

EXHIBIT 2

**VA/DoD Joint Executive Committee
Annual Report
FISCAL YEAR 2014**

VA/DoD

Joint Executive Committee Membership List

(as of September 30, 2014)

Department of Veterans Affairs (9)

Deputy Secretary of Veterans Affairs

Under Secretary for Health

Under Secretary for Benefits

Executive in Charge for Information and
Technology

Assistant Secretary for the Office of
Public and Intergovernmental Affairs

Assistant Secretary of Policy and
Planning

Assistant Secretary of Congressional and
Legislative Affairs

Assistant Secretary for the Office of
Management & Chief Financial Officer

Executive Director, Office of Acquisition,
Logistics & Construction

Department of Defense (9)

Under Secretary of Defense (Personnel
and Readiness)

Assistant Secretary of Defense (Health
Affairs)

Principle Deputy Assistant Secretary of
Defense (Readiness and Force
Management) Performing the Duties of
Assistant Secretary of Defense
(Readiness and Force Management)

Principal Deputy Assistant Secretary of
Defense (Health Affairs)

Director, DoD/VA Interagency Program
Office

Deputy Assistant Secretary of Defense
(Warrior Care Policy)

Assistant Secretary of the Army
(Manpower and Reserve Affairs)

Assistant Secretary of the Navy
(Manpower and Reserve Affairs)

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



VA/DoD Joint Executive Committee Annual Report FISCAL YEAR 2014

A handwritten signature in blue ink, appearing to read "Sloan Gibson".

Sloan D. Gibson
Deputy Secretary
Department of Veterans Affairs

A handwritten signature in blue ink, appearing to read "Laura Juno".

Laura Juno
Principal Deputy Under Secretary of
Defense for Personnel and Readiness

Table of Contents

SECTION 1 – INTRODUCTION	1
SECTION 2 - ACCOMPLISHMENTS	2
BENEFITS AND SERVICES	2
Sub-goal 1.1:	2
<i>BEC Communications of Benefits and Services Working Group</i>	2
GOAL 2	3
HEALTH CARE	3
Sub-goal 2.1:	3
<i>HEC Patient Safety Working Group</i>	3
<i>HEC Evidence Based Practice Working Group</i>	5
<i>HEC Health Professions Education Working Group</i>	6
<i>HEC Deployment Health Working Group</i>	7
<i>HEC Psychological Health/Traumatic Brain Injury Working Group</i>	11
<i>HEC Vision Center of Excellence</i>	19
<i>HEC Hearing Center of Excellence</i>	23
<i>HEC Extremity Trauma and Amputation Center of Excellence</i>	27
<i>HEC Medical Research Working Group</i>	30
Sub-goal 2.2:	32
<i>HEC Psychological Health/Traumatic Brain Injury Working Group</i>	32
<i>HEC Pain Management Working Group</i>	36
<i>HEC Telehealth Working Group</i>	38
Sub-goal 2.3:	39
<i>HEC Vision Center of Excellence</i>	39
<i>HEC Interagency Clinical Informatics Board</i>	40
<i>DoDVA Interagency Program Office</i>	42
GOAL 3	44
EFFICIENCY OF OPERATIONS	44
Sub-goal 3.1:	44
<i>BEC Disability Evaluation System Working Group</i>	44
Sub-goal 3.2:	48
<i>BEC Medical Records Working Group</i>	48
Sub-goal 3.3:	49
<i>BEC Information Sharing/Information Technology Working Group</i>	49
Sub-goal 3.4:	53
<i>HEC Continuing Education and Training Working Group</i>	53
<i>HEC Information Management/Information Technology Working Group</i>	54
<i>Health Architecture Review Board</i>	55
<i>HEC Acquisition and Medical Materiel Management Working Group</i>	57
<i>HEC Financial Management Working Group</i>	59
<i>HEC Joint Venture & Resource Sharing Working Group</i>	60
<i>James A. Lovell Federal Health Care Center Advisory Board</i>	61
DoDVA Interagency Program Office	63
Sub-goal 3.5:	65
<i>JEC Strategic Communications Working Group</i>	65
Sub-goal 3.6:	66
<i>JEC Construction Planning Committee Working Group</i>	66
Sub-goal 3.7:	68
<i>JEC Separation Health Assessment Working Group</i>	68
ADDITIONAL ACCOMPLISHMENTS	70
<i>Interagency Care Coordination Committee</i>	70
<i>Health Care Resource Sharing</i>	71

<i>Pharmacy Ad Hoc Working Group</i>	76
<i>Credentialing and Privileging Working Group</i>	76
SECTION 3 – NEXT STEPS	78
APPENDIX A	I
APPENDIX B	V
GLOSSARY OF ABBREVIATIONS AND TERMS	VI

VA/DoD Joint Executive Committee Fiscal Year 2014 Annual Report

SECTION 1 – INTRODUCTION

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Joint Executive Committee (JEC) is pleased to submit this *VA/DoD JEC Fiscal Year (FY) 2014 Annual Report (AR)*, for the period of October 1, 2013, to September 30, 2014, to Congress and the Secretaries of Defense and Veterans Affairs as required by law¹. The intent of the AR is to provide Congress with the collective accomplishments between the two Departments and highlight the current efforts to improve resource sharing. This report does not contain recommendations for legislation related to health care resource sharing.

The JEC provides senior leadership a forum for collaboration and resource sharing between VA and DoD. By statute, the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness co-chair JEC meetings. JEC membership includes the VA/DoD co-chairs of the Health Executive Committee (HEC), the Benefits Executive Committee (BEC), the Interagency Care Coordination Committee (IC3), the Director of the Interagency Program Office (IPO), and other senior leaders, as designated by each Department.

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

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

SECTION 2 - ACCOMPLISHMENTS

This section highlights the FY 2014 accomplishments of the HEC, BEC, IPO, IC3, and Independent Working Groups (IWGs). These accomplishments reflect the efforts of VA and DoD in improving resource sharing between the Departments and in furthering the mission to optimize the health and well-being of Service members, Veterans, and their eligible beneficiaries. The *VA/DoD Joint Executive Committee FY 2014 Annual Report* links the year's accomplishments to the sub-goals and performance measures established in the *VA/DoD Joint Executive Committee Joint Strategic Plan FY 2013-2015*. This approach clarifies the connection between strategic planning and outcomes achieved through VA and DoD's coordination, collaboration, and sharing efforts. The report also demonstrates achievements beyond planned activities.

GOAL 1

Benefits and Services

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

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

BEC Communications of Benefits and Services Working Group

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

The CBSWG achieved many beneficial outcomes in FY 2014 through leveraging both DoD and VA communication outlets to share benefits information. Specific marketing of the eBenefits portal contributed to the addition of over 1 million new individuals with Defense Self-Service (DS) Logons and double digit increases in the use of numerous self-service features, such as a 22 percent increase in the generation of self-service letters and a 51 percent increase in the request of official military personnel records.

VA and DoD launched a new marketing plan using 21 videos to promote both internal and external awareness of eBenefits. Among the external videos that were launched were "How to get a DS Logon," "The benefits of working with a VSO," and "The process for filing e-claims." E-claims are expected to become the preferred method for Service members filing pre-discharge claims. The e-claims video, launched in May 2014 had received 55,000 views on YouTube as of September 2014.

Additionally, two new radio and television public service announcements (PSAs) promoting eBenefits, featuring radio and NASCAR personalities were launched in February 2014. The television PSAs were distributed to over 1,000 outlets and the radio PSAs to over 4,000 with a combined receipt of over \$1 million in donated airtime.

