VA/DoD Joint Executive Committee
Annual Report
FISCAL YEAR 2012

VA/DoD
Joint Executive Committee
Membership List

(as of September 30, 2012)

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Department of Veterans Affairs

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Veterans Health Administration

Under Secretary for Benefits
Veterans Benefits Administration

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Department of Veterans Affairs

Executive Director for Public & Intergovernmental Affairs
Department of Veterans Affairs

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VA/DoD Joint Executive Committee
Annual Report
FISCAL YEAR 2012

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Department of Veterans Affairs

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VA/DoD
Joint Executive Committee
Fiscal Year 2012
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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) 2012 Annual Report (AR),* for the period of October 1, 2011, to September 30, 2012, to Congress and the Secretaries of Defense and Veterans Affairs as required by law[1]. The intent of the AR is to provide Congress with the collective accomplishments between the two Departments and highlight the current efforts to improve resource sharing. This report does not contain recommendations for legislation related to health care resource sharing.

The JEC provides senior leadership a forum for collaboration and resource sharing between VA and DoD. By statute, the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness Co-Chair JEC meetings. JEC membership includes the VA/DoD Co-Chairs of the Health Executive Committee (HEC), the Benefits Executive Committee (BEC), the Director of the Interagency Program Office (IPO), and other senior leaders, as designated by each Department.

For the past 5 years, joint VA-DoD priorities were overseen by two different governance bodies, the JEC and the Senior Oversight Committee (SOC).

- The JEC was created by Congressional action in 2003 to increase resource sharing between VA and DoD. The JEC was designed to focus on broad issues affecting all Service members, Veterans, military retirees, and their families.
- The Secretary of Defense formed the SOC in 2007. The purpose of the SOC was to ensure that the recommendations of the various task forces and commissions established to address the issues identified at Walter Reed Army Medical Center were promptly and properly integrated, implemented, coordinated, and resourced.

On January 19, 2012, the JEC Co-Chairs agreed to consolidate the SOC and JEC forums. This decision was based on a recommendation from DoD's Recovering Warrior Task Force. The overarching purpose of the consolidation was to streamline the processes between VA and DoD in order to make more efficient use of time and resources, benefiting Service members, Wounded, Ill, and Injured Warriors, Veterans, and their families.

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

As a result of the consolidation, the subordinate HEC, BEC, IPO, and additional Independent Working Groups (IWG) assumed increased responsibilities in order to maintain the Departments' commitment to collaborative issues, especially those pertaining to Wounded, Ill, and Injured Service members and Veterans. In addition, a specific concern of the task force was ensuring that the new consolidated committee adequately addressed any new and emerging recovering Warrior issues. As a result, the Departments created a Wounded, Ill, and Injured Committee under the JEC to oversee these matters.

Effective October 1, 2012, the JEC Co-Chairs also approved the proposed governance, of a DoD/VA Interagency Care Coordination Committee (IC3) reporting directly to the JEC to collaborate on establishing joint VA/DoD policy guidance, processes, and metrics for the coordination of all case management and care coordination programs within the two Departments related to the delivery of care, benefits, and services to Wounded, Ill, or Injured Service members and Veterans. As part of its mission, the IC3 oversees ongoing efforts to reconcile overlaps between the Federal Recovery Coordination Program (FRCP) and the Recovery Coordination Program (RCP).

The JEC continues to invite other Federal Departments and agencies to meetings as appropriate. In 2012, representatives from the White House, Office of Management and Budget, and the Government Accountability Office (GAO) attended for awareness and information sharing.

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

The *VA/DoD Joint Executive Committee Joint Strategic Plan* (JSP) is the primary means to advance performance between VA and DoD, and is continuously evaluated, updated, and improved. Historically, the JSP has been attached as an appendix to the AR; however, in 2011, the JEC Co-Chairs decided to permanently separate these documents and realign the publication timelines. The intent of this decision was to improve the JSP's ability to drive JEC activities while still allowing the AR to be published by the Congressional deadline.

SECTION 2 - ACCOMPLISHMENTS

This section highlights the FY 2012 accomplishments of the HEC, BEC, IPO, and IWGs. These accomplishments reflect the efforts of VA and DoD in improving resource sharing between the Departments and in furthering the mission to optimize the health and well being of Service members, Veterans, and their eligible beneficiaries. The *VA/DoD Joint Executive Committee (JEC) FY 2012 Annual Report (AR)* links the year's accomplishments to the sub-goals and performance measures established in the *VA/DoD Joint Executive Committee Joint Strategic Plan* (JSP) FY 2011-2013. This approach clarifies the connection between strategic planning and outcomes achieved through VA and DoD's coordination, collaboration, and sharing efforts. The report also demonstrates achievements beyond planned activities.

GOAL 1
Benefits and Services

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

Sub-goal 1.1: Coordinate efforts to improve participation in the Pre-discharge Programs Benefits Delivery at Discharge (BDD)/Quick Start and the VA benefits portion of the Transition Assistance Program (TAP).

BEC Pre-discharge Working Group

The BEC Pre-discharge Working Group (WG) mission is to coordinate efforts to improve the participation rate in the Pre-discharge Program, a joint endeavor between VA and DoD consisting of the BDD and Quick Start programs. The Pre-discharge program affords Service members the opportunity to file VA disability compensation claims up to 180 days before separation, demobilization, deactivation, or retirement from active or full-time duty. This includes Reserve Component and National Guard Service members who meet the criteria for the Pre-discharge Programs. Filing a claim before separation allows a Service member to receive benefits sooner upon discharge, consistent with the statutes and regulations governing VA benefits.

DoD continues to expand BDD and Quick Start information on the TurboTAP Web site (TurboTAP.org). There is now unlimited access to BDD and Quick Start information for all Service members to include demobilization/deactivating National Guard and Reserves. The Veterans Opportunity to Work (VOW) to Hire Heroes Act of 2011, requires VA to provide VA benefits briefings, which includes information on BDD and Quick Start, and DoD to provide pre-separation counseling to all eligible separating or transitioning Service members. Historically, pre-separation counseling is required for all Service members leaving the military. Now, with adding the mandatory counseling for BDD and Quick Start, around 300,000 transitioning Service members received counseling on the BDD and Quick Start programs in FY 2012. DoD also provided BDD and Quick Start program information to over 120 Recovery Care Coordinators that provide non-medical transition support to selected Wounded, Ill, and Injured Service members.

VA continues to maintain its Pre-discharge program Web site and Pre-discharge video as part of the American Veteran Series currently available on the VA Web site. As a result of the Presidential Veterans Employment Initiative Task Force, the Veterans Benefits Administration (VBA) has redesigned the VA Benefits TAP Briefing. The redesign includes an in-depth explanation of the BDD and Quick Start program to include claims filing procedures. Additionally, an online version is being developed in the same style to replace the current version on the eBenefits Web site. Facilitators will be trained to deliver the new class to 100 percent of separating Service members. VBA continues to conduct a monthly conference call, hosting subject matter experts (SME) from the various benefit business lines to provide direct information to VA briefers. These initiatives are needed to achieve the goal of providing the TAP Briefing on VA benefits to 100 percent of transitioning Service members prior to separation.

Additionally, in FY 2012, VBA and the Office of the Secretary of Defense jointly awarded a BDD award to the military intake sites with high participation rates. In FY 2012, as a result of these efforts, 44,267 claims were received at approved VA/DoD BDD intake sites. Of these claims, 29,787 were pre-discharge claims (67.29 percent). For these pre-discharge claims, 16,173 were BDD claims (36.54 percent) and 13,614 were Quick Start claims (30.75 percent). In response to GAO Report 08-901, a BDD and Quick Start Standing Operating Procedure Guide for joint site visits was drafted in March 2011. Due to logistical and resourcing issues in FY 2012, the joint site visits were postponed. A new plan is being developed for implementation during FY 2013. Based on impact on resources and development of the new TAP, additional marketing of BDD and Quick Start has not been developed.

Sub-goal 1.2: Identify and communicate strategic messages and priorities of the JEC.

BEC Communications of Benefits and Services Working Group

The mission of the BEC Communications of Benefits and Services Working Group (CBSWG) is to increase awareness of VA and DoD benefits and services available to Service members throughout their military personnel life cycle. The CBSWG expands communication of VA and DoD benefits and services on military and VA Web sites through continued partnerships within VA and DoD. The CBSWG also functions as a vehicle to assist in the dissemination of new or expanded VA and DoD benefits or services to military members and their beneficiaries.

The CBSWG achieved many beneficial outcomes in FY 2012 through leveraging both VA and DoD communication outlets to share benefits information. This was evidenced by a 92 percent (927,130) increase, as compared to FY 2011, in eBenefits DoD Self-Service (DS) Logon accounts. VA and DoD continue efforts to minimize the number of logons and passwords users must have to access applications and manage their benefits. This has been made easier by increasing access to multiple applications through a single DS Logon. With the increase in DS Logon accounts, the CBSWG was able to provide health, benefits, and personnel information to an increased number of Service members and Veterans. The eBenefits marketing initiative, including print ads and a Web badge, which is an eBenefits logo, were made available on the eBenefits portal, which has allowed for co-branding with state

government Web sites. Marketing initiatives also included Service member and Veteran user personalization features based on gender and Veterans Service Organization (VSO) selection targeted to receive specific information relevant to the individual. Through continual marketing of eBenefits, Service members will learn the value of using the portal throughout their military careers, learn to manage their DoD benefits and, upon separation, and have continuity in accessing their records as a Veteran.

An additional 10 Early Communications Messages were released through the eBenefits portal in FY 2012, bringing the total to over 60 unique messages. The new messages included 7 health, 2 vocational rehabilitation and employment, and 1 education related message. Specifically for education, an early communications message was deployed and will notify Service members of the rules regarding transfer of entitlement of Post 9/11 G.I. Bill benefits prior to discharge.

Between October 2011 and September 2012, CBSWG promoted the awareness and use of the eBenefits site through numerous partnering efforts such as highlighting the site on the Air Force portal, promoting the eBenefits badge on the Department of Labor (DOL) Web site, and ensuring full-time availability of the eBenefits badge and messaging on Army Knowledge Online. These efforts allow for continuous announcements to 2.6 million Army and Army National Guard Service members.

Collaboration with the Social Security Administration (SSA) led to including four separate links to SSA web pages on eBenefits. In addition, an eBenefits link is now posted on the SSA Wounded Warrior Web site under both VA and DoD resources. Thirteen states now have the eBenefits widget or badge on their respective Web sites as a result of a 2012 eBenefits marketing effort with state VSOs. Additional external coverage included an eBenefits feature on the Pentagon Channel, featured articles in the July America Online Government Publication, and VSO magazines to include the Disabled American Veterans and Veterans of Foreign Wars and Vietnam Magazine. eBenefits was also featured in articles and blog postings in the VA publication *Vanguard*, and the VA blog *VAntage Point,* respectively.

During FY 2012, the CBSWG partnered with Duty First Consulting to create eBenefits Public Service Announcements (PSA) recorded with NASCAR drivers Tony Stewart and Ryan Newman. The PSAs are currently posted through VA and DoD social media outlets and as of September 30, 2012, have had over 24,000 airings with over 31,000,000 gross impressions (a gross impression is the number of times a PSA airs combined with the audience figures as defined by the Arbitron rating). The estimated paid media equivalency for the 24,000 plus airings is $1,249,300. Additionally, an eBenefits video PSA was released to the public around Veterans Day 2012.

The CBSWG collaborated with the JEC Strategic Communications Working Group (SCWG) to provide content for the VA/DoD strategic communications direction for FY 2013. Additionally, the CBSWG along with the SCWG is working on an effort to update the DoD/VA Strategic Communications Plan to include reference of sharing links and information between eBenefits and the National Resource Directory (NRD). The CBSWG has also been working with DoD's Personnel Readiness & Information Management to review and include the eBenefits Communications Plan with the Virtual Lifetime Electronic Record (VLER) Communications

Plan. As eBenefits is the designated access point into VLER, this collaboration will ensure that both communication plans are fully coordinated. This is still a work in progress as the teams continue to review and attempt to incorporate all communications plans into a potential joint effort.

To assist with additional benefits messaging, an eBenefits pamphlet was created. Initially, 2 million pamphlets were printed and made available to VA regional offices. VA also provided 140,000 Summary of Benefits Pamphlets to 65 Military Entrance Processing Stations.

The VBA Benefits Assistance Service supported over 72 outreach and advertising activities to ensure that information about new benefits was disseminated to Service members, Veterans, and their families as mandated by law. Several of the events attended included "Rolling Thunder," the Small Business Administration Hiring Fair, and the 2012 National Veterans Wheelchair Games.

eBenefits outreach was included in the four Recovery Coordination Program training events. These were half day events with 30 Federal Agencies to include VA benefits. The eBenefits Web site and NRD were showcased at an individual table for the events. There were quarterly postings of eBenefits on the NRD, Facebook, Twitter, and WarriorCare.mil for news events.

The CBSWG, in collaboration with DoD and the Department of Education (ED), worked to support Executive Order 13607, Establishing Principles of Excellence for Educational Institutions Serving Service Members, Veterans, Spouses, and Other Family Members. The eBenefits portal was updated to facilitate access to school performance information, consumer protection information, and key Federal financial aid documents through the deployment of College Navigator on the eBenefits home page. The CBSWG also implemented several links on eBenefits to ED's Web pages. The eBenefits team launched the Career Center with single sign on access to VAforVets and VetSuccess in June of 2012. The Career Center includes employment self-assessment tools, a resume builder, and a Military Skills Translator that relates military expertise to civilian work skills.

By leveraging the amount of data that is exchanged between VA and DoD, eBenefits can be used as a tool that proactively tailors messages to the Service member throughout their military career lifecycle. This provides them with important benefits and health services information from both agencies in addition to state and local information, thus allowing them to make informed choices about employment, education, housing or any other relevant demographic factors that may impact their decision making process as they transition back to their communities.

Sub-goals 1.3-1.7: Federal Recovery Coordination Program and Recovery Coordination Program

During FY 2012, the Federal Recovery Coordination Program (FRCP) and Recovery Coordination Program (RCP) continued to provide quality care coordination and case management for Wounded, Ill, and Injured Service members and Veterans. The JEC

continued to pursue efforts to reduce redundancies between these and other care coordination programs.

In May 2012, the Departments established the VA-DoD Care Coordination Task Force to provide concrete proposals to ensure collaborative and synchronized delivery of care and services to Wounded, Ill, and Injured Warriors and Veterans. The objectives of the task force were to: create an overarching program which includes DoD and VA programs with common mission, language and concerns around Warrior Care and Coordination; provide concrete recommendations to optimize collaborative and synchronized care and services delivery and information for Wounded, Ill, and Injured Warriors, Veterans and their families; and minimize patients' and families' confusion with numbers of VA and DoD staff who manage and coordinate delivery of care and benefits. The task force proposed a series of immediate, near term and long-term recommendations to correct long-standing gaps and redundancies and to establish a model for the coordination of care for ill and injured Veterans and Service members.

In August 2012, the JEC approved the task force's recommendations. Among the recommendations approved was the implementation of the Lead Coordinator role. One Lead Coordinator, clearly identified to all, will serve as the primary communications link to the patient and family – and ensure warm handoffs. The JEC also approved the recommendation to develop and implement a single, interagency comprehensive plan, to produce a "common operational picture" of the Warrior's status and need and in September 2012, the JEC approved the recommended governance structure, activating the IC3 under the JEC, which was chartered to continue efforts to implement the task force recommendations and coordinate efforts that fall in the "white space" between the HEC and BEC.

GOAL 2
Health Care

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

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

HEC Patient Safety Working Group

In FY 2012, the Patient Safety Working Group (PSWG) continued to enhance the overall quality of care to Service members and Veterans through collaborative efforts in strengthening and coordinating safe patient care. In FY 2011, the PSWG implemented a new process to set expectations for timely sharing of patient safety notifications. In FY 2012, a gap in the process was identified; so, the process was improved and updated. The PSWG continues to monitor and refine the process.

As a result of agency requirements, TRICARE Management Activity (TMA) was required to update its data sharing agreement (DSA) with VA, which authorizes the DoD Patient Safety

program to share data with the VA Patient Safety program. In FY 2012, the PSWG coordinated DSA language with both Departments. In FY 2013, TMA will initiate the formal DSA coordination.

In FY 2012, lessons learned sharing exchanges were maintained despite transitions in Co-Chairs and PSWG membership. The lessons learned sharing exchanges included forums, virtual or in-person, where PSWG members or invited guests offered insights and resources for the purposes of preventing adverse events. These exchanges centered on leveraging existing tools, education and training programs, patient safety information dissemination, medication safety, and leveraging existing resources.

- Leveraging existing tools: VA hosted an on-site learning session on its root cause analysis process at DoD's request to assess functional feasibility of adapting VA's process.
- Sharing education and training programs: VA invited DoD to participate in its abbreviated root cause analysis training; seven members of the DoD team attended. VA and DoD exchanged each Department's patient safety course material.
- Patient safety information dissemination: VA and DoD discussed how information technology patient safety alerts or advisories are shared with the functional patient safety teams. To determine how the safety alerts or advisories are disseminated at joint sites with separate information systems, a call was held with a joint VA/DoD site to determine if areas of opportunities exist to improve or accelerate information transferred.
- Medication safety: VA and DoD medication experts co-presented prescription label literacy research to the DoD Pharmacy Board of Advisors. The research indicated the importance of standardized labeling to assist patients' understanding of their medication.
- Leverage existing resources: VA and DoD held a planning meeting to collaborate on the Department of Health and Human Services' (HHS) Partnerships for Patients' national campaign. Consequently, the PSWG updated its FY 2013-2015 JSP objectives to reflect goals set by the national campaign and identified specific opportunities for joint collaboration.

The PSWG continued pursuing collaborative efforts across Departments' SMEs. In FY 2012, the PSWG increased collaboration by 20 percent over the previous year. Those joint efforts encompassed matters of patient safety software, medication safety, patient falls prevention, technical tool sharing, and education efforts.

- Technical tool sharing: the lead developer of VA's patient safety software tool provided technical expertise to DoD on VA's software to help DoD determine the feasibility of adapting VA's tool.
- Suicide prevention: DoD invited VA's suicide prevention expert to share information on tactics and results of patient safety oriented suicide prevention efforts.
- DoD presented at the May 2012 Medication Use Crisis Virtual Conference; VA and DoD worked together to plan the virtual conference.
- Patient Falls remained a leading cause of preventable harm events in the civilian and military sectors. DoD representatives across the Military Departments attended the VA Annual Falls Conference. DoD participated in VA's quarterly Falls collaborative calls to gain ideas as DoD formulated a standardized approach to limit these adverse events.

HEC Evidence Based Practice Working Group

The Evidence Based Practice Working Group (EBPWG) continued to improve the health of VA and DoD beneficiaries by collaborating in the development of Clinical Practice Guidelines (CPG), using clinical and epidemiological evidence. CPGs assist VA and DoD health care teams by providing evidence based recommendations. This leads to improved quality of clinical decisions, improved consistency of care, and reduced variation and cost in clinical practice for Veterans, Service members, and their families. VA/DoD CPGs are posted on the VA Web site[2] and the Army Quality Management Web site[3]. A robust contract for CPG development was secured in June 2012 that will support target completion of four CPGs annually. Multidisciplinary and collaborative expert groups representing VA and DoD are currently developing a Suicide Prevention CPG with an anticipated completion of December 2012. The EBPWG partners with the DoD Tri-Service WG in the development of electronic health care record Alternative Input Method forms to facilitate implementation and documentation of VA/DoD CPGs at the point of care.

To date, all VA/DoD CPGs have been submitted and met the inclusion criteria by the National Guideline Clearinghouse (NGC). The NGC mission is to provide physicians and other health professionals, health plans, integrated delivery systems, purchasers, and others an accessible mechanism for obtaining objective, detailed information on evidence based CPGs and to further their dissemination, implementation, and use. The EBPWG's commitment to educating health care teams on evidence based clinical practices was accomplished through exhibits and podium presentations. The VA/DoD staff exhibited at 19 VA, DoD, and national medical conferences. Twenty formal podium presentations on a variety of CPGs were completed at VA, DoD, and national health care conferences. These efforts resulted in educating thousands of VA and DoD health care team members regarding the availability of the 23 VA/DoD CPGs, the medical evidence behind the CPG recommendations, and the value of implementation.

Marketing efforts included providing information regarding the process for ordering and shipping CPG tools directly to medical facilities. The tools offer health care teams valuable support materials to assist with CPG implementation and ultimately facilitate improved care delivery for patients and families across the systems. Two CPG broadcasts, Pregnancy and Post-traumatic Stress Disorder (PTSD), were completed and are available on the VA and Army Web sites. Both broadcasts provide continuing medical education credit.

VA and DoD received 868,942 CPG internet requests in FY 2012. The data provided clear evidence that health care teams across VA and DoD are successfully accessing CPG information. During FY 2012, VA/DoD staff produced 44 new CPG tools - an unprecedented accomplishment. Currently, 170 different CPG tools are available to facilitate promotion of evidence based care to beneficiaries. During FY 2012, DoD had 881,411 CPG tools ordered from the Army Web site. This provided ongoing evidence that health care teams across DoD are actively ordering and utilizing tools to assist with implementation of VA/DoD CPGs.

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[2] www.healthquality.va.gov
[3] www.QMO.amedd.army.mil

In addition to the collaboration between VA and DoD, there are specific efforts directed toward external agencies. The EBPWG shares information with national professional organizations to include the Inter-organization Guideline Forum, Agency for Healthcare Research and Quality, Institute of Clinical System Improvement, and Kaiser Permanente. Collaboration continues with the American Pain Society on the development of the Peri-Operative Pain CPG. This collaboration is expected to result in the ability to produce a greater number of CPGs while at the same time conserving valuable personnel and monetary resources.

HEC Health Professions EducationWorking Group

The Health Professions Education (HPE) WG remains committed to educational sharing opportunities between both Departments to improve the access, quality, effectiveness, and efficiency of health care for all Service members, Veterans, and their beneficiaries. The WG focuses on and promotes collaborative HPE and shared trainee programs between VA and DoD. The WG successfully established four HPE trainee exchange programs within academic year (AY) 2011-2012, for a total of six programs since FY 2010.

- Graduate Medical Education (GME) trainee exchange program between Brooke Army Medical Center (BAMC) and South Texas Veterans Health Care System (VHCS) in AY 2009-2010.
- Psychology trainee exchange program between Hampton VA Medical Center (VAMC) and the Naval Medical Center Portsmouth in AY 2010-2011.
- GME trainee exchange program between BAMC and South Texas VHCS in AY 2011-2012.
- Psychology trainee exchange between Lackland Air Force Base and South Texas VHCS (San Antonio) in AY 2011-2012.
- Preventive Medicine trainee exchange program between the Office of Public Health and Environmental Hazards, VA Central Office (Washington, DC) and the National Capital Consortium (NCC) (Bethesda, Maryland) in AY 2011-2012.
- Family Medicine Residency between Womack Army Medical Center and Fayetteville VAMC, established in August 2012, for the AY 2012-2013.

Qualitative interviews were conducted with VA and DoD resident trainees who have had training experiences in both a VA and a DoD medical facility. Appropriate learner's perception survey questions related to VA and DoD trainee experiences are currently in development.

In addition, the HPE WG, through continued collaboration with Air Force, Army, Navy, and VA SMEs, developed and approved two templates for a standardized National VA/DoD Training Affiliation Agreement. One template is for VA trainees training in a DoD Military Treatment Facility, and the other template is for DoD trainees training in a VAMC. These National VA/DoD Training Affiliation Agreement templates will facilitate health professional trainee exchanges. Trainee exchanges have been shown to provide high-quality trainee experiences with a diverse mix of patients and clinical problems.

The impact on quality health care is enhanced through these diverse trainee experiences. The exchanges provide trainees exposure to a variety of patient populations and clinical material not possible in a single institution. For example, civilian trainees see a younger, healthier patient population in DoD, while military trainees see an older population with a heavier chronic disease

burden in VA. Trainees experience a greater holistic experience when they see the continuity of care from Active Duty Service to Veteran status. These exchanges promote trainee awareness and understanding of the capabilities and differing cultural aspects and goals of both health care systems.

The HPE WG continues to assess the challenges and barriers to successful inter-agency cooperation in HPE. To date, the GME programs of the NCC have not been impacted by the Base Realignment and Closure (BRAC) Act. In 2011, the NCC (as the sponsoring institution) received accreditation for 5 years from the Accreditation Council of Graduate Medical Education and remains focused on continuing high quality GME training programs in the National Capital Region.

HEC Deployment Health Working Group (DHWG)

The Deployment Health WG (DHWG) was established to ensure coordination to maintain, protect, and preserve the health of Armed Forces personnel. The DHWG focuses on the health of Active Duty and Reserve Service members and Veterans, during and after combat operations and other deployments. The primary emphasis 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.

In FY 2012, the DHWG facilitated VA and DoD efforts to identify situations in Theater, which could place military personnel and Veterans at potentially significant risk, and to ensure that VA and DoD responses were appropriately coordinated. The DHWG coordinated DoD's identification and responses to major environmental and occupational exposures, DoD's sharing of data with VA, and development of appropriate VA and DoD follow-up activities. The DHWG took concrete steps to improve the sharing of Service member and Veteran health information between the Departments, by developing an interagency Data Transfer Agreement (DTA), as described below. The DHWG facilitated interagency sharing between VA, DoD, and the Military Departments, including the Army Public Health Command, Navy Bureau of Medicine and Surgery, and Air Force Medical Support Agency.

The DHWG organized 12 meetings in FY 2012 to coordinate VA and DoD responses to 5 major environmental exposures in Iraq, Afghanistan, Japan, and the United States, each of which is described below.

- Potential health effects of exposure to burn pit smoke in OEF/OIF/OND.
- Potential health effects of high ambient concentrations of particulate matter in OEF/OIF/OND.
- Potential health effects of chromate exposure at Qarmat Ali, Iraq in 2003.
- Potential health effects of exposure to the radiation release from the damaged Japanese nuclear power plant in 2011.
- Potential health effects of contaminated drinking water at Camp Lejeune, North Carolina.

During the 1950s to 1980s, some of the drinking water at Marine Corps Base Camp Lejeune was contaminated with low levels of industrial chemicals, including trichloroethylene and perchloroethylene. The Navy estimated that approximately 630,000 Marines and Sailors were potentially exposed to this contaminated drinking water, as well as DoD civilians and family

members. In FY 2012, the DHWG held many meetings to coordinate VA and DoD responses to the exposures at Camp Lejeune. The DHWG requested a briefing by epidemiologists from the Agency for Toxic Substances and Disease Registry (ATSDR) in Atlanta. ATSDR is conducting four health studies related to Camp Lejeune, which are funded by the Navy. The DHWG organized meetings of senior scientists from the Navy, Marines, Veterans Health Administration (VHA), and VBA to discuss how to streamline procedures to transfer DoD paper and electronic personnel records to VA related to Camp Lejeune. The DHWG facilitated provision of a DoD personnel database to VA to assist in verifying that Veterans lived at Camp Lejeune during 1978 to 1987.

The DHWG organized a VA/DoD Environmental Exposures Task Force in May 2012 to develop a detailed Joint Action Plan for VA/DoD responses to environmental exposures, in general, and to the drinking water contamination at Camp Lejeune, North Carolina, in particular. In late May, the DHWG Co-Chairs submitted an "Executive Summary on the Joint VA/DoD Approach to Respond to Environmental Exposures" to the JEC, which described six major tasks needed to develop the Action Plan. In June, the DHWG provided an "Executive Decision Memorandum Regarding the Joint DoD/VA Approach to Respond to Environmental Exposures," which provided milestones to develop an overarching Joint Action Plan on environmental exposures. The DHWG Co-Chairs presided over weekly task force meetings for several months, which included representatives from DoD Health Affairs, Navy, United States Marine Corps (USMC), VHA, and VBA. The task force built consensus by bringing experts together with different perspectives to plan the way forward on complex issues related to Camp Lejeune. The task force coordinated with:

- VBA, which performed a review and analysis of almost 1,100 adjudicated disability claims related to Camp Lejeune (both granted claims and denied claims);
- ATSDR on their research on health effects related to Camp Lejeune;
- USMC to determine the availability of personnel and housing records of Marines and family members who lived at Camp Lejeune in 1957 to 1987; and
- USMC General Counsel to plan for increased Marine Corps/VA communications related to Camp Lejeune.

