VA and DoD Pharmacy functional communities continued with standards identification and mapping supportive of interim solutions for implementation to support the James A. Lovell FHCC Pharmacy business needs not addressed by a technical Orders Portability Solution. The VA/DoD IPO was re-chartered by the Deputy Secretaries of the VA and DoD, due to a shift from the VA/DoD joint development strategy of the Integrated Electronic Health Record, to focus on the interoperability of electronic health records. This new Charter included the transition of responsibility of the James A. Lovell FHCC Demonstration Program back to the VA and DoD. It was been determined that continued James A. Lovell FHCC technical and business support be provided by each Department beginning October 2014, coinciding with the Program's sustainment.

Business Process Reengineering

During FY 2015, the contracting team focused on providing business process reengineering, sustainment activities, and administrative assistance for the FHCC in the following areas: Departmental Security Officer System Access, logistics/operating room supply ordering process, terminology table mapping, pharmacy/third party billing analysis, recruit batch registration, laboratory standard operating procedure, and Patient Registration Correlation of Patient Records. Additionally, the contracting team assisted and collaborated with the IM/IT departmental stakeholders in the establishment of an Interoperability Support Team, which was instrumental in laying a roadmap to establish plan of action and milestones defining roles/responsibilities, service level agreements, SOPs, and change management to discuss/resolve orders portability issues for laboratory, radiology, consults, patient registration, and information resource management.

Clinical Productivity Benchmarking and Reporting

The FHCC has made tremendous progress in establishing, implementing, and achieving visibility of productivity measures in the majority of the clinical specialties in operation at the facility. Locally developed tools and processes have been developed to assist management and clinical operations staffs to identify, maximize, and optimize their resources with the goal of providing the most effective healthcare possible.

One of the tools developed in FY 2015 was a monthly stoplight report, with drill-down to individual providers. This allows executive leadership to view clinical and individual workload data, and supports ready management and data driven decision-making ability. Along with the stoplight report, the Integrated Workload Dashboard was developed in FY 2015 for use by anyone in the organization to allow access to staffing, productivity, and workload data from their workstation. Put together, these reports provide unprecedented visibility to clinical operations.

Logistics

Operating Defense Medical Logistics Standard Support (DMLSS) at both VA and DoD facilities will reduce medical supplies and equipment costs via large economies of scale, increase ease of use by both VA and DoD staff, enable greater process efficiency through standardized operating procedures, improve facilities sharing and management, and improve patient safety via greater asset accountability and quality management. The pilot decision was reaffirmed on April 15, 2015, by VA and DoD, and is still on target for IOC by October 2016.

In the acquisitions and contracting arena in FY 2015, FHCC used the acquisition/ contracting resources of the Naval Facilities Engineering Command (NAVFAC) to maintain its ability to advance construction projects. The principal factors necessitating NAVFAC augmentation have been internal FHCC engineer staffing shortages and staffing shortages within FHCC's principal acquisition support office, the VA Great Lakes Acquisition Center. In FY 2015, NAVFAC has engaged in project/acquisition management on five projects, with a total value of nearly $6 million.

Manpower & Staffing

In December 2014, the Financial Manager informed the Total Force Management Committee (TFMC) that the Non-CUM Full Time Employment Equivalent (FTEE) percentage had reached the ceiling authorized in the Presidential Budget prescribed by Congress. Based on the number of additionally approved FTEE since 2010, the FHCC had increased its civilian salary operating budget by more the 120 FTEEs.

In order to address this situation, the TFMC began to re-evaluate the approval processes for new positions as well as identifying a prioritization of existing vacant positions that needed to be hired. Resource Management was given the responsibility of identifying, by month, the number of positions that the Department could support (salaries). Based on that number, the Services within the facility were directed to identify the positions most critical to operations. Since the onset of the prioritization process, methods have been reworked and redefined for moving forward with the hiring process.

Through best practices, the total number of vacancies in the facility and each Directorate's percentage of the total amount were identified. The Directorates with the larger percentage of vacancies initially would receive a larger share of the identified positions to be filled, and subsequently, a rotational methodology would be in place to ensure all Directorates have an equivalent opportunity to participate in this process. Two positions would be held back each month to fill critical/urgent hires. In addition, it was determined internal hires would be allowed based on zero net FTEE gain. Moving forward, Services would be able to select positions for internal hires based on the number allowed during a particular month, i.e., if the Service has two authorized selections in June, the Service would also be allowed to select two internal hires in June; however, if the Service does not have a selection in a particular month, the Service would be allowed one internal hire. As the FHCC addresses the parameters of this method and staffing capacity of the organization, the organization may have to rework or revise current practices to accommodate fiscal obligations.