In April 2014, a major combining of benefit resources occurred with the integration of the National Resource Directory (NRD) into eBenefits. NRD was able to keep its .gov identity while taking advantage of the heavy volume of web traffic that eBenefits receives and thus increased its own site visit numbers by over 37 percent.

The workgroup continued its promotion of benefits made available to Service members and Veterans by other federal agencies such as the Social Security Administration and United States Department of Agriculture (USDA). eBenefits and NRD promoted expedited claims service for seriously injured Service members and the USDA's New Farmer and Rancher Program with emphasis on transitioning Service members beginning careers in agriculture.

Twelve specialty web badges were created for targeted deployment that utilized eBenefits branding while promoting partner features such as accessing MyPay, obtaining a home loan certificate or accessing Post 9/11 GI Bill enrollment information.

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 Fiscal Year (FY) 2014, the Department of Veterans Affairs (VA)/Department of Defense (DoD) Health Executive Committee (HEC) Patient Safety Working Group (PSWG) continued to enhance the overall quality of care to Service members and Veterans through collaborative efforts in strengthening and coordinating safe patient care. As a result of Departmental requirements and recent leadership changes the VA initiated a new data sharing agreement with DoD that was pending signature at the end of the fiscal year.

Data methodologies and approaches are shared from several venues, including those related to nine Hospital Acquired Conditions (HAC) specified in the Department of Health and Human Services Partnership for Patients initiative. Other efforts include, but are not limited to Medication Reconciliation and Medication Safety that directly impacts on Hospital Readmissions.

VA is currently mapping multiple approaches that target health care transitions/readmission concerns. Both VA and DoD embrace Patient Centered Care approaches under the rubrics of Patient Care Alignment Teams (VA) and Patient Centered Medical Home (DoD) that further enhance multidisciplinary care approaches; opportunities to share lessons learned and further strengthen affinities among these efforts to be explored.

Noteworthy are promising trends in the VA readily accessible from both ASPIRE and VA's Linking Information Knowledge and Systems (LINKS) data that enables sharing of data and can be readily accessed at the VA's Hospital Care Web site². Data trends substantiate a focused effort on patient safety. VA improvements since the fourth quarter FY 2011 related to HACs include 34 percent reduction in Hospital Acquired Pressure Ulcers and a 24 percent reduction in Ventilator Acquired Pneumonia. A slight improvement of seven percent reduction in Central Line Associated Blood Stream Infections reflects continued incremental progress over the last two years (this reflects a 41 percent improvement since the fourth quarter 2009). New data dashboards are in the process of being developed to render enhanced fidelity on other HACs and safety concerns.

The National Center for Patient Safety, in partnership with other Veteran Health Administration (VHA) offices, launched an Institute of Healthcare Improvement Model Breakthrough Series that focused on both Catheter Acquired Urinary Tract Infections (CAUTI) and Hospital Acquired Pressure Ulcers. This approach was shared with DoD and is currently being reviewed. VA embarked on new Falls Breakthrough Series with State Veterans Home Project.

A joint VA/DoD Patient Safety Webinar occurred in March 2014 that addressed the following topics:

- Protecting Patients from injurious falls; Best Practices Sepsis; Suicide Prevention; Preventing CAUTI.
- Opioid safety; Pressure Ulcer Prevention; High Reliability Organizations; Best Practices Delirium; Enterprise strategy to partner with patients for medication reconciliation.
- Surgical Site Infections; Clinical Team Training; Human Factors Engineering for Purchasing; Just Culture.

These conferences familiarize staff with proven methods to assemble a team, garner leadership support, and utilize process mapping to identify challenges and specific steps for improvement. Facilities from VA and DoD share results of their efforts to improve their medication reconciliation processes at discharge.

The Federal Interdisciplinary Skin Integrity Group, that included both VA and DoD participants, met in November 2013, as a breakout session at the Association of Military Surgeons United States Annual Meeting in Seattle to address skin pressure ulcers and wound treatment. Curriculum reflected 13 topics related to pressure ulcers and wound care.

² <http://www.hospitalcompare.va.gov/>

VHA's Innovation Community for Falls presented in conjunction with Indian Health Service and the Minnesota Hospital Engagement Network on innovative practices to prevent falls. Both DoD and VA participated in this Partnership for Patients Event held in April 2014. The primary purpose of this effort is protecting patients from injury due to falls by integrating fall injury risk into assessment processes and injury prevention into care planning.

VA and DoD continue to share Patient Safety as well as medication alerts and advisories. The VA and DoD continue to collaborate on the proposed Prescription Labeling Literacy initiative. The Joint Navy/VA Federal Health Care Center in Great Lakes Illinois moved to the VA Patient Centric Label in March 2014. The prescription labeling literacy initiative brings clarity to the patient to enhance their understanding of medication, dose, timing and other important pertinent directions. Prior to this initiative it was discovered that medication errors were occurring because patients did not understand prescription labeling.

HEC Evidence Based Practice Working Group

Clinical Practice Guidelines (CPGs) assist VA/DoD health care teams by providing evidence based recommendations which lead to improved quality of clinical decisions and reduced variation in clinical practice for Veterans, Service Members and their families. CPGs are posted on the VA Web site³ and the Army Quality Management Office (QMO) Web site⁴. During FY 2014, the HEC Evidence Based Practice (EBP) Working Group (WG) simultaneously worked on a record number of eight CPGs. The working group achieved the identified annual target of completing four Clinical Practice Guidelines during this past year to include two updated CPGs: Screening and Management of Overweight and Obesity and Management of Chronic Multi-symptom Illness (formerly Medically Unexplained Symptoms), and two new CPGs: Nonsurgical Management of Knee and Hip Osteoarthritis and Upper Extremity Amputation and Rehabilitation. The annual target to complete four CPGs was met and three additional CPGs are on track to be completed in October 2014.

All CPGs submitted to the National Guideline Clearinghouse (NGC) have met their stringent inclusion criteria. The NGC's mission is to provide physicians and other health professionals, health plans, integrated delivery systems, purchasers, and others an accessible mechanism for obtaining objective, detailed information on evidence based CPGs to further disseminate, implement and use. The EBP WG is committed to educating health care teams. Due to budgetary constraints, the VA/DoD staff was unable to exhibit at VA or DoD conferences. The staff presented at multiple formal podium presentations on a variety of the 24 CPGs at local DoD and VA educational settings. In coordination with the Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury, 40 webinars were presented across the VA/DoD on a wide range of existing VA/DoD CPGs.

An unprecedented 19 new CPG tools were developed during FY 2014. Over 160 different CPG tools are now available to VA/DoD health care team members. These products educate

³ www.healthquality.va.gov

⁴ <https://www.qmo.amedd.army.mil>

thousands of VA and DoD health care team members regarding the medical evidence behind the CPG recommendations and the value of implementation. The tools specifically provide health care teams valuable support materials to assist with implementation and ultimately facilitate improved care delivery for patients and families across VA and DoD. One CPG broadcast, Screening and Management of Overweight and Obesity, was completed in September 2014. The broadcast will be available for on-demand viewing.

The EBP WG continued to collaborate with the DoD Tri-Service Work Flow Group in the development of evidence based CPG Alternate Input Method (AIM) forms to facilitate implementation of CPGs at the point of care in DoD ambulatory clinics to include Patient Centered Medical Homes. Key recommendations from eight VA/DoD CPGs were converted into AIM forms and 23 million AIM forms were loaded across the DoD to provide evidence based care at the point of service; strong evidence that CPG implementation is growing across DoD.