The HEC and JEC approved the overarching Joint Action Plan and the specific plan on Camp Lejeune in August 2012, subject to available funding.

The task force provided guidance in the planning of the "Veterans Health Examination Survey," which will be a VA national survey of Veterans of all eras, and which will include physical examinations and biological sampling. The task force also provided guidance on the planning of the Individual Longitudinal Exposure Record (ILER), which will be a tool that will link Service member deployment locations over their careers with time and location-specific environmental monitoring data to identify possible exposures. This exposure information on individual Service members could be used by health care providers to inform diagnosis and treatment, and by claims adjudicators to establish service connection.

The DHWG developed a DTA, which will provide two-way data exchange between VA and DoD. This improved data exchange will facilitate the identification of deployment-related hazards that could lead to long-term adverse health effects. Recent DHWG actions on environmental exposure issues have reinforced the need for increased sharing of environmental health data between VA and DoD. The DTA is intended to facilitate the exchange of personnel, medical, and

environmental data to enable VA and DoD to make the best clinical care decisions, to establish levels of exposures, and to support the determination of disability benefits. The DHWG worked to identify the full spectrum of data that VHA needs to support quality health care and that VBA needs to support timely determination of benefits, related to environmental exposures. There are numerous stakeholders in both Departments in the data sharing process including program offices, data users, legal and privacy offices, and the Information Management (IM)/Information Technology (IT) offices.

Exposure to smoke from the burn pits in OEF/OIF/OND could potentially impact tens of thousands of deployed Service members. In 2010, VA funded an Institute of Medicine (IOM) study, titled "Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan." DoD provided considerable health outcome and environmental health monitoring data to IOM for this study. This IOM report was published in October 2011, and concluded that there was limited or suggestive evidence of an association between exposure to combustion products and reduced pulmonary function tests. This conclusion was based on studies of fire fighters and municipal incinerator workers, not on studies of Service members exposed to burn pits. The IOM concluded that there was inadequate evidence to draw conclusions on the association of exposure to combustion products and many other types of diseases. The IOM also concluded that the airborne contamination of greatest concern might be the high ambient concentration of particulate matter (such as that associated with blowing and suspended dust) and urban pollutants in OEF/OIF/OND, rather than burn pit emissions. The IOM provided recommendations on future health surveillance and epidemiological research on Service members exposed to burn pits and other airborne hazards.

The DHWG evaluated this IOM report to identify lessons learned related to future health surveillance, research on inhalational hazards in Theater, and possible preventive measures for future deployments. The DHWG coordinated VA and DoD responses to air pollution in Theater throughout FY 2012. DHWG members planned and participated in a full-day VA/DoD workshop in November 2011, titled "Pulmonary Issues Related to Deployment." DHWG members also planned and chaired a 3-day symposium in August 2012, titled "VA/DoD Airborne Hazards Symposium." This symposium focused on potential long-term health effects of exposure to burn pits, high ambient levels of particulate matter, and other airborne hazards; it was attended by more than 100 VA, DoD, and university scientists. The proceedings of this symposium will be published as a monograph, and several DHWG members will author chapters. The DHWG is currently developing a VA/DoD Airborne Hazards Joint Action Plan, which will be completed in late 2012.

The DHWG coordinated outreach efforts to Active Duty Service members and Veterans on environmental exposures and risk communication products to ensure consistency between VA and DoD. In 2003, approximately 900 members of the National Guard and Army Corps of Engineers worked at an industrial plant in Qarmat Ali, Iraq, where they were potentially exposed to sodium dichromate, a carcinogen. The DHWG facilitated VA and DoD coordination of a joint medical surveillance program. VA and DoD sent a joint letter and fact sheet to these military personnel and DoD civilians to invite them to participate in a medical evaluation. As of July 2012, approximately 200 hundred individuals had completed the medical evaluation.

In March 2011, a nuclear power plant in Japan was damaged in an earthquake and tsunami, which caused the release of low levels of radiation for months. The closest U.S. military base is about 150 miles from the power plant. In 2011, DoD collected daily location reports on all 70,000 local United States Service members, as well as their family members and DoD civilians. DoD collected environmental data on air, water, food, and soil. It is noteworthy that DoD started collecting the data on locations of individuals and radiation measurements immediately after the accident, rather than trying to reconstruct the data years later. The radiation measurements indicated that the radiation exposures to DoD personnel were very low, and the risk of long-term health effects is extremely low. DoD developed the Operation Tomodachi Registry, which includes radiation dose reconstructions for potentially affected individuals, performed by the Armed Forces Radiobiology Research Institute. The DHWG coordinated VA/DoD communication related to the Japanese radiation release, including DoD plans to share registry data with VA. VBA staff described the procedures to determine disability claims related to radiation exposures, during a DHWG meeting. In September 2012, DoD launched a public Web site, in collaboration with VA, which featured the results of the dose assessments for locations of each United States military installation on the mainland of Japan. DoD coordinated the key messages for the Web site with VA before launching it. DoD plans to finish dose reconstructions for individuals by the end of 2012, which will be available on request. These registry data will be useful for surveillance, research, diagnosis, treatment, and claims adjudication.

In FY 2012, the DHWG analyzed research literature and government reports on environmental exposures during military service. In response to a request from VA's Deputy Secretary, the DHWG evaluated five scientific reports on the potential health effects of trichloroethylene. DHWG scientists from DoD Health Affairs, the Navy, and VA used their expertise in occupational medicine to develop an analytical framework. They completed a side-by-side comparison of the conclusions of reports by the Environmental Protection Agency (EPA) and the National Academy of Sciences. The DHWG submitted an information paper to the HEC and JEC in November 2011, titled "*Assessment of Policy Implications of an EPA Report on the Health Effects of Trichloroethylene*." This scientific analysis provided evidence for policy recommendations to senior VA and DoD leadership. In particular, the DHWG concluded that the new EPA report did not change the weight of evidence on the potential health effects of trichloroethylene; and it did not influence the current ATSDR studies related to Camp Lejeune. The DHWG also concluded that VA and DoD did not need to change their current policies related to the provision of medical care and disability benefits for Veterans who lived at Camp Lejeune, as a result of the new EPA report.

In summary, the DHWG coordinated VA and DoD actions related to potential health effects of environmental exposures that could impact hundreds of thousands of Veterans in FY 2012, including air pollution from burn pits and particulate matter in OEF/OIF/OND, and drinking water contamination at Camp Lejeune.

HEC Psychological Health/Traumatic Brain Injury Working Group

The Psychological Health (PH)/Traumatic Brain Injury (TBI)WG goal is to increase and sustain communication and collaboration between VA and DoD on issues related to PH and TBI. This includes identification, evaluation, and provision of services for both VA and DoD beneficiaries with PH conditions and TBI. Also covered is the promotion of PH and resilience from the time of enlistment throughout the adult lifespan.

Within the PH/TBI WG purview is the Integrated Mental Health Strategy (IMHS), which was developed to address the growing population of Service members and Veterans with needs related to PH. Mental health care provides unique challenges for the two Departments in that they serve the same population, but at different times in their lives and careers. As such, the IMHS centers on a coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services for Active Duty Service members, National Guard and Reserve members, Veterans, and their families. The IMHS is defined by 28 Strategic Actions (SA) which were approved by the HEC on November 8, 2010, as a 3-year initiative, and fall under the following four strategic goals:

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

Each of the 28 SAs has defined end states by which the success of the activity is determined. SAs were developed with corresponding metrics (some of which are outcome, some are process, depending on the structure of the activities) to be used when the SAs are mature. A VA lead and DoD lead have been designated for each IMHS SA.

Since the WG was rechartered in 2010 to include an expanded focus on TBI, the Co-Chairs have worked closely with each Department's WG TBI leads and additional SMEs to define a strategy for jointly addressing TBI issues in this venue. The PH/TBI WG established a standing TBI sub-WG with leadership from VA and DoD that has the lead on joint efforts to advance TBI care in both Departments.

<u>Common Standard of Care to Support TBI</u>

VA and DoD continued to ensure that all clinicians, from medic/corpsmen to licensed independent providers, receive training in evidence based clinical practices to cover the full spectrum of care. Army Office of the Surgeon General/Rehabilitation and Reintegration Division coordinated multi-service TBI staff to develop a curriculum to teach/train a total of 135 providers at the TBI for Deploying Providers Course, which was held December 2011, February 2012, June 2012, and August 2012. In addition to medics, occupational therapists, physical therapists, psychologists, nurse practitioners, physician assistants and physicians, training also included social workers, registered nurses and U.S. Air Force Independent Medical Technicians. The training included didactics as well as hands on skills stations and trauma training tracks. Navy has a dedicated training program for in-Theater/deployment TBI management including training on the Military Acute Concussion Evaluation, concussion management algorithms, and DoD policy guidance.

In FY 2012, a total of 1,233 Navy personnel were trained, of which 792 were corpsmen and 116 were providers. The USMC continued to incorporate TBI training into multiple venues and schools throughout career progress, as well as annual and pre-deployment training. VA held the New Horizons in Rehabilitation Conference from June 19 to June 21, 2012, with 320 providers in attendance. The conference provided evidence-based education and training that addressed current and emerging health care requirements for Veterans and Service members with rehabilitative needs. Topic areas covered at the conference included telehealth, rural health, geriatrics and long-term care, mental health, pain management issues, and women's health. In addition, VA continued to offer comprehensive training through the Talent Management System (TMS) regarding TBI presentation, symptoms and treatment in Service members and Veterans through the Veteran's Health Initiative course. This course was updated in 2011 with 17,327 providers completing the course from February 2011 to August 2012.

VA and DoD continued to invest heavily in TBI research and actively participate in jointly reviewing each other's research portfolios. Translation of research to clinical practice is a top priority of both Departments given the pressing clinical needs of Service members and Veterans. To date in VA, two large scale implementation trials are relevant. First, VA's screening and evaluation practices were validated and periodic updates regarding further validation efforts are shared with senior leadership and the field. Second, scientific inquiries related to the cost of care for TBI and various comorbidities were recently published and have led to a heightened awareness of resource utilization by Veterans in the immediate period after TBI diagnosis is assigned. The Defense and Veterans Brain Injury Center (DVBIC), which is a component center under the Defense Centers of Excellence for PH and TBI (DCoE), initiated its congressionally mandated 15-year longitudinal study for Service members and Veterans from OEF/OIF/OND as well as their caregivers. This study parallels VA's TBI Model System project for moderate to severe TBI but has a broader scope to include mild TBI (mTBI). DVBIC also initiated the Study for Cognitive Rehabilitation Effectiveness (SCORE!) in San Antonio, Texas. This prospective, randomized, controlled trial of cognitive rehabilitation for OEF/OIF/OND Service members with mTBI and persistent cognitive complaints will test the relative effectiveness of four cognitive rehabilitation approaches.

Outcome metrics for TBI services in each Department's health care system are in different phases of implementation and tracking. VA has partnered with the TBI Model System, funded by the National Institute on Disability and Rehabilitation Research, to implement a longitudinal outcomes project for those Service members and Veterans who are diagnosed with moderate to severe TBI and receive services in the Polytrauma Rehabilitation Centers. This system incorporates initial evaluation, 1 year follow up, annual follow up through the 5th year post-injury, and follow up every 5 years thereafter. At present, VA is exceeding its enrollment goal of 80 percent of admissions at the polytrauma sites for this project. In addition, VA coordinated a national release of the Mayo-Portland Adaptability Inventory-4 Participation Index on August 8, 2012, to ensure outpatient rehabilitation outcome monitoring. A WG including VA and DoD counterparts was convened in July 2012, to crosswalk current outcome measurement approaches for TBI in both systems, and to identify shared metrics for implementation by 2013.

VA and DoD collaborated on the production of 12 Web-based case studies that feature aspects of the VA/DoD CPGs for the Management of Concussion/mTBI (2009) in grand rounds style presentations. These are hosted on the TMS in VA and Military Health Systems (MHS) Learning Portal (MHS Learn) in DoD with one free continuing education credit available upon completion of

each course. Between February 2011, and September 2012, all 12 cases were available on MHS Learn and 8 were available on TMS. As of September 2012, a total of 4,587 participants completed the course through DoD, VA, and civilian portals available through MHS Learn.

Common Standard of Care to Support Psychological Health

Ongoing work to develop consistent and coordinated standards across VA and DoD for training in evidence-based psychotherapies (EBP) for PH conditions is well underway. As part of the IMHS SA on this topic, VA and DoD are working to implement common and coordinated training and increase the availability of effective psychological treatments for PTSD, major depression, and other PH conditions across both Departments. VA and DoD training program staff are working in close collaboration to implement the training and ensure comparable training content and treatment delivery.

- In FY 2012, VA provided training to over 700 staff in the delivery of Cognitive Processing Therapy (CPT) and/or Prolonged Exposure Therapy (PE); 81 percent of these staff are currently in consultation or have successfully completed the competency-based training process. VA added 22 new trainers/consultants to these programs, creating a capacity of over 130 trainers/consultants.
- VA continued and expanded training efforts in Cognitive Behavioral Therapy for Depression (CBT-D), Cognitive Behavioral Therapy for Insomnia (CBT-I), Motivational Interviewing, and other evidence-based psychotherapies. VA provided training in one or more of these therapies to over 900 staff; 99 percent of these staff are currently in consultation or have successfully completed the competency-based training process. These EBP training programs added over 120 additional trainers/consultants in FY 2012, creating a capacity of over 175 trainers/consultants.
- Recently published program evaluation results have shown that the training in and implementation of EBPs in VA resulted in significant, positive training outcomes for therapists and clinical outcomes for patients.
- In FY 2012, DoD provided training in CPT and/or PE to over 800 mental health providers from DoD and community based clinics who provide services to Service members and Veterans. The Center for Deployment Psychology (CDP) added 31 new trainers/consultants to these programs, creating a capacity of 38 consultants.
- DoD continued and expanded training efforts in CBT-I, CBT-D, Cognitive Behavioral Treatment of Chronic Pain, and an evidence-based focused curriculum focused on the assessment and treatment of suicidal ideation and behavior. The CDP provided training in 1 or more of these therapies to over 450 mental health providers and added 4 trainers/consultants, creating a capacity of 5 trainers/consultants.

VA and DoD continued to work together to develop a comprehensive multimedia training for providers that focuses on military culture, signs, and symptoms of deployment-related mental health conditions, and effective methods for the treatment and prevention of mental health conditions through another IMHS SA. The target audiences will include VA and DoD primary care and mental health providers, civilian primary care and mental health providers, and other care providers such as chaplains and case managers. The first module of the curriculum is expected to be available in the first quarter of FY 2013 and will be accessible on the VA TMS and MHS Web site[4].

[4] www.health.mil

Suicide Risk and Prevention Strategies

The joint suicide prevention activities described are elements of one of the IMHS SAs. The most significant addition in FY 2012 was the creation of the Defense Suicide Prevention Office (DSPO) in November 2011. The Secretary of Defense has deemed DSPO as the focal point for all DoD suicide prevention policy, training, and programs. DSPO is the lead agent on implementing the DoD Task Force Report on Suicide Prevention and for collaboration with the Military Departments and VA. This has created another element of collaboration and cooperation in suicide prevention between VA and DoD. A VA suicide SME was detailed to the DSPO for 4 months in FY 2012 to assist in expanding avenues for collaboration between the VA Suicide Prevention Program and DSPO. Additional elements to the integrated strategy will be forthcoming as the organizations examine current strategies, research, and data.

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

The PH/TBI WG established the Suicide Nomenclature and Data WG in FY 2010. In 2011, the Suicide Nomenclature and Data WG recommended the adoption of the Centers for Disease Control and Prevention (CDC) suicide nomenclature in VA and DoD. The implementation of the nomenclature is underway and will include training of all VA clinicians and development of documentation standards and requirements that went into effect in 2012. DoD is piloting the nomenclature in the DoD suicide surveillance program, known as the DoD Suicide Event Report. Recognizing the need for a more comprehensive understanding of suicide prevalence and factors contributing to suicide, the HEC requested development of a single DoD-VA repository to store all suicide-related events for Service members and Veterans. The JEC approved the plan that DSPO and VA outlined. As a key data element in the VA/DoD Suicide Data Repository (SDR), DoD and VA coordinated to jointly purchase Service member and Veteran mortality data from the CDC's National Death Index Plus. In turn, DoD agreed to confirm the military status for CDC so as to reduce reliance on disparate state status reports.

The Military Data and Surveillance Working Group and a Board of Governors (BOG), Co-Chaired by the DSPO and the VA, identify standardized approaches for calculating, tracking, reporting, and utilizing suicide-related data. The BOG and SDR will fill critical gaps in knowledge about Service members, particularly transitional populations and members of the National Guard/Reserve mortality, on issues such as developing decision rules and guidance on the use of suicide-related data for research projects and policy.

In June 2012, the VA/DoD Suicide Prevention Conference (SPC) titled "Back to Basics: Enhancing the Well-Being of our Service Members, Veterans, and their Families," was attended by approximately 1,152 participants (roughly 1/3 VA and 2/3 DoD personnel). This represents a 25 percent increase over attendance in 2011. The 2012 SPC included 3 days of plenary, panel, clinical, practical, and research-based conference sessions intended to strengthen core skills for suicide prevention training. The conference was addressed by three Department Secretaries:

Defense, HHS, and VA, demonstrating a commitment within all three Departments to cooperate and collaborate to address suicide. With nearly 70 sessions offered, the information reflected the diverse range of basic skills necessary for meaningful suicide prevention training in varied settings and for all provider and leadership levels. The conference also serves as a forum to collect feedback on community needs. The SPC is now an internationally recognized annual suicide prevention conference. Individual evaluations from the 2012 conference indicated that SPC attendees reported general satisfaction with the breakout sessions, session speakers, SPC tracks, as well as the overall conference and continuing education unit offerings. While some attendees felt there were too many breakout sessions, others appreciated the range and diversity of conference offerings. With increasing recognition of the need to implement both innovative and practical suicide prevention efforts, the SPC provides an important vehicle to educate and empower the diverse network of stakeholders working to reduce suicide within the military and Veteran community. The joint VA/DoD planning committee for the 2013 conference has been formed and is in the process of developing the conference agenda and obtaining approvals.

In March 2011, the Veterans Suicide Prevention Hotline was renamed the Veterans Crisis Line (VCL) to be more proactive in suicide prevention and reach people before they get to the point of being actively suicidal. An online chat function is also available to enhance the availability of this confidential resource for Veterans, Service members, and their families. The initial message was modified to increase access of the VCL to Service members and their families. In 2012, the Military Crisis Line (MCL) and Military Chat were established, using the same numbers and resources of the VCL, rebranded for Service members. Texting services were also added in FY 2012. The DSPO and VA are working with each Military Department to develop DoD and Service-specific promotional materials, and availability of toll-free calling is being developed for locations outside of the continental United States. Toll-free lines opened in early FY 2012 for 6 European countries and an Asian line is planned for 2013. In FY 2012, there were 193,507 total calls to the VCL, as compared to 164,101 total calls in FY 2011. In FY 2012, there were 45,014 online chats with the VCL, as compared to 18,438 in FY 2011. Since its launch in 2007, the VCL/MCL has received 687,849 calls, 72,787 chats, and 3,800 text messages, and has initiated more than 24,550 rescues of suicidal callers. A rescue occurs when a caller communicates an immediate suicidal intent and the crisis line respondent contacts local emergency services to attend to the caller and ensure his or her safety.

The DoD/VA Suicide Outreach Web site[5] provides suicide prevention resources for Service members, Veterans, their family members, and staff. The Web site was launched in October 2010, and until October 1, 2012, managed by the National Center for Telehealth & Technology. The site is currently transitioning to DSPO management and is in the process of being redesigned and updated with a relaunch scheduled for FY 2013. In FY 2012, the total number of visits to the site was 21,625. There were 9,448 visits to informational resource pages. This metric references individual page visits tapping links to self-assessments and educational information about suicide and warning signs. The Suicide Outreach Web site also generated 530 immediate contacts to the VCL and the DCoE Outreach Center.

[5] www.suicideoutreach.org

HEC Vision Center of Excellence (VCE)

The Vision Center of Excellence (VCE) was established to improve the prevention, diagnosis, mitigation, treatment, research, and rehabilitation of military eye injuries and diseases including visual dysfunction related to TBI for Service members and Veterans. The VCE receives operational support from the Navy within DoD, and from the Office of Patient Care Services within VA. The VCE is jointly staffed, and the current leadership team includes the Executive Director (DoD), Deputy Director (VA), and Executive Officer (Public Health Service).

The VCE operates as a virtual and distributed organization, headquartered at the Walter Reed National Military Medical Center in Bethesda, Maryland, that links together a network of VA and DoD clinical and research centers around the world facilitated by regionally distributed VCE coordination centers. The headquarters opened in the second quarter of FY 2012. The VCE's integrated interagency capability enables programs that cross the continuum from event to clinical intervention to final rehabilitation and reintegration.

The VCE implemented several key initiatives as part of a performance improvement strategy for vision trauma. The VCE established a monthly worldwide ocular trauma video teleconference linking providers from combat Theaters to VA Polytrauma Centers in a case-presentation format to improve ocular trauma care. VCE's vision services care coordination staff provide early identification and support case managers to coordinate vision care services for Active Duty Service members and Veterans requiring referrals, follow-up care, and rehabilitation. The VCE partnered with the Defense Center of Excellence for Psychological Health and TBI to develop clinical recommendations to address the management of visual dysfunction associated with TBI. In addition, the VCE established working groups WGs comprised of VA, DoD, and private sector SMEs, as well as patient and family representatives, to assess technology gaps for Service members and Veterans with visual impairments. A clinical update titled "Focus on Capabilities Not Disabilities – Sports and Recreation for the Visually Impaired Service member and Veteran" was published in the June 2012 issue of *Federal Practitioner*, circulation 35,000. Other VCE accomplishments included:

- Leading an effort to establish the Ocular Trauma Training Course as an interagency program with a future goal of transitioning leadership of the course to the VCE.
- Coordinating with the Committee for Tactical Combat Casualty Care to include eye shield use in the medic (pre-hospital) training programs.
- Leading the effort with Military Health Systems Office of Strategic Communications for the www.health.mil Web site redesign and inclusion of provider portals.
- Coordinating transitions for vision rehabilitation care between VA and DoD for Service members and Veterans.
- Directing a gap analysis for assistive technology for the visually impaired addressing communication, driving, sports and recreation, and mobility.
- Implementing a pilot vision impairment education center for Service members, Veterans and their families at Walter Reed National Military Medical Center, Bethesda.
- Authoring an Army Small Business Innovative Research topic to develop a smartphone-based handheld slit lamp, an instrument used during eye exams, to enhance far-forward telemedical ocular diagnosis by non-ocular providers.
- Partnering with Harvard Medical School/Massachusetts Eye and Ear Infirmary/Schepens Eye Research Institute/United States Army Medical Research and

Materiel Command /Telemedicine & Advanced Technology Research Centerto conduct the fifth biennial Military Vision Symposium on Ocular & Vision Injury.

- Partnering with Smith-Kettelwell Research Institute to conduct a biennial meeting on vision research gaps especially regarding visual dysfunction associated with TBI.
- Hosting a multidisciplinary, Government-Academia WG symposium to create a roadmap for simulation in eye care.
- Initiating a capabilities assessment of vision care capabilities in fixed Military Treatment Facilities and VAMCs.

Since inception, the VCE has been a leader in the analysis of research gaps in the prevention and treatment of eye and vision injury, vision impairment, and blindness, including TBI-related visual dysfunction. Under the aegis of the VCE's Vision Research Portfolio, DoD developed a comprehensive inventory of needed research in blindness, vision impairment, and TBI-related visual neurosensory dysfunctions caused by military trauma. The range of these research topics spans the discovery of better methods of protecting deployed individuals, improved battlefield treatments that will save the sight of the wounded, development of long-term treatments for chronic visual dysfunctions, the need for better surveillance tools for as yet undetected problems, and developing valid approaches to the restoration of sight. The Vision Research Program is an ongoing requirements-based program with 42 current research projects in 17 states and 2 foreign counties focused on translating solutions.

Hearing Center of Excellence (HCE)

The Hearing Center of Excellence (HCE) is a highly effective collaboration among VA and the Military Departments. This joint Federal effort, in a very short time span, is delivering solutions and has identified initiatives to identify value, promote prevention, improve clinical care and transition of care, and coordinate the translation of research, focused on enhancing readiness and improving hearing health and quality of life for Service members and Veterans.

The HCE Concept of Operations was approved on January 10, 2012. A Director was identified through a nominative process and approved by the lead component, Office of the Surgeon General of the Air Force. HCE and VA representatives worked closely to establish cross-Departmental support and funding to include an embedded VA deputy and three other primary positions as approved by the VA Under Secretary for Health to support the HCE. Hiring actions to populate the San Antonio, Texas headquarters staff are ongoing. A memorandum of agreement (MOA) was signed between the Air Force host organization (59th Medical Wing) and the Air Force Medical Operations Agency delineating operational support roles. Contract services and leveraged staff (clinicians, researchers, engineers, administrators) from across VA and DoD conducted operations to deliver mission requirements during the staffing process.

The HCE is organized into five interactive directorates: Informatics, Global Outreach, Prevention, Clinical Care and Rehabilitation, and Research. Each directorate is focused on making a positive difference for Service members and Veterans, specifically with regards to preventing loss, preserving function, and restoring hearing where possible. The HCE executive council met twice and met with the VA field advisory council to develop strategies for integrating Departmental care and sharing resources to the extent practicable.

Information Management

The HCE is concurrently developing the Joint Hearing Loss and Auditory System Injury Registry while exploring existing data warehouse capabilities at the Military Department level to capture clinical audiograms generated at 60 MTFs. The objective is to share data and report diagnoses and clinical treatment to VA in a timely manner. A Defense Information Assurance and Compliance Process is underway that will allow digitized capture of clinical data to facilitate sharing and processing of information. The HCE resourced upgrades to the Defense Occupational and Environmental Health Readiness System for Hearing Conservation (DOEHRS-HC), developed a reporting format optimized for VA disability determination, and inserted the DOEHRS-HC into the enterprise level VA/DoD DSA in progress. Completion of the DSA is expected by summer 2013 and will provide VA with access to DoD audiograms to document service connection to hearing loss upon separation or retirement.

Global Outreach

The objectives of organizing manpower and resources, sharing data, developing best practices and standards, and facilitating collaboration require transparent operations and communication that enhance capability and capacity, reduce duplicity, and impart value to the system. HCE efforts continued to build a strong collaborative environment amongst clinical and research technical experts, between the Departments, and between Centers of Excellence (CoE) and associated academic, industry, and international interests. In February 2012, the HCE launched a Web site[6] that supports a clearing house of clinical and research tools, education, outreach and networking products and opportunities. In addition, the HCE facilitated interactivity between directorates, spoke sites, academic affiliates and sister CoEs through a network of coordinating employees, organization and administration of focused work streams, and support services to establish a hearing health improvement network. The HCE developed ties with national specialty academies and reenergized the Congressional Hearing Health Caucus, supporting two events in 2012. The HCE promoted hearing loss prevention and awareness through print, television and radio media exposure. The HCE leads a North Atlantic Treaty Organization (NATO) research technical group effort to optimize hearing loss prevention, treatment, rehabilitation and reintegration of soldiers with acoustic trauma that includes developing a standardized data collection process for comparison and identification of best practices. Additionally, HCE representatives presented at international scientific forums in Belgium, Germany, Austria, Poland, France, and the United Kingdom.