The Human Resources Department grew from nine (9) personnel at the time of integration to 60 civilian employees and military staff members supporting more than 2,147 employees and 950 military personnel. In 2015, the Human Resources Department conducted a Lean Six Sigma-Rapid Improvement Event (RIE) in order to streamline the recruitment process. The VACO mandated metrics called for Human Resources to submit a tentative offer of employment within 60-days of a recruitment request being submitted by the requesting Service, no less than 80-percent of the time. Prior to the RIE, Human Resources achieved less than 40-percent timeliness in this metric. Since the RIE, Human Resources has been able to achieve no less than an average of 95 percent of all applicants being given a tentative offer of employment within 60-days of a recruitment request.

Performance Metrics and Data Disparity

The monitoring of the 15 benchmarks of integration remains intact. The overall performance has remained stable and shows no degradation in performance for FY 2015. An improved monitoring and reporting system for DoD Healthcare Effectiveness

Data and Information Set (HEDIS) measures has been in place, which resulted in steady improvement on lesser performing metrics (Behavioral Health Measures and Acute Condition Management).

In FY 2015 the FHCC moved from a 3-star to a 4-star Strategic Analytics for Improvement and Learning Value Model (SAIL) Quality Rating and saw noted improvement in highly weighted metrics within SAIL; Ambulatory Care Sensitive Condition Hospitalizations moved from 2nd quintile to 1st, and Length of Stay from 5th quintile to 4th. The FHCC has had marked improvement in overall Length of Stay through an aggressive Rapid Improvement Event led by Inpatient Services Directorate, capturing both VA and DoD beneficiaries. The real-time bed days of care data indicates the FHCC can anticipate continued improvement on SAIL scores. A proactive monitoring and reporting process of VISTA clinics has aided in 1st Quintile HEDIS-like performance for all of FY 2015.

VA/DoD Interagency Program Office

In FY 2015, the IPO Development Team and VA and DoD Pharmacy functional communities initiated a pharmacy data standardization effort, which will be synchronized with the VA's Pharmacy Product System – Local (PPS-L) and Pharmacy Product System – National (PPS-N). The Departments' improved management of pharmacy technologies will facilitate more effective data quality and sharing.

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 2015 communications activities in support of the specific objectives in the JEC JSP included regular coordination with representatives from the HEC, BEC, IPO, Transition Assistance Program, VA/DoD Congressional affairs, and VA/DoD public affairs to enable ongoing collaboration between subject matter experts and communications professionals.

The JEC SCWG continued to build on outreach activities in FY 2015, and conducted:

- Briefings and hearings to Congressional stakeholders.
- 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.

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) Working Group provides a formalized structure to facilitate cooperation and collaboration in achieving an integrated approach to planning, design, construction (both major and minor), leasing, and other real property initiatives for shared medical facilities that are beneficial to both Departments.

Progress was made through FY 2015 towards the CPC's activities and milestones as outlined in FY 2013 to 2015 JSP Objective 3.6.A as follows:

- Invite appropriate CPC members from each Department to participate in VA's Strategic Capital Investment Planning (SCIP) and DoD's Capital Investment Decision Making (CIDM) planning process to assist in identifying possible projects that may benefit through joint collaboration before the start of each Department's planning cycle.

  Status: DoD CPC members continued to participate in VA's SCIP process and VA representatives participated in DoD's CIDM process. This reciprocal involvement assists in the identification of potential joint project opportunities for further consideration by the Departments. Any joint project opportunities not selected due to lack of funding availability or maturity of project(s) at time of scoring will likely be re-evaluated in future CIDM / SCIP sessions based on local demand.

- Update the CPC charter to modify the scope statement in recognition of its efforts beyond physical construction to include leasing and to expand membership to include Service representation.

Status: The CPC charter revision was drafted to include the proposed committee name change from the CPC to the Capital Asset Planning Committee (CAPC) to reflect the committee's efforts to support not only construction projects, but also leasing and other real property initiatives. The draft revision also expands the committee membership to include field-level representation for both Departments. Completion of the charter revisions will be based on resolving the impact of organizational changes at the DHA.