During FY 2014, VA and DoD had 1,161,834 internet requests as compared to 2,206,552 in FY 2013. The decrease in internet numbers is most likely due to the fact that the DoD now has the ability to utilize VA/DoD CPGs through AIM forms. This data provides evidence that health care teams across VA and DoD are successfully accessing CPG information via the internet or directly through the use of AIM forms to enhance the delivery of quality health care. CPG tools are available in hard copy and are downloadable to medical facilities providing health care teams with needed patient, family and provider support tools to assist with CPG implementation. During this fiscal year, VA and DoD had 674,870 CPG tools ordered from the QMO Web site and the VA's Talent Management System compared to 804,404 in FY 2013. While the decrease is a potential result of fiscal constraints, the data reflects that health care teams across the VA and DoD are actively ordering and using the tools.

HEC Health Professions Education Working Group

DoD created the Defense Health Agency (DHA) in FY 2014, incorporating TRICARE and Shared Healthcare Services among the three Military Services. In light of the creation of the DHA and the ongoing Departmental modernization studies, Military Graduate Medical Education (GME) training programs and resident positions may change.

While the Health Professions Education (HPE) WG transitioned to ad-hoc status in March 2014, it remains committed to promoting accredited HPE training programs and resident trainee exchanges between VA and DoD. From July 1, 2013, to June 30, 2014, the two Departments established eight new VA and DoD Trainee Exchanges for a total of 21 programs. These 21 VA and DoD Trainee Exchanges enabled 239 VA resident trainees to receive part of their academic HPE training in a DoD facility and 304 DoD resident trainees to receive part of their academic HPE training in a VA facility.

Resident exchanges expose trainees to a variety of patient populations and clinical presentations not possible in a single institution. For example, VA trainees rotating to DoD see a younger, healthier patient population which includes both women and children, while military

trainees rotating to VA see an older population with a heavier chronic disease burden mixed with multiple socio-economic challenges. Trainees experience a greater holistic patient care perspective when they see the continuity of care from active duty service through Veteran status. Furthermore, trainee exchanges promote awareness and understanding of the capabilities and differing cultural aspects of both health care systems.

The HPE WG continues to evaluate the challenges and barriers to successful interagency cooperation in HPE training programs. The HPE WG remains committed to promoting HPE trainee programs and exchanges between VA and DoD; this year will see DoD Chief Residents participating in VA's Chief Resident in Quality and Safety training program.

In November 2013, VA executed a contract with the National Board of Medical Examiners to develop and include questions related to Military and Veteran health on the United States Medical Licensing Exam (USMLE), a pre-requisite for practice for all allopathic physicians in the United States. VA has facilitated the inclusion of DoD experts on these question-writing taskforces, in addition to the representatives from VA and the academic community. The VA and DoD Task Forces are meeting, and sample questions have been submitted to the National Board. This ongoing process and involvement of DoD experts will ensure that pertinent, high quality, and topical medical knowledge will be included on the USMLE, and this alone will drive curriculum development on Military and Veteran Health throughout the nation's medical schools and teaching hospitals.

HEC Deployment Health Working Group

In FY 2014, the Deployment Health (DH) WG facilitated DoD and VA efforts to identify situations in theater, which could place military personnel and Veterans at risk, and to ensure that DoD and VA responses were appropriately coordinated. The DHWG took concrete steps to improve the sharing of Service member and Veteran health information between DoD and VA. In particular, the DHWG provided ongoing oversight of the development of the Individual Longitudinal Exposure Record (ILER). The DHWG facilitated interagency sharing between DoD, VA, and the Services, including the Office of the Under Secretary of Defense for Acquisitions, Technology, and Logistics/Installations and Environment, Army Public Health Command, Navy Bureau of Medicine and Surgery, Marine Corps Installations Command, and Air Force Medical Support Agency.

The DHWG held 12 monthly meetings in FY 2014 to coordinate DoD and VA responses to five major environmental exposures in Iraq, Afghanistan, and the U.S., as 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 historical exposure to contaminated drinking water at Marine Corps Base Camp Lejeune, NC;
- Potential health effects of exposure to Agent Orange in C-123 aircraft after the Vietnam War; and
- Potential health effects of blast exposures during the 1990-91 Gulf War and OEF/OIF/OND.

In FY 2014, the DHWG facilitated DoD and VA responses to airborne hazards in theater. Exposure to smoke from the burn pits in OEF/OIF/OND could potentially impact hundreds of thousands of deployed Service members. In FY 2014, the DHWG continued to evaluate the findings of the VA funded Institute of Medicine (IOM) study, entitled *Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan* in order to identify lessons for future health surveillance and research on airborne hazards in theater. The IOM concluded there was limited or suggestive evidence of an association between exposure to combustion products and decreases in pulmonary function tests. The IOM concluded there was inadequate evidence to draw conclusions on the association of exposure to combustion products and cancer, respiratory diseases, and many other types of diseases. The IOM also concluded that the air contamination of greatest concern could be the high ambient concentrations of particulate matter in OEF/OIF/OND, such as sandstorms, rather than just burn pit emissions.

The DHWG addressed the IOM recommendations on health surveillance and research in a comprehensive VA/DoD Airborne Hazards Joint Action Plan. The plan includes four major activities: Follow-up Medical Care of Deployed Populations, Outreach and Health Risk Communication Products, Medical Surveillance, and Research Initiatives. The plan provides an integrated approach to health concerns related to airborne hazards and it was coordinated with scientists in VA and the three Military Services. This plan was updated in FY 2014 to incorporate recent activities.

The DHWG played an active role in the development and roll out of the VA's Airborne hazards and Open Burn Pit Registry, which is designed to provide outreach to Veterans and Service members of the Iraq and Afghanistan conflicts with health concerns that may be attributable to the inhalation of airborne hazards, including burn pit emissions. Two joint VA/DoD committees planned the questionnaires and procedures for the Registry. They developed an occupational and environmental exposure questionnaire that Veterans complete online during enrollment. A committee of VA and DoD clinicians developed clinical guidance for primary care providers on diagnosis and treatment of Veterans who have post-deployment respiratory concerns. VA provided a webinar to train 400 VA clinicians in March 2014. VA and DoD performed usability tests of the Registry Web site with a small number of Veterans and Service members in April 2014.

In June 2014, VA launched the Registry and opened enrollment to Veterans and Service members, with the concurrence of the Assistant Secretary of Defense for Health Affairs. Participants can use the Registry questionnaire to report exposures to various sources of air contamination, including smoke from burn pits, oil-well fires, ambient particulates due to sandstorms, and industrial pollution during deployments, as well as other exposures and health concerns. Veterans who deployed to OEF/OIF/OND or Djibouti, Africa, in or after 2001 are eligible to enroll. Veterans of the 1990-1991 Gulf War are also eligible. Participation in the Registry is voluntary, and Veterans and Service members are given the option to request a medical examination. More than 2,400 individuals enrolled in the Registry in the first week, and more than 16,000 individuals enrolled by mid-September 2014. Registry data will be analyzed to monitor trends in health conditions over time.

Scientists at the U.S. Army Public Health Command worked closely with VA to develop a parallel process for Active Duty personnel who enroll in the VA Registry, including procedures to provide medical exams in Military Treatment Facilities (MTFs). All Active Duty, Reserve, and National Guard personnel who enroll in the Registry receive a DoD Fact Sheet on how to request a voluntary medical exam. An educational package with clinical guidance was developed for military health care providers. DoD and VA staff also collaborated in developing joint communications products for the launch of the Registry. In September 2014, the U.S. Army released an All Army Activities message to communicate with 100 percent of Active Duty soldiers and to encourage them to enroll in the Registry.