Prevention

With the primary objective of preventing and mitigating hearing loss and auditory injury, the HCE is in the execution phase of a comprehensive prevention campaign to educate, enhance awareness, and change behaviors detrimental to hearing preservation. HCE members worked with the Defense Safety Oversight Committee's High Noise Source Reduction Initiative to preemptively establish acquisition noise standards or mitigate inventory sources. The HCE organized an Auditory Fitness for Duty WG to expand environmental awareness of job specific exposures and requirements for communications as a roadmap to fitness standards determination and prevention strategies. The HCE worked as a unified team with the DoD Hearing Conservation WG (HCWG) and VA representatives to execute responses to GAO recommendations. The WG also consulted with the Accessions Medical Standards WG

[6] hearing.health.mil

(AMSWG), the Longitudinal Study of Medical Requirements for Wounded, Ill, or Injured Service Members WG, and the Medical Personnel Executive Steering Committee Disability WG related to developing surveillance and auditory testing standards for DoD members that will assist with accession, retention, waiver, and medical board/disability determination. Working together with the DoD HCWG, tinnitus language, and questions were added to and strengthened in the post-deployment survey. Additionally, a collaborative white paper for an aural screening protocol was developed. All Military Departments are now conducting or planning towards capturing baseline audiograms as well as improved hearing protection education. Working with the Army Public Health Command, the HCE developed an engineer position for FY 2013 within Soldier Protective Equipment, Program Executive Office Solider, Ft. Belvoir. This position is envisioned to serve as the earPro program manager, creating a DoD-qualified hearing protection products list and review process. The HCE also participated on the Defense Safety Oversight Committee's High Noise Source reduction initiative, working to mitigate noise production.

Clinical Care

VA and DoD clinical leaders established clear communications through the HCE communications hearing health improvement network. Working together to define resources and identify value and best practices, the HCE developed policy to improve DoD ordering practices for hearing aids and implants. This new policy will allow DoD to leverage VA's ordering system, reducing costs and improving timeliness and continuity of care from DoD to VA systems. The HCE participated with the Recovering Warrior Task Force to improve transition between VA and DoD. With the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, the HCE developed a Primary Care Provider Clinical Practice Guideline for optimized care of the post-blast injury patient. The HCE trained audiologists and other providers through the 2012 Military Vestibular Assessment and Rehabilitation Conference, increasing DoD vestibular assessment and treatment capability and capacity; provided temporal bone surgical dissection simulators to improve education and training of surgeons caring for acoustic injury; and trained DoD otologists in emerging, fully and semi-implantable hearing devices. In FY 2012, the HCE initiated an outcome analysis and value management assessment of current practices related to treatment of asymmetric sensorineural hearing loss in the DoD population. The HCE executive council reviewed capabilities that could extend and augment Theater and isolated site care through telehealth and remote care delivery and purchased pilot testing equipment to develop an implementation plan. The HCE continues dialogue with VA to assess and promote duplicity reduction and resource sharing across the Departments, including exit exams, data sharing, implant center agreements, and telehealth.

Research

To optimally utilize registry and data sharing capabilities, the HCE re-established the DoD Auditory Research WG (ARWG) and expanded its scope to include technical experts across VA and the National Institutes of Health (NIH), to include a Scientific Advisory Board (SAB) capacity for validating internal and external needs. The intent of organizing a transparent and coordinated practice-based research network (PBRN) is to encourage and facilitate research and best practices development. This PBRN utilizes HCE-developed communications platforms and strategies to define capability and determine capacity across the system. Such increased transparency enhances teamwork and focuses productivity through a unity of effort. Through the SAB, the HCE prioritized gaps for the various research-sponsoring organizations in VA, DoD, and NIH. The HCE funded a Research Portfolio Coordinator position to work with portfolio

managers to identify all hearing and balance projects across VA and DoD, to serve as a central coordinator for academic and industry collaboration and to orchestrate best use of limited Federal research funding. A six-person, regionally based HCE research administration team was funded to maintain program focus and build efficiency guiding ARWG investigators through project development, grant awards, institutional review board (IRB) submissions, education, and counseling.

The HCE developed a MOA for a centralized IRB with the United States Army Medical Research and Materiel Command USAMRMC and funded a central DoD IRB portfolio analyst to facilitate multi-site research projects. The HCE worked with the Office of Naval Research (ONR) to coordinate product development translation of three clinical projects. As well as building the PBRN, the HCE organized several work streams through this networked effort. HCE investigators continued work on basic mechanism of blast injury to the brain in model systems, and began to characterize these injuries which will allow for development of improved diagnostic and treatment strategies. The HCE chartered the DoD Auditory Fitness For Duty WG (AFFDWG) to determine auditory standards required for specific military occupations as a joint collaboration effort among the Military Department researchers and clinicians. The expectation is to ensure Service members have appropriate hearing prior to deployment to meet critical mission requirements. This group presented studies to the AMSWG that will tie future accession hearing standards to operational performance. The AFFDWG will continue to advocate for operationally based hearing standards for retention across the Military Departments. The HCE organized the Pharmaceutical Interventions for Hearing Loss WG, which is also a collaborative group of VA, DoD, NIH, academic, and industry interests focused on standardizing the research methods related to pharmaceutical developmental strategies. The August 2012 kick-off meeting was held in conjunction with the ONR Noise Induced Hearing Loss programmatic review for cost efficiency. The HCE organized the Military Operational Medicine sensory breakout session at the Military Health System Research Symposium 2012, and supported a military operational mini-seminar at the annual American Academy of Otolaryngology meeting.

The HCE identified potential value in integrating research efforts with sister DoD CoEs and initiated discussion to develop a roadmap based on a common model. The HCE began a business case analysis to define comorbid injuries, develop integrated gap analysis, and project the value of investigating injury patterns and interventions conjointly as an integrated CoE-led research consortium. This concept, labeled the Allied NueroSensory Warrior Related Research Consortium, held a capacities conference, and meetings with VA, USAMRMC Joint Program Committees, NIH, academia, and industry to analyze integration of currently siloed research. The proposed integrated approach across the DoD CoEs would guide a system-of-systems, holistic approach to research planning.

In summary, the HCE is well organized in concept and function, and continues to develop the hiring actions for continuity staffing. Many HCE efforts and products will add value across the nation to other Federal, state, and local occupationally-exposed, disaster/emergency response, counter-terrorist, and counter-narcotic teams that potentially face similar exposures and injuries. The HCE is positioned to integrate resources and programs providing a collaborative milieu that will support operational readiness and positively impact Service members' and Veterans' health and quality of life.

Sub-goal 2.2: Access – Facilitate improved availability and access to health care 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 any barriers to care and health care utilization.

HEC Psychological Health/Traumatic Brain Injury Working Group

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

Following the comprehensive revision of the Pre-Deployment Health Assessment, Post-Deployment Health Assessment (PDHA), and Post-Deployment Health Reassessment (PDHRA) in FY 2011, DoD moved toward implementing the revised forms in FY 2012. At the end of FY 2012, the Department documented that 79 percent[7] of those who responded affirmatively to the TBI Risk Assessment during the PDHA were referred for further evaluation and received an evaluation by a provider within 60 days of PDHA certification date. This is important as a history of TBI is a risk factor for subsequent brain injury, psychiatric disorder, suicide, headaches, cognitive problems, and other negative health outcomes. DoD continued to integrate training strategies on the PDHA/PDHRA and appropriate TBI coding for clinical providers throughout the Military Departments to facilitate consistent follow-up after TBI. VA continued to screen all Veterans from the OEF/OIF/OND cohort who receive services at VHA at their entry to the VA health care system. Through August 2012, VA screened 644,023 Veterans from OEF/OIF/OND for TBI with a resultant 127,901 positive screens. The length of time to complete the comprehensive evaluation from the time of the initial positive screen averaged about 22 days, well below the 30 day target.

The Directive Type Memorandum 09-033, "Policy Guidance for Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting," was replaced by the Department of Defense Instruction (DoDI) 6490.11, signed September 18, 2012. The mandate of this enduring policy is to ensure Service members involved in potentially concussive events in the deployed setting will be screened and treated promptly for concussion. The policy seeks to prevent long-term problems associated with concussions by providing treatment earlier and reducing the possibility that Service members could be exposed to further injury. The DoDI also identifies specific reporting requirements so that Service members who have been exposed to potentially concussive events are identified and tracked. From October 1, 2011 through September 30, 2012, a total of 3,601 Service member exposures to potentially concussive events were reported to the Combined Information Data Network Exchange/Blast Exposure and Concussion Incident Report event-triggered system. Among these, 3,012 had identifiable medical records and were evaluated for concussion, resulting in 541 identified concussions. The initial identification of a concussion is provisional, pending confirmation by a comprehensive medical record review.

[7] FY 2012 numbers lag reporting by approximately 120 days due to variability in Service member PDHA completion dates after return from deployment and Military Department submission of the certified PDHA.

The Army Training Network records show that from October 1, 2011, to September 30, 2012, a total of 247,476 TBI trainings were completed. Service members completed training in the basics of TBI (154,861), leaders and commanders completed TBI education (39,077), and health care providers completed more advanced training in care for TBI (25,298). Specific training for health care providers targeted non-primary care providers (8,081), primary care providers (4,972), and combat medics (8,182). An additional 4,874 Service members completed supplemental TBI trainings also during this period.

In addition, VA and DoD continued to raise awareness in the general public about the signs and symptoms of TBI and how to access resources. VA Rehabilitation and Prosthetics Services released the Polytrauma Awareness Campaign in October 2011. The campaign utilizes Web sites, public service announcements, print advertisements, and other media to highlight the rehabilitation services available through VA for individuals with TBI and provides education on the signs, symptoms, and available treatments. Since January 2012, the Web site has had 110,195 visitors, and the documentary associated with the campaign received the Gold ADDY award from the American Advertising Foundation in March 2012. Further, DVBIC distributed 764,500 TBI educational tools and pamphlets from January to September 2012, mainly through requests to www.DVBIC.org and info@dvbic.org. DVBIC.org, Brainline.org, and BrainlineMilitary.org are Web sites that provide information and education on TBI and resources, including a TBI online course for civilian providers. The DVBIC Regional Education Coordinator network delivered over 392 presentations, briefs, and trainings to over 69,000 people including Active Duty, National Guard, Reserves, Veterans, family members, civilians, and providers.

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

There have been a number of efforts in FY 2012 to improve access to and reduce the stigma associated with seeking mental health care in both VA and DoD. They include a variety of approaches that focus on facilitating connections with available services, providing services outside of traditional specialty mental health care settings, utilizing technological approaches to reduce barriers to care, and engaging in national efforts to reduce the stigma associated with mental health problems and seeking mental health care.

Facilitating Connections with Care

The *inTransition* program is a program to assist Service members requiring behavioral health treatment and who are transitioning between health care systems, status, or location. *inTransition's* mission is to support continuity of care for the Service member during transition. A transition coach provides support and guidance on psychological health concerns, resources, and healthy living, while motivating and assisting the Service member to connect with a treatment provider post-transition. VA and DoD developed and provided joint training to promote referrals from VA and DoD providers to the *inTransition* program. This program is also one of the Integrated Mental Health Strategy Strategic Actions.

Since the program began, there have been a total of 2,499 coaching cases through August 2012. Service members were asked to complete a voluntary satisfaction survey at the end of the program and in January 2012, DoD issued an Interactive Customer Evaluation (ICE) satisfaction survey for this program. Of the 43 ICE satisfaction surveys completed by a Service member from January 2012 through August 2012, 100 percent of responders reported being satisfied with their

experience and 100 percent of responders reported they would recommend this program to others. Data collected from nine providers who returned a provider ICE survey, with the same date range as above, indicated that 89 percent reported overall satisfaction with the program and 88 percent would recommend the program to others.

Providing Care in Alternative Settings

Integrating mental health care into primary care settings is a critical element of improving access to and reducing stigma associated with seeking mental health care. Through the IMHS, considerable work is underway to develop consistent models of care, and a VA/DoD WG was established to address common issues related to integrating behavioral health care into primary care programs. Funds to hire new behavioral health personnel in the DoD Patient-Centered Medical Home (PCMH) were released to the Military Departments in February 2012. Sixty-eight new personnel have been hired, and 74 personnel, including existing providers who were already in place, have received phase one (a three and a half day initial training) of a three phased training approach to work in primary care. DoD reviewed process and outcome metrics to evaluate the impact of behavioral health services and is in the process of formalizing research design/methods and timeline to collect data. A draft DoDI, which will set minimum clinical, administrative, and operational standards for behavioral health services in the PCMH, is working through coordination and is expected to be published in FY 2013. Work has started on creating distinct Tri-Service work flow forms for use by behavioral health providers in primary care as part of the DoD electronic health record. Consistent, discrete data fields are expected to improve efficient and effective evidence-based service delivery and data collection.

VA's Primary Care-Mental Health Integration Programs combine co-located collaborative care and care management components to support primary care providers within the Patient Aligned Care Teams in treating common mental health conditions within the primary care setting. Expansion of the scope of these activities continues, as does support of regional-based training of integrated mental health staff. As of the third quarter of FY 2012, 299 (85 percent) of the 351 VA Medical Centers and Community-Based Outpatient Clinics (CBOC) classified as large and very large have integrated behavioral health programs, and 6 percent of all primary care patients at these sites were directly served by the program.

National Efforts to Reduce Mental Health Stigma

VA and DoD have launched successful national public awareness campaigns aimed at reducing the stigma associated with mental health concerns and seeking treatment. The two campaigns, VA's "Make the Connection" and DoD's "Real Warriors Campaign," are described below. While they are separate campaigns designed to target their audiences somewhat differently, they are complementary to one another, and there is ongoing coordination between the teams working on both campaigns.

During FY 2012, VA launched *Make the Connection*[8], a national public awareness campaign to connect Veterans and their families with information about mental health resources and to help them discover ways to live more fulfilling lives. Testimonials from Veterans of all eras, genders, and backgrounds are at the heart of the campaign. The campaign goals are to: reduce the stigma Veterans and their families associate with seeking mental health services; educate

[8] Maketheconnection.net

Veterans and their families about the signs and symptoms of mental health issues; increase awareness of and trust in VA's advances in mental health services and its commitment to delivering accessible, high quality, patient-centered care; and promote help-seeking behavior for those who need care. The campaign has achieved many successes since November 2011:

- There were over 1.4 million Web site visits.
- *Make the Connection's* videos have been viewed over 3 million times and over 4,900 viewers are subscribed to the campaign's YouTube channel.
- Launched June 2012, the campaign's Facebook page[9] is the fastest growing Facebook account in the government/military sphere to date with over 890,000 fans in just over three months and 10 percent of fans commenting on, sharing, or liking posts on a weekly basis – 5 times greater than the average rate of engagement for similar pages. In addition, the Facebook page has achieved more than 1 billion total impressions[10] from organic, viral, and paid advertisements.
- The campaign's PSA, *Veterans' Voices*, was ranked by Nielsen in the top two percent of all PSAs distributed and achieved over 130 million impressions for a media value of over $2 million.
- The campaign's paid media, which included online, television, radio, and print, achieved over 2 billion impressions.
- The campaign garnered over 30 awards from many notable organizations and associations including the Association of Marketing and Communication Professionals, the Service Industry Advertising Awards, the Telly Awards, American Psychological Association, Interactive Media Awards, and the National Association of Government Communicators.
- The American Legion and the White House blogged about the campaign and it was referenced in congressional testimony multiple times since its launch.
- Collaborating with the Entertainment Industries Council, Inc., the campaign developed *Picture This: Veteran Mental Health Challenges and Solutions*. This guide was written with input from mental health experts, Veterans, advocates, policymakers, the entertainment industry, and many others who are committed to honoring the service of Veterans and helping them overcome challenges. *Picture This* will help writers, actors, producers, and others create authentic depictions of Veterans facing and overcoming mental health challenges. It includes background data on America's Veterans and explains terminology on symptoms, conditions, and treatment options. Detailed information on mental health topics is accompanied by candid and unscripted accounts of Veterans and their family members who faced difficult life events and experiences, reached out for support, and found resources for getting their lives back on track.
- The campaign filmed over 226 Veterans, in 13 locations nationwide, for a total of 264 live videos (over 15 hours of video content) on the Web site. These candid, powerful stories of Veterans' strength and resilience are the centerpiece of the campaign.

DoD's Real Warriors Campaign[11] is a multimedia public awareness campaign launched by DoD to encourage help-seeking behavior among Service members, Veterans, and their families coping with psychological health concerns and to promote awareness and use of available resources.

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[9] www.facebook.com/VeteransMTC

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

[11] Realwarriors.net

The campaign is an integral part of DoD's overall effort to eliminate stigma and encourage Service members and families to seek appropriate care and support for mental health concerns.

To reach the broadest audience possible, the campaign features a variety of strategies including event outreach and partnership engagement, print materials development and dissemination, media outreach, an interactive Web site, and social media engagement. The campaign features stories of real Service members who reached out for psychological support or care with successful outcomes, including learning coping skills, maintaining their security clearance, and continuing to succeed in their military or civilian careers. There were 228,417 Web site visits to the Real Warriors Campaign Web site in FY 2012. This reflects a 38 percent increase over the 165,149 Web site visits in FY 2011. Additional FY 2012 accomplishments for the Real Warriors Campaign as of September 15, 2012 include:

- Garnered 88,692 interactions (i.e., likes, comments, shares, re-tweets) via social media channels and potentially reached nearly 1.1 million unique Facebook users and 10,170 Twitter followers through more than 3,300 campaign messages promoting campaign content and directing warriors and their families to actionable resources. On average in FY 2012, online audiences engaged with the campaign 246 times every day, a 607 percent increase in engagement from FY 2011.
- Completed a pilot 10-week crowdsourcing[12] effort to solicit responses to stigma and behavioral health related questions. This effort resulted in posting 110 crowdsourcing questions on the Real Warriors Campaign's Facebook and Twitter channels, which resulted in 2,389 responses from Facebook and Twitter users, including Service members, members of the National Guard and Reserves, Veterans, military spouses, providers, and the public at large.
- Produced one video profile highlighting the story of U.S. Navy Chaplain Steve Dundas, four PSAs (29-second and 59-second versions of the *Leadership* and *Caregivers* PSAs), four video clips for the Military Health System conference (introducing medical, leadership, peers, and family topics), sound bites and videos for Suicide Prevention Awareness Month, and 25 podcast episodes.
- Through video and radio PSAs on Armed Forces Radio and Television Service, the campaign continued to reach international military audiences. In FY 2012, campaign video PSAs aired 69,008 times and radio PSAs aired 68,880 times, reaching more than 2 million Service members in 177 countries each week, including Iraq and Afghanistan. A total of 19 video and radio PSAs aired on 6 TV and radio military stations or networks in FY 2012, potentially reaching an estimated 2 million individuals. Two radio PSAs aired 26,065 times on 269 civilian channels, reaching an estimated 27 million listeners. A total of 3 audio news releases (ANR) were produced, featuring Service member profiles. A total of 7,020 stations and networks aired the ANRs 8,294 times, garnering an estimated 29 million impressions.
- The campaign confirmed 25 partners in FY 2012 for a cumulative 200 campaign partners (DoD, Federal, national, and community groups) to offer the most relevant and updated resources to members of the military community and spread campaign communications and information to our target audience worldwide.

[12] In the context of communications, crowdsourcing is defined as soliciting input or feedback through communications channels to support innovation and improvement of a campaign, initiative or other outreach effort.

- The campaign potentially reached more than 8 million Service members, Veterans, and military families through 214 campaign articles in partners' blogs, newsletters, and publications since its launch.
- The Real Warriors Campaign won seven industry awards in FY 2012, including awards honoring the campaign as an integrated campaign, and recognizing its achievements for its mobile site, video products, Web site, and social media channels.

Technological Innovations to Reduce Barriers to Care
There are a range of strategies being utilized in both VA and DoD to leverage technology in ways that will reduce barriers to care and educate and empower Service members, Veterans, and their families. These innovations provide increased access to information online, the ability to complete screening and self-assessments, and ready access to information and assistance via mobile tools.

AfterDeployment.org is a multifaceted Web-based application providing information and self-help resources for Service members, Veterans, their families, and health care providers. The site features educational libraries, self-assessments, interactive exercises, personal story videos, community forums, resource lists, a provider locator, links to social media, polls, daily quotes, and health tips on common post-deployment adjustment issues (e.g., stress, depression, etc.). The Provider Pro section of the site features information specifically for health care providers working with the military community. In FY 2012, the total number of visits to AfterDeployment.org is 80,254. Through FY 2012, of the site's 18 modules, the top 5 most frequently visited were: PTSD, Families & Friendships, Sleep, Depression, and Anger.

The Military Pathways® Web site[13] was established to assist Service members and their families who are facing various mental health challenges. It includes Web-based, anonymous, and voluntary self-assessments and screening for common mental health issues and suicide prevention materials. Service members, Veterans, and family members can answer questions on a variety of problems including PTSD, depression, anxiety, and alcohol problems, and receive feedback when further evaluation is needed, as well as guidance on where to seek assistance. In FY 2012, there were 294,361 visits to the Military Pathways® Web site, a 79 percent increase over the 164,628 visits in FY 2011; this far exceeded the goal of a 10 percent increase. Compared to 36,998 completed screenings in FY 2011, there were 43,888 screenings completed in FY 2012, an 18 percent increase. PTSD screenings accounted for 30 percent of total screenings in FY 2012, a 9 percent increase over FY 2011. Since the availability of online screenings is Military Pathway's primary purpose, the "conversion rate," defined as the number of visitors to the Web site who *complete a screening,* is a more accurate measure of the program's effectiveness than the number of Web site visits. Typical conversion rates for most Web sites are between 1 percent and 3 percent. In FY 2012, Military Pathway's conversion rate was 14.1 percent; the 8 percent decrease from the FY 2011 conversion rate of 22.5 percent is attributed to the increase in other engaging resources that have been added to the Web site.

The principal objectives in developing the Web-based application MilitaryKidsConnect.org was to provide online support to children of military families. MilitaryKidsConnect.org is the first comprehensive Web application designed to help military children of all ages affected by deployment. The site features content for three age groups: children, tweens, and teens. Users

[13] www.militarymentalhealth.org

visit an age-appropriate homepage to find interactive maps, a personal scrapbook application, age-appropriate games, videos of military kids describing how they cope with deployment, instructional vignettes, and moderated social networking message boards for tweens and teens (parent approval required for registration). The site also provides content for parents and educators, including tips on how adults can use the content to encourage positive conversations about deployment with children, information on common behavioral responses to deployment by age group, and a primer on military life for educators working outside the military community.

As part of the IMHS, VA and DoD are collaborating on additional self-help Web-based resources that allow for anonymous, self-paced, 24 hour access that can be used by Service members and Veterans on their own or in conjunction with medical treatment. In FY 2012, the Departments collaborated on developing the StartMovingForward.org Web site. *Moving Forward* is an educational, life-coaching program for individuals who are having problems but are not yet in need of or willing to engage in mental health treatment. The program is based on the principles of Problem Solving Therapy, an evidenced-based cognitive behavioral treatment for depression and other distress. The *Moving Forward* Web course uses highly interactive, multi-media presentations to teach problem-solving skills through text, videos, exercises and games. The Web site will officially launch in FY 2013.

In addition to innovative Web-based approaches, VA and DoD are leveraging mobile applications (apps) for smartphones and tablet computers to enhance access to mental health information and care for Veterans and Service members. For example, VA and DoD jointly launched the PTSD Coach smartphone application in April 2011. At of the end of FY 2012, the PTSD Coach app was downloaded in 68 countries. PTSD Coach helps users track their PTSD symptoms, links them with public and personalized sources of support, provides accurate information about PTSD, and teaches helpful strategies for managing PTSD symptoms. PTSD Coach won two awards in FY 2012: the Chairman's Award for Advancements in Accessibility from the Federal Communications Commission and the President's Innovation Award from the American Telemedicine Association.

PE Coach, another joint VA/DoD mobile app, guides and facilitates evidence-based PE treatment for PTSD. The app is designed to be installed onto a patient's personal phone and brought into therapy sessions, used during and between treatment sessions. The app includes the ability to audio record the therapy session (as required by the treatment protocol) directly onto the patient's phone, removing the typical logistical challenges associated with audio recording in the past. The app also delivers text-based psychoeducational handouts as multimedia experiences; provides all patient homework in a digital format; utilizes an interactive breathing retraining tool to improve learning and rehearsal of the PE relaxation skill; provides clinicians with the ability to review compliance with PE protocol homework based on patient's actual use of the various components of the PE Coach app; integrates phone calendar functionality with the PE Coach app to increase the likelihood of patient recall and attendance of PE therapy sessions; tracks a patient's self-reported symptoms and subjective distress over time; and display outcomes for convenient review of progress.

VA/DoD, in collaboration with the National Child Traumatic Stress Network, launched a Psychological First Aid (PFA) app in August, 2012 called PFA Mobile. PFA Mobile is a mobile phone app for mental health providers and other response workers who provide PFA shortly after

disasters and emergencies to affected children, families, and adults, as part of an organized response effort. Materials in this app are adapted from the PFA Field Operations Guide (2nd Edition), which was created by the National Child Traumatic Stress Network and the National Center for PTSD. The guide has been used for successful disaster response around the world over the past 6 years. World-leading experts and trainers participated in the design of the app, focusing on the actual implementation challenges faced by first responders. The app provides reminders of PFA fundamentals to strengthen providers' knowledge of the guiding principles of PFA, and to connect this information with readily accessible examples and intervention suggestions. The app additionally allows providers to self-screen for readiness to respond, record needs of survivors, guides survivors to appropriate PFA actions, and engages with local resources.

In addition to these joint VA/DoD efforts, DoD has developed several other apps to enhance the psychological health of the military community. DoD's T2 Mood Tracker is a mobile application that allows users to self-monitor, track, and reference their emotional experience over a period of days, weeks, and months using a visual analogue rating scale. Users can self-monitor emotional experiences associated with common deployment-related behavioral health issues like PTSD, life stress, depression, and anxiety. Self-monitoring results can be a self-help tool or they can be shared with a therapist or health care professional, providing a record of the patient's emotional experience over a selected time frame.

DoD's Breathe2Relax application is a portable diaphragmatic breathing exercise instructor. Breathe2Relax can be used as a stand-alone stress reduction tool or in tandem with clinical care directed by a health care worker. Breathe2Relax uses state-of-the-art graphics, animation, narration, and videos to deliver a sophisticated, immersive experience for the user.

DoD's Tactical Breather provides a simple, guided, four-count audio/video diaphragmatic breathing practice. The app also includes an overview of the physiology of stress and the effects of diaphragmatic breathing as well as a tutorial on diaphragmatic breathing. Tactical Breather can be used as an always available, standalone stress reducer and to augment face-to-face care with health care professionals.

Two DoD apps based on clinical practice guidelines, the mTBI Pocket Guide app and the Co-occurring Conditions Toolkit app, give health care providers instant access to comprehensive quick-reference guides on improving care for mTBI patients. Designed to reflect current clinical standards of care, military and civilian physicians, physician assistants, nurse practitioners, and related treatment and therapy providers can use the application to find information on assessing, treating, and managing common symptoms of mTBI and its co-occurring conditions.

DoD's LifeArmor is a mobile app consisting of 17 modules mirroring much of the content on AfterDeployment.org. This app educates Service members and concerned significant others about specific topic areas, allows for self-assessment for particular issues using validated measures, provides normalization and modeling from others who have struggled with similar issues, and assists users in locating necessary/desired care related to the topic area.

DoD's Positive Activity Jackpot uses augmented reality technology to combine a phone's global positioning system and camera to find nearby enjoyable activities or pleasant diversions. This app

leverages key components of Pleasant Event Scheduling, an evidence-based treatment for depression. While this app does not require clinical training to use, it should not be used as a substitute for treatment by a therapist.

The launch date, number of FY 2012 downloads, and total number of downloads since the launch are as follows:

Application	Launch Date	FY2012 Downloads	Total Downloads
PTSD Coach	4/11	50,619	76,532
T2MoodTracker	9/10	34,165	60,405
Breathe2Relax	3/11	74,630	99,730
mTBI Pocket Guide	5/11	9,395	10,250
Tactical Breather	6/11	11,152	12,192
Co-Occurring Conditions Toolkit	12/11	2,967	2,967
LifeArmor	2/12	3,473	3,473
Positive Activity Jackpot	3/12	946	946
PE Coach	3/12	5,417	5,417
PFA Mobile	8/12	1,292	1,292

HEC Pain Management Working Group (PMWG)

During FY 2012, the Pain Management Working Group (PMWG) continued to develop strategies and processes to ensure eligible beneficiaries receive the highest standards of pain care, delivered seamlessly across both health care systems. This includes the development of education and training programs for clinicians and beneficiaries, and the development of a pain data registry that will assure the development and dissemination of outcomes-driven, evidence-based pain management and continuous quality improvement for use within the VHA and DoD. In addition, the PMWG is developing standardized assessment and treatment guidelines for use in a stepped care pain management model throughout both systems.