- Document a standardized, repeatable process for ongoing data sharing to inform annual SCIP and CIDM processes.

  Status: VA and DoD coordinated efforts to identify and develop an internally supported standardized data exchange process. VA and DoD share capital planning data to include population/network enrollees, treating facility proximity, and direct and purchased care data. The consolidated VA/DoD capital planning data are made available to both Departments' local planners at the VA Medical Center (VAMC) and MTF levels for use in VA's SCIP and DoD's CIDM processes. Annual updates will be jointly developed for continued use in both Departments' processes. This standardized process resulted in a cost savings, and facilitates the timely availability and distribution of the data.

- Re-submit like legislation to leadership if appropriate for submittal in FY 2014 National Defense Authorization Act. If proposed legislation is approved, communicate no later than 90 days after bill enactment the benefit of legislation changes to field planners and other interested parties.

  Status: VA resubmitted its proposed legislative language in 2015 in its FY 2016 budget submission and in draft construction authorization bills. DoD submitted its proposed legislative language in August 2015 to the Unified Legislative and Budgeting process that determines legislative priorities for FY 2018. The goal of these initiatives was to change existing statutes to provide inherent authority for the acquisition of shared medical facilities by leasing and construction. The legislation would allow the Departments to effectively plan, design, lease, and construct joint capital projects and to better align joint construction planning and execution. It also would allow VA and DoD to incorporate each agency's current and future projected healthcare workload for such acquisition of facilities. It would help to improve the access, continuity, quality, and cost effectiveness of direct health care provided to Veterans, Service members, and their beneficiaries. VA CPC leadership briefed the JEC in October 2015 to inform and seek support of JEC leadership for the proposed legislation. VA and DoD plan to continue their coordination to explore the viability of obtaining such legislation.

- Advance VA/DoD joint market planning efforts.

  Status: In FY 2015 the CPC identified joint market planning as an appropriate focus for its efforts to meet its goal of optimizing capital asset planning for both

Departments. VA initiated its Integrated Master Planning (IMP) initiative at the VISN level and DoD initiated its enhanced Multi-Service Market (e-MSM) planning efforts. VA initiated local market planning processes in three VISNs, each included outreach to and participation by local market DoD providers. DoD conducted e-MSM planning efforts in the San Antonio, Colorado Springs, Puget Sound, and Hawaii markets. VA was included as a part of the study team in each of those markets. Joint reports are being prepared for leadership in each of the study markets. Coordinating the active involvement of each Department within these ongoing joint market planning efforts will be a CPC focus going forward.

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

Based on the SHA pilot, on December 4, 2012, VA and DoD agreed to share responsibility for ensuring that each departing Service member receives a Separation Health Assessment (SHA) according to a common standard. A memorandum of agreement outlining the standards for the assessment and how VA and DoD will share the responsibility for completing it was signed in December 2013. The SHA is mandatory for all separating Service members, to include Reserve Component members who have been on Title 10/32 orders for longer than 180 days, or 30 days in a contingency operation. The agreed upon processes include the completion of DD Forms 2807-1 and 2808 (or their electronic record equivalents) by the DoD on all Service members not making a disability claim, or those less than 90 days from separation, and by VA for those who submit a disability claim more than 90 days from separation. The exam will include a threshold audiogram (with full audiology evaluation required if the threshold test is abnormal), and any appropriate or required ancillary testing. A DoD Instruction specifying policy and procedures to be fully implemented is in formal coordination, and will replace the DoD Directive Type Memorandum (DTM) 14-006, “Separation History and Physical Examination (SHPE).”

VA and DoD are currently using physical exam templates that include all of the jointly agreed upon data elements. VA performed SHAs continue to increase in number, with over 2,500 being performed per month as of October 2015. The DoD is performing over 10,000 SHPEs per month and refining processes to ensure that every qualifying Service member receives the exam. A key IT system capability needed to support process improvement was achieved in September 2015, and the remainder of the critical requirements should be met by end of the 3rd quarter FY 2016. VA and DoD have also begun to design and execute a small scale pilot employing the new capabilities to

streamline the SHA work flow, so as to leverage the DoD record archival process and reduce the current burden on the Service member to provide a record copy for VA performed exams. Results will inform future decision making about the SHA initiative and will guide more efficient processes to achieve the goal of the VA exam meeting the requirement for all qualifying Service members who choose to file a claim.