During the 1950s to 1985, some of the drinking water at Marine Corps Base Camp Lejeune was contaminated with 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 2014, the DHWG coordinated VA and DoD responses to the exposures at Camp Lejeune. The DHWG built consensus by bringing experts from VA, DoD, and Marine Corps together with different perspectives to plan the way forward.

In mid-2014, the Office of Management and Budget (OMB) performed its second review of regulations to provide care to Veterans and families who lived at Camp Lejeune. The regulations for Veterans and families were published as a Final Rule on September 24, 2014, effective immediately; and they were entitled "Hospital Care and Medical Services for Camp Lejeune Veterans" and "Payment or Reimbursement for Certain Medical Expenses for Camp Lejeune Family Members." As outlined in the regulations, VA, as payer of last resort, is required to reimburse qualified medical expenses of family members retroactively, back to March 2013. VA provided the communications package on the release of these two sets of regulations to the US Marine Corps (USMC) for linkage on the USMC Web site on Camp Lejeune.

VA developed an internal clinical guideline for VA physicians, which provides instructions to determine eligibility of a Veteran or family member, related to the 15 medical conditions. This guideline was finalized in January 2014. VA asked the IOM to review this clinical guideline to validate its scientific validity, with a particular focus on two broad categories of conditions, "neurobehavioral effects" and "kidney toxicity." The IOM study is titled "Review of Clinical Guidance for the Care of Health Conditions Identified by the Camp Lejeune Legislation." It started in May 2014, and is scheduled to be completed by IOM by March 2015.

The DHWG facilitated the coordination of the VA and the USMC to determine the availability of personnel and housing records of Marines and family members who lived at Camp Lejeune from 1957 to 1987. Verification of residence needs to be done, one at a time, on a case-by-case basis. The USMC worked with VHA and the VA Business Office to identify various DoD databases that could provide historical residence data at Camp Lejeune. In March 2014, VHA and the Veterans Benefits Administration (VBA) signed a Memorandum of Understanding (MOU) on retrieval of Veteran records from the National Personnel Records Center (NPRC) in St. Louis. VBA staff work at the NPRC to pull thousands of records for disability claims

annually, for Veterans of all eras. The MOU enabled VHA to request VBA staff to retrieve records of Veterans who lived at Camp Lejeune. The Marine Corps has kept attendance lists of names through 1971 called muster rolls, totaling over five million names. In late 2013, the USMC started to computerize the muster rolls of Service members who were stationed at Camp Lejeune during the 1950s to 1971. There are about 59 million pages of records to be computerized. This work should take about 18 months, at which time the USMC will share the database with VA.

The Agency for Toxic Substances and Disease Registry (ATSDR), which is a part of the Centers for Disease Control and Prevention, has been evaluating the health of the Camp Lejeune population since 1991. The Navy has provided more than \$40 million to fund these ATSDR studies. ATSDR holds quarterly public meetings related to its Camp Lejeune research, in which VA and Navy staff participates. ATSDR recently published the results of three Camp Lejeune studies in the journal *Environmental Health*. These studies focused on:

- Birth defects and childhood cancers (December 2013)
- Mortality in Marines and sailors (February 2014)
- Mortality in DoD civilian employees (August 2014)

DoD, Navy, USMC, and VA staff coordinated their agency responses to these three ATSDR studies. In February 2014, the USMC performed a mass mailing in response to the mortality study in Marines. They sent two documents to the Camp Lejeune notification database, which includes more than 200,000 individuals. These documents were the ATSDR fact sheet on the study and the VA fact sheet for Veterans and family members who lived at Camp Lejeune. This massive communication effort exemplifies the excellent cooperation between the Marine Corps and VA.

The DoD Co-Chair of the DHWG wrote information papers on the three ATSDR studies; sent the papers to members of the DHWG and to senior DoD and USMC leaders; and provided briefings to the Assistant Secretary of Defense for Health Affairs (HA). These studies could have an impact on policy decisions regarding VA disability compensation. ATSDR is currently completing data collection on a national health survey of the Camp Lejeune population. In addition, ATSDR recently started planning a national cancer incidence study, which was requested by Veterans groups and Congress. ATSDR convened an expert panel to provide guidance on the study design in July 2014 and VA and Navy scientists participated on the panel.

In FY 2014, the DHWG analyzed research literature on environmental exposures during military service to mitigate the potential health effects of hazardous exposures. Congress mandated VA to request biennial IOM reports on exposure to Agent Orange and environmental exposures during the 1990-91 Gulf War. VA uses the conclusions of these IOM reports to determine if presumption of service connection is warranted for specific diseases in Vietnam and Gulf War Veterans. In December 2013, IOM published *Veterans and Agent Orange: Update 2012*. This included a review of more than 700 articles published between 2010 and 2012. There was only one change in the categorization of diseases in the new report; IOM re-categorized strokes from "insufficient evidence" of an association to "limited or suggestive evidence" of an association. VA established a Task Force to determine if VA should grant a

presumption of service connection for stroke in Vietnam Veterans. Based on the totality of scientific evidence available, the Task Force made a recommendation against granting a presumption for stroke and the Secretary of VA approved this recommendation.

The DoD, as lead agent for the development of the ILER, with the VA in a supporting role, is creating the capability to assemble individual longitudinal exposure records on Service members over the course of their careers, as part of an ongoing pilot project. In January 2013, a Joint Incentive Fund (JIF) project was approved for a two-year pilot project to develop ILER. The goals of the pilot are to demonstrate the feasibility of producing ILER, and develop a prototype that provides an Initial Operating Capability for ILER. At the end of the two years, DoD and VA will decide whether or not to proceed to Full Operating Capability, which would require additional funding from both agencies.

In 2014, the DoD/VA ILER Integrated Project Team (IPT), which the DHWG supported, completed a number of important actions, including finalizing the ILER Concept of Operations, developing the ILER Business Use Case, completing functional requirements, and documenting as-is and to-be process flows. Since then, the ILER project has been proceeding through the Departments' respective governance boards.

HEC Psychological Health/Traumatic Brain Injury Working Group

The goal of the Psychological Health (PH)/Traumatic Brain Injury (TBI) (PH/TBI) WG is to increase and sustain communication and collaboration between DoD and VA on issues related to PH and TBI, as well as provide oversight of all joint PH and TBI initiatives. Within the purview of the PH/TBI WG is the DoD/VA Integrated Mental Health Strategy (IMHS), developed to address the growing population of Service members and Veterans with PH and related needs. The IMHS centers on a coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services for Active Duty Service members, National Guard and Reserve members, Veterans, and their families. The IMHS is defined by 28 Strategic Actions (SA), which fall under the following four strategic goals:

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

At the start of FY 2014, six of the 28 IMHS SAs were complete. During FY 2014, 11 additional IMHS SAs fulfilled their originally planned milestones, including those addressing:

- Integration of mental health services into primary care (SA #2);
- Expansion of eligibility of Vet Center readjustment counseling services to Service members, as well as Service members and Veterans in rural areas (SA #3 & SA #4);
- Mechanisms for sharing mental health care personnel between Departments to meet urgent needs (SA #5);

- Recommended quality measures for mental health services and evaluating patient outcomes (SA #10 & SA #12);
- Dissemination of knowledge of suicide risk and prevention strategies (SA #15);
- Mechanisms for reviewing activities of outside organizations and developing collaborations or partnerships (SA #18);
- Approaches to promote utilization of self-help strategies for mental health concerns through Web services, print material and seminars and facilitating access to these Web-based resources (SA #20 & SA #21); and
- The role of chaplains in mental health care (SA #23).