Standardizing Pain Measurement

The use of a common tool across VHA and DoD for the assessment of pain is both appropriate and desirable. The Army Pain Management Task Force May 2010 report called for a standardized pain assessment tool to provide a common set of pain measurement questions and visual cues. The most commonly used tool to measure pain in both VHA and DoD facilities is an 11-point, 0-10 Visual Analog Scale (VAS). Although this scale is broadly used, even in the civilian

community, many health care providers have negative feelings about the usefulness of VAS Pain Scale. They find the scale to be inconsistently administered, feel it is very subjective and without functional anchors, and feel numerical assessments (0-10) recorded in patient medical records are not very helpful indicators of the severity and negative impact of pain and of clinical progress when treating pain. The new tool would have the following capabilities:

- A validated tool, able to measure pain intensity, mood, stress, biopsychosocial impact, and functional impact.
- Objective and useful in evaluating treatment effectiveness.
- Practical and adaptable to multiple clinical settings and scenarios throughout the continuum of care (e.g., battlefield, combat support hospital, primary care, medical center, and pain medicine specialty services).
- Easily adapted and integrated into VHA and DoD computer medical databases.
- Standardized into all levels of medical training across all roles of care (e.g., useful for the medic, the ward nurse, the primary care provider, the pain researcher, and the pain management specialist).
- Consistent with current validated pain research tools.

In early 2011, the PMWG endorsed pursuing a more in-depth analysis of an alternative pain assessment tool known as the Defense and Veterans Pain Rating Scale (DVPRS). During FY 2012, development of this tool was completed by the Defense and Veterans Center for Integrative Pain Management (DVCIPM), and DoD launched the DVPRS validation study. This was the first attempt by a major medical system to develop a new pain scale and to standardize the way we measure pain throughout the military care continuum. The first validation study of the DVPRS was completed, using a sample of 350 Active Duty or retired military Service members, and a manuscript describing the study and its results has been accepted for publication in *Pain Medicine*. Additional validation studies of Service members and Veterans in various settings are underway. If the results support the course of action, the DVPRS will be recommended as the common VHA and DoD pain assessment tool. Pain management has been identified as a key marker of quality health care. Standardization of how patients are queried about their pain will provide VHA and DoD a tremendous advantage in evaluating the longitudinal course and treatment outcomes of our patients and in developing effective pain treatment strategies.

<u>The Pain Assessment and Outcome Registry (PASTOR)</u>

During FY 2012, the PMWG continued to collaborate with the DVCIPM on further development and deployment of the PASTOR, which was launched as a demonstration project as part of the Chronic Pain Impact Network between Walter Reed National Military Medical Center, Madigan Army Medical Center (AMC), and the University of Washington in collaboration with the NIH Patient Reported Outcomes Measurement Information Systems project. PASTOR is a patient self-reported, Internet based information system designed to support primary care physicians and pain specialists. Efficient for both patient and provider, the system generates information that can assist the provider in enhancing care by increasing awareness of real or potential pain-related health problems. Questions within the system explore substance abuse issues, mental health, and pain therapy effectiveness to name just a few. PASTOR will also be the key resource for pain management outcomes data for both VHA and DoD. PASTOR is also being designed to work with and complement the PCMH.

The PCMH and the Stepped Care Model of Pain Management

To ensure a patient's care needs are coordinated and/or integrated across the entire health care system as well as the patient's community, the PMWG fully endorses the PCMH concept. In the PCMH model, the primary care provider leads a team of health care professionals who collectively take responsibility for the ongoing care of the patient. The team is supported by access to specialty services in a collaborative care model to assure the continuum of expert care, at the level of expertise needed by the patient, from the onset of pain through recovery to a meaningful, quality life in a person's community. VA and DoD have adopted a single model of care, the Stepped Care Model to accomplish this continuum of care in the large populations we serve. In this model, the Primary Care Team (Patient Aligned Care Team in the VHA) is responsible for either personally providing care for the patient, or for appropriately arranging treatment by other qualified health care professionals. The PCMH facilitates education of both the patient and his/her family on the etiology and management of acute and chronic pain, which may reduce the likelihood of disability, addresses the under-treatment of pain, and provides individual tailoring of treatment plans. During FY 2012, DoD received formal recognition by the National Committee for Quality Assurance for 47 of its PCMH clinics. Both VHA and DoD have developed models to integrate pain teams within their PCMHs to improve access to pain management services and to improve the quality of care provided to their beneficiaries. The PMWG has a sub-WG to continue to explore additional ways to further integrate pain management treatment and education for providers and beneficiaries into the PCMH model. This sub-WG reports its findings monthly to the PMWG to ensure full integration with other ongoing efforts. Education efforts to help establish this model are described below.

Pain Management Education and Pain Medicine Training

According to the IOM Report *Pain in America* many health care professionals have little or no training in pain management and are unable to effectively respond to the pain care needs of their patients. Pain management receives very little attention in the curricula of many U.S. medical schools and residencies (Lippe P et al, *Pain Medicine* 2010; 11(10):1447-1468) and in other health professions schools. In fact, health care professional programs at most major medical educational and training sites do not include a dedicated pain management curriculum. The lack of a consistent approach to pain management education results in considerable variation in pain management understanding and practice within all medical professions. In July 2012, the PMWG provider and patient education subgroup worked with DoD to post an interactive, Web-based video to the Internet to help educate VHA and DoD providers about risk factors, risk stratification, and mitigation strategies for medication misuse. To encourage providers to participate, continuing education credits are offered for successful completion of this online course. Throughout FY 2012, VHA, in collaboration with DoD, engaged in developing an educational curriculum which will be made available for providers in both Departments through the VHA's Specialty Care Access Networks-Extension for Community Healthcare Outcomes (SCAN-ECHO) ™ program. This curriculum includes instructional videos on how to perform physical examinations to assess various types of pain, along with PowerPoint presentations discussing a variety of pain topics to include medication management. The presentations are based upon the most current medical evidence and have been peer reviewed by experts in the field of pain management.

In an effort to improve pain management education provided to clinicians in training, the NIH designated 11 professional schools as Centers of Excellence in Pain Education (CoEPE) in June, 2012. The institutions selected were: University of Washington, Seattle; the University of Pennsylvania School of Nursing and Perelman School of Medicine, Philadelphia; Southern Illinois University, Edwardsville; the University of Rochester, New York; the University of New Mexico, Albuquerque; the Harvard School of Dental Medicine, Boston; the University of Alabama at Birmingham; the Thomas Jefferson University School of Medicine, Philadelphia; the University of California, San Francisco; the University of Maryland, Baltimore; and the University of Pittsburgh. In addition, many of the new CoEPEs will build curricula across several of their health professional schools. These new centers will enhance provider training by utilizing findings from the most current pain management research to enable clinicians across multiple specialties to partner with their patients in making better and safer choices about pain treatment. A key goal of these new CoEPEs will be to help prevent adverse outcomes by designing curricula that promote appropriate screening and management of chronic pain patients, to include education about the risks of opioid and other prescription drug abuse. The PMWG began collaborating with Dr. David Thomas from the National Institute on Drug Abuse, NIH Pain Consortium on the CoEPE, to incorporate relevant components of this educational initiative at the Uniformed Services University of the Health Sciences and within VHA and DoD training initiatives.

The subgroup will continue to work with VHA and DoD on their SCAN-ECHO™ projects. Providing access to specialty care for patients with complex chronic diseases, such as chronic pain, who reside in areas that are relatively inaccessible to or remote from critical specialized services is challenging for both Departments. The ECHO™ program, which was pioneered at the University of New Mexico, employs an “academic detailing” intervention using video technology. The program offers local providers the opportunity to co-manage difficult and complex patients, while simultaneously affording them with the training and technical skills that, over time, allows them to become highly skilled in the treatment of these chronic and complex diseases. Ultimately, this creates a center of excellence in their own community, and diminishes the need to obtain specialty evaluations in these remote areas. ECHO™ has demonstrated lower costs and improved outcomes in the treatment of chronic diseases such as Hepatitis C. VHA adopted the ECHO™ model, and since 2011 has been transforming their Specialty Care Services program by developing SCAN-ECHO™, so that all Veterans, even those distant from medical centers, will have access to specialty level care for chronic disease management when needed. Presently, seven regional VHA centers host SCAN-ECHO™ videoconferencing training in pain management. During FY 2012 DoD began adapting the ECHO™ program to provide pain management services in remote sites and smaller Military Treatment Facilities. A pilot project is currently under development at the Walter Reed National Military Medical Center.

A DCoE joint task force developed tools that will help clinicians practically implement the DoD/VA Chronic Opioid Therapy Clinical Practice Guideline in the clinics and at the bedside. There will be print ready documents available on the Internet, as well as hard copies that will be available from U.S. Army Medical Command for DoD and from the Employee Education System and My Healthe*V*et for VA. The toolkit contains a laminated card for providers (pocket card) and some patient education tools.

Patient Education

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

VHA's Office of Health Information's "Clinic in Hand" initiative is currently in the final stages of development of a smart phone mobile pain app that will support patients and care partners in chronic pain self-management. Importantly, the mobile pain app will interface with VHA's Computerized Patient Record System, providing a unique opportunity to integrate patient-reported information on their pain experience, behavioral goals, and goal accomplishment into their Electronic Health Record (EHR). Building from this success, the project group is now funded for the development of a clinician facing clinical decision support tool. The tool is being designed to integrate patient-reported information entered from their smart phone with information from the EHR in support of promoting patient-centered, goal driven, and empirically informed pain care for Veterans and, eventually, military personnel.

Complementary and Alternative Medicine

The Stepped Care Model advocates for personalized integrated pain management that incorporates self-management and clinical team interventions that can reduce dependency on medications and procedures and improve outcomes. To enhance the capability of front line health care clinicians in managing pain before resorting to medications and procedures, the Acupuncture sub-WG developed recommendations for a tiered set of credentialing standards for different levels of providers and different types of acupuncture that can be used safely throughout VHA and DoD.

Transitions in Pain Care

To assure smooth and effective transitions in pain care from DoD to VHA, the PMWG established a sub-WG on VA/DoD Pain Care Transitions for Returning Combat Veterans. This sub-WG, Co-Chaired by leaders from Warrior Transition Units in the military and leaders of the Post-Deployment Program in VHA, met intensively throughout 2012 to systematically identify potential gaps in care and to make recommendations for optimizing the continuum of pain care as military personnel transition from DoD to VHA. They completed their analysis in September 2012, resulting in nine recommendations with action plans. The sub-WG will continue meeting to implement action plans and will report progress monthly at the PMWG.

Sub-goal 2.3: Value – Encourage substantive improvement for patient-focused, high-value care, which includes assuring 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 Interagency Clinical Informatics Board

The Interagency Clinical Informatics Board (ICIB)serves as the primary source of input from clinical stakeholders in recommending priorities for enhancing information sharing in support of

the care delivery process for common beneficiaries of VA and DoD. The ICIB received a new and updated charter from the HEC in February 2012. The charter expanded the ICIB's role in providing input to the new integrated Electronic Health Record (iEHR) and VLER programs. The scope of the ICIB was broadened to ensure that clinical input from practicing health care providers is received for iEHR, VLER, and other health IT programs across their full development and implementation life cycle. Given the fast-moving or "agile" schedule of the iEHR program, the focus of the ICIB was redirected almost entirely toward these new programs.

By the end of the second quarter of FY 2012, interagency business requirements documentation in the form of a Business Requirements Specification and Business Requirements Document (BRD) for both TRICARE Encounter Data (TED) and family health information was developed in advance of projected milestone dates. This marked 100 percent completion for 3 FY 2011-2013 JSP activities.

Requirements for the iEHR are currently being refined. Data from legacy systems Standard Inpatient Data Records and TED will likely be subsumed under the iEHR capability titled "document management" which requires that the system be able to retrieve and display clinical information from a variety of legacy systems. The family health information legacy system will likely be subsumed by the "personal health record" capability of the iEHR. Similarly, clinical registry capabilities have been identified as a functional capability of the iEHR as well. Lastly, the approach to common clinical quality measures was recently documented in the Enterprise-Level Clinical Quality Requirements for the iEHR program and endorsed by the ICIB. These quality measurement attributes are designed to draw upon recommendations widely endorsed at national levels including Healthcare Effectiveness Data and Information Set and EHR Meaningful Use measures.

As the Departments continued support of the iEHR initiative in FY 2012, the ICIB established six new WGs, known as Capability-Integrated Project Teams (C-IPT), to analyze the interagency capabilities and support the requirements definition process. The ICIB formally activated C-IPTs for User Experience (UX) in December 2011, Patient Identity Management (PIDM) in April 2012, Access Control (AC) in April 2012, Laboratory/Anatomic Pathology (Lab/AP) in April 2012, Orders Service in August 2012, and clinical decision support in August 2012. These iEHR C-IPTs brought together SMEs from all three Military Departments, TRICARE Management Activity, and VA to perform business architecture, requirements development, and business process re-engineering activities to produce Business Justification Packages (BJP) for the iEHR capabilities. This serves as a blueprint to help make decisions regarding selection of Commercial off-the-shelf products versus custom development. Components of BJPs include the following documents:

- Integrated Business Requirements Document (iBRD) – A compilation of the business needs, owner requirement, functional requirements, non-functional requirements, and Health Level Seven standards.
- Integrated Information Model Report – Describes and provides a listing and locations of all associated information models created by the C-IPT.
- Integrated Business Process Reengineering (iBPR) – A checklist that documents business process re-engineering efforts, decisions, and recommendations.
- Integrated Process Model Report – Describes and provides a listing and locations of all associated business process models created by the C-IPT.

The ICIB completed the review and endorsement of six iEHR BJPs during FY 2012 with three of those capabilities' requirements being approved by the HEC. The Joint Immunization Capability (JIC) C-IPT completed its BJP and attained HEC approval in June 2012. This BJP led to completion of a Request for Information to industry. Additionally, the efforts from the first iEHR capability, Pharmacy, which received HEC approval in November 2011, led to a DoD/VA IPO-hosted Industry Day which attracted 47 vendors. Furthermore, four other C-IPTs (UX, PIDM, Lab/AP, and AC) completed BJPs for governance review.

The Business Process Group (BPG) and the Functional Capabilities Group (FCG) were stood up as sub-WGs under the ICIB in January 2012. The BPG and FCG scope statements were formalized in May 2012. Primary responsibilities for the BPG are to define business processes and manage the C-IPT Management Plan (MP) and the FCG manages the C–IPTs. The FCG worked with the BPG to accurately capture and document the C-IPT processes, and the C-IPT approach was solidified in the original C-IPT MP version 1.0. C-IPT MP v1.0 was developed utilizing the lessons learned from the FY 2011 C-IPTs, Pharmacy and JIC, to provide a standardized process that will guide each capability through the development lifecycle and meet the needs of both VA and DoD functional end-users. This methodology is continuously improved for the C-IPTs and BJP artifacts. During FY 2012, BPG sub-WGs revised the C-IPT MP v1.0 from lessons learned and published v2.0 and v2.5 to guide subsequent C-IPTs. Requirements and architectural products from the C-IPTs will help both VA and DoD leadership assess and select the best iEHR IT solution that meets the needs of both Departments.

The ICIB also approved the Integrated Program Level Requirements (iPLR) in June 2012, which defined 718 high level iEHR requirements providing the initial requirements baseline for the iEHR program. These interagency requirements were derived from a mapping of 5,978 requirements from the integrated Business Requirements Model (iBRM) and HL7 EHR System Functional Model Release 1. The iPLR was approved by the HEC in July 2012 and provided input to the overall iEHR costing effort. In addition to the iPLR, the ICIB and the FCG were critical in the IPO Capstone Document review and development process creating foundational documents for the iEHR program. The FCG developed the iEHR Business Need Statement which helped define the business need, metrics, and justification of the iEHR program as a whole. These Capstone Documents received Milestone Decision Approval for the iEHR program to enter Milestone B for Increment 1 and Milestone A for increment 2 as of August 29, 2012. This approval moved forward the effort to reach Initial Operating Capability (IOC) in FY 2014. The ICIB worked with the IPO to define IOC, culminating in approval by the HEC in September 2012. IOC will deliver new clinical functionality to include Laboratory, Immunization, and Presentation Layer to two interagency sites located in Hampton Roads, Virginia and San Antonio, Texas.

HEC Vision Center of Excellence

During the second quarter of FY 2012, the VCE deployed the Defense Veterans Eye Injury and Vision Registry (DVEIVR) pilot and began refining business processes for the data abstraction within DVEIVR. The Registry, a collaborative effort between VA and DoD, is a centralized repository of ocular clinical and related data from Service members and Veterans with vision trauma and disorders. DVEIVR will provide consolidation of eye injury and vision loss data acquired from VA and DoD systems, enabling predictive and longitudinal outcome analyses to promote best practices in vision care as well as guidance for current and future research.

DVEIVR will be the first registry to combine VA and DoD clinical ocular information into a single system for longitudinal analyses and assessing outcomes. Other significant FY 2012 accomplishments in the development of DVEIVR included:

- Implementing the social security number reduction directive and the deployment of two maintenance releases containing business process refinements identified by the functional community.
- Renewing Authority to Operate on August 21, 2012, and updating and finalizing Memoranda of Understanding for the various databases used by DVEIVR.
- Establishing the interface between the VA Eye Injury Data Store and the DVEIVR pilot.
- Facilitating collaboration within the ocular community of interest to define the functional requirements of a joint VA/DoD electronic eye note for the iEHR.

Sub-goal 2.4: Satisfaction – Promote measurable, safe, effective, timely, efficient and equitable, client-centered quality health care for all Service members, Veterans, and their beneficiaries.

HEC Extremity Injuries and Amputation Center of Excellence

The Extremity Injuries 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 our Service members and Veterans. The EACE provides bi-directional information sharing and enhances coordination, collaboration, and integration between VA and DoD networks. In FY 2012, outstanding collaboration between VA and DoD continued to improve rehabilitation techniques, prosthetic and orthotic technology, coordination of care, quality of life, and satisfaction for Service members and Veterans with amputations.

During FY 2012, there were 199 Service members who suffered limb loss, 78 of whom lost multiple limbs, bringing the 10 year total for OEF/OIFOND to 1,560 Service members who have suffered a major amputation. Of those, 482 have lost 2 or more limbs, including 5 Service members who lost all 4 extremities. The vast majority of the acute care and initial rehabilitation has occurred within the DoD Advanced Rehabilitation Centers (ARC), which continue to provide rehabilitative techniques and advanced prosthetic technologies that facilitate maximum functional outcomes. Of the 1,560 amputees, 320 have been voluntarily retained on active status following their amputation and 55 have redeployed to a combat Theater of Operations. This is a very positive indicator of the high-quality, patient-centered care, and rehabilitation services received by our injured Service members.

As of September 30, 2012, more than 1,170 combat-injured Service members from OEF/OIF/OND who sustained major limb amputations have transitioned to Veteran status, joining more than 40,000 Veterans with amputations (over 12,000 service-connected) already receiving care in VA. A FY 2012 VA Office of Inspector General (OIG) report, "Prosthetic Limb Care in the VA," reported that Veterans with amputations and extremity trauma are a complex population with a variety of medical conditions requiring more health care services than non-amputees. Despite the greater needs of this population, the majority of the OEF/OIF/OND Veterans interviewed by OIG were

satisfied with their care and considered their life “full.” This also is a positive indicator of the services provided.

VA, DoD, and the EACE promulgated several outstanding initiatives in FY 2012 to meet the goal of promoting measurable, safe, effective, timely, efficient, and equitable, patient-centered quality health care for all Service members, Veterans, and their beneficiaries. These are highlighted below:

- DoD, along with VA, developed and/or implemented several new orthotic and prosthetic technologies, which in FY 2012 were available for Service members and Veterans. The Intrepid Dynamic Exoskeletal Orthosis brace, developed at the Center for the Intrepid (CFI), demonstrated significant promise in the treatment of catastrophic extremity injuries by reducing the number of patients seeking delayed amputations by half. For those with a lower extremity amputation, new advances in prosthetic technology such as the Genium, X-2, the Power Knee and the BiOM powered ankle, provided by VA and DoD, significantly improved function. Service members and Veterans reported better quality of life and a significant decrease in pain with their use.
- The Service Member Transitional Advanced Rehabilitation (STAR) pilot program was launched for recovering Service members and Veterans with amputations and other serious injuries who are not yet ready to live independently. The STAR program provides 10 residential beds for post-acute rehabilitation services, while focusing on community reintegration, vocational rehabilitation services, and job placement.
- VA achieved the Commission on Accreditation of Rehabilitation Facilities (CARF) amputation specialty accreditation in 15 of its 22 Regional Amputation Centers (RAC) or Polytrauma Amputation Network (PAN) facilities. Only 42 health care facilities nationwide hold this specialty accreditation. VA will continue to pursue the CARF amputation specialty accreditation for the remaining facilities by 2014.
- Telehealth offers a way to provide expert specialty care to the patient as close to his or her home as possible. VA continued to increase its capabilities to provide this service with more than 1,181 telehealth amputee clinic visits occurring through September 30, 2012. Expansion of these clinics from all RAC and PAN sites will occur through 2013, offering more interdisciplinary and coordinated expert specialty care to the patient closer to their home.
- VA continued to develop the Veterans Tracking Application (VTA) to ensure that Service members transitioning to VA receive the amputation care and follow up they need. Amputation Regional Coordinators within each RAC and PAN use the information from the VTA to contact and address any needs of the transitioning Service member before his or her arrival to the VA facility.
- Education was a significant initiative in FY 2012. VA produced two national conferences supported by DoD speakers and attendees. *NewHorizons,* conducted in June, brought together several hundred providers covering the vast range of comorbidities associated with the amputee population. A second conference held in August addressed the rehabilitation of upper limb amputees, which account for nearly 20 percent of the OEF/OIF/OND amputees. In addition, VA produced several Web-based courses for providers on amputation care, seating systems, and other topics related to this population of patients.

VA and DoD continued to work collaboratively on research efforts aimed at saving injured extremities, avoiding amputations, and preserving and restoring function of injured extremities. The EACE has taken the lead in establishing an embedded clinician-researcher personnel infrastructure across the three DoD ARCs to execute a multi-site, clinically-relevant, DoD intramural research program. Twenty percent of the embedded clinical researchers were hired during this reporting period and their efforts will greatly improve clinically-relevant research for Wounded Warriors who have suffered amputations and extremity trauma. In FY 2012, the EACE met its goal of three ongoing collaborative research protocols between extremity trauma VA/DoD patient care centers. These are highlighted below:

- Collaborative development of a VA/DoD Collaboration Guidebook for Healthcare Research, published online, and summarized in a publication in *Military Medicine*[14].
- Tampa and Manhattan VAMCs and CFI: Successful completion of the DEKA Arm Optimization Study. This success led to two VA-funded collaborative efforts: a DEKA arm home study is ongoing at the Tampa and Manhattan VAMCs and CFI, and a CFI-based study to assess upper extremity functional activity kinematics[15].
- Collaborative discussions are ongoing between DoD sites and Salt Lake City VAMC to facilitate a clinical trial of osseointegration, defined as "the formation of a direct interface between an implant and bone, without intervening soft tissue." The study is projected to begin at the Salt Lake City VAMC in 2013 and could potentially include DoD facilities as early as 2014.

During FY 2012, EACE ARC research activities led to 22 platform and podium presentations at national and international conferences exceeding the FY 2011-2013 JSP goal of 15 annual presentations. These activities also led to 16 new research projects and 29 publications in peer-reviewed journals.

The EACE engaged in several clinically relevant protocol activities during FY 2012. In the first activity, EACE researchers in the CFI spearheaded an effort to establish and publish reliable, valid, and relevant science-based metrics for clinical use within the CAREN systems worldwide. There are currently 16 facilities worldwide utilizing the CAREN for clinical care, with 3 of these systems located within the EACE ARC sites. To date, the CFI has published 7 manuscripts related to CAREN treatment, 4 of which were during FY 2012.

The second activity targeted review of current CPGs to ensure they are current and relevant and promoting development of new CPGs to fill "gaps" in care. Following a determination of need for an Upper Extremity CPG, the EACE was approved in FY 2012 to begin the development of a CPG for Rehabilitation of the Upper Extremity Amputee. VA and DoD have amassed an unprecedented amount of experience, expertise, and research in the care of the upper extremity

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[14] https://cdmrp.org/files/forms/generic/va-dod-guidebook-research-collaboration.pdf Resnik L, Reiber G, Evans RK, Steager P, Barnabe K. New guidebook to facilitate VA/DoD collaborations in health care research. *Military Medicine*, 2011 Oct; 176(10):1085-7

[15] VA Study to Optimize the DEKA Arm. PI Linda Resnik, CFI Site PI Lisa Smurr, OT (Completed); VA DEKA Arm Home Study PI Linda Resnik, CFI Site PI Lisa Smurr, OT (Began July 2012) and Upper Limb Kinematics during Functional Activities: Impact of Prosthetic Use. PI Linda Resnik, CFI Site PI Lisa Smurr, Gait Lab Deanna Gates, Jason Wilken (Study Ongoing)

and multi-limb amputee over the past decade of conflict. Having this CPG will culminate in an enhanced standard of care, accelerated research translation into clinical practice, and ultimately into improved health, quality of life, and satisfaction for this population of patients.

The EACE participated in meetings with VA, DoD, and TRICARE representatives to develop recommendations regarding Vascularized Composite Allograft /Limb Transplant. The EACE will continue to represent the needs of the Service member and Veteran with limb amputation in any future development of limb transplant activities within VA and DoD.

The EACE sought to develop and manage data and information reported through DoD and VA health care systems to support improved treatment strategies, mitigation of long-term disability, and EACE research efforts. The EACE Amputation Registry Database is currently used to maintain the consistency of data and reports, entering data, generating reports, monitoring utilization of data, and verifying and controlling access limits, as determined by role-based permissions. A crucial initiative for the EACE is to define and quantify the major demographic, socioeconomic, and co-morbid characteristics of VA and DoD beneficiaries affected by traumatic extremity injury and amputation. The key to achieving this goal is to establish a “federated” registry/repository of patient information. The VCE is working toward a pilot of this concept which may provide the necessary “back-end” enterprise capability. A functional working group of VA and DoD SMEs was established by the EACE to identify crucial “front-end” data elements which would integrate data and information from many existing or developing data sources and outcome tools. These existing data systems include the Joint Theater Trauma Registry, Military Orthopaedic Trauma Registry, the VA Amputation System of Care Outcome Repository, and other clinical and non-clinical data sources. Through these linkages, the federated registry will identify individuals, demographics, and practices to enable study of the variations and effectiveness of acute care, rehabilitation care, prosthetic technology and services, incidence of complications, mitigation of secondary disabilities, patient outcomes, and quality of life.

Although the VA OIG report released in FY 2012 reported on satisfaction and quality of life of OEF/OIF/OND Veterans with amputations, work continues on development of criteria to assess satisfaction and functional outcomes. The Polytrauma Quality Enhancement Research Initiatives awarded funding to a research team from both VA Health Sciences Research & Development and the Amputation System of Care to review outcome measures for Veterans with amputations and determine the most appropriate outcome measures for utilization in the development of the Amputation System of Care data repository. This work included outcome measures specific for individuals with amputations and outcome measures focused on prosthetic usability and prosthetic satisfaction.

In support of its global outreach mission, the EACE participated in several international collaborative efforts on amputee care. Leadership from the EACE and the ARCs participated in international efforts to meet the clinical needs of defense forces worldwide through involvement in NATO Research and Technology Organization (RTO) efforts. The RTO is the single focus in NATO for defense research and technology activities, with a mission to conduct and promote cooperative research and information exchange. In FY 2012, the EACE participated in three Human Factors Medicine initiatives to support this NATO effort. Additionally, the EACE participated in a European Command sponsored conference in Tbilisi, Republic of Georgia (RoG). The visit objective was to develop a plan to establish an amputee care system for the RoG, who

have experienced a significant number of amputation injuries while fighting in Afghanistan. The U.S. European Command is also publishing a guideline for this effort, based on significant input from the EACE. The EACE continues to assess DoD clinical capacity and provide critical guidance to the Office of the Assistant Secretary of Defense for Health Affairs regarding medical regulation of Secretarial Designee patients to the ARCs.