ADDITIONAL ACCOMPLISHMENTS

Interagency Care Coordination Committee

The Department of Veterans Affairs/Department of Defense (VA/DoD) Interagency Care Coordination Committee (IC3) oversees implementation of the November 2012 Secretaries' Intent Memorandum to achieve: "One Mission – One Policy – One Plan." The goal of the IC3 is to streamline, synchronize, coordinate, and integrate the full spectrum of complex care, benefits, and services provided to Service members, Veterans, and their families as they transition from military service to civilian status.

<u>One Mission</u>
During FY 2015, the IC3 advanced the implementation of a standard model of care coordination for Service members and Veterans with complex care needs by operationalizing key initiatives within the IC3 Community of Practice Workgroup (CoP WG). A key component of this effort is the Lead Coordinator (LC) concept, providing a primary point-of-contact and enhanced intra- and interagency transitions for Service members and Veterans who require complex care coordination. The CoP WG developed LC training in FY 2015 and began the national rollout of the LC Role. A program exploration tool was also developed, which will guide the LCs to address Service Members' and Veterans' needs for care, benefits, and services across Interagency Comprehensive Plan (ICP) domains and categories before, during, and after their transition.

The IC3 CoP, made up of the leaders from approximately 50+ care, benefits, and services coordination programs across VA and DoD, continued to drive key IC3 initiatives, focusing on member engagement, communications, and creating common tools and shared resources. In January 2015, the CoP facilitated two LC "refresh" trainings in the WRNMMC and San Antonio Military Medical Center for care coordinator staff. The refresh trainings were based on lessons learned from the FY 2014 feasibility assessment (pilot training conducted at the same two facilities) and was the precursor to the launch of the LC Training national rollout in July 2015. The training provides two components: LC training (for individuals who will likely serve in the role of LC) and LC Awareness training (for individuals who provide services to Service members and Veterans and work with LCs, but will not be assigned as LCs). These two complementary curriculums are targeted to meet the differing needs of the LCs and the other supportive services and programs. The LC training and the LC Awareness

training are being conducted at 12 sites throughout the nation with expected completion in November 2015.

CoP leaders are supporting the LC implementation and other IC3 efforts by:

- Engaging and communicating with their CoP colleagues and staff.
- Developing internal and external communications to promulgate awareness of upcoming changes and expectations regarding IC3 initiatives and complex care coordination.
- Using Co-Lab, a Personal Identity Verification (PIV) card and Common Access Card (CAC) secure website for interagency care coordinators to connect, learn more about each other's programs, and find each other through a master Care Coordinator Directory (CCD).

Over the past year, based on feedback from Co-Lab users, CoP WG members improved Co-Lab search functionality and developed a care coordination benefits and services exploration tool. Through coordinated communications and the use of common tools, the CoP WG strives to make it easier for Care Management Team (CMT) members to navigate continuum of care options for Service members and Veterans to allow them, their families, and caregivers to focus on recovery.

<u>One Policy</u>
Subsequent to the VA/DoD Memorandum of Understanding (MOU) for Interagency Complex Care Coordination Requirements for Service members and Veterans signed on July 29, 2014, a VA Directive and a DoD Instruction were released to their respective Departments. These governing documents established the MOU as policy for complex care coordination processes, and assigned responsibilities in accordance with the overarching guidance and gave it the force of policy across both Departments. Ongoing efforts continue to identify, review, revise and sunset (as necessary), any VA and DoD policies with any connection to complex care coordination to ensure alignment with the MOU.

Additionally, the IC3 has developed methodologies to quantify the VA and DoD complex care coordination population. The complex care coordination population includes all Service members and Veterans that meet the criteria for Complex Care Coordination for LC assignment, and is estimated to include approximately 14,000 Service members from DoD and 40,000 Veterans from VA. These may include Service members and Veterans who are represented in both the VA and DoD estimates; a data match effort is underway to compare data and eliminate duplicates. Also, progress has been made towards implementing an oversight process and mechanism to track IC3 performance measures and outcomes, and interim performance metrics have been identified. Metrics will begin to be reported in October 2015.