At the end of FY 2014, 11 SAs remain open. Most of these SAs are in the process of revising final reports and documentation, though two SAs, focused on joint tele-mental health services (SA #6) and exploring the VA Justice-Outreach Program Model in DoD (SA #22), have begun their pilots, but will remain open for most of FY 2015 to ensure adequate time for outcomes to be realized.

Four DoD/VA PH-related initiatives, funded in FY 2013, that are direct follow-on projects to IMHS SAs have received two-year JIF funding and are well underway. These four projects address: the role of chaplains in provision of mental health services; piloting the use of local clinical champions to promote and support use of EBPs; establishment of a practice-based implementation network (PBI Network) across select DoD and VA facilities; and implementation of Problem Solving Training in DoD and VA.

Common Standard of Care to Support TBI

Training

DoD and VA continued to ensure that all clinicians, from medics/corpsmen to licensed independent providers, received training in evidence-based clinical practices to cover the full spectrum of TBI care. The Departments are actively collaborating to coordinate common training events, to disseminate training to providers in both Departments, and are in the process of developing training events more focused on a garrison-based force. These garrison-focused training events are important because more than 80 percent of TBI cases in the DoD are diagnosed in the non-deployed environment, requiring providers to have a clear understanding of non-combat related injuries such as those caused by falls, training, and motor-vehicle crashes.

The Defense and Veterans Brain Injury Center (DVBIC) hosted the annual virtual conference on TBI diagnosis, treatment, and prevention updates for Military and VA health care providers. Conference presentations spanned a wide range of topics including advances in clinical care and psychological health programs, critical role leadership plays in TBI awareness, global impact of the International Classification of Diseases, ninth revision (ICD-9) coding system and the importance of avoiding common ICD-9 coding errors, risk of cumulative concussions in high-risk occupations (such as professional sports), moderate/severe TBI and polytrauma, and an in-theater update focusing on TBI in combat.

The DVBIC and VHA-Employee Education System (EES) also signed a sharing agreement and presented the first combined DoD/VA Grand Rounds in September 2014.

The DoD/VA TBI community has extensive training and education programs that include electronic distribution of materials through the DVBIC Web site and virtual shopping cart and remote training and educational efforts coordinated regionally throughout the United States at DoD and VA medical facilities. The DoD/VA TBI community distributed approximately 700,000 TBI educational tools and pamphlets from October 2013 through July 2014.

The DCoE for Psychological Health and Traumatic Brain Injury holds TBI Webinars on a monthly basis. From October 2013 to July 2014, over 3,374 providers were trained on a wide range of TBI topics including prevention, diagnosis, acute care and rehabilitation. In a recent Webinar on gender differences in concussion, 32.5 percent of participants were Active Duty providers, 24.7 percent were VA providers, and the remainder was civilian providers or non-providers.

Research Translation

During FY 2014, the translation of TBI research into optimal clinical practice was realized through completion of two research programs and findings as follows:

- The Neurocognitive Assessment Tool (NCAT) “Head-to-Head” reliability study to allow informed decisions regarding best practices for the use of computerized neurocognitive assessment tools to monitor cognitive deficits following Mild Traumatic Brain Injury (mTBI). The first phase was a study to measure test-retest reliability of four computerized neuropsychological test batteries in a sample of healthy soldiers over a 3-6 week interval. The second phase NCAT “Head-to-Head” validity study was completed and is expected to contribute to informed decisions regarding best practices for the use of a computerized neuropsychological assessment battery with Service members who have mTBI.
- DoD/VA are coordinating the Study of Cognitive Rehabilitation Effectiveness (SCORE!) in mTBI which is evaluating the effectiveness of cognitive rehabilitation in OEF/OIF/OND Service members with a history of mTBI and persistent (3-24 months post-injury) cognitive complaints. The study is coming to a close, and will place the Departments in a position to develop common measures and standards that are relevant to cognitive rehabilitation.

In addition, VA and DoD developed two evidence-based clinical recommendation guidance documents for health care providers on management of sleep disturbances following mTBI, and progressive return to activity following acute mTBI. The guidance provided in these documents was developed through a thorough evaluation of the published literature, as well as DoD and VA-funded research. DoD led in the development of these clinical recommendations with the support of DoD and VA health care providers serving as Subject Matter Experts (SMEs). Through this process, DCoE and DVBIC have now produced a total of 16 evidence-based Clinical Recommendations (CRs) on medical topics directly related to the diagnosis and management of Service members with a concussion or post-concussion syndrome. The CRs

represent a collaborative approach between the DVBIC, VA, and the DoD TBI Leads across the Army, Navy, Marine Corps and Air Force, as well as the U.S. Army Medical Research and Materiel Command; Joint Trauma Analysis and Prevention of Injury in Combat program; National Intrepid Center of Excellence; U.S. Central Command; Readiness Division of the Defense Health Agency; and the Coast Guard.

VA's Polytrauma and Blast-Related Injuries Quality Enhancement Research Initiative (QUERI) also continues to drive enhancement of current clinical programs, including educational interventions to improve VA's TBI screening program; refining and validating the TBI screening and evaluation program; and driving innovation, including evaluation of smart phone applications to improve patient self-management of mTBI symptoms. In November 2013, VA launched the Concussion Coach smart phone application for self-management and monitoring of mTBI symptoms. Through August 2014 it has been downloaded 2,624 times. VA's TBI screening and evaluation practices implemented in FY 2012 continue to be refined and validated, and shared monthly with senior leadership and the field. A meeting was held in August 2014 with senior VA leadership, QUERI investigators, and stakeholders from Primary Care, Mental Health, and Care Management to provide updates on current protocols to further develop and enhance the use of the screening and evaluation data.

Outcome Measures

A major focus for both Departments is to understand the chronic effects of mild to severe TBI. The VA TBI Model Systems Study has enrolled over 553 participants across the five Polytrauma Rehabilitation Centers (Richmond, Tampa, San Antonio, Palo Alto, and Minneapolis VA Medical Centers (VAMCs)) through March 2014. This study, conducted in partnership with the National Institute of Disability and Rehabilitation Research, utilizes common data elements to track the outcomes of and course of recovery for moderate to severe TBI. This project is also actively collaborating with the Chronic Effects of Neurotrauma Consortium, a \$60 million joint research initiative to understand the long-term effects of TBI in the military and Veteran population.

The DVBIC Concussion Health Care Outcomes Standardization Initiative was established in FY 2013 to coordinate outcomes activities across DoD, with the goal to identify, standardize, and implement core measures applicable across the continuum of care. Two measures that will be shared by DoD and VA were identified, and VA adopted both measures in FY 2014. DoD is in the process of approving the measures with the Services and the DHA through the policy governance process.

Common Standard of Care to Support Psychological Health

Evidence-Based Psychotherapies

In FY 2014, DoD and VA continued to expand efforts to provide consistent and coordinated training in Evidence-Based Psychotherapies (EBP) for PH conditions. As part of IMHS SA #9, DoD and VA have implemented common and coordinated evidence-based training to increase availability of effective psychological treatments for posttraumatic stress disorder (PTSD),

major depression, and other PH conditions across both Departments. DoD and VA training program staff are working in close collaboration to implement the training and ensure comparable training content and treatment delivery.