There has been an enormous amount of progress in the past year with the many successful research and outreach efforts, as well as provision of outstanding clinical care and superior technology for our amputee patients. The EACE will continue to focus on providing unsurpassed clinical care and advanced technology in the coming year, as well as developing the Upper Extremity CPG, the EACE registry, conducting studies on the DEKA arm and other research imperatives, filling the embedded researcher positions in the ARCs, and exploring opportunities for collaboration with both the public and private sector. Although the total number of Service members and Veterans with amputations and catastrophic extremity injuries continues to increase, the collaborative efforts of VA, DoD, and the EACE will ensure the finest clinical expertise is readily available to this population.

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-goals 3.1 and 3.2: Jointly refine the improved IDES process, and jointly expand the improved IDES process to new locations, as directed.

BEC Disability Evaluation System (DES) Working Group

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

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

Since November 26, 2007, DoD enrolled 62,763 Service members in the IDES. A total of 29,254 Service members completed IDES by returning to duty or by being discharged or retired from service and receiving a VA benefits decision and 2,586 were removed for other

reasons (e.g., additional medical treatment, administrative discharge). At the end of FY 2012, 30,923 Service members remained enrolled in the IDES.

Active Component Service members who completed the IDES in September 2012 by returning to duty or by being discharged or retired from service and receiving a VA benefits decision averaged 364 days from IDES entry. This 364-day average is 23 percent slower than the IDES goal of 295 days established for Active Component Service members, but includes an average of 77 days of transition time during which Service members out-process their installation and take voluntary, pre-separation leave and permissive travel. Reserve Component and National Guard Service members who completed the IDES averaged 344 days from entry to a VA benefits decision, which is 13 percent slower than the IDES goal of 305 days. Overall, IDES was 36 percent faster in FY 2012 than the 540-day benchmark for the pre-IDES DoD and VA disability evaluation processes. At the end of FY 2012, 26 percent of Service members (Active and Reserve combined) met the overall timeliness goal. IDES also reduced the post-separation gap between military pay and receipt of VA disability benefits from 240 to an average of 50 days at the end of FY 2012.

The Departments collaborate closely on efforts to jointly refine and improve the IDES. In FY 2012, major efforts in this area included:

- The Military Departments increased IDES staff levels in FY 2012. DoD added authorizations for over 800 case managers, administrative assistants, and lawyers over the next 4 FYs to improve case processing timeliness and customer service. Additionally, each of the Services is increasing efforts to hire and retain physicians as well as behavioral and mental health professionals.

- In June 2012, VA released version 2.0 of the VTA. Originally VA and DoD developed and used VTA to track cases though the IDES. This version incorporated operational reports that improved IDES case oversight capabilities. Additionally, DoD developed and fielded a Medical Evaluation Board Watchboard and a Physical Evaluation Board Watchboard that enable installation-level visibility of case duration and data errors. This added capability will assist installations in proactively managing their cases.

- In April 2012, the Secretary of Defense and Secretary of Veterans Affairs directed their Departments to implement a paperless, searchable claims file for the IDES. The Departments created an electronic case file transfer capability for IDES cases as an interim step towards that objective. The Departments initiated a pilot test of that capability at 11 locations in September 2012. Based on conclusions discovered by the pilot, the Departments will decide whether to field the electronic case file transfer capability in FY 2013.

- Surveys of over 18,000 Service members in the DES from 2009 – 2011 showed that IDES participants were more satisfied with their overall experience and fairness of the process than participants in the legacy DES (pre-IDES) process. DoD is improving IDES customer satisfaction surveys and methodology to ensure better coverage and to provide more actionable results.

- A DoD IDES Task Force, comprised of senior leaders from the Department, conducted an end-to-end business process review of the IDES and, as of the end of September 2012, is preparing recommendations for additional improvements for the Secretary of Defense.

Sub-goal 3.3: Oversee the entire life-cycle of the paper military service treatment record (STR).

BEC Medical Records Working Group (MRWG)

The BEC Medical Records Working Group (MRWG) was established to oversee the entire lifecycle of the paper military STR, with an emphasis on ensuring accurate and complete STR related information for all Service members, in all components, is available to VA and DoD designated benefits adjudicators. In FY 2012, the MRWG concentrated its energy on enhancing and improving collaborative efforts in managing paper records in support of improving Veterans' disability claims processing.

In FY 2012, the Military Departments continued to reduce the amount of loose (documentation sent separately from the transfer of the official STR) and late flowing medical documentation to the VA Records Management Center. This metric is important because loose and late flowing documentation creates delays in claims processing for VA and can result in Veterans having claims denied due to lack of medical evidence. The baseline at the end of FY 2011 was 390,000 documents, and at the end of this FY the amount of loose and late flowing medical documentation was 285,000 documents. This was a decrease of 27 percent, substantially less than the 50 percent target. The reason for falling short was the delay Army experienced in establishing the "central cell" that will become the clearing house for all Army medical records prior to transfer to VA. The contract was awarded in mid-September and the "central cell" was operational at the end of the fiscal year, so it is believed the target will be achieved in FY 2013.

The MRWG continued to work closely with the Military Health System Chief Information Officer's office as they develop and test a scanning capability. Once implemented, this will provide the opportunity for designated field level units within the Military Departments to scan loose medical documentation into dedicated repositories. This will make the documents globally accessible electronically to support VA benefits decision makers and the continuity of health care.

The MRWG accomplished its second milestone this FY with the approval of the STR disposition schedule by the National Archives and Records Administration. This milestone was identified as vital to bringing DoD into compliance with Federal record keeping standards by providing mandatory instructions on how to maintain, dispose, and eventually destroy the record when the government no longer has a business need for the record. The Disposition was officially signed by the Archivist of the United States on August 3, 2012.

Sub-goal 3.4: Ensure appropriate Departments, Agencies, Service members, Veterans, and family members have immediate and secure access to reliable and accurate personnel and beneficiary data.

BEC Information Sharing/Information Technology Working Group

The purpose of the VA/DoD BEC Information Sharing/Information Technology (BEC IS/IT) WG is to leverage 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.

To meet its objective to support stakeholder data needs, the BEC IS/IT WG continued to monitor DS Logon implementation and coordinated with the Services to begin to issue DS Logons at accession. A DS Logon is a secure identity (username and password) that is used by various DoD and VA Web sites, including eBenefits. The Services shared their respective implementation plans in January 2012 to ensure all current Service members have a DS Logon by November 2013. The Defense Manpower Data Center provided monthly metrics that reflect DS Logon accounts by Service (Active and Reserve Components) and Veteran accounts. As of September 30, 2012, there were 1,937,021 registered users in over 25 countries. The rapid growth of registered eBenefits users represents growth rate of 92 percent in FY 2012 as compared to the previous FY.

<u>eBenefits Self Service Features</u>

eBenefits is a joint VA/DoD initiative that, through a single, self-service portal, increases access to information and streamlines the application process in the delivery of benefits and health care for Service members, Veterans, and their families. The BEC IS/IT WG has provided proactive and transactional self-service capabilities through 12 consecutive quarterly releases since October 2009 in support of the VLER Capability Area (VCA) 4. In FY 2012, over 18 eBenefits self-service features and major enhancements were deployed, bringing the total number of self-service capabilities to 49. The quarterly releases in FY 2012 provided users with new or improved access to information and resources as follows:

- Winter 2011 (Release 3.3)
  - Chapter 33 Post-9/11 GI Bill Education Enrollment Status
    - Provides users the ability to view their current and past enrollment authorizations for Chapter 33 education benefits
  - Mobile access to Post-9/11 GI Bill Education Enrollment Status
    - Allows users the ability to view their current and past enrollment authorizations for Chapter 33 education benefits from their mobile devices
  - VA Compensation and Claims Status
    - Enhancements that allow users to view their claim status broken down into eight phases instead of only four, giving the users twice the detail about their status
  - Mobile Compensation and Claims Status Update
    - Enhancements that allow users to view their claim status broken down into eight phases instead of only four, giving the users twice the detail about their status from their mobile devices

- Early Communications
    - Vocational Rehabilitation and Employment messaging
- Exam Appointments Calendar
    - Provides users the ability to view claims related appointments at VA medical facilities
- Patient Authorization (Phase II)
    - Allows users to digitally sign participation requests and selectively remove organizations from receiving their health information

- Spring 2012 (Release 4.0)
    - VA for Veterans Single Sign On
        - Enables logged-in users to transition from eBenefits to VAforVets without reauthenticating
    - Enhanced Personalization
        - Enables users to personalize their experience with built in features
    - Veterans Relationship Management-Customer Relationship Management Integration
        - Enables sharing of eBenefits user account activities with the VA National Call Centers
    - Chapter 33 Post-9/11 GI Bill Enrollment Status Upgrade
    - MyHealtheVet (MHV) Single Sign On
        - Enables logged-in users to transition from eBenefits to MHV without reauthenticating

- Summer 2012 (Release 4.1)
    - Early Communications – Health Messages
        - Seven new health messages to Service members regarding health benefits available to them during and after service
    - Career Center
        - Provides users with information and single sign on access to VAforVets and VetSuccess Web sites, including tools for Self-Assessment, Military Skills Translator, and Resume Builder

- Fall 2012 (Release 4.2)
    - Early Communications – Education Messages
        - Messaging on the transfer of Post 9-11 GI Bill Benefits: Provides the Service member the criteria for transferring Post 9-11 GI Bill benefits, and explains how to complete the transfer
    - Compensation and Pension Claims Status Enhancement (Portal and Mobile)
        - Provides the user with specific claim phase processing times, specific to that claim type and regional office
    - Search for Representative
        - Updates include a Google map of Veterans Service Organization offices near user
    - Reserve Retirements Benefits Selection
        - Enables Service members to view Retirement Benefits options

eBenefits provides unprecedented self-servicing capabilities for Service members, Veterans, and their families to access and update VA and DoD information. Through eBenefits, 63 Early Communications Messages based on “life-changing” events have been deployed. Early Communications messages are sent via e-mail to notify Service members and Veterans of potential eligibility for health, education, and disability benefits.

By allowing 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), efficiencies can be realized. The frequency of logged-in users for specific key features from October 1, 2011, through September 30, 2012, is as follows:

- Compensation and Pension Claims (9,043,677)
- VA Home Loan Certificate of Eligibility (119,410)
- Official Military Personnel File (127,747)
- Chapter 33 Post-9/11 GI Bill Enrollment-Released December 2012 (1,465,363)
- Payment History (4,374,853)
- Appeals (1,673,772)
- Letter Generator (1,066,575)

The eBenefits portal is continuously reviewed in an effort to respond to customer feedback. Overall customer satisfaction has improved in FY 2012. September 2012 satisfaction numbers have increased six points from September 2011, and 5 out of the previous 6 months have met or exceeded historical highs. Web site traffic visits have effectively tripled; increasing from 6.6M visits in FY 2011 to 19.57M visits in FY 2012. September 2012 delivered a historical “high” for monthly eBenefits site visits of 3,252,449. The most active pages on eBenefits relate to self-help/self-service features. Checking compensation and pension claim status was the most active feature. Other top features include access to online forms through Veterans Online Application), checking payment history, Chapter 33 enrollment Post-9/11 GI Bill Enrollment, and access to documents including Military Personnel File and “Letter Generator” where users can download their Department of Defense (DD) Form 214 and other service and benefits verification letters.

<u>VTA in support of IDES</u>
The VTA for the IDES, or VTA IDES Module, replaced the original DoD database hosted on Army Knowledge Online in FY 2009 as the IDES primary tracking and metrics reporting application. VTA is a tracking application that allows VA and DoD non-clinical case managers to monitor Service member and Veteran progress through the IDES process. Personnel from both Departments utilize the application. VA users include: Military Service Coordinators, Disability Rating Activity Sites, Regional Office Management, and Central Office Management. DoD users include: Military Treatment Facilities, Physical Evaluation Board Liaison Officers, Physical Evaluation Board Administrative Staff, and DoD and Service Leadership.

In FY 2012, the VA VLER IT Program Management Office (PMO), Warrior Support VTA team deployed the VTA 2.0 release. VTA 2.0 included 76 enhancements for tracking Service members in IDES through case management and benefits delivery.

In addition to IDES, the VLER IT PMO also deployed; the ability to provide and receive care coordinator profiles consisting of each case managers basic contact information with case/care management tracking applications in support of the Information Sharing Initiative; the ability to add and edit a Casualty Record or a Contact Record within the Casualty module without all fields being required by the system, and; the expansion of existing notification e-mails in support of 38 U.S.C. Chapter 63-Outreach Activities by sending them to the Regional Office Director mailboxes as well as the Chapter 63 mailboxes. Enhancements are tailored to improve VTA reporting functionality and capabilities.

In support of electronic information sharing for disability claims and other benefits processing during FY 2012, the BEC IS/IT WG focused on IS/IT business requirements and use cases aimed at supporting the sharing of Service members' and Veterans' electronic administrative and health information with VBA and SSA benefits adjudicators for disability benefits processing as part of the VLER initiative.

BEC IS/IT WG activities included development of IS/IT business requirements and use cases for the VCA 2 expanded capability to share electronic administrative and health information specific to disability claims adjudication. The VCA 2 expanded capability is anticipated to be available by December 2014. BEC IS/IT WG activities also continued to support the development of IS/IT business requirements in support of VCA 3. The VCA 3 capability is expected to be available to VA benefits adjudicators by December 2014. Additionally, efforts continued to bolster the eBenefits portal with additional self-service features to share administrative and health information under VCA 4 and additional eBenefits self-service features were added or enhanced.

VCA 2:
The VCA 2 effort seeks to foster efficient adjudication of claims to support the timely delivery of benefits for Service members and Veterans through the sharing of administrative and health information to support VA and SSA disability claims processing.

The BEC IS/IT WG collaborated with the VA VLER Enterprise Program Management Office and DoD Health IT and completed the draft VCA 2 Concept of Operations (CONOPS) document during FY 2012. The VCA 2 CONOPS document is currently in coordination pending signatures from DoD and VA leadership. VLER Capability Area 1 (VCA 1) foundational health data are shared from DoD to VA today. It is anticipated VHA will provide access to the VA benefits adjudicators by December 2012. The BEC IS/IT WG also completed the prioritization of health data required for disability benefits adjudication for VCA 2 expanded capability in collaboration with the DoD, VA, and SSA functional communities. The BEC IS/IT WG delivered the VCA 2 expanded capability prioritized data requirements on January 31, 2012.

DoD is required to validate patient authorizations before releasing personal health information (PHI) to SSA for disability determinations.[16] DoD plans to use staff to manually review and

[16] While DoD provides PHI to VBA to assist in VBA's disability adjudications, those data exchanges are specifically exempted by HIPAA 45 C.F.R. §§ 164.500(a), 164.502(a), and 164.512(k) (2005).

process patient authorizations obtained by SSA and sent to DoD electronically.[17] DoD plans to use an updated version of the CONNECT software developed by HHS' Office of National Coordinator (ONC) for Health Information Technology, which was released on March 16, 2012. This update to CONNECT is designed to support a pause in the automated patient discovery process, which will enable covered entities to manually review the patient authorizations before protected health records are released.

Due to delays in the receipt of funding and internal DoD acquisition processes, DoD will not be able to meet the December 2012 VCA 2 Health Data Sharing Initiative IOC milestone date for sharing electronic health data with SSA through eHealth Exchange (formerly Nationwide Health Information Network Exchange [NwHIN]). The requirement for DoD staff to manually view and validate the individual's authorization prior to release of health data requires a technical solution which will not be in place. Given the complexity of the business rules required to comply with Health Insurance Portability and Accountability Act (HIPPA) and DoD regulations, and the multiple competing demands being placed on the VLER initiative, DoD is working with SSA to update the VCA 2 IOC milestone date and development schedule.

DoD completed development of information management functional requirements to support the technical development of the VCA 2 expanded capability health data exchange between VA and DoD in June 2012. In May 2012, the BEC IS/IT WG completed the development of a detailed roadmap to include the activities and milestones to support the VCA 2 foundational data capability. VCA 2 associated performance evaluation plans, metrics, and lessons learned documentation and development are pending implementation of VCA 2.

VCA 3:
VCA 3 foundational capability will provide VBA benefits adjudicators at the VA Regional Offices and National Cemetery Administration access to administrative and benefits information necessary to support outreach, registration and enrollment, eligibility, and the adjudication of Service members' and Veterans' claims for benefits eligibility/entitlement. The BEC IS/IT WG completed the draft VCA 3 CONOPS document during FY 2012. Three additional use cases were identified in July 2012 to support the VCA 3 expanded capability via the BEC IS/IT Requirements Working Group. The draft use cases relevant to education and employment related information sharing requirements are currently being vetted through interagency partners within VA, DOL, and Department of Education in support of VCA 3 expanded capability. VCA 3 associated performance evaluation plans, metrics, and lessons learned documentation and development are pending implementation of VCA 3.

VCA 4:
eBenefits is a joint VA/DoD Web portal that provides resources and self-service capabilities to Veterans, Service members, and their families to research, access and manage their VA and military benefits and personal information. eBenefits uses secure credentials to allow access to personal information and gives users the ability to perform numerous self-service functions. It also provides a list of links to other sites that provide information about military and Veteran

[17] SSA indicated that it has requested the ONC to commence work on NwHIN standards for automated authorizations. Where this request fits in ONC's standards queue is unknown, so the timeline for completion is undetermined. Even with a standard in place, DoD's preliminary analysis of the issue suggests that a variety of potential exceptions will prevent the complete automation of this process (e.g., the frequent need for manual intervention to achieve a reliable patient match).

benefits. It is an essential way for Veterans, Service members, and their families to receive access to and service from VA and DoD.

The BEC IS/IT WG developed the third consecutive yearly eBenefits Roadmap for calendar year (CY) 2013, showing the scheduled releases of enhancements and new capabilities, for each quarter. VCA 4 functionalities are currently incorporated into the eBenefits portal and are continuously evaluated based on customer satisfaction surveys conducted through the site and user experience focus workgroups. DoD and VA continually identify new requirements for VCA 4 capabilities through interagency collaboration and with other partners as deemed necessary.

A VLER benefits milestone timeline was developed by the BEC IS/IT WG to graphically track major milestones encompassing all VLER benefits capabilities (VCAs 2-4). A review of the DoD/VA health and administrative data sharing aspects in the DoD/VA Collaboration Summit on September 10, 2012, identified the need to: 1) provide electronic information on-demand from DoD to VA in response to a VA claim filed by a Service member or Veteran, rather than replicate and store large amounts of data for all Service members within VA; 2) decommission antiquated paper-based information sharing processes, such as transferring the hard copy of Copy 3 DD Form 214 to VA, by the end of CY 2014; and 3) provide electronic access to VA required information for efficient use of DD Form 214 and health information to support benefits adjudication and delivery. Once these objectives are met, the time it takes to adjudicate a Veterans claim for benefits should be reduced significantly.

Sub-goal 3.5: 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 2012, there were a number of significant activities and accomplishments which resulted in an increased number of continuing education and in-service training programs shared between VHA and DoD. Significant among these were a number of enhancements to the shared training distributed learning architecture which optimized the resources being utilized to provide clinical and clinically related training. This was accomplished through the following initiatives:

- Developed a portal on the DoD outfacing open source Web site Health.mil which allows all Federal personnel including all DoD personnel to access shared training courses at a single shared training site.
- Developed a shared training content on demand distribution system for MHS Learn in DoD.
- Enhanced the scope of training deployed via the VHA/DoD Virtual Clinical Grand Rounds program.
- Improved the process for vetting and deploying satellite training from DoD to VHA.
- Implementing a strategy for deploying training to DoD which was made available from the Federal Healthcare Training Partnership.

- Increased the number of participants in the VHA/DoD Facility Based Educators Community of Practice while enhancing the communication strategies utilized to share information with the community.
- Significantly enhanced the marketing activities in both VHA and DoD to assure that those responsible for the deployment of training were aware of the resources being provided.

As a result of these improvements, the WG exceeded the FY 2012 direct cost avoidance target by 57 percent for a total of over $32 million; over $22 million for DoD and over $10 million for VHA. In addition, the WG exceeded the FY 2012 volume of shared training target by 97 percent having coordinated the sharing of 1,108 programs between the Departments; 825 programs from VHA to DoD; and 283 programs from DoD to VHA at no cost to either Department.

Several enhancements to the electronic learning systems capabilities in the VA TMS and DoD MHS Learn improved participant data management and facilitated increased deployment of training between the Departments, resulting in increased sharing and enhanced VHA/DoD collaboration in the collection and analysis of learner participation data. Among these enhanced capabilities were the ability to deploy training from the VA TMS to VHA and DoD staff at integrated and joint venture sites more efficiently and with fewer resource expenditures. In addition, these electronic learning system enhancements provided the capability to collect and deploy VHA and DoD learner course completion data from these sites; from VA TMS to both VHA and DoD while maintaining information technology security. They also provided the capability for VHA and DoD SMEs to access and review VHA and DoD courses prior to deployment to ensure the content validity and the technical compatibility with VHA and DoD electronic learning systems. Lastly, they provided the enhanced capability to track and report on VHA and DoD staff participation in shared training on those systems. In a similar manner, the capacity to collect, aggregate, and report participant data from MHS Health.mil and MHS Learn have significantly improved the ability of the shared training enterprise to identify and share VHA and DoD participant data.

Another major initiative successfully implemented in FY 2012 was the implementation of a process by which training programs developed by the VHA Interagency Healthcare Training Consortia, which is composed of 12 Federal entities, were made available to DoD and the Military Departments to be used in training their personnel. The initiative resulted in an increase in the number of programs shared with DoD by 339 and generated a direct cost avoidance for DoD of over $16 million.

In FY 2012, the WG coordinated and/or managed a number of special training initiatives in support of the VHA and DoD health care mission to develop and deploy high value education and training programs in VHA and DoD. Some examples include the VHA/DoD Virtual Clinical Grand Rounds program, the VHA DoD Military Culture Awareness program, the Managing Violent and Disruptive Behavior training program, 12 TBI case studies, the Case Management training program, the Compensation and Pension training initiative, the Pharmacy Technician training program, the Clinical Practice Guidelines training program, the *InTransition* training initiative, the MOVE diet and fitness program, 36 radiology case studies for VHA and DoD Radiology, and Nuclear Medicine clinical staff and Compliance training for VHA and DoD staff. The deployment of these special initiatives resulted in more than 184 hours of instruction available to VHA and DoD personnel and generated more than $9.2 million in direct cost avoidance.

The WG also managed or coordinated a number of activities intended to decrease mandatory continuing education and in-service training programs redundancies between VHA and DoD. The WG implemented and completed a pilot project in FY 2011 which validated the effectiveness of the proposed strategy for identifying overlapping mandatory training programs in VHA and DoD for staff who serve in VHA and DoD facilities and for DoD staff at VHA/DoD integrated or joint venture sites. In FY 2012, the WG began developing a tactical plan for implementing a process to reduce redundant mandatory training. The plan involves converting mandatory training into a competency based format. The course content will be linked to a pretest, allowing the learners to test out of the course if they can demonstrate course content competency regardless of whether the competency was derived from VHA or DoD. The WG began consulting with VHA and DoD SMEs and training management officials to validate the competency based training process. If consensus in support of this strategy is achieved then the process will be implemented in FY 2013 and all learner participation in mandatory training courses will be based on need, eliminating redundancy.

The WG achieved its objective of deploying 100 percent of requested training curriculum to the Captain James A. Lovell Federal Health Care Center (FHCC) in FY 2012. This allowed the FHCC to meet its VHA and DoD staff orientation, in-service, and continuing education training needs and established a curriculum model that will be used as a basis for developing and deploying this training to other VHA/DoD integrated or joint venture health care facilities. This training curriculum will support these joint facilities' efforts to provide state of the art health care.

In FY 2012, the WG also launched two major initiatives and invested a considerable effort in the pre-work necessary to successfully enhance the shared training distributed learning architecture. When fully implemented, they will significantly enhance the distributed learning architecture, positively impacting the number of programs shared between VHA and DoD in FY 2013 and thereafter. The addition of a VHA Employee Education System Web-Based Shared Exchange will allow all Web-based courses available to be shared between VHA and DoD to be reviewed for content. This will ensure that the technical requirements of the Department seeking to deploy the training are met. It will also provide an environment in which Sharable Content Objects can be accessed by those building new programs, saving on developmental costs. Lastly, it will provide a single source for training that can be downloaded to VHA and DoD electronic learning systems. This Exchange was designed and the contract was established. Development and implementation is expected in FY 2013.

The second initiative is the addition of the previously mentioned MHS Health.mil Web site to the VHA/DoD distributed learning architecture which allows the deployment of all Web-based shared training from a single source to all Federal workers, including VHA and DoD staff, from government or private sector computers. This has resulted in a dramatic increase in the efficiency of sharing programs between the Departments and a significant reduction in the resources necessary to deploy shared training in DoD. It removes the need to deploy shared training from VHA or DoD to the partner systems, reducing the time and resources necessary to deploy training. It also provides more accurate reports on Federal agency staff participation, allowing for better documentation of shared training impact.

HEC Information Management/Information Technology Working Group

The Information Management (IM)/Information Technology (IT) WG provides executive oversight of joint integrated health information sharing activities and ensures that commonly accepted government IT program management practices are utilized. Since 2001, DoD has provided VA with one-way historic information on separated Service members through the Federal Health Information Exchange. On a monthly basis, DoD sends laboratory results, radiology reports, outpatient pharmacy data, allergy information, discharge summaries, consult reports, admission/discharge/transfer information, demographic data,
Pre- and Post-Deployment Health Assessments (PPDHA), and Post-Deployment Health Reassessments (PDHRA). Sharing electronic health information at the time a Service member separates allows VA providers and benefits specialists to access secure data for use in delivering health care and making claims determinations.

For shared patients being treated by both VA and DoD, the Departments continued to maintain the jointly developed Bidirectional Health Information Exchange (BHIE) which was implemented in 2004. Using BHIE, VA and DoD clinicians are able to access each other's health data in real time, including the following types of information: allergy, outpatient pharmacy, inpatient and outpatient laboratory and radiology reports, demographic data, diagnoses, procedures, vital signs, problem lists, family history, social history, other history, questionnaires, inpatient notes, outpatient encounters, periodic health assessments, and Theater clinical data to include inpatient notes, outpatient encounters, and ancillary clinical data (such as pharmacy data, allergies, laboratory results, and radiology reports).

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 the Armed Forces Health Longitudinal Technology Application (AHLTA), DoD's EHR, and VA's Health Data Repository (HDR). This initiative is called the Clinical Health Data Repository (CHDR). In September 2008, DoD automated a previously manual process to identify patients being treated in both Departments and began setting an active dual consumer (ADC) "flag" which facilitates the exchange of outpatient pharmacy and medication allergy data. Exchanging computable electronic health data on patients supports improved patient care and safety through the ability to conduct drug to drug and drug to allergy interaction checks using data from both VA and DoD systems.

To increase the availability of clinical information on a shared patient population, VA and DoD collaborated to further leverage BHIE functionality to allow bidirectional access to inpatient discharge summaries from DoD's inpatient documentation system. In 2008, additional DoD inpatient note types became available to all DoD providers and VA providers in the Puget Sound area including: inpatient consultations, operative reports, history and physical reports, transfer summary notes, initial evaluation notes, procedure notes, evaluation and management notes, pre-operative evaluation notes, and post-operative evaluation and management notes. DoD completed implementation of its inpatient documentation system enterprise wide, enabling access to inpatient documentation from 59 DoD inpatient facilities. VA providers now have access to the additional DoD inpatient note types enterprise wide. However, over the past year, the number of DoD inpatient facilities with access to inpatient documentation has decreased from 59 to 57 as a result of the BRAC Act of 2005. In September 2011, Walter Reed Army Medical Center and National Naval Medical Center jointed to form Walter Reed National Military Medical Center. In October 2011, Wilford Hall Medical Center, San Antonio, ceased to be an inpatient facility when it

transitioned into Wilford Hall Ambulatory Surgical Center. San Antonio Military Medical Center, within the component of Brook Army Medical Center, now provides inpatient needs no longer provided by Wilford Hall.