<u>One Plan</u>
During FY 2015, the IC3 continued to ensure effective development and utilization of a single, shared comprehensive plan for Service members and Veterans in need of

complex care coordination for care, benefits, and services. The Interagency Comprehensive Plan (ICP) covers the full range of services and benefits needed by Service members and Veterans as they progress in their rehabilitation. This includes care, benefits, and services encompassing eight domains: career, daily living, family, finances, health, legal, military, and spirituality. The ICP is a plan, which is developed and updated by a LC, in coordination with the CMT, and follows Service members and Veterans through the continuum of care. LCs are being trained on the ICP and are using it as a reference to ensure an exhaustive set of care, benefits, and services is considered in a standardized manner for Service members' and Veterans' recovery, rehabilitation, and reintegration within and across the Departments.

The Departments have agreed to pursue a technical solution for sharing and accessing the ICP electronically using existing VA and DoD systems [Federal Case Management Tool (FCMT) and Interagency Comprehensive Plan for Care Coordination Support (ICPCCS)]. The IC3 Technology, Tools, and Change Work Group is planning for a full scale, interoperable, electronic ICP. The electronic ICP will improve coordination, transparency, and interoperability across programs by allowing VA and DoD care coordinators to view and share client data. In April 2015, initial technical requirements were gathered in a collaborative manner between VA and DoD to determine the best path forward. Both VA and DoD awarded contracts to execute the development of the electronic ICP with a goal of the ICP being operational by September 30, 2016.

Health Care Resource Sharing

Charleston-Beaufort Joint Venture
Naval Health Clinic Charleston, South Carolina (NHCC); Ralph H. Johnson VAMC (RHJVAMC); 628th Medical Group (MDG), Joint Base Charleston, South Carolina; NH Beaufort, South Carolina (NH Beaufort)

In FY 2015, the Charleston Joint Venture activated the JIF expansion project to the existing Physical Therapy Clinic to provide services to DoD family members and Veterans who receive services at the CBOC. In FY 2015, the JACC continued to provide mobile magnetic resonance imaging (MRI) services to both VA and DoD beneficiaries through equipment purchased through the JIF. Through healthcare resource sharing agreements, NHCC/628 MDG/RHJVAMC provided joint services in optometry, ophthalmology, cardiology, diagnostic radiology, phlebotomy, consultant pathology services, and physical therapy and shared training/clinical skills enhancement opportunities.

Joint Ambulatory Care Center, Charleston

Service	DoD Beneficiary Services	TRICARE Maximum Allowable Charges (TMAC)	VA Beneficiary Services	VA Savings

Service	DoD Beneficiary Services	TRICARE Maximum Allowable Charges (TMAC)	VA Beneficiary Services	VA Savings
MRI	1,785* studies	$427,149*	762* studies	$126,493*
Optometry	6,759* visits	$244,746*	1,718** visits	$197,845**
Ophthalmology (Part-time)	551* visits	$ 45,672*	1,352** visits	$278,823**
Outpatient Cardiology (Resource Sharing Agreement (RSA))	534* visits	$ 44,460*	374** visits	$184,594**
Reimbursed Diagnostic Radiology For Veterans provided by NHCC (RSA)			2,826* studies	$54,640*
Physical Therapy JIF	8,874 visits	$363,240.76*	7,453** visits	$330,157**
Total	**18,503 visits**	**$1,125,267.76**	**14,485 visits**	**$1,172,552**

DoD workload values based upon data from October 1, 2014 to August 31, 2015 (CHCS or Vista data/TMAC*)
VA workload/VA Savings based upon data from October 1, 2014 to August 31, 2015 for MRI & Diagnostic Radiology and October 1, 2014 to July 31, 2015 for Optometry, Ophthalmology, Cardiology and Physical Therapy (Decision Support System (DSS)**/TMAC*).

In FY 2015, NH Beaufort, along with RHJVAMC, continued MRI services through the FY 2012 JIF mobile MRI, providing 954 studies for Veterans and 1,801 for DoD beneficiaries. This collaboration yielded a Federal health care cost avoidance of $784,569 (VA- $243,471 and DoD- $541,098) and $33,398 in Veteran travel benefits in FY 2015. With a shared VA lab technician, the laboratory performed over 7,600 phlebotomy draws for VA patients, saving time, travel dollars, and providing improved access to and ease of care. Navy podiatrists performed over 600 exams for Veterans in FY 2015, valued at $38,275. Navy radiologists and technicians performed and read over 3,990 radiology procedures for VA patients, valued at $124,072 TMAC in professional fees and technical services. In 2014, the Beaufort-VA Joint Venture was awarded a JIF project to provide Dermatology services to VA and DoD CBOC patients at NH Beaufort. The Joint Dermatology Clinic grand opening was held February 26, 2015. Also in 2015, the third Beaufort-RHJVAMC JIF project was awarded to establish Joint VA/DoD Physical Therapy Services at the NH Beaufort site.