In FY 2014, VA provided training to more than 630 staff in the delivery of Cognitive Processing Therapy (CPT) and/or Prolonged Exposure Therapy (PE); 97 percent of these staff are currently in consultation or have successfully completed VA's competency-based training process. VA has maintained a capacity of more than 120 trainers/consultants for these two training programs. VA continued to expand training efforts in Cognitive Behavioral Therapy for Depression (CBTD), Cognitive Behavioral Therapy for Insomnia (CBT-I), Motivational Interviewing (MI), and a number of other evidence-based psychotherapies. VA provided training in one or more of these therapies to more than 580 staff; 99 percent of these staff are currently in consultation or have successfully completed the competency-based training process. These EBP training programs added 89 trainers/consultants in FY 2014, creating a capacity of more than 330 trainers/consultants. This represents VA training only; however, it is coordinated across Departments.

DoD provided training in EBPs for PTSD, depression, and other PH conditions to 1,143 providers (514 trained in PTSD EBPs and 629 trained in EBPs for other PH conditions). In addition, DoD provided consultation to 214 providers (147 for PTSD EBPs and 67 for EBPs for other PH conditions for providers within DoD). In FY 2014, 24 providers were trained to be DoD trainers/consultants in EBPs for PTSD, depression, and other PH conditions, and DoD has maintained at least 40 DoD trainers/consultants in EBPs for PTSD and at least 30 trainers/consultants in EBPs for other PH conditions. DoD has increased consultation marketing efforts and recently developed two new refresher/consultation workshops that were rolled-out in May 2014. The EBP JIF project, awarded in FY 2013, is placing one consultant at each of 10 MTFs to further assist DoD in providing consultation and implementation of EBPs for PTSD.

Program evaluation results from VA EBP training programs have recently been published (or accepted for publication) in various outlets, including the *Clinical Journal of Pain*, *Professional Psychology: Research and Practice*, *Behavior Research and Therapy*, the *Journal of Consulting and Clinical Psychology*, and *Journal of Traumatic Stress*. These results have generally shown that the training in and implementation of EBPs in VA resulted in significant, positive training outcomes for therapists and clinical outcomes for patients, including overall large reductions in symptoms and improvements in quality of life.

Military Culture

In FY 2014, DoD and VA, through the IMHS, finalized the most comprehensive multimedia online course in military culture currently available. The four-module course focuses on understanding military culture and the potential impact of the military ethos on health care for Service members, Veterans, and their families. Additionally, signs and symptoms of deployment related mental health conditions and effective methods for the treatment and prevention are discussed and reviewed. A companion Web site is publically available and makes access to the content and resources provided available instantly and in a format that is

easily updated and sustained. The course and Web site are designed for DoD and VA primary care and behavioral health providers, community civilian primary care and behavioral health professionals, and other care providers such as chaplains and case managers. The four module course has been available on the VA Talent Management System (TMS), the Military Health System (MHS) Health Professions Consortium, and the Center for Deployment Psychology (CDP) Web sites since February 2014 and up to eight free CE/CEUs (two per module) can be earned for completion of the course.

The IMHS SA #25 Military Culture task group has developed a national dissemination plan for this training that will utilize professional health care organizations, government partners, and educational institutions. The dissemination plan was coordinated to follow the President's announcement of 19 new Executive Actions (EA) that DoD and VA are undertaking to improve mental health care for Service members, Veterans, and their families. One of these EAs is the expansion of military cultural competency training through this jointly developed course. The EA goal is to train 3,000 community providers through their completion of one or more of these modules in FY 2015. Over 300 providers have completed and been awarded continuing education credits for at least one module of the comprehensive four-module course. Since the launch of the companion Web site in November 2013, there have been over 8,000 unique visitors to the site. In FY 2014, over 2,000 providers have completed the online military culture course currently offered by CDP and over 2,300 providers have received live military culture education through CDP programs both of which are supplemented with content from the four-module curriculum.

Research Translation

During FY 2013, the WG launched a pilot to test a process for identifying, prioritizing, and recommending actionable research findings for potential implementation across DoD and VA. The piloted process was designed to help ensure that significant scientific discoveries with strong evidence would be considered by senior mental health leadership for implementation across the Departments. The pilot was completed during FY 2014 and resulted in recommendations for a framework to routinely review and prioritize actionable research findings. Pilot lessons learned formed the basis for the development of a strategic proposal aimed at further developing the infrastructure for identifying new evidence-based practices for DoD and VA consideration. Actionable research findings were identified during the pilot process and recognized by the joint DoD/VA workgroup as high impact practices that should be considered for possible widespread implementation. These include treatment outcomes-monitoring for PTSD and other mental health conditions, and integrated smoking cessation for patients with PTSD.

The Departments are currently piloting a JIF project to develop a network of at least 20 sites (10 in each Department) for implementation of specific practice changes, identify implementation barriers, and identify and share solutions to implementation roadblocks. Following the recommendations based on the SA #26 pilot process, the PBI Network is currently implementing clinical outcomes monitoring using the PTSD Checklist for patients being treated for PTSD. Implementation has begun and will continue into FY 2015. This practice change also includes potential changes in clinical data collection methods, analysis,

and interpretation of outcome measures including the use of electronic data platforms such as DoD's Behavioral Health Data Portal to enable standardized collection, documentation, and analysis.

Suicide Risk and Prevention Strategies

Extensive collaboration and cooperation in suicide prevention efforts between DoD and VA continued in FY 2014. The Defense Suicide Prevention Office (DSPO) fully developed its role as the focal point for all DoD suicide prevention policy, training, and programs and as the DoD lead for DoD/VA collaboration on suicide prevention. VA's Suicide Prevention Program also continued to expand, develop, and incorporate more relevant information from their collaboration efforts with DoD.

The Suicide Nomenclature and Data WG, under the auspices of the PH/TBI WG, recommended the adoption of the Centers for Disease Control and Prevention (CDC) suicide nomenclature in DoD and VA. In January 2014, the collaborative agreement between VA, DoD, and CDC on the Military Mortality Database – Suicide Data Repository (SDR) was established as the authoritative data repository for Department of Defense deaths. This agreement avoids duplicate and conflicting records when comparing data across the agencies. It also abates costs by avoiding duplicative maintenance of the data. The Board of Governors (BOG) Charter for the SDR was signed in February 2014, which established a framework for the BOG to provide the mechanism for the adjudication of data requests and allows for the joint sharing of National Death Index data between DoD and VA researchers and their partners. The DoD/VA SDR has reached initial operating capability and the data are being used now for several suicide program surveillance efforts by the respective program offices at both DoD and VA. The first data refresh cycle is currently being worked with the CDC. DoD and VA are providing feedback of "true matches" to the CDC for a data quality check and to assist in a collaboration between the Agencies to calculate adjusted rates for comparison within the civilian, military and Veteran populations. Since February 2014, the BOG has convened three times to review a total of 39 data requests for both DoD and VA studies. The BOG approved or conditionally approved 33 requests for data. Conditionally-approved requests were typically approved upon the condition that the missing information is provided before data can be released. In all cases, once a request was approved and any conditions resolved, data was provided in less than 60 days.

As an alternative to the Annual DoD/VA Suicide Prevention Conference, three one-day summits were held and focused on community-based and clinical approaches to prevent suicide, system dynamics, and innovative practices in research. These events were attended by more than 400 participants. The goal was to create a learning environment that fostered knowledge sharing, collaboration, and innovation from leaders and support professionals engaged in suicide prevention.