Between October 2011 and September 2012, the HEC IM/IT WG successfully completed 100 percent of FY 2012 quarterly metric milestones to support the bidirectional exchange of electronic health data between the Departments. The benefit of this progress is that more Service members and Veterans than ever have had more health data available, electronically and in real-time, to support the provision of care and the adjudication of claims:

- The number of DoD Service members with historical data transferred to VA increased from over 5.7 million to over 5.8 million.
- The number of PPDHA and PDHRA forms transferred to VA increased from over 3.3 million to over 3.4 million.
- The number of individuals with PPDHA and PDHRA forms transferred to VA increased from over 1.52 million to over 1.54 million.
- The percentage of DoD inpatient beds providing VA provider access to inpatient documentation (e.g., discharge summaries) was maintained at 100 percent of total DoD inpatient beds.
- The number of DoD beneficiaries with viewable data available real-time to VA and DoD providers increased from over 4.2 million to over 4.6 million.
- The number of data queries by VA and DoD providers increased from over 17.5 million to over 25.2 million.
- The number of shared patients flagged as ADCs for computable pharmacy and allergy data exchange increased from over 1.2 million to over 1.5 million.

The DoD NeuroCognitive Assessment Tool (NCAT) is designed to support pre- and post-event screenings of possible mTBI at all echelons of care, including Theater and sustaining base, augmenting the Automated Neuropsychological Assessment Metrics (ANAM) program that DoD uses to perform computer-based neurocognitive assessments. The ANAM has been in use since DoD issued policy directing its use in 2008. Additionally, NCAT was designed to provide timely, Web-based access; support comparison of results across current, baseline, and normative populations; and enable VA and DoD clinicians the ability to electronically track and trend mTBI data in a central database.

DoD technical development supporting the capture and display of automated neuropsychological assessment data from NCAT was completed in FY 2011. VA technical development efforts related to the Clinical Display Module, to enable providers to view NCAT data, are complete; software was nationally released in November 2011. VA/DoD end-to-end testing was successfully completed in April 2012. While NCAT automates ANAM data access and reporting capabilities, all three Military Departments have expressed concerns regarding NCAT's limitations and cost, prompting a recommendation for termination of NCAT to the DoD Senior Military Medical Advisory Council (SMMAC). The SMMAC, in turn, recommended termination to the Component Acquisition Executive, who has the final decision, but has not ruled on the matter as of September 2012.

VA and DoD continued to closely collaborate on the development of joint patient registries to enable the Departments to capture and create a robust store of data on patients affected by specific conditions. The intent is to use this advanced data registry management capability to

enable VA and DoD medical and research communities to conduct multidimensional and longitudinal studies to benefit medical readiness, patient care services, and outcomes management.

Close interagency registry collaboration continued with the CoEs including Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, the VCE, HCE, and the EACE. The Center for the Intrepid collaborates with the CoEs and will serve as a data source for the registries. The CoEs completed the following activities in support of interagency electronic patient registries in FY 2012:

- Defense and Veterans Eye Injury and Vision Registry Deployed registry software application.
    - Data abstraction ongoing.
    - Established interfaces with six VA and DoD systems.
    - Achieved 3-year Information Assurance approval.
- Joint Hearing and Auditory System Injury Registry
    - Transferred registry to Force Health Protection and Readiness (FHP&R) Theater Functional Management Office (TFMO).
    - Refined functional requirements and related documentation are awaiting final review and approval.
- EACE Registry
    - FHP&R TFMO assisting EACE with review, refinement, and expansion of functional requirements and related documents.
    - Utilizing the current amputation database to facilitate identification of data needs for traumatic extremity and amputation registry.
- Psychological Health/Traumatic Brain Injury Registry
    - Functional requirements approved and submitted for costing.
    - Final Concept of Operations and other documents in coordination.

The HEC IM/IT WG successfully completed 100 percent of FY 2012 quarterly milestones to increase the type and amount of electronic image data shared between VA and DoD. The Healthcare Artifact and Image Management Solution (HAIMS) is a MHS project that will enhance medical informatics through integration of medical digital artifacts and images (A&I) into the EHR. The objective of HAIMS is to give health care provider's global awareness and access to essential health care A&I throughout the continuum of care from Theater to garrison to VA, and from VA to DoD when needed. When fully developed, HAIMS will provide an enterprise-wide image sharing capability for multiple types of A&I, including radiographs, photographs, waveforms, audio files, video, and scanned documents. The following activities were completed in FY 2012:

- DoD successfully completed HAIMS Release II Developmental Test and Evaluation phase; capacity analysis testing is planned to begin in the first quarter of FY 2013.
- VA's Advanced Web Image Viewer, a technical solution which enables VA providers to view DoD scanned documents and related artifacts, was released enterprise-wide in November 2011.
- DoD successfully completed development of the HAIMS Release II software and completed hardware deployment to selected sites in May 2012.
    - Enables up to 6,270 licensed DoD users to view VA A&I.
- VA/DoD electronic image sharing capability in production since January 2012

    - VA providers at over 150 VAMCs are currently accessing DoD A&I through an interface with the VA's EHR.
    - Over 2,635 A&I have successfully passed through the interface as of September 2012.
- Access to DoD images from Theater by VA and DoD providers is planned to begin in the first quarter of FY 2013.

Additionally, the DoD MHS Cyberinfrastructure Services (MCiS) directorate provided quarterly briefings regarding bandwidth and network performance of the north, south, east, and west multipurpose VA/DoD network gateways to the HEC IM/IT WG. MCiS continues to monitor traffic analysis reports to identify traffic levels, types, and patterns (including protocol type and distribution of imaging traffic) and overall bandwidth demand levels for inbound and outbound wide area network traffic. The current assessment is that the existing network infrastructure and available bandwidth is more than adequately supporting current VA/DoD data traffic based on the established FY 2012 metric: network availability was maintained at 98.5 percent or better across the four multipurpose gateways.

HEC Acquisition and Medical Materiel Management Working Group

The Acquisition and Medical Materiel Management WG (A&MMMWG) continued to identify, review, and implement joint VA/DoD medical materiel management sharing initiatives to achieve joint operational and business efficiencies. During the reporting period, VA and DoD awarded a ninth and final contract for Digital Imaging Network – Picture Archive and Communications Systems (DIN-PACS). For radiology, VA and DoD awarded one new contract from last year's open season, with one other contract pending award. These long-term contract awards provide for continued contract coverage for DIN-PACS and expand the vendor base and product offerings for radiology to all VA and DoD customers.

As evidenced in the chart below, total, pharmaceutical and equipment sales showed solid growth from FY 2011 to FY 2012. Total joint sales increased by 12.6 percent; joint equipment sales increased 18.1 percent; and joint pharmaceutical sales increased 11.6 percent. All 3 categories exceeded the A&MMMWG's goal of 5 percent.

Joint VA/DoD Sales
(Dollars in Millions)

Commodity	FY 2012	FY 2011	Change
Pharmaceuticals	$2,690.920	$2,411.355	$279.565
Medical/Surgical	$0	$0	$0
Equipment	$480.061	$406.518	$73.543
Total	$3,170.981	$2,817.873	$353.108

Data Synchronization
FY 2012 was the first year the VA/DoD data synchronization program performed in the operation and maintenance life cycle phase. During this reporting period, DoD drafted its implementation plan to integrate the medical/surgical business intelligence (BI) tools and data into its enterprise medical logistics systems. DoD initiated implementation of the plan by using Product Data Bank (PDB) medical/surgical data feeds in its enterprise Medical Master Catalog (MMC) processes; the cleansed and synchronized PDB data confirms the product data attributes presented to purchasers and logisticians in the field, ensuring they are accurate. This initiative supports the DoD Medical Prime Vendor program's Generation IV contracts. This BI drives DoD spending toward the best pricing available to each particular purchasing site. The PDB data are a contributor to the logistics efficiencies sought by the Defense Logistics Agency.

The spend analysis capability in the Medical Surgical PDB (MedPDB) continued to play an active role in VA's health care efficiency initiative for commodity standards. The objective of this initiative is to develop an integrated approach to commodity standardization (equipment, supplies, and services). VA implemented the initiative to align processes, stakeholders, and resources across all organizational levels to achieve sustainable, measureable cost savings/avoidances, and efficiencies. The data synchronization program enabled VA national and regional standardization. VA program managers analyzed the best standardization candidates by clinical category using program tools and working potential cost reductions in the range of $35-50 million. Regional standardization opportunities were also identified on clinical item categories not nationally standardized. VA continued to investigate and develop compliance reports to assist in monitoring compliance with committed volume and VA standardization contracts.

The data synchronization program conducted training for new users and refresher Webinars for existing users to promote the availability of contract and pricing data for procurement decisions. The A&MMMWG targeted an increase in users of 60 percent by September 30, 2013. The program is well within reach of the 2013 goal: As of the end of FY 2012, 67 out of 129 VA facilities were actively using the program's BI tools, representing 52 percent of its sites. DoD use of BI data through initial integration efforts with the MMC increased usage to 93 percent, or 134 out of 144 facilities.

The data synchronization program was actively involved with field users, through MedPDB site feedback and help desk calls, to explain product data queries and results as users were working purchase recommendations generated by the BI tools. The A&MMMWG targeted a

total of $24 million in additional product price reductions by September 30, 2013, as a result of using the BI tool. As of the end of FY 2012, VA and DoD users accepted purchase recommendations that, if implemented, could reduce medical/surgical product costs by a projected $20.7 million in FY 2012, exceeding the target increase by $16 million, or 67 percent (see chart below).

Data Synchronization Potential Product Price Reductions

FY	DOD	VA	Total
11	$ 11,448,700	$ 7,975,456	$ 19,424,166
12	$ 15,375,862	$ 5,391,446	$ 20,767,307
Total	$ 26,824,561	$ 13,366,901	$ 40,191,474

The data synchronization program also achieved the A&MMMWG's target of participation in at least two industry forums, venues, and/or pilots to advance adoption of industry-wide use of medical surgical product data standards and data sharing networks. The Deputy Program Manager attended GS1[18] and Strategic Marketplace Initiative forums that emphasized data standards for the health care industry.

The A&MMMWG Co-Chairs agreed that future proposed partnering agreements will be evaluated and accepted by the A&MMMWG and approved by the HEC via the WG minutes. The Co-Chairs agreed that there was no need to revise the 1999 VA/DoD MOA on combining buying power and its appendices detailing medical logistics and related partnering initiatives. The A&MMMWG declared the 1999 VA/DoD MOA obsolete and, therefore, no longer in effect or binding.

HEC Financial Management Working Group

The Financial Management Working Group (FMWG) collaborates to ensure the highest level of economic and organizational efficiency, effectiveness, and productivity related to financial operations in support of VA and DoD health care systems, and manages the Joint Incentive Fund (JIF). In FY 2012, the Army, Navy, and VHA completed the series of briefs to the FMWG begun last year by Air Force, on their respective internal JIF proposal application and review process and best practices. This resulted in modifying the scoring criteria to further incentivize first time applicants. In FY 2012, nine JIF projects were brought to completion. In September 2012, additional contributions above the usual $30 million were made to the fund, and the FMWG WG worked with various HEC and JEC WGs to identify, prioritize, and recommend approval of projects focused on national strategic VA/DoD goals. Thirteen projects were submitted and 10 were approved. The FMWG continued to monitor actual obligations of all active JIF projects on a quarterly basis.

VHA/DMA/IDES, in conjunction with VHA's Chief Business Office (CBO), continually reviewed and revised the IDES registration and billing guidance to improve the quality of claims regarding payment for exams performed as part of IDES. Guidance updates were shared with VHA, VBA, DoD, and TRICARE managed care support contractor (MCSC) partners. In September 2011,

[18] GS1 is an international not-for-profit association dedicated to the design and implementation of global standards and solutions to improve the efficiency and visibility of supply and demand chains globally and across sectors.

VHA/DMA/IDES, in conjunction with key personnel from the VHA Allocation Resource Center and Decision Systems Support (DSS) Office, revised the guidance to include the proper requirements for IDES clinic set-up in the VHA system. Efforts were made throughout FY 2012 to educate VAMC staff on those requirements.

VHA/DMA/IDES personnel monitored a SharePoint Site and DSS reports to review billing and collection data, as well as workload and no-show information. VHA/DMA/IDES, the Medical Sharing Office, and CBO personnel are reviewing the need for requesting a revision to the MOA as it relates to the registration and billing guidance, with particular attention to billing reimbursement rates. The billing and reimbursement process will have no direct impact to Service members, however there will be an indirect impact to Veterans; according to Title 38, Section 8111, when reimbursements are received by the VAMC, they should be used to improve Veteran programs or augment existing programs and staff.

TMA trained additional personnel to improve the time frame for processing paper claims. VHA/DMA/IDES sent final paper claims for dates of care prior to January 1, 2011, with the exception of those paper claims for one VISN still under review. The TRICARE MCSCs will now process claims electronically with a date of care on or after January 1, 2011.

The VHA IDES Program Office established and continues to monitor the quality of claims submitted to TMA for examinations of referred conditions and associated ancillaries since FY 2011. As a result of a combined effort between the IDES Program office and TMA, the FY 2012 IDES claims for reimbursement experienced a 35 percent increase over the 21 percent reimbursements received in the FY 2011 base period. The primary tenets used in managing the quality of claims submitted to TMA now include:

- Elimination of paper claims. VHA has now instituted the use of the Electronic Data Interface as the primary mechanism for submission of medical claims. This approach has greatly enhanced the quality of claims by reducing the number of invalid claims and improving accountability of claims processed and received.
- Increased coordination with TMA to identify and eliminate data discrepancies which could result in invalid claims. The principal focus of this effort was to ensure and monitor the issuance of TRICARE Authorization Numbers by the MTF; a critical process necessary for the TMA Fiscal Intermediaries to process VA claims. This effort will be continuous and will require strict adherence and attention by all MTFs to ensure IDES beneficiaries are assigned TRICARE authorization numbers when referred to the VA for IDES examinations for referred conditions.
- Active participation in TMA-hosted meetings. These forums now routinely include the issuance of authorization numbers as part of their agenda discussion.
- Continuous education and assistance. The VHA IDES Program Office instituted a continuous education and training program focused on assisting VAMCs in correctly preparing claims submitted to TMA. This multi-pronged effort included several routine briefings and presentations in various VHA meetings to leaders and staff associated with the billing and reimbursement activities at VA facilities; and the design of a Web-based IDES introductory presentation which also addressed billing processing and procedures as well as one-on-one instruction and assistance to VA facilities. This combination of efforts yielded very positive results and facilitated continued improvement in base lining the quality of IDES claims.

- Active reporting and monitoring. This is a multifaceted approach which is evolving and will require continued collaboration and support of TMA.

HEC Joint Facility Utilization and Resource Sharing Working Group

The Joint Facility Utilization and Resource Sharing Working Group (JFU&RS WG) was formally renamed and rechartered in March 2012 as the Joint Venture/Resource Sharing Working Group (JV/RS WG). Its mission remains to explore and identify opportunities and make recommendations for increased collaboration between VA and DoD to maximize care available to beneficiaries of both health care systems. The name change was necessary to explicitly distinguish its role from that of the Construction Planning Committee.

In late FY 2011, the JEC tasked the JV/RS WG to develop an information paper to describe the process for identifying potential opportunities for future joint ventures similar to the FHCC in North Chicago. The JV/RS WG determined that further data collection was needed before a sufficient analysis on similar expansions could be conducted. Data included information collected from the annual GAO progress reports, results from the IOM 2-year study, and HEC interviews with key FHCC personnel to gather positive and negative components.

During the first quarter of FY 2012, the JEC charged the JV/RS WG to develop a uniform joint venture definition to include the concept of value, quality, and cost. The framework for a uniform definition was developed, presented, and discussed at the FY 2012 Joint Venture Conference.

In October 2011, the FY 2012 Joint Venture Conference was held in Charleston, South Carolina titled, “Creating Value for Veterans, Active Duty and Taxpayers.” All joint venture sites presented updates on the progress of their current shared initiatives, and provided cost-benefit performance reports which documented actual or expected future cost savings as a result of their joint initiatives. Instructions and guidance were given to joint venture and joint market site attendees to identify and submit new joint service initiatives targeted for FY 2012, and identify and develop the performance metrics that will be used to measure the joint projects beginning the first quarter of FY 2013.

The HEC tasked the JV/RS WG to chronicle the successes and failures of the current joint venture sites using measurable evaluation criteria and processes. A rigorous set of criteria for both the selection of new joint venture sites and the evaluation of current sites is needed to extrapolate lessons learned and identify potential future enterprise-level collaboration efforts. In June 2012, the JV/RS WG outlined the premise for the joint market selection and joint venture evaluation measures. The approved, refined selection criteria includes: facility proximity locations, enrollment population densities, outsourced care expenditures by product line, previous service and staff collaborative efforts, and planned or future joint construction efforts. The criteria will also include the review of inpatient facility census and resource availability, and Graduate Medical Education training programs. Development of joint venture evaluation criteria will include detailed quality, access, and cost measures. Some of these measures include:

- The level of patient case mixing that supports professional skill development, improvement and maintenance.
- Staff cross-training.
- Enhancement of teaching programs.

- Improved patient access leading to decreased reliance on purchased sector care with increases in partner seen care.
- Improvement of appointment/procedure scheduling.
- Location of patient care site to patient home availability.
- Cost effectiveness, such as decrease in purchased sector care expenditure savings versus internal federal sector care costs (staff, ancillary services/tests, overhead or lease).

The JV/RS WG began collecting and will identify successes and failures of current joint venture sites and the potential for additional opportunities to improve quality, increase access, and decrease costs at each site. Due to the new HEC requirement for the JV/RS WG to evaluate the effectiveness of the current joint venture sites, the selection of new joint market sites for FY 2012 was not conducted in order to focus on developing joint venture evaluation criteria and improve upon the joint market site selection criteria for future years.

Throughout FY 2012, the JV/RS WG identified and collected performance metrics that may potentially be used to measure joint venture initiatives based on the JEC requirement to provide operational efficiencies and dollar target savings from joint initiatives. These performance metrics continue to be compiled and reviewed by the JV/RS WG.

Telephonic In-Progress Reviews were conducted during the year for previously visited joint venture and joint market sites: San Diego, California; Puget Sound, Washington; Charleston-Beaufort, South Carolina; Fayetteville, North Carolina; Killeen-Temple, Texas; Gulf Coast (Keesler, Biloxi); Luke-Phoenix, Arizona, and Columbia, South Carolina. A JV/RS sub-WG was formed to review and study the current Interim Progress Reports (IPR) process and determine if improvements can be made.

Evaluation of the Enhanced Document and Referral Management (eDR) tool showed it to be an effective mechanism for process improvements in appointing and referral times. Its use has allowed Tripler Army Medical Center (TAMC) to process 100 more referrals per week without additional staff; appointments are now established within 5 days for 80 percent of Veterans seeking care from TAMC, with the actual appointing time reduced from approximately 90 minutes to less than 5 minutes per transaction. Expansion of this tool to other sites is dependent upon the implementation of JANUS, the front-end Web application of the eDR; this effort is now under the control of the IPO, thus concluding the efforts of the JV/RS WG for this activity.

HEC Contingency Planning Working Group

The Contingency Planning WG ensures that VA maintains a contingency capability to support DoD wartime bed requirements in accordance with 38 U.S.C., Section 8110. A VA/DoD Contingency Plan was developed in 2006 to support DoD contingency bed requirements; in FY 2012, the WG began analyzing the requirements in greater detail. During the year, the WG participated in planning several training events and exercises using the contingency plan.

Using the 2006 legacy plan as a starting point, VA and DoD agreed to use the Aeromedical Evacuation analysis of the Joint Staff's Mobility Capabilities and Requirements Study as a framework in delineating DoD's wartime bed requirements. The Aeromedical Evacuation analysis, including the verification of assumptions regarding inpatients' lengths of stay, locations for final patient movement, and other critical details, was completed in FY 2012. In addition to these data,

other assets that support unique DoD wartime requirements were identified. Examples of these assets are the VA Polytrauma Network medical centers and civilian hospitals that are members of the National Disaster Medical System. The effort to fully plan for support of DoD's wartime bed requirements will be complete when the assets identified above are incorporated into the U.S. Transportation Command's (USTRANSCOM) new Global Campaign Plan for Distribution (currently scheduled for completion in March 2013) and when the 2006 VA/DoD Contingency Plan is revised.

Both Departments continued training and exercise programs geared to ensure the preparedness of existing contingency assets. The Defense Medical Readiness Training Institute (DMRTI) incorporated the basic and advanced Federal Coordinating Center (FCC) training courses into its curriculum, ensuring these courses will be regularly enhanced and taught by SMEs from both VA and DoD. In May 2012, the advanced FCC course was presented by DMRTI to more than 50 VA and DoD participants as part of the 2012 Integrated Training Summit hosted by Health and Human Services.

As in previous years, full scale patient reception exercises were independently conducted at various FCCs throughout 2012. Eleven such exercises occurred in FY 2012. In addition, VA and DoD participated in a national medical regulating exercise conducted by USTRANSCOM to ensure FCC readiness. All FCCs continue to conduct bi-monthly bed availability drills.

Finally, VA and DoD patient movement systems were exercised extensively in conjunction with the National Guard Bureau's Patriot exercise in July 2012. Simulated patients were successfully regulated and moved from Wisconsin to Missouri, Alabama, Indiana, and Illinois over 2 days.

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

Sub-goal 3.6: Inform Veterans, Service members, military families, and other stakeholders of key, identified strategic messages and priorities of the JEC.

JEC Strategic Communications Working Group (SCWG)

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 2012 communications activities in support of the specific objectives in the JEC JSP for FY 2011-2013 included:

- Production of the FY 2013 JEC Strategic Communications Plan.

- Establishment of quarterly communications meetings with representatives from the HEC, BEC, IPO, Veterans Employment Initiative Task Force, Camp Lejeune Working Group, Gulf War Task Force, VA-DoD legislative affairs, and VA-DoD public affairs to enable ongoing collaboration between SMEs and communications professionals.

The JEC SCWG continued to build on the outreach activities of FY2011, and conducted:

- Eight briefings and 13 hearings to Congressional stakeholders; including the first ever joint hearing before the House Armed Services Committee and House Veterans' Affairs Committee on July 25, 2012, with the Secretary of Defense and Secretary of Veterans Affairs testifying as lead witnesses.

- VA and DoD program manager joint briefings for congressional staff from six stakeholder committees on the status of several transition programs for Service members and Veterans including the IDES, iEHR, and redesigned TAP.

Joint VA and DoD communication efforts facilitated several collaborative events with major news organizations and stakeholders on a myriad of issues:

- The Secretaries of Defense and Veterans Affairs conducted quarterly meetings (October 17, 2011; December 11, 2011; May 29, 2012; and September 10, 2012), to focus on priority VA-DoD issues. The December, May and September meetings were followed by issuance of joint public statements to transparently inform stakeholders of the nature and substance of these discussions. The centerpiece of this senior engagement strategy for FY 2012 was the Secretaries' joint testimony to Congress on July 25, 2012, which highlighted:

    - The President's commitment to transforming the way the two Departments care for and provide services to Service members and Veterans both through guidance and budgetary support.
    - The commitment to VA-DoD Collaboration.
    - The need for a truly seamless transition from Service member to Veteran status.
    - Recognition that the Departments have unique requirements for active collaboration, joint planning and coordination, and determined execution of shared priorities.

- The Secretaries quarterly meetings in 2012 produced a more proactive media posture going into FY 2013, resulting in the first-ever joint press conference hosted by VA with Secretaries Shinseki and Panetta on December 6, 2012, (the first joint meeting of FY 2013). Fifteen media outlets attended the conference, which VA transmitted live to the media in collaboration with DoD public affairs.

- VA-DoD public affairs worked to jointly communicate on significant issues such as:
    - Military and Veteran suicides (June 2012 VA-DoD suicide prevention conference).

- Establishment of the 2011 Japanese Tsunami Tamadachi registry.
- TAP redesign: Both Departments collaboratively worked from June through September 2012 to craft a joint communications plan that followed the roll-out of the jointly redesigned military transition program to achieve compliance with the VOW to Hire Heroes Act.
- On October 19, 2012, VA/DoD representatives participated in the Military Reporters and Editors Conference to discuss new TAP redesign. Approximately 50 reporters were in attendance.
- VA/DoD/DOL representatives conducted joint media round table discussion to shape stories focused on the new TAP redesign announced at Secretaries' December 6, 2012, meeting.
- Joint Release announcing 100 million Consortium for PTSD/TBI Research.
- Multiple efforts to increase usage of the MCL as directed by a Presidential Executive Order called, Improving Access to Mental Health Services for Veterans, Service Members, and Military Families, which calls on VA and DoD to develop a 12-month national suicide prevention campaign that focuses on connecting Veterans, Service members, and their families to mental health services. Regarding Camp Lejeune, the Departments continued close collaboration in communicating on the ongoing Camp Lejeune Historic Drinking water issue as well as joint compliance issues in light of the enactment of the "Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012," that mandated Veteran and family member care for those affected by the Camp Lejeune water contamination.

These collaborative efforts ensured message consistency throughout both Departments and gained overall balanced 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 3.7: Identify, propose, and increase collaborative opportunities for Joint Capital Asset Planning.

Construction Planning Committee Working Group

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

In late FY 2011, the CPC developed a concept for a common approach to capital asset management planning through identification and sharing of planning data information based on three data points: population, workload, and purchased care. The data, along with point-of-contact information, was shared with both VA and DoD planners and utilized for each Department's capital investment planning process in FY 2012. The recipients indicated that the information was helpful and that its availability will become increasingly valuable for future capital asset planning cycles. It is believed that this enhanced data sharing will encourage local VA and DoD planners to expand their existing collaborative relationships by enabling

early identification of locations where there is a common need and a potential for a joint solution resulting in an increase in the quantity and scope of future shared medical facilities. In 2013, this information will be further refined and the additional data elements may be added to aid in identifying potential joint collaborative opportunities to increase the availability and delivery of services to active duty Service Members and Veterans.

In FY 2012, the CPC reached agreement on comparable VA and DoD legislative language that would provide a refined budget mechanism to streamline planning and alleviate funding challenges for joint projects. The language was submitted to the leadership of each Department for consideration as part of its annual budget submission. If passed, the Departments would have inherent authority to transfer funds to one another for the purposes of building and leasing a shared medical facility to meet each other's needs when appropriate. VA received Office of Management and Budget conceptual approval in the FY 2013 Budget Submission; approval of specific language is now pending. DoD has submitted like language provisions as part of their FY 2014 Budget Submission that would allow DoD to enter into agreements with VA. The CPC anticipates that the language will be enacted in the future.

The CPC provided important information to GAO for sections of the GAO Report on VA and DoD Healthcare (GAO-12-992). Also, the CPC coordinated the preparation of two mandated reports to Congress on VA/DoD Joint Medical Facilities in response to the House Appropriations Committee (H. Rept 112-94) and the Senate Appropriations Committee (S. Rept 112-29).

The CPC also completed a review and revision of the committee charter. The updates include a proposed committee name change from the CPC to the Capital Asset Planning Committee (CAPC) to more accurately reflect the committee's efforts to support not only construction projects, but also leasing and other real property initiatives. The charter has also been refined to expand the committee membership to include field-level representation for both Departments. It is anticipated that the charter will be approved in FY 2013.

Sub-goal 3.8: Develop a common set of criteria or process for performing separation health assessments for eligible Service members who are leaving the military to meet the requirements of both Departments.

JEC Separation Health Assessment Working Group (SHAWG)

The Separation Health Assessment Working Group (SHAWG) was established to develop a common set of criteria, or process, for conducting Separation Health Assessments (SHA) on eligible Service members prior to separation from the military that would meet the requirements of both Departments.

In FY 2012, the SHAWG completed a pilot study of the SHA concept at four DoD installations (Ft. Bragg, Ft. Leonard Wood, Naval Station Bremerton and Travis Air Force Base) in conjunction with VA between November 2011 and May 2012. The SHAWG coordinated with Army, Navy, Air Force, and VA representatives to conduct SHAs on 50 Service members per site. The minimum exam consisted of review of the medical record, a threshold audiogram, a report of medical history (Department of Defense [DD] Form 2807) and a physical examination

(DD Form 2808). Service members who chose to file a claim with the VA were directed to the BDD program, where in addition to the basic SHA, they received more detailed examinations to evaluate their claimed conditions. Regular teleconferences were held during the course of the pilot, and a SHAWG representative visited all pilot sites to facilitate communication and observe operations. The report on the pilot, with analysis of resulting data, was finalized and briefed to the JEC on September 27, 2012.