Resource Sharing and JIF Initiatives, Beaufort

Service	DoD Beneficiary Services	TMAC	VA Beneficiary Services	VA Savings
MRI (JIF)	1,801*	$ 541,098*	954*	$ 243,471*
Diagnostic Radiology including x-ray, CT, and US (RSA)	--	--	3,990*	$ 124,072*
Podiatry (RSA)	--	--	608*	$ 38,275*
Laboratory (RSA)	--	--	7,674*	$ 235,968*
Dermatology JIF	265*	$ 22,586.60*	528**	$ 91,377**
Physical Therapy JIF	**Opening FY 2016**	--	1,208 visits	$ 67,057
Total	**2,066**	**$ 563,684.60**	**14,962 visits**	**$ 800,220**

DoD workload values based upon data from October 1, 2014 through July 31, 2015 (CHCS or Vista data/TMAC*)
VA workload/VA Savings based upon data from October 1, 2014 through July 31, 2015 (DSS**/TMAC*)
Benchmarking and communications are coordinated through the Lowcountry Federal Healthcare Alliance (LFHA), 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/South Carolina area. As a result, the Charleston-Beaufort Joint Venture team is able to reduce costs and provide high quality care to Veterans and DoD beneficiaries.

Wright-Patterson Medical Center, 88th Medical Group (88 MDG) and the Veterans Integrated Network System 10

In FY 2015 Wright-Patterson Medical Center, 88th Medical Group (88 MDG) and the VISN 10 established a mutual relationship to optimize utilization of VA and DoD medical resources through a Master Sharing Agreement. This Master Sharing Agreement built an environment where providers and beneficiaries within the region are able to deliver and obtain medical services in the most efficient manner. The scope of care includes all medical, surgical, and therapeutic services within the 88 MDG and VISN 10, subject to a patient's eligibility, access, priority to care, and the supplying facility's excess capacity/availability of that service, as well as any constraints imposed by applicable law or regulation. The analysis below shows the increased number of Veterans using DoD services in FY 2015 and illustrates how strong the relationship has become between the 88 MDG and VISN 10.

Service	FY 2014 Encounters	FY 2015 Encounters	Differential	Percent Increase
Cardiology	94	165	71	76
Hematology/Oncology	23	52	29	126
Internal Medicine	12	296	284	2,367
Neurosurgery	374	627	253	68
Orthopedics	67	160	93	139
Nutrition	15	67	52	347
Physical Therapy	1	22	21	2,100
Pulmonary Disease	6	43	37	617
Radiation Therapy	6	289	283	4717
Urology	165	519	354	215

David Grant Medical Center (DGMC), Travis AFB, 60th Medical Group (60 MDG) and Veterans Affairs Northern California Health Care System (VANCHCS)

In FY 2015 David Grant Medical Center (DGMC), Travis AFB, 60th Medical Group (60 MDG) and Veterans Affairs Northern California Health Care System (VANCHCS) expanded their robust sharing relationship by including new Hematology and Oncology and Radiation Oncology clinics. These services were made possible by securing funds through the JIF program. Originally they proposed to provide 60 concurrent therapies (patients requiring both radiation and chemo treatments) per year. However, this innovative effort has exceeded its original estimates with 110 concurrent therapies in FY 2014 and is on track to exceed the goal again in FY 2015, as they have provided 58 therapies in the first three quarters of the FY even with a shortage of one physician. This increased case volume augments their readiness platform and provides familiarity with high acuity/complex patients for Air Force med techs and nursing staff as well as saving VA community care dollars and recapturing DoD purchased care services.

Pharmacy Ad Hoc Working Group

The Departments continued to maximize efficiencies through joint efforts when possible. National contracts are at an all-time high with 138 existing contracts, of which 52 were new in FY 2015; there are currently 22 joint contracts pending at the National Acquisition Center (NAC) and 18 pending at DLA. The VA/DoD pharmacy team identified 40 commonly used pharmaceutical products and manufacturers for potential joint contracting action and continued to seek new joint contracting opportunities where practicable. In FY 2015 through the third quarter, VA spent $260 million on joint national contracts, and DoD spent $132 million. In FY 2015 through the third quarter, VA joint national contract prime vendor purchases represented 6.34 percent of total prime vendor purchases; DoD purchases represented 3.8 percent. VA identified 59 new molecular entities used in the ambulatory setting for contracting opportunities. All

59 have been reviewed or are currently under review. DoD performed seven drug-class reviews, comprised of 38 molecular entities, representing $753 million of the total spend with estimated cost avoidance and direct refunds of $124.6 million. One hundred and thirteen joint national contracts expired in FY 2015 and were reviewed for renewal, re-procurement, or termination. One hundred and three of these contracts were renewed, and 10 were resolicited but resulted in a no award.