The combined Veterans Crisis Line (VCL) and Military Crisis Line (MCL) continues to utilize proactive approaches in suicide prevention and reaches individuals both before and at the point of having thoughts of suicide. An online chat function and texting service are also available to enhance the availability of this shared confidential resource for Veterans, Service

members, and their families. Overall, since its launch in 2007 through June 2014, the VCL/MCL has received more than 1.25 million calls, more than 175,000 chats, more than 24,000 text messages, and has initiated more than 39,000 rescues of suicidal callers. A rescue occurs when a caller communicates an immediate suicidal intent or inability to remain safe and the crisis line respondent contacts local emergency services to attend to the caller and ensure his or her safety. VCL/MCL usage volume from FY 2013 was maintained in FY 2014. Suicide Prevention information, a self-assessment, and resources for Veterans, Service members, family members, and professionals can be found at the VCL/MCL Web site⁵.

In January 2014, procedures were established for Vets4Warriors (V4W) and the VCL/MCL staff to refer Service members and their families for appropriate follow-up care. Subsequently, a Memorandum of Agreement for warm handoffs between DoD and VA was established in February 2014. V4W promotes resilience by providing Active Duty and National Guard/ Reserve Service members, retirees, Veterans, and their families worldwide with 24/7 peer-to-peer support. The call center is staffed with Veteran and family member peers representing all branches of the armed forces and assists callers and chatters to overcome adversity, manage stress, and access resources.

Between September 2013 and September 2014, the total number of V4W calls was 29,076. Of these calls, 14,527 (49.97 percent) were incoming calls, and 14,545 (50.03 percent) were outgoing calls conducted by peer specialists for follow-up. Overall, since its launch in 2011, V4W has received more than 54,194 calls and has initiated more than 49,726 outreach calls. The ability to conduct live chats began at the end of December 2013; since then there have been 318 online chats. A new data collection method was implemented in November 2014, to track number of referrals from V4W to VCL and from VCL to V4W. For those MCL callers who agree to a referral to V4W, V4W has followed up with 100 percent of those callers within 24 business hours of the initial MCL call. During the follow-up call, V4W peer specialists offer referrals to appropriate services including, but not limited to, ongoing peer support through V4W, referrals to chaplains, appointments with military counselors and other available services and supports.

DSPO and VA's Suicide Prevention Office continue to work with each Military Department to develop DoD and Military Department-specific promotional materials. In September 2013, DoD and VA developed a plan for a joint Suicide Prevention awareness campaign to the President's Executive Order, "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families." DoD and VA have developed 32 milestones for their efforts in FY 2014 to encourage help-seeking behaviors. This includes developing and participating in events, coordinating messaging, releasing public service announcements, and enhancing Web site content. Also, DSPO developed a guide for military families that provides information on suicide warning signs, risk factors, actions to help those in crisis, and other resources. A guide for supporting military families in crisis was initially published in August 2013, and was updated significantly in September 2014. DSPO has distributed more than 5,000 guides to diverse military installations and events across the country. VA has developed and nationally disseminated a gun safety video, which discusses the importance of securing

⁵ <http://www.veteranscrisisline.net>

weapons especially during times of crisis and, along with DSPO, has also distributed thousands of gun locks to Veterans and Service members throughout the country. Although this initiative is preventive in nature, both Departments have continued to focus on encouraging help-seeking behaviors and leadership involvement, especially for at-risk individuals in order for them to receive the health care they need, as appropriate.

Through FY 2014, the total number of visits to the DSPO Web site was 21,988. The Web site provides centralized suicide prevention information and resources for Service members and family members, and suicide prevention resources and DoD Suicide Event Report information for command and staff across DoD. The Web site also generated 148 immediate contacts to the VCL/MCL since January 2014. For FY 2014, the total number of visits to the VCL website was 761,527. Of those total visitors, 23,456 used the resource locator to identify local support options. In the same period, VCL responders engaged in 47,409 anonymous online chats, and visitors completed 14,349 self-check quizzes. Upon engaging in online chats and completing self-check quizzes, Veterans are encouraged to reach out to providers for ongoing care, treatment, and support.

HEC Vision Center of Excellence

The Vision Center of Excellence (VCE) seeks to identify evidence-based best practices and optimize ocular and visual outcomes, and engages in a dynamic transfer of scientific and medical knowledge. Throughout 2014, the VCE continued to provide solutions for improving the health and quality of life for Service members, Veterans and families through development of initiatives focused on the prevention, diagnosis, mitigation, treatment and rehabilitation of disorders of the visual system.

Research

VCE works in collaboration with a wide variety of government and private sector partners to identify emerging clinical needs and address them through directed research efforts. VCE maintains its lead role in the development of DoD vision research portfolio by chairing and participating in the US Army Medical Research and Materiel Command's (MRMC) Congressionally Directed Medical Research Program Vision Research Program Steering Committee activities including identifying and updating vision research gaps, developing research program announcements, and reviewing proposals.

VCE chaired a working group in collaboration with the Combat Critical Care Research Program to identify studies that support the potential uses of eye-movement techniques and technologies for the assessment of mTBI and concussion. The consensus will be used to inform an Integrated Product Team at MRMC and contribute to the selection and development process of effective solutions for mTBI diagnosis in Military Service members. Results were documented in a report completed December 3, 2013, entitled *Traumatic Brain Injury Detection using Oculomotor and Eye Movement Tracking – A Technical Working Group Critical Review*. VCE is currently in the development stages of a manuscript for publication in a peer-reviewed journal.

VCE has also partnered with the MRMC in identifying critically important parameters in the development of a public-private partnership designed to produce biotechnological innovation to support restoration of neurosensory losses associated with combat injury. The Horus Vision Restoration Project is the first project identified under this initiative and seeks to develop technology to restore sight in blinded individuals. The VCE is a founding partner of this initiative.

VCE continues to work in collaboration with other Centers of Excellence (CoE). VCE participated in the Allied Neuro-Sensory Warrior-Related Research (ANSW2R) initiative spearheaded by the Hearing Center of Excellence and provided capability analysis to be included in multi-sensory capability gaps and improved business practices. A concept overview of ANSW2R future state operating model is currently under review by stakeholders. In FY 2014, VCE provided guidance into the development of the DoD/VA Chronic Effects of Neurotrauma Consortium (CENC) Program Announcement which will address sensory deficits associated with mTBI/concussion. VCE also provided input on the methodology of testing for TBI-related visual dysfunctions to the CENC-funded Observational Study led by Virginia Commonwealth University.

VCE conducted a systematic review and produced a meta-analysis of published literature related to visual field loss and oculomotor dysfunctions associated with TBI. This meta-analysis examined the available scientific evidence concerning the prevalence/incidence of oculomotor dysfunctions and visual field loss in patients who have a sustained TBI as well as whether or not there is a significant evidence base regarding the rehabilitation practices. The meta-analysis document is currently being finalized and a manuscript is being developed for publication in a peer-reviewed journal.

VCE is conducting an environmental scan to identify currently published research and literature pertaining to BrainPort sensory substitution and sensory stimulation technology as it relates to vision. This scan and analysis will identify technologies as well as to provide information to further guide VCE in the development of future research initiatives.