The VOW to Hire Heroes Act of 2011 was passed on November 21, 2011, and subsequently impacted how DoD and VA viewed the SHA pilot and the SHAWG's vision for deployment. The Act includes mandatory participation in the TAP for all eligible separating Service members and has the potential to increase the numbers of Service members seeking disability benefits at separation through the BDD program. Despite the small sample size, the SHA pilot supported the prediction that an increase in counseling and BDD program availability was correlated with an increase in the numbers of Service members applying for disability benefits through that program. The SHA report therefore included a reference to the possible implications of the VOW Act.

In the SHAWG's report, established contract costs were applied to estimate the costs for SHAs conducted on all separating Service members. These costs were applied to four possible options that provided varying scenarios of splitting the workload between DoD and VA. JEC leadership requested additional information on costs in full-time equivalents (FTE) for the options outlined.

Using historical data, DoD staff worked with Service representatives to convert contracted costs into FTEs, and provided workload estimates for the proposed options to the DoD JEC Co-Chair. VA staff developed cost estimates for the provision of additional disability examinations. Those projections were developed using the costs of current contact vehicles and were provided to the VA JEC Co-Chair. At the end of FY 2012, the JEC Co-Chairs were considering the updated cost estimates in order to make a decision on the way forward.

Additional Accomplishments

Integrated Electronic Health Record

In March 2011, the Secretary of Defense and the Secretary of Veterans Affairs mandated that the Departments develop and acquire a new, single, integrated Electronic Health Record (iEHR) system. The iEHR program was formally established under the DoD/VA IPO in the second quarter of FY 2012. During FY 2012, the primary focus of the iEHR program was establishing the programmatic baseline for proceeding with acquisition and development of clinical capabilities.

The scope of the iEHR solution includes 54 joint capabilities that the Departments agree address clinical and infrastructure requirements to establish the EHR management system. Capabilities will be delivered through six planned increments in an agile approach taking into consideration functional priority, technical feasibility, and financial viability.

In FY 2012, the iEHR program focused on the infrastructure capabilities that will enable the use of common tools and applications, and the sharing of data and information between VA and DoD clinicians to provide coordinated health care in a standardized and non-duplicative manner. Key iEHR program accomplishments included:

- Awarded the Service Oriented Architecture (SOA) Suite / Enterprise Service Bus (ESB) Contract.
- Demonstrated SOA Suite/ESB requirements for message capacity.
- Initiated mapping of VA data to the Healthcare Data Dictionary in support of iEHR data
- Defined the iEHR Increment 2 Program Baseline, to include business requirements, initial architecture, and initial life cycle cost estimate, resulting in milestone approval for Increment 2 execution.
- Developed initial iEHR Increment 2 technical baseline architecture and initiated design activities.
- Finalized iEHR Increment 1 program, technical, and cost baselines, including architecture and design artifacts, resulting in milestone approval.
- Delivered Single Sign-On (SSO) and Context Management (CM) capabilities to four San Antonio sites. SSO and CM are part of the iEHR infrastructure that will provide an efficient method of accessing and viewing patient information across multiple applications. SSO and CM offer clinical users secure, unified access to patient data through a single authenticated sign-on. Furthermore, the capabilities enable safer, more efficient delivery of services to Service members and Veterans by reducing potential risk while increasing productivity.
- Completed business requirements documents for Lab, Pharmacy, Identity Management, Access Control, and Presentation Layer capabilities.
- Achieved Development and Test Center (DTC)/Development and Test Environment (DTE) IOC – Increment 1 will use the DTC to test target iEHR applications and infrastructure in a DTE, enabling risk reduction in the development process.
- Developed Data Management Strategy and Roadmap.
- Published a Technical Specifications Package that described architecture standards and compliance criteria for use by industry in support of iEHR acquisitions. This release via

a public Web site provides the technical detail necessary for potential vendors to prepare to respond to solicitations for participation in the iEHR development process. Finalized SOA Services Catalogue that identifies targets to be implemented within the iEHR infrastructure. SOA Services Catalog defines the cross-enterprise standardized architectural products available. All of the capabilities will access the treatment facilities and legacy applications via the SOA/ESB.

- Completed Portal Framework assessment of the commercial off-the-shelf product Liferay for potential use within the iEHR infrastructure.
- Developed initial Deployment and Implementation Strategy to include major milestones, and roles and responsibilities.
- Initiated development of Sourcing Methodology Procedure and Policy to support buy, adopt, build acquisition decisions.
- Defined the Network & Security Architecture to support the implementation of a single medical enclave known as the Joint Medical Community of Interest (MED COI). The Joint MED COI will provide a single logical network solution for iEHR data exchange across all systems.
- Gained IOC definition concurrence between the DoD/VA ICIB and IPO.
- Finalized the Memorandum of Understanding (MOU) between the IPO and Telemedicine Advanced Technology and Research Center (U.S. Army)(TATRC). TATRC is performing research on data exchange technologies that could be applicable to iEHR implementation.
- Finalized North Chicago Stakeholder Analysis to assess joint clinical capability for iEHR implementation.
- Completed James A. Lovell FHCC Lessons Learned Program information collected and began validating that the lessons learned are accurately documented.
- Began Increment 2 IOC site visits (Hampton Roads, Virginia and San Antonio, Texas)
- Submitted iPLRD to the HEC for final approval. The iPLRD addresses both the enterprise level functional requirements and non-functional requirements for the 54 iEHR joint capabilities agreed upon by the ICIB. The ICIB submits recommendations to the HEC.
- Identified the clinical metrics for Increment 2 IOC.

Given the iEHR program's joint nature and extensive scope, the program is adhering to the intent and requirements of both the VA and DoD acquisition lifecycle processes. These processes have been streamlined and documented in an integrated acquisition framework. At the program level, the iEHR program operates under the DoD's Business Capability Lifecycle structure, while at the project level, individual projects adhere to the VA's Program Management Accountability System. The IPO is applying a disciplined and systematic agile approach to all aspects of the iEHR lifecycle. The approach is incremental and iterative, and the functional, program management, and technical communities work collaboratively and continuously throughout the lifecycle of projects.

Virtual Lifetime Electronic Record Health

Virtual Lifetime Electronic Record (VLER) Health contains the portfolio of programs that manage the electronic exchange of clinically relevant health information between VA, DoD, and other Federal and non-Federal health exchange partners. Between January 2010 and September 2011, VA and DoD implemented VLER Health Exchange pilots at four joint locations, partnering with private sector health information exchange (HIE) organizations in San Diego, California (January 2010 with Kaiser Permanente), the Tidewater area of Virginia (October 2010 with MedVirginia), Spokane, Washington (March 2011 with Inland Northwest Health Services), and the Puget Sound area of Washington (September 2011 with the MultiCare Health System). Additionally, VA has partnered with private sector HIEs in implementing the VLER Health Exchange at seven more locations.

The VLER Health Exchange capability provides VA, DoD, and private sector providers with the 21-module foundational health data set which includes patient demographics, medications, procedures, laboratory test results, allergies, problems, immunizations, discharge summaries, and other medical record data. The capability provides the potential for improved care for Service members and Veterans, and reduces the need for unnecessarily repeating laboratory and other tests and procedures.

By the beginning of FY 2012, VA and DoD achieved the ability to exchange health information with a private sector HIE partner at the fourth and final joint pilot site in the Puget Sound region of Washington. HIE activities continued throughout FY 2012 at all four joint pilot locations. Early in FY 2012, VA began HIE activity in Buffalo, New York; Minneapolis, Minnesota; Charleston, South Carolina; Salt Lake City, Utah; and Grand Junction, Colorado. By the close of FY 2012, VA established HIE in Altoona, Pennsylvania and in San Diego, California. Data was collected from the pilots, and the Departments produced evaluation reports to facilitate a "Go/No-Go" decision by the VA/DoD JEC. On August 9, 2012, the JEC clarified the program objectives for the incremental rollout of VLER Health capabilities and approved a "Go" decision. The program objectives are:

- Execute VLER Health program with appropriate controls to create integration with iEHR for both Departments.
- Resolve and mitigate policy and technical risks and issues related to Opt-in and Opt-out regarding inclusion of DoD Service member beneficiaries (family members) in HIE initiatives (Exchange and Direct).
- Support the eHealth Exchange initiative by:
    - Increasing the rates of adoption at existing locations;
    - Adding partners based on mutual identification of business drivers and ability to engage in high volume high quality exchanges;
    - Trait Matching, HIE maturity, Exchange Volume expansion, Standards Use, Population increase;
    - Emphasizing "gaps" to promote regional health exchange (i.e., southeast, intermountain west); and
    - Adding exchange partners at iEHR IOC Sites: San Antonio, Hampton Roads
- Deploy the Direct Project for consult referrals by focusing on a few high value, shared use cases, such as mammograms.

- Provide more control to Veterans, Service members and potentially beneficiaries (family members) by increasing “Fine-grained” consent directives, and assisting in “Blue-Button” sharing from EHR.
- Identify and prioritize best opportunities to maximize early return on investment.

The Departments achieved the ability to exchange a foundational health data set using the eHealth Exchange (formerly the NwHIN). The eHealth Exchange is an initiative led by HHS’ Office of the National Coordinator for Health Information Technology. The eHealth Exchange is a confederation of trusted entities, from public and private sector, bound by mission and governance to securely exchange health information. VA and DoD were flagship eHealth Exchange participants, and the IPO is positioned to take a lead role in the two Departments’ joint Health Information Technology programs in the broader HIE arena.

A companion initiative to the eHealth Exchange is The Direct Project. The Direct Project was created to specify a simple, secure, scalable, standards-based way for participants to send authenticated, encrypted health information directly to known, trusted recipients over the Internet. VLER Health is the IPO program through which the Departments share expertise and capabilities for eHealth Exchange and the Direct Project.

FY 2012 IPO eHealth Exchange and Direct Project activities included the following:

- Assisting a partner in eHealth Exchange with new interoperability specifications for the conformance testing process for on-boarding new eHealth Exchange members. Working with and assisting existing and potential eHealth Exchange partners helps improve the volume and quality of the data exchanged and provided to VA and DoD clinicians.
- Meeting with the state and private sector HIE entities to gauge their ability to stand up eHealth Exchange and Direct Project capabilities. The goal of these meetings is to expand the number of potential HIE partners, increase HIE volume, and improve the quality and amount of information about Service members and Veterans available to VA and DoD clinicians.
- Consolidating VA and DoD eHealth Exchange and Direct Project program management at the IPO.
- Continuing DoD business discussions for including non-active duty members in VLER Health Exchange.
- Receiving the authority to Operate Stage 1 (of 3 initiative stages) of the DoD Direct Project Innovation Initiative through the TMA accreditation and certification process.
- Approval of Hill Air Force Base near Ogden, Utah by the Joint Health Operations Council as the location for a Direct Project pilot.
- Communications by IPO senior staff with local health exchanges and providers in Washington DC, Alaska, Hawaii, Guam, Rhode Island, Connecticut, Texas, Nebraska, Idaho, California, Florida, and Pennsylvania about implementing Direct Project exchanges with VA facilities. Discussions centere on guiding private sector providers in configuration of software, acquisition of Public Key Infrastructure certificates, and business process redesign to prepare for pilots.

The VLER Health Program continues to evolve to enable secure, electronic health care information sharing among VA, DoD, and their health care partners.

Captain James A. Lovell Federal Health Care Center

North Chicago Advisory Board

On October 1, 2010, the North Chicago VAMC and the Naval Health Clinic Great Lakes integrated to become the Captain James A. Lovell Federal Health Care Center (FHCC). The FHCC provides care for Active Duty Service members, Veterans and TRICARE dependents (military families, including infants and children). Both VA and DoD Secretaries signed an Executive Agreement in April 2010 detailing the specifics of how the FHCC would function. The FHCC was created with guidance provided from the National Defense Authorization Act of FY 2010.

The FHCC is a fully-integrated facility with VA and DoD staff working together toward a single, combined VA and Navy mission. A FHCC stakeholder advisory group meets quarterly to advise the Director on how well the FHCC is meeting the needs of local VA and DoD beneficiaries.

The FHCC was one of the first VA facilities to offer compensation examinations to Service members before they leave the military. Additionally, the FHCC participates in the IDES program. The FHCC implemented a single discharge physical so that a Service member leaving the military and receiving a VA compensation examination now only has to undergo one physical, with the results shared between VA and the Navy. The single discharge physical as well as the collocation of the Physical Evaluation Board Liaison Officer resulted in an IDES average completion time of 239 days, 56 days below the DoD standard.

In October 2011, the FHCC received CARF Accreditation in Community Integration, Community Services Coordination, Employment Planning Services and Residential Treatment. The FHCC also received accreditation from the Joint Commission in January 2012.

Information Technology Capability Delivery to Support FHCC Operations

In order to safely exchange data between VA and DoD IT systems and allow health care providers and administrative personnel to deliver high-quality services at the FHCC, the Departments developed and refined the following IT capabilities to support North Chicago during the reporting period:

- *Single Patient Registration*. This IT solution supports the capability to register and update a patient via a single graphical user interface (GUI). Through legacy VA and DoD systems, the patient is registered, eligibility is verified, and updates are made. This common service is used by both VA and DoD. During FY 2012, enhancements related to correlating the records between VA and DoD systems were implemented. Defense Enrollment Eligibility Reporting System (DEERS) expanded their system to eliminate backlogs. Better coordination of system down times was initiated between VA and DoD both locally, and with DEERS and the Master Veterans' Index. An initiative to have recruit files sent directly from the Defense Manpower and Data Center through the registration GUI is underway.

- *Medical Single Sign-on (MSSO).* Users are able to access the individual clinical applications presented via MSSO to include a new GUI, leveraging JANUS, based upon the user's access rights for the individual systems available using a single user authentication process via VA Personal Identity Verification Card or DoD Common Access Card.
- *Clinical CM.* Along with the addition of the GUI this year, continuous enhancements to VA and DoD CM solutions enable users to select a patient from one application, which then automatically selects the same patient when accessing another VA or DoD application.
- *Orders Portability (OP).* OP provides the ability for a provider, or authorized user on behalf of a provider, to place or enter an order in the VA and/or DoD clinical system and have that information available for an authorized user in either system. In FY 2012, laboratory OP was fully implemented. Increment 1 for Consults OP began phased roll out in August 2012 and Increment 2 for Consults started the initial phase.

Additionally, VA and DoD continued to work with the GUI solutions to improve viewing health care data and to implement a common GUI for providers at the FHCC. Going forward, the Departments will continue to maintain these delivered IT capabilities.

IT capabilities planned, including the Integrated Electronic Health Record and Pharmacy, but not yet delivered for the FHCC will be led by the DoD/VA IPO.

The following are notable statistics from FY 2012:

- Operating Beds: 369 (Authorized 442)
- Total outpatient visits captured in VistA and Armed Forces Health Longitudinal Technology Application (AHLTA): 804,610
- Total inpatient admissions: 4,773
- Total dental visits to West Campus: 7,707
- Total dental visits to East Campus: 195,250 (702,241 Dental Weighted Values)
- Pharmacy prescriptions: 1,773,836
    - Total outpatient prescriptions filled: 610,735
    - Total inpatient prescriptions filled: 53,607
    - Total unit-dose prescriptions filled: 1,095,353
    - Total local mail-order prescriptions filled: 14,141
- USS Red Rover processed more than 38,000 Navy Recruits, delivering more than 400,000 immunizations

Information Technology Capability Delivery to Support FHCC Operations

The FHCC is a fully integrated health care facility in North Chicago staffed and operated by VA and DoD personnel. The facility brings together into a single operation two health care facilities that were formerly operated separately in the same geographic area by VA and the Department of the Navy. The FHCC provides care for Service members, Veterans, and beneficiaries of TRICARE, the health insurance program for retired military members and families of current and retired military members.

The IPO manages ongoing and future joint development and sustainment efforts for the software development life cycle in the FHCC demonstration project. One of the eight branches of Clinical Informatics Research and Development (CIRD) in the IPO is dedicated to the FHCC project. The CIRD FHCC branch will share lessons learned from the FHCC project that will inform ongoing development of the iEHR program.

The Departments maintained, deployed, and refined the following IT capabilities for the FHCC during FY 2012:

- Deployed iEHR Presentation Layer.
- Deployed Laboratory OP and first increment of Consults OP.
- Conducted maintenance and enhancement activities for Laboratory and Radiology OP.
- Enhanced Single Patient Registration.
- Improved access to two different MSSO products.
- Expanded Testing Platforms used to facilitate joint VA/DoD end-to-end testing for all FHCC releases.
- Delivered software development solution for Financial Reconciliation.
- Completed preliminary design review of software development solution for Billing and Accounts Receivable.
- Completed preliminary design review of software development solution for Billing and Accounts Receivable. This will allow FHCC to collect from third party insurance providers for Veterans. Another benefit is that the VHA will perform all first party and third party billing, accounts receivable and collection activities for the FHCC solely through the VistA system.

The IT activities and accomplishments during FY 2012 in the FHCC 5-year demonstration project support the transition from the Departments' legacy health care IT systems to iEHR. Each product development effort listed above is required to support the health IT framework FHCC providers and clinicians use to access interagency health care data and enable health care documentation in support of medical readiness and continuity of care. Progress in product development enhances the provider's ability to provide seamless health care to both VA and DoD beneficiaries in the FHCC integrated environment. Lessons learned at FHCC inform the process for using the legacy systems while establishing a single, integrated system.

Telehealth Working Group

As a result of the JEC identifying joint VA/DoD telehealth expansion as a priority item, HEC leadership established a VA/DoD TWG in FY 2011. DoD's National Center for Telehealth & Technology (T2) and VA's Telehealth Services leads were selected as Co-Chairs of the WG. The WG Co-Chairs identified additional WG members that include senior telehealth representatives from the Military Departments and from relevant VA offices. The Telehealth WG charter was approved in FY 2012.

The WG's mission is to identify opportunities to expand the joint telehealth program and optimize joint capabilities between Departments. Pursuant to that mission, the Telehealth WG developed a Telehealth JSP for FY 2013-2015. The Telehealth JSP identified several areas of focus to

improve standardization and integration of telehealth activities between Departments. In FY 2012, the TWG established five main areas of focus:

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

The Telehealth WG began work in these five areas during FY 2012. The WG began to analyze how to integrate recent changes in DoD licensure law into policy improvements that will benefit telehealth services within and between Departments. The WG reviewed existing telehealth credentialing and privileging processes within each Department and recently gained representation on a joint DoD/VA Credentialing and Privileging Task Force in order to better coordinate knowledge of credentialing and privileging processes for telehealth and other health care areas. The WG identified TeleIntensive Care Unit training materials to share between Departments and is looking into solutions for identifying and sharing additional telehealth training resources. In collaboration with the Integrated Mental Health Strategy Strategic Action item six, the WG helped create a VA/DoD demonstration project to deliver telebehavioral pain consultation from VA clinicians with specialized expertise to DoD patients through telehealth. Issues raised from that demonstration project are allowing for further telehealth policy improvement analysis.

Health Care Resource Sharing

Facilities and Environment

460th Medical Group (MDG), Buckley Air Force Base (AFB) and VA Eastern Colorado Health Care System (HCS)

The 460th MDG (460th MDG), Buckley AFB and VA Eastern Colorado HCS in Colorado, initiated their partnership at the new location for the Denver VAMC with a sharing agreement for facilities and environment. Facilities and operations between the 460th MDG and the Denver VAMC assumed a consolidated but not fully integrated model of operations with this agreement. Similar to the tenant concept, with VA as the majority space occupant, the 460th MDG reimburses VA based on proportionate expenses related to operations. Both partners integrate operational elements wherever possible including physical access, medical equipment (and other technology acquisitions), laundry/linen, operations, and hazardous/bio-hazardous waste management. It is anticipated that this agreement will lead to more sharing opportunities in the future.

Training Agreement

Air Force Medical Operations Agency and Baltimore VAMC

The Baltimore VAMC, VA Maryland HCS and the Air Force Medical Operations Agency initiated a Center for Sustainment of Trauma and Readiness Skills (C-STARS) Training sharing agreement. The nature of this agreement is to allow C-STARS providers to earn or maintain their trauma care credentials by providing services to VA patients, utilizing work areas

at VA facilities. Active Duty providers will act as fully privileged and credentialed providers at the VA facility to provide services free of charge in order to maintain critical medical/surgical war-time skills they cannot get elsewhere. This benefits both Active Duty providers, because they are able to maintain their clinical skills, and VA, as it benefits from the use of the Active Duty provider's clinical experience and performance.

Same Day Surgery Unit

377th MDG, Kirtland AFB and New Mexico VAHCS

The 377th MDG (377th MDG), Kirtland AFB and New Mexico VAHCS (NMVAHCS) entered into a Joint Venture Same Day Surgery Unit (SDSU) sharing agreement. In this sharing agreement, the 377th MDG provides full use of its SDSU space and equipment to the NMVAHCS, allowing the NMVAHCS to increase its ability to better provide same day surgical services for its beneficiary population vice sending them out for fee care. It also recaptures ambulatory surgical services for the 377th MDG. This agreement uses a bartering approach for reimbursement where 30 surgical procedures are provided to beneficiaries of the 377th MDG in lieu of NMVAHCS reimbursement for the use of the space.

Medical Services/Procedures

59th Medical Wing (MDW) and South Texas Veterans Health Care System (STVHCS)

The 59th MDW (59th MDW) and STVHCS started an overarching Medical Services/Procedures sharing agreement. This agreement is for multiple medical services and procedures including, but not limited to, endoscopic ultrasound, sleep studies, dermatology laser treatments, endoscopic retrograde cholangiopancreatography, dialysis treatments, and movement disorders. STVHCS will reimburse 59th MDW at current Civilian Health and Medical Program of the Uniformed Services **(**CHAMPUS) Maximum Allowable Charge (CMAC) rates minus 10 percent, and for any VA patient transportation requirements.

Naval Hospital Pensacola

Naval Hospital (NH) Pensacola has two resource sharing partners, the VA Gulf Coast VHCS and the Memphis VAMC. There are currently 14 sharing agreements between NH Pensacola and these two partners. The resource sharing program at NH Pensacola covers the following: emergency room services, inpatient services, Joint Ambulatory Care Center (radiology, laboratory, dental and obstetrics/gynecology), sleep lab, surgical services, and urology services. Naval Branch Health Clinic Panama City has dental, laboratory, pharmacy, and radiology. Naval Branch Health Clinic Millington has mental health, magnetic resonance imaging (MRI), and optometry.

This table represents NH Pensacola's average monthly workload shared with its VA partners.

Monthly Average Workload Comparison			
FY 2011		**FY 2012**	
Inpatient Admissions	12	Inpatient Admissions	13
Outpatient Visits	182	Outpatient Visits	203
Laboratory Tests	934	Laboratory Tests	1,140
Radiology Exams	64	Radiology Exams	86

In June 2012, TMA approved a waiver request for an increase in the inpatient services discount to 25 percent off of the Diagnosis Related Group rates.

The partners on the Gulf Coast have been working for a couple of years to share and transfer digital radiology images. This was accomplished in summer FY 2012 by establishing a secure communication and transfer linkage between Picture Archive and Communications Systems servers at NH Pensacola and the VA Joint Ambulatory Care Center (JACC). This connection will provide better quality support to the beneficiaries served by both partners.

Charleston Joint Venture

In October 2011, the Charleston-Beaufort commuting area was officially designated as a VA/DoD joint venture which consists of: Naval Health Clinic, Charleston (NHCC), Ralph H. Johnson VAMC (RHJVAMC), 628th MDG (Joint Base Charleston), and NH Beaufort.

RHJVAMC shares spaces with NH Beaufort and NHCC to provide CBOC services to Veterans. In Charleston, services are shared at the Captain John G. Feder JACC and at the Joint Optometry/Ophthalmology Clinic. Ophthalmology services were added in FY 2012 as a JIF initiative. The JACC continues to provide mobile MRI services to both VA and DoD beneficiaries through equipment purchased through the JIF. Through resource sharing agreements, NHCC/628th MDG/RHJVAMC provided joint services in cardiology, phlebotomy, consultant pathology services and shared training and clinical skills enhancement opportunities. In Beaufort, RHJVAMC and NH Beaufort were recipients of a FY 2012 JIF award to institute mobile MRI services at NH Beaufort. Additionally, NH Beaufort and RHJVAMC have resource sharing agreements for laboratory, radiology, podiatry, audiology and optometry services.

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

Naval Medical Center San Diego and VA San Diego HCS

Naval Medical Center San Diego (NMCSD) and the VA San Diego HCS (VASDHCS) have a strong sharing arrangement which includes six reimbursable agreements. Under the comprehensive medical services sharing agreement, all health care resources are shared between NMCSD and VASDHCS where demand and capacity exist. In FY 2012, NMCSD treated VASDHCS patients for critical care services and 3D Echocardiography. The NMCSD is currently evaluating performing cataracts surgery, plasmapheresis, and brachytherapy services for VASDHCS. NMCSD and VASDHCS are also evaluating the use of the NMCSD ambulatory surgery spaces for VA physicians to perform cardiology electrophysiology surgery for VA patients.

Currently, VASDHS does not offer obstetrics services. NMCSD assists the VASDHCS by seeing their Veterans for obstetrics services at both the main hospital and two branch medical clinics. The Obstetrics Department has provided services for over 100 VASDHCS mothers.

In FY 2012, four Navy Clinical Pastoral Education (CPE) residents participated in the VA/DoD CPE satellite center located in San Diego, as a result of the VA/DoD CPE sharing agreement.

The laboratory sharing agreement between NMCSD and VASDHCS is a unique bi-directional sharing agreement. The VASDHCS performs testing for NMCSD and NMCSD performs laboratory services and laboratory testing for VASDHCS. The mammography sharing agreement provides screening and diagnostic mammograms and ultrasound guided biopsies to VASDHCS patients at NMCSD. The VASDHCS receives, itemizes, logs, inventories, and sterilizes items from NMCSD under the ethylene oxide sterilization services agreement. NMCSD delivers and picks up items at VASDHCS.

NMCSD and VASDHCS submitted and received FY 2010 JIF funding for $5.81 million to obtain staffing and linear accelerator (LINAC) radiation therapy ancillary equipment for the treatment of VASDHCS radiation oncology patients at NMCSD. The project required reconstruction of an existing space for the LINAC, asbestos abatement, installation, software programming, calibration, testing and final acceptance. In August 2012, NMCSD treated the first VA LINAC patient.

Dwight David Eisenhower AMC, Charlie Norwood VAMC, and Carl Vinton VAMC

In January 2012, Dwight David Eisenhower AMC (DDEAMC), Charlie Norwood VAMC (CNVAMC) and Carl Vinson VAMC (CVVAMC) established the Georgia Federal Healthcare Executive Council (GFHEC). The Council serves as the governing body for the management of approved federal resource sharing (FRS) agreements and JIF proposals/projects between the three facilities. The GFHEC's goal is to enhance and improve the delivery of quality health care and access to care for Service members and Veterans through collaborative partnership.

Effective October 1, 2011, the FRS master sharing agreement between DDEAMC and CNVAMC was amended to include all long-term shared services previously covered by individual FRS agreements as well as additional shared services. The successful sharing of Cardiothoracic (CT) surgical services continued to generate tangible benefits for both facilities. For DDEAMC, these benefits included provider readiness, increased third party collections, Graduate Medical Education program support, increased operating room utilization, and additional prospective payment system earnings. CNVAMC benefits through significant cost reduction compared to local network costs for CT surgery, equating to an average of $1.4 million per year. CNVAMC also benefits through direct communication from DDEAMC providers about patient status and outcomes, a benefit not easily established with external civilian facilities.

A FRS master sharing agreement between DDEAMC and CVVAMC is being established and will include the Cardiology and CT surgery currently covered under a separate FRS agreement. This new agreement will also add general surgery, hyperbaric therapy, gastrointestinal services, and orthopedic services. Other initiatives being explored include urology and ophthalmology shared services.