Credentialing and Privileging Working Group

The Joint Centralized Credentials Quality Assurance System (JCCQAS) is a two-phased project. Phase 1 activities and timelines focus on preparing the current DoD legacy Centralized Credentials Quality Assurance System (CCQAS) as the foundation for JCCQAS. CCQAS upgrades in Phase 1 include conversion of CCQAS software code to a *.NET platform (i.e., current technological standards); moving to Capacity Services (i.e., improve security, availability, scalability; and reduce extended down time potential); bringing CCQAS into compliance with Section 508; and updating the protection of information under the Privacy Act through updating the CCQAS System of Records Notice.

The initial Phase 1 proposal for a joint prototype credentialing solution was approved with FY 2014 Joint Incentive Funds (JIF). As funding permits, Phase 1 will take the current, prioritized list of the 41 approved requirements, high-level user stories and acceptance criteria for JCCQAS, and start development of a prototype that will demonstrate “proof of concept” for the identified joint requirements that must be incorporated into the final JCCQAS product. JCCQAS Phase 1 is on track for completion in September 2016, and the project is within the JIF allocated budget. JCCQAS Phase 2, funded through a second approved JIF proposal in 2015, will focus on the actual IT development, testing, data migration, training and deployment of the VA/DoD joint credentialing system. The conclusion of Phase 2 will be the realization of the joint prototype solution into a production-ready VA/DoD JCCQAS system that is planned for deployment after March 2018. Budget obligations of Phase 2 joint activities will begin in 2016.

At the time the Credentialing and Privileging Working Group was chartered, three subgroups were developed: Business Processes, Policy and Regulation, and Information Technology Assessment. The on-going business and technical work that these three subgroups are engaged in accomplishing is being incorporated into the approved JCCQAS requirements, user stories and acceptance criteria. These three subgroups remain intact and continue to provide expert guidance for each of the policy and business requirements in support of the joint VA/DoD credentialing system. The Business Process subgroup focuses on the business requirements and necessary capabilities through the functional requirements, user stories, and acceptance criteria being designed into the prototype by the software developers. The Policy and Regulation subgroup focuses on regulatory policy of both Departments to identify policies needing to be coordinated in support of a joint credentialing platform. The

Information Technology Assessment subgroup supports the needs and technology requirements of both Departments.

FY 2015 HEC updates for JCCQAS:

- April 3, 2015: update focused on a need for CCQAS technology upgrades and the project schedule to support “proof of concept” and development of JCCQAS.
- July 13, 2015: HEC Co-Chairs request a new aggressive plan of action and milestones with associated costs.
- September 3, 2015: Presented the plan of action and milestones to the HEC Executive Session, which recommended continuing on course, exploring opportunities as available to expedite contracting without increased risk to functionality or quality.

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) 2015 Annual Joint 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 JSP framework for joint coordination and sharing efforts between VA and DoD. The Departments will continue to demonstrate and track progress toward defined goals, objectives, and end-states, and provide the continuum of care needed to successfully meet the needs of Service members and Veterans.

Appendix A – 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 81 11 (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.5 1104), titled "Sharing of Resources with the Department of Veterans Affairs," which incorporates Title 31, United States Code, section 1535 (31 U.S.C. 51 535), 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.l., 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, VA and DoD 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 VA and DoD 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 VA and DoD 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 VA and DoD 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:/lwww1.va.gov/vapubs/. For DoD: DoD Instruction 6010.23, VA and DoD Health Care Resource Sharing Program: http://www.tricare.osd.mil/DVPCOldefault.cfm

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

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

Appendix B – Cost Estimate to Prepare Congressionally-Mandated Report

Title of Report: VA/DoD JEC FY 2014 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	$	21,600
Contract(s) Cost	$	12,100
Production and Printing Cost	$	4,100
Total Estimated Cost to Prepare Report	$	37,800

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 2014 hourly rate structure for the metropolitan Washington, DC area. The calculated net labor costs were multiplied by the fiscal year 2014 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.