Lyster Army Health Clinic and Central Alabama VHCS

Lyster Army Health Clinic's sharing agreement between Central Alabama VHCS at Fort Rucker, Alabama has vastly improved the region's quality of care through mutual financial and

human resource allocation. The sharing agreement created an opportunity to provide nearly 27,000 radiological studies to both VA and DoD patients since October 2010. These numbers will only increase as both clinics continue to provide quality medical services to Fort Rucker and the surrounding population.

Fort Sill and Lawton/Fort Sill VA CBOC

The Lawton/Fort Sill VA clinic is located on Fort Sill. Many radiology orders are written by VA providers for their beneficiaries, but the nearest VAMC is located approximately 90 miles north of the VA clinic, potentially causing VA beneficiaries to drive 180 miles round trip to complete ancillary procedures; VA beneficiaries are entitled to $0.51 per mile for travel expenses. Reynolds Army Community Hospital (RACH) is located adjacent to the Lawton/Fort Sill Clinic; having RACH provide these procedures saves on VA travel expenses, convenience for the VA beneficiary, and allows faster health care services. VA is given a 10 percent discount of the current CMAC rate for each procedure.

Fort Sam Houston and South Texas VHCS

The sharing agreement between Fort Sam Houston and STVHCS for internal medicine has focused on cardiology, pulmonary and gastroenterology procedures. In terms of educational opportunities, this agreement has improved exposure to low volume procedures significantly without impacting outpatient access to care for beneficiaries. The agreement provided 382 outpatient encounters with an estimated value of $62,635 that would have otherwise been sent to the network or diverted to another VA facility outside of the area. Inpatient services provided secondary to the procedural encounters and surgical agreement resulted in 37 medicine ward patient dispositions with an estimated value of $564,638.

The sharing agreement for surgical services has focused on those surgical sub-specialties that are not able to generate enough surgical cases from the DoD beneficiary population for staff to remain current and for residents to obtain sufficient numbers of cases for their resident training programs. The STVHCS does not have any retina capability but the San Antonio Military Health System has four retina specialists who need more surgical cases to maintain skills and train residents. Occuloplastics at San Antonio Military Medical Center are also in need of additional surgical cases, which are available in the VA system. In Otolaryngology, the Resident Review Committee issued a citation to their resident training program for low case volumes in head and neck cancer and laryngology cases. These cases are available in the VA patient population and treating these patients has increased the volume in these sub-specialties by over 40 percent in the last year since the agreement was established. Overall, in FY 2012 this agreement has added over 1,210 encounters to our surgical specialties with estimated earnings to the MTF of $209,000; inpatient services provided secondary to the procedures resulted in 92 surgical ward patient dispositions with estimated earnings of $1.5 million to the MTF.

Pharmacy Ad Hoc Working Group

In FY 2012, the Pharmacy WG identified 32 commonly used pharmaceutical products and manufacturers for potential joint contracting action and continued to seek new joint contracting opportunities where practicable. In addition, the Departments have been analyzing overlapping operational and clinical areas for potential increased collaboration.

A review of purchases for new and existing joint contracts yielded 83 joint national contracts, of which 18 were new contracts. In FY 2012, VA spent $192 million on joint national contracts, and DoD spent $124 million. In FY 2012, VA joint national contract prime vendor purchases represented 4.47 percent of total prime vendor purchases; DoD purchases represented 3 percent. VA identified 3 drugs within the top 25 drugs as measured by VA's acquisition dollar volume that lost patent exclusivity. VA identified 41 new molecular entities used in the ambulatory setting for contracting opportunities. All 41 have been reviewed or are currently under review. DoD performed 8 drug-class reviews with 8 sub-classes and 115 drugs, representing $1.4 billion of the total spend with estimated cost avoidance and direct refunds of $119 million. Sixty-five joint national contracts expired in FY 2012. All 65 expiring contracts were reviewed for renewal, reprocurement, or termination.

Joint contracting efforts maximize leverage with the pharmaceutical industry resulting in lower pharmaceutical procurement prices and significant cost avoidance for both Departments. These cost avoidance opportunities help to sustain the robust pharmacy benefits provided to both VA and DoD beneficiaries.

Other joint pharmacy initiatives were discussed by the Department Secretaries, focusing on potential efficiencies to be gained. The JEC identified several initiatives for further consideration to determine the extent of cost savings potential, if any. The initiatives include:

- Expanding the number of VA pharmacies designated as TRICARE pharmacies.
- Allowing VA to utilize the TRICARE Retail Pharmacy network for VA beneficiaries with urgent prescription needs.
- Consolidating the pharmaceutical prime vendor distribution contracts.
- Changing Federal pricing regulations for retail pharmacy workload.
- Joint pharmaceutical contracting.
- Formulary management.
- Uniform Formulary modifications (reviewing newly approved drugs before they are added to the DoD formulary).
- Mail order prescription fulfillment.

Three of these initiatives are currently under review and analysis: formulary management, consolidating pharmaceutical prime vendor distribution contracts, and mail order prescription fulfillment. Full reports on these issues are due in FY 2013. The initiative to change Federal pricing regulations for retail pharmacy utilization is no longer under consideration. The joint pharmaceutical contracting initiative is considered complete. Three initiatives are being actively pursued: Uniform Formulary modifications, VA pharmacies designated as TRICARE pharmacies, and VA use of TRICARE Retail Pharmacy Network for urgent VA prescriptions.

Medical Research Working Group (MRWG)

VA and DoD currently collaborate on many diverse medical research initiatives, including coordination on the planning, implementation, and evaluation of major research programs. The DoD/VA Medical Research WG (MRWG) was established in FY 2012. The overall goal of the MRWG is to ensure coordination through the identification of new research directions and approaches, identification of gaps in scientific knowledge, and development of recommendations on future research coordination.

In FY 2012, the HEC appointed the MRWG Co-Chairs, who work for the Office of the Assistant Secretary of Defense for Health Affairs and the VA Office of Research and Development (VA ORD). The charter was approved in August 2012; it established the members who represent several DoD offices, including the three Military Departments, and four VA offices. In 2012, the Co-Chairs submitted a JSP objective for FY 2013-2015; therefore, FY 2013 will be the first year that the MRWG will have activities to report to the HEC. The MWRG Co-Chairs and members met several times unofficially in 2012 to work on these activities.

Joint VA/DoD efforts have been responsible for major breakthroughs in many medical specialties. VA and DoD have identified several high priority medical research areas, including PTSD and other psychological conditions, TBI, multidisciplinary treatment of polytrauma, pain management, rehabilitation, advanced prosthetics, and the long-term health effects of deployments. VA scientists compete very successfully for funding from DoD; there are hundreds of DoD-funded research projects in the VA system. DoD currently funds VA scientists for more than $30 million. These investigations include several high-priority topics, including PTSD, alcohol abuse, mental health of female Veterans including military sexual assault, resilience to mitigate combat stress and post-deployment reintegration problems, treatment of TBI and spinal cord injuries, treatment of amputations and improved prosthetics, visual and hearing impairments, rehabilitation, and illnesses in Veterans of the 1990-91 Gulf War and OEF/OIF/OND.

In FY 2012, DoD invited senior VA research managers and scientists to participate in full-day program evaluations of three DoD research portfolios. Each of these comprehensive portfolio reviews included hundreds of DoD-funded projects: the Military Infectious Diseases Research Program; the DoD Military Operational Medicine Research Program; and the DoD Combat Casualty Care Program. In addition, DoD and VA collaborated on the first three joint comprehensive program reviews, which included hundreds of VA and DoD projects on PTSD, suicide, and other psychological conditions; TBI; and medical training and health information technology. These joint program reviews identified complementary research projects, new research approaches, and gaps in scientific knowledge; the reviews improved interagency research coordination. In 2012, two reports on the comprehensive program reviews were published on combat casualty care, and clinical and rehabilitation medicine.

Scientists in DoD Health Affairs and VA ORD wrote an information paper, titled “DoD and VA evaluation of the effects of meditation treatment for PTSD.” VA and DoD are currently funding extensive research on meditation treatment, which will provide much needed scientific evidence on the effectiveness of this alternative therapy.

In FY 2012, VA and DoD worked to increase coordination on studies of the long-term health effects of military Service, and to improve collaboration on epidemiological studies that follow Service members from Active Duty through Veteran status. This could improve early identification of long-term health effects and enable early treatment and prevention. Scientists in DoD Health Affairs and VA ORD provided leadership in the development of two jointly-funded program announcements on PTSD and Neurotrauma TBI, which were published in September 2012. These solicitations will fund two consortia that are designed to investigate the long-term health effects of PTSD and TBI after Service members leave the military. These

solicitations represent an unprecedented collaboration between the Departments, in terms of joint oversight and total funding of $100 million.

The Millennium Cohort Study (MCS) includes more than 150,000 Service members, who started enrollment in 2001. The health of the cohort will be evaluated every three years until 2022, to determine the course of diseases over time. Thirty percent of the cohort has already separated from the military, and are eligible for VA medical care. DoD has funded the MCS since its inception. In 2012, VA ORD and the VA Office of Public Health worked to increase collaboration with DoD in the MCS, through planning for substantial VA funding and dedicated VA research staff. Increased VA/DoD collaboration on long-term cohort studies will build on the effectiveness of the existing foundation of interagency research.

Health Architecture Review Board (HARB)

The DoD/VA Health Architecture Review Board (HARB) is currently an advisory sub-WG to the HEC. The charter was approved in February 2012 to provide architecture oversight and approval due diligence for joint VA/DoD health programs to facilitate interagency cooperation and foster collaboration on enterprise architecture (EA) for interagency Health Information Technology (HIT) initiatives; activities that were previously the responsibility of the HEC IM/IT WG.

FY 2012 primarily served as an establishment year for the HARB, which also included assumption of the Health Architecture Interagency Group (HAIG) responsibilities, and provided oversight on all aspects of joint architecture. This adjustment was made in response to leadership's decision to pursue development of a joint architecture supporting the future (iEHR). Since its inception, the HARB has continued to bring together the architecture communities from VA, DoD, and IPO in an effort to ensure effective collaboration on HIT initiatives. The HARB is focused on a common technical approach and solution architecture supporting improved adherence to standards, quality assurance, integration, transparency, visibility, monitoring, and alignment and interoperability, as needed, of the enterprise architecture supporting VA/DoD interagency HIT.

Key roles and responsibilities identified in the HARB charter include:

- Serve as the Joint HIT EA decision support sub-WG to the HEC.
- Establish and provide architecture oversight for joint VA/DoD health EA.
- Guide and oversee the establishment of joint VA/DoD core architecture artifacts for interagency HIT systems.
- Act as the architectural governance body for HEC HIT related initiatives.
- Facilitate interagency cooperation and foster collaboration.

Since its inception, the HARB has reviewed and supported completion of a number of artifacts. These activities facilitated architecture development, compliance, and acceptance between the Departments. Completed activities include:

- Developing Architecture and Standards Compliance Criteria.
- Reviewing and revising the HAIG VA/DoD architecture review checklist.
- Drafting VA/DoD architecture development processes.

- Reviewing and approving updates to the VA/DoD Information Exchange (IE) Tool and Target DoD/VA Health Standards Profile.

The Architecture and Standards Compliance Criteria was developed to assist with evaluating the technical architecture of products being developed or newly acquired by IPO, in accordance with joint SOA technical standards which span across all enabling capability areas (SOA/Enterprise Service Bus, Identity Management and Access Control, Data Federation, Cloud Architecture, Common User Interface). These criteria are currently used by the IPO to grade technical vendor responses to each of the IOC requests for information. Graded responses will inform which vendors most appropriately conform to agreed-upon iEHR technical standards and requirements.

The VA/DoD Architecture Review Checklist informs the assessment of architecture products based on acquisition milestone needs, business and technical architecture requirements, and overall EA compliance. Based on the HAIG's Architecture Review Checklist, the HARB architecture checklist aligns to version two of the DoD Architecture Framework and the Federal Enterprise Architecture Framework. This checklist is used in conducting VA/DoD electronic health data sharing architecture compliance reviews relating to various aspects of project architecture. Under the auspices of the HARB, the checklist continues to change and adapt to the growing needs of the IPO, VA, and DoD. Anticipated updates include a joint list of engineering and technical architecture standards and Department specific requirements depending upon the lifecycle of the product.

The VA/DoD Architecture Development Process outlines interactions between enterprise stakeholders and facilitates streamlined architecture development and review. The process is based on interactions between the IPO, ICIB and functional C-IPTs, and the HARB. While the process provides a solid foundation for current board interactions, it continues to be refined based upon the IPO program schedule, capability sequencing as defined by the ICIB, technical input required based on acquisition lifecycle, and available staffing.

The VA/DoD IE Tool enables Department stakeholders to establish and prioritize measurable data sharing, determine IM/IT program compliance with interoperability standards, and approve the annual interoperability standards for the Departments in a more streamlined manner. The IE Tool also identifies the current state of exchanges to assist in the prioritization of new requirements, identify interoperability information gaps and provides a reference for future architecture development.

The Target VA/DoD Health Standards Profile incorporates interoperability standards applicable to joint VA/DoD initiatives including the iEHR. It includes message formats, data representation, and technical and security standards. The annual update of the profile requires identifying gaps and incorporating nationally recognized HIT standards. During this activity, members of the HARB reviewed current standards profile and provided comments.

Currently, the HARB is working to finalize a joint VA/DoD architecture assessment checklist that incorporates architecture lessons and standards from a variety of iEHR EA stakeholders to ensure all review points are sufficiently captured. The HARB is also working to finalize a joint VA/DoD architecture development process based on evolving VA, DoD, and IPO

organizational roles and responsibilities. The group is involved with finalizing the joint iEHR Enterprise Architecture Management Plan that outlines EA processes and tools within a single document and identifies roles and responsibilities of iEHR architecture components. Additionally, each of the Business Justification Packages produced by the C-IPTs, which capture specific 'to-be' joint business processes, as well as recommended improvements, are being vetted through the HARB for review and approval. Finally, members will collaborate to finalize joint architecture development activities and maintain a joint schedule in alignment with Department-specific and IPO acquisition milestone needs. The HARB is dedicated to serve as a joint collection base for architecture lessons learned that can be leveraged across VA, DoD, and IPO organizations.

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) *2012 Annual Report* demonstrate concerted efforts within VA and DoD to improve the multiple areas of joint responsibility that directly affect the care and benefits of Service members and Veterans. This report provides updates in strategic areas that will continue to evolve until these joint initiatives become fully institutionalized into everyday operations. Both Departments are sincerely committed to maintaining and improving the collaborative relationships that make this progress possible.

Moving forward, the JEC will continue to set the strategic direction using the revised Joint Strategic Plan (JSP) framework for joint coordination and sharing efforts between VA and DoD. The *VA/DoD JEC JSP FY 2013-2015* updates and improves upon the objectives from the JSP FY 2011-2013 to focus on performance outcomes and will be published later this year. These enhancements are designed to help VA and DoD demonstrate and track progress toward defined goals, objectives, and end-states, and provide the continuum to successfully meet the needs of Service members and Veterans.

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

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

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

I. PURPOSE

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

II. AUTHORITY

The Secretary of Veterans Affairs and the Secretary of Defense establish these guidelines pursuant to the authorities in and requirements of Title 38, United States Code, section 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 VNDoD sharing agreements is delegated to the VA-DoD Health Executive Council (HEC). Although most sharing agreements will use the reimbursement methodology outlined in the VNDoD Outpatient and Inpatient guidance agreed to by the Departments, DoD and VA facilities are authorized to provide services in kind provided the exchange is clearly documented in the sharing agreement and can be expressed by a monetary value.

D. Scope of Agreements:

1. Sharing agreements include agreements between the two Departments; between Service regions of each Department; or between the heads of individual DoD and VA medical facilities where health care resources are acquired or exchanged between VA and DoD. A Memorandum of Agreement (MOA) shall accompany each VA Form 10-124% and identify the health care or other health-related resources to be shared and demonstrate that the agreement is in the best interest of both Departments' beneficiaries and mission. In general, health care resources covered under these agreements include hospital care, medical services, rehabilitative services, and any other health care services including health care education, training, and research as the providing Department has authority to conduct; and any health care support or administrative resource or service in support of VA medical facilities or Service MTFs.

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

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

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

E. Dual Eligibility: VNDoD beneficiaries provided care under a VNDoD 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 VNDoD resource sharing agreements and joint ventures is delegated to the Secretaries of the Military Departments (or their designees) for DoD and to the appropriate VA Central Office designees for VA. The designated approval authority for both DoD and VA must approve or disapprove a proposed agreement within 45 days of receipt. If action is not communicated to both signatories to the agreement at the end of the 45-day period, the agreement is considered as approved on the 46th day.

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

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

V. EFFECTIVE DATE AND MODIFICATION OF GUIDELINES

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

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

C. Departmental Policies: For VA**:** VHA Handbook 1660.4, VA-DoD Direct Sharing Agreements Handbook: http:/lwww1.va.gov/vapubs/. For DoD: DoD Instruction 6010.23, DoD and VA Health Care Resource Sharing Program: http://www.tricare.osd.mil/DVPCOldefault.cfm

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

Gordon England (date) OCT 3 1 2008
Deputy Secretary of Defense

Appendix B
Cost Estimate to Prepare Congressionally-Mandated Report

Title of Report: VA/DoD JEC FY 2012 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	$	86,101
Contract(s) Cost	$	156
Production and Printing Cost	$	4,100
Total Estimated Cost to Prepare Report	$	90,357

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 2012 hourly rate structure for the metropolitan Washington, DC area. The calculated net labor costs were multiplied by the fiscal year 2012 fringe benefit amount of 36.25 percent. The reported information in the cost statement reflects the sum of direct labor hour costs and fringe benefits.

Glossary of Abbreviations and Terms

A&I – Artifacts and Images
A&MMMWG – Acquisition and Medical Material Management Working Group
AC – Access Control
ADC – Active Dual Consumer
AFB – Air Force Base
AFFDWG – Department of Dense Auditory Fitness for Duty Working Group
AHLTA – Armed Forces Health Longitudinal Technology Application
AMC – Army Medical Center
AMSWG – Accessions Medical Standards Working Group
ANAM – Automated Neuropsychological Assessment Metrics
ANRs – Audio News Releases
APPs – Applications
AR – VA/DoD JEC Fiscal Year 2012 Annual Report
ARCs – Advanced Rehabilitation Centers (ARCs)
ARWG – Auditory Research Working Group
ATSDR – Agency for Toxic Substances and Disease Registry
AY – Academic Year
BAMC – Brooke Army Medical Center
BEC – Benefits Executive Council
BDD – Benefits Delivery at Discharge
BHIE – Bidirectional Health Information Exchange
BI – Business Intelligence
BJPs – Business Justification Packages
BOG – Board of Governors
BPG – Business Process Group
BRAC – Base Realignment and Closure
BRD – Business Requirements Document
CAPC – Capital Asset Planning Committee
CAREN – Computer Assisted Rehabilitation Environment
CARF – Commission on Accreditation of Rehabilitation Facilities
CBO – Veterans Health Administration Chief Business Office
CBOC – Community-Based Outpatient Clinic
CBSWG – Communication of Benefits and Services Working Group
CBT-D – Cognitive Behavioral Therapy for Depression
CBT-I – Cognitive Behavioral Therapy for Insomnia
CDC – Centers for Disease Control and Prevention
CDP – Center for Deployment Psychology
CDR – Clinical Data Repository
CFI – Department of Defense Center for the Intrepid
CHAMPUS – Civilian Health and Medical Program of the Uniformed Services
CHDR – Clinical Health Data Repository
CIRD – Clinical Informatics Research and Development
C-IPT – Capability-Integrated Product Team
CM – Context Management

CMAC – CHAMPUS Maximum Allowable Charge
CNVAMC – Charlie Norwood VA Medical Center
CoE – Center of Excellence
CoEPE – Centers of Excellence in Pain Education
CONOPS - Concept of Operations
CPC – Construction Planning Committee
CPE – Clinical Pastoral Education
CPG – Clinical Practice Guideline
CPT – Cognitive Processing Therapy
C-STARS – Center for Sustainment of Trauma and Readiness Skills
CT – Cardiothoracic
CVVAMC – Carl Vinson VA Medical Center
CY – Calendar Year
DCoE – Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DD – Department of Defense Forms 214, 2807, and 2808
DDEAMC – Dwight David Eisenhower Army Medical Center
DEERS – Defense Enrollment Eligibility Reporting System
DES – Disability Evaluation System
DHWG – Deployment Health Working Group
DIN-PACS – Digital Imagine Network – Picture Archive and Communications System
DMA – Disability and Medical Assessments
DMDC – Defense Manpower and Data Center
DMRTI – Defense Medical Readiness Training Institute
DoD – Department of Defense
DOEHRS - Defense Occupational and Environmental Health Readiness System
DOEHRS-HC - Defense Occupational and Environmental Health Readiness System for Hearing Conservation
DoDI – Department of Defense Instruction
DOL – Department of Labor
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
DTE – Development and Test Environment
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 – Enterprise Architecture
EACE – Traumatic Extremity Injuries and Amputations Center of Excellence
EBP – Evidence Based Psychotherapy
EBPWG – Evidence Based Practice Working Group
ED – Department of Education
eDR – Enhanced Document Referral

EHR – Electronic Health Record
EPA – Environmental Protection Agency
ESB – Enterprise Service Bus
FCC – Federal Coordinating Center
FCG – Functional Capabilities Group
FHCC – Federal Health Care Center
FHP&R – Force Health Protection and Readiness
FMWG – Financial Management Working Group
FRC – Federal Recovery Coordinator
FRCP – Federal Recovery Coordination Program
FRS – Federal Resource Sharing
FTE – Full-Time Equivalents
FY – Fiscal Year
GAO – Government Accountability Office
GFHEC – Georgia Federal Healthcare Executive Council
GME – Graduate Medical Education
GUI – Graphical User Interface
HAIG – Health Architecture Interagency Group
HAIMS – Healthcare Artifact and Image Management Solution
HARB – Health Architecture Review Board
HCE – Hearing Center of Excellence
HCS – Health Care System
HCWG – Hearing Conservation Work Group
HDR – Health Data Repository
HEC – Health Executive Council
HHS – Department of Health and Human Services
HIE – Health Information Exchange
HIT – Health Information Technology
HIPPA – Health Insurance Portability and Accountability Act
HPE – Health Professions Education
iBPR – Integrated Business Process Reengineering
iBRD – Integrated Business Requirements Document
iBRM – Integrated Business Requirements Model
IC3 – DoD/VA Interagency Care Coordination Committee
ICE – Interactive Customer Evaluation
ICIB – VA/DoD Interagency Clinical Informatics Board
IDES – Integrated Disability Evaluation System
IE – Information Exchange
iEHR – integrated Electronic Health Record
ILER – Individual Longitudinal Exposure Record
IMHS – Integrated Mental Health Strategy
IM/IT – Information Management/Information Technology
IOC – Initial Operating Capability
IOM – Institute of Medicine
iPLRD – Integrated Project Level Requirement Document
IPO – Interagency Program Office
IPR – Interim Progress Reports

IRB – Institutional Review Board
IS/IT – Information Sharing/Information Technology
IT – Information Technology
IWG – Independent Working Groups
JACC – Joint Ambulatory Care Center
JEC – Joint Executive Council
JFU&RS WG – Joint Facility Utilization and Resource Sharing Working Group
JIC – Joint Immunization Capability
JIF – Joint Incentive Fund
JSP – VA/DoD JEC Joint Strategic Plan
JV/RS WG – Joint Venture and Resource Sharing Working Group
Lab/AP – Laboratory/Anatomic Pathology
LINAC – Linear Accelerator
LUT – Limited User Testing
MCiS – Military Health System Cyberinfrastructure Services
MCL – Military Crisis Line
MCS – Millennium Cohort Study
MCSC – Managed Care Support Contractor
MDG – Medical Group
MDW – Medical Wing
MED COI – Joint Medical Community of Interest
MedPDB – Medical Surgical Product Data Bank
MHS – Military Health System
MHS Learn – Military Health System Learning Portal
MHV – MyHeatheVet
MMC – Medical Master Catalog
MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MP – Management Plan
MRI – Magnetic Resonance Imaging
MRWG – Medical Records Working Group (BEC)
MRWG – Medical Research Working Group
MSSO – Medical Single Sign-On
mTBI – Mild Traumatic Brain Injury
MTF – Military Treatment Facility
NATO – North Atlantic Treaty Organization
NCAT – NeuroCognitive Assessment Tool
NCC – National Capital Consortium
NGC – National Guideline Clearinghouse
NH – Naval Hospital
NHCC – Naval Health Clinic Charleston
NIH – National Institutes of Health
NMCSD – Naval Medical Center San Diego
NMVAHCS – New Mexico Veterans Affairs Health Care System
NRD – National Resource Directory
NwHIN – Nationwide Health Information Network
OEF – Operation Enduring Freedom

OIF – Operation Iraqi Freedom
OIG – Office of Inspector General
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
PAN – Polytrauma Amputation Network
PASTOR – Pain Assessment and Outcome Registry
PBRN – Practice-Based Research Network
PCMH – Patient-Centered Medical Home
PDB – Product Data Bank
PDHA – Post-Deployment Health Assessment
PDHRA – Post-Deployment Health Reassessment
PE – Prolonged Exposure Therapy
PEBLO – Physical Evaluation Board Liaison Officers
PFA – Psychological First Aid
PH – Psychological Health
PHI – Public Health Information
PIDM – Patient Identity Management
PMO – Program Management Office
PMWG – Pain Management Working Group
PPDHA – Pre- and Post-Deployment Health Assessment
PSA – Public Service Announcements
PSWG – Patient Safety Working Group
PTSD – Post Traumatic Stress Disorder
RAC – Regional Amputation Centers (RAC)
RACH – Reynolds Army Community Hospital
RCP – Recovery Coordination Program
RHJVAMC – Ralph H. Johnson VAMC
RoG – Republic of Georgia
RTO – Research and Technology Organization
SA – Strategic Actions
SAB – Scientific Advisory Board
SCAN-ECHO™ – Specialty Care Access Networks-Extension for Community Healthcare Outcomes
SCORE! – Study for Cognitive Rehabilitation Effectiveness
SCWG – JEC Strategic Communications Working Group
SDSU – Same Day Surgery Unit
SDR – Suicide Data Repository
SHAWG – Separation Health Assessment Working Group
SMMAC – Senior Military Medical Advisory Council
SME – Subject Matter Expert
SOA – Service Oriented Architecture
SOC – Senior Oversight Committee
SPARRC – Suicide Prevention and Risk Reduction Committee
SPC – Suicide Prevention Conference

SSA – Social Security Administration
SSO – Single Sign-On
STAR – Service members Transitional Advanced Rehabilitation (STAR)
STR – Service Treatment Record
STVHCS - South Texas Veterans Health Care System
T2 – Department of Defense's National Center for Telehealth and Technology
TAMC – Tripler Army Medical Center
TAP – Transition Assistance Program
TATRC – Telemedicine Advanced Technology and Research Center
TBI – Traumatic Brain Injury
TED-I/NI – TRICARE Encounter Data – Institutional/Non-Institutional
TFMO – Theater Functional Management Office
TMA – TRICARE Management Activity
TMS – Talent Management System
USAMRMC – United States Army Medical Research and Material Command
USMC – United States Marine Corps
USTRANSCOM – United States Transportation Command
UX – User Experience
VA – Department of Veterans Affairs
VA CARES – Veterans Affairs Capital Assets Realignment for Enhanced Services
VAMC – VA Medical Center
VAORD – VA Office of Research and Development
VAS – Visual Analog Scale
VASDHCS – Veterans Affairs San Diego Health Care System
VBA – Veterans Benefits Administration
VCA – VLER Capability Area
VCE – Vision Center of Excellence
VCL – Veterans Crisis Line
VHA – Veterans Health Administration
VHCS – Veterans Health Care System
VISN – Veterans Integrated Service Network
VISTA – Veterans Health Information System Technology Application
VLER – Virtual Lifetime Electronic Record
VOW Act – Veterans Opportunity to Work Act
VSO – Veterans Service Organization
VTA – Veterans Tracking Application
VTA IDES – Veterans Tracking Application for the Integrated Disability Evaluation System
WG – Working Group