Appendix C – Glossary of Abbreviations and Terms

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

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

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

ECHO – Exercise in Communication and Hearing Operation
ED – Department of Education
eDR – Enhanced Document Referral
EES – Employee Education System
EHR – Electronic Health Record
EMS – Emergency Medical System
e-MSM – enhanced Multi-Service Market
EP – End Product
ePER – electronic Patient Event Report
FAAST – Federal Advanced Amputation Skills Training
FCMT – Federal Case Management Tool
FDM – Fully Developed Claim
FHA – Federal Health Architecture
FHCC – Federal Health Care Center
FHP&R – Force Health Protection and Readiness
FISIG – Federal Interdisciplinary Skin Integrity Group
FMWG – Financial Management Working Group
FOC – Full Operating Capability
FRS – Federal Resource Sharing
FTE – Full-Time Equivalents
FTEE – Full Time Employee Equivalents
FY – Fiscal Year
GAO – Government Accountability Office
GME – Graduate Medical Education
HACs – Hospital Acquired Conditions
HAIMS – Healthcare Artifact and Image Management Solution
HARB – Health Architecture Review Board
HCE – Hearing Center of Excellence
HCP – Hearing Conservation Program
HCS – Health Care System
HCWG – Hearing Conservation Work Group
HDI – Health Data Interoperability
HDIMP – Health Data Interoperability Management Plan
HDR – Health Data Repository
hEARoes Tour – large airshows in military dense communities focused on mobile health outreach providing hearing healthcare through music experiences
HEC – Health Executive Committee
HEDIS – Healthcare Effectiveness Data and Information Set
HHS – Department of Health and Human Services
HIE – Health Information Exchange
HIEA – Health Information Exchange Architecture
HIPPA – Health Insurance Portability and Accountability Act
HIT – Health Information Technology
HL7 – Health Level 7
HPE – Health Professions Education
I2F – Intent to File

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

JTTR – Joint Theater Trauma Registry
JV/RS WG – Joint Venture and Resource Sharing Working Group
Lab/AP – Laboratory/Anatomic Pathology
LC – Lead Coordinator
LINAC – Linear Accelerator
LINKS – Linking Information Knowledge and Systems
MAAG – Military Health System Application Access Gateway
MAP-D – Modern Awards Processing Development
MCiS – Military Health System Cyberinfrastructure Services
MCL – Military Crisis Line
MCS – Millennium Cohort Study
MCSC – Managed Care Support Contractor
MDG – Medical Group
MDW – Medical Wing
MEB – Medical Evaluation Board
MEBTO – Military Evaluation Board Tracking Office
MedPDB – Medical Surgical Product Data Bank
MHICS – Mental Health Integration for Chaplain Services
MHS – Military Health System
MHS Learn – Military Health System Learning Portal
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 Material Command
MRWG – Medical Records Working Group (BEC)
MRWG – Medical Research Working Group
MSC – Military Services Coordinator
MSSO – Medical Single Sign-On
mTBI – Mild Traumatic Brain Injury
MTEC – Medical Technology Enterprise Consortium
MTF – Military Treatment Facility
MVAR – Military Vestibular Assessment and Rehabilitation
NAC – National Acquisition Center
NATO – North Atlantic Treaty Organization
NAVFAC – Naval Facilities Engineering Command
NCAT – NeuroCognitive Assessment Tool
NCC – National Capital Consortium
NCC – National Call Center
NCPS – National Center for Patient Safety
NCR – National Capital Region
NCRAR – VA National Center for Rehabilitative Auditory Research
NDAA – National Defense Authorization Act

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

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

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

VHA – Veterans Health Administration
VHCS – Veterans Health Care System
VHI – Veteran's Health Initiative
VISN – Veterans Integrated Service Network
VISTA – Veterans Health Information System Technology Application
VLER – Virtual Lifetime Electronic Record
VONAPP – Veterans Online Application
VOW Act – Veterans Opportunity to Work Act
VR&E – Vocational Rehabilitation and Employment
VSO – Veterans Service Organization
VTA – Veterans Tracking Application
VTA IDES – Veterans Tracking Application for the Integrated Disability Evaluation System
WG – Working Group
WRNMMC – Walter Reed National Military Medical Center