Clinical Support

The VCE continued a monthly worldwide ocular trauma call for providers caring for Service members and Veterans with eye trauma throughout FY 2014. This effort has been a key platform for the identification of process improvements and clinical lessons learned. Nowhere was the importance of this knowledge better exemplified than in the direct support provided and coordinated by VCE clinicians to the clinicians responding to the ocular injuries incurred during the Boston Marathon bombing and the West Texas fertilizer explosion. VCE collaborated on a peer-reviewed article on these seminal events published in September 2014 (Ophthalmology).

In FY 2014, VCE initiated the clinical recommendations related to the assessment, management and referral considerations for:

- Visual dysfunctions associated with blast exposure and possible TBI (for use by eye care providers)
- Visual field loss associated with TBI (for use by specialty care providers and rehabilitation specialists)
- Oculomotor dysfunctions associated with TBI (for use by specialty care providers and rehabilitation specialists)

These clinical recommendations draw from the evidence in current literature and the expert consensus obtained during workgroups hosted by VCE. The recommendations will provide expert guidance for the screening, assessment, referral, management and rehabilitation of eye and visual dysfunctions associated with blast exposure, concussion and TBI and will be used to inform providers in best practices and clinical considerations.

Continued VCE collaboration with the tactical combat casualty care (TCCC) community has resulted in significant impacts to improve Point of Injury/ Pre-hospital care. Examples include: inclusion of rigid eye shield (Fox shield) documentation on the TCCC card and After Action Report; the addition of eye shields to tri-service individual and joint first aid kits as well as Warrior Aid and Litter Kits found in all vehicles in theater and even modification of Fairfax County, VA, ambulance equipment to include eye shields. VCE further collaborated on publication of articles on theater eye shield compliance (Journal of Trauma and Acute Care Surgery, September 2014) and Mass Casualty Situations and Emergency Retinal Care (Retinal Physician) September 2014.

The advent of iPhone/iPad and similar technologies has produced many opportunities for the blind and visually impaired to have better access to internet, GPS, text to voice reading and a host of other innovative technology assistance mechanisms. The VCE is leading the way in this effort by performing environmental scan searches, looking for the latest in adaptive technologies that may serve these communities. In FY 2014, VCE cooperated with the University of Pittsburgh program on innovative solutions by providing speaker support for their series. VCE is also partnering with the Blinded Veterans Association to engage the community of Blinded Veterans in technology development discussions with the communities of rehabilitation specialists and industries developing technologies. VCE staff collaborated with VA on an evidence-based synthesis project entitled, "Visual Dysfunction in Patients with TBI: A Systematic Review".

VCE has initiated the development of an updated and validated visual functioning questionnaire (VFQ) for age specific populations of Service members and Veterans with eye injuries and diseases. VCE has completed an initial literature search and review of existing VFQ instruments, which was used to inform a project white paper, and is in the process of identifying focus groups and SMEs across a variety of vision care specialties to create a draft instrument for initial testing.

Education and Outreach

VCE works in collaboration with the Uniformed Services University of the Health Sciences (USUHS), VHA EES and others to ensure knowledge concerning the state of vision care treatment and rehabilitation is managed as a strategic asset and transferred to clinicians; and provide Service members, Veterans, and families the tools, techniques and information they need to prevent or accommodate ocular trauma and vision impairment.

In coordination with the VA Blind Rehabilitation Service (BRS) and the VA Polytrauma Field Advisory Committee, VCE completed a fact sheet, *Caring for Patients who are Blind or Visually Impaired: A Fact Sheet for the Inpatient Care Team*. This fact sheet, which is written to assist those who are caring for blind and visually impaired patients in the hospitalized setting, is currently being disseminated across the DoD and VA. Work is in progress on a second fact sheet, which provides guidance to providers caring for patients in the outpatient setting.

VCE continues to lead development of relevant educational outreach through design and dissemination of classroom-based training courses, podcasts and educational fact sheets, geared toward improved care and treatment of ocular injuries and vision problems. This included collaborating on major training efforts such as the USUHS Ocular Trauma Training Course, which is one of the primary means by which military eye surgeons maintain their trauma skill readiness. In parallel, VCE worked jointly with VHA EES to develop a course on the management of ocular trauma for non-eye care providers. This content was presented in August 2014, as a web-based EES learning event. In addition, VCE provided a presentation entitled *Combat Eye Injuries* at the July 2014, Defense Centers of Excellence Webinar Series. The VCE also completed development of courses for the Military Health System Speaker Series to be held in November 2014.

In collaboration with VHA EES, the Rehabilitation and Reintegration Directorate hosted a face-to-face knowledge-based workshop entitled *Managing Vision Disorders Following Traumatic Brain Injury* to teach VA ophthalmologists and optometrists how to clinically assess and manage eye and vision disorders associated with blast injury and TBI. The videos of this workshop are under development to be converted into an eLearning format.

Simulation

The VCE team engaged external stakeholders to identify requirements for new simulation capability requirements. A survey instrument has been developed to gauge use and needs across DoD. Separately, the VCE co-hosted a national working group to develop a Roadmap for Simulation in Eye Care under MRMC sponsorship. Work on development and validation of an ocular trauma simulator continues in conjunction with personnel from Massachusetts General Hospital and Massachusetts Eye and Ear Infirmary.

HEC Hearing Center of Excellence

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

Operations

Throughout FY 2014, HCE and VA representatives worked closely to establish cross-Departmental support and funding to include the embedded VA Deputy Director and VA Associate Director for the Clinical Directorate, and two additional VA positions to support HCE.

The HCE leadership participated in various working groups and task forces involved in defining CoE governance and alignment within the DHA. The HCE reported to the House Committee on Veterans Affairs, House Armed Services Committee (twice), Senate Armed Services Committee (twice), and was solicited to provide information regarding various hearing and balance programs supported by Senate appropriations. As the common voice for auditory sciences, HCE has further developed partnerships with multiple external organizations within academic, public, private, governmental, and international arenas for research, clinical, advocacy and outreach opportunities.

Tinnitus and hearing loss remain the most prevalent Veteran disabilities in all peacetime eras, according to the annual Veteran Benefit Report. HCE's mission includes outreach to raise awareness and improve prevention, military readiness and care. A strategic communication plan has been developed, and HCE has partnered with a variety of communities and organizations, including the Hearing Health Foundation and the American Tinnitus Association.

The HCE supports a robust network of advocates who interface with DoD and VA programs and organizations in support of the objectives of HCE directorates. The HCE maintains a small virtual footprint and achieved force multiplication through engaging, supporting, and leading this network. Through these partnerships, HCE is helping to develop awareness and also creating standardization which helps improve care for those with hearing and balance problems.

Information Management

In FY 2014, HCE began the Defense Business Certification process for the Joint Hearing Loss and Auditory System Injury Registry (JHASIR) development for FY 2015 funding. As part of this initiative, HCE completed requirements that led to receiving approval from the DHA Clinical Portfolio Management Board and the Medical Operations Group for JHASIR and the Enterprise Clinical Audiology Application (ECAA). The ECAA is an application for the collection of clinical audiometric data from all DoD MTFs with audiology services. The HCE awarded a contract for an ECAA solution that electronically captures clinical audiograms for inclusion within JHASIR. This initiative facilitates the standardization and quality of clinical

audiometric data. In the first phase of ECAA deployment, 43 MTF sites received ECAA. Phase two deployment of ECAA is expected during FY 2015 for 58 sites and data will begin to populate the JHASIR in 2016 when the auditory data mart is established under the Clinical Enterprise Intelligence Program.

The HCE's and VA's information technology/information management teams have continued collaborating to develop a bidirectional mechanism for data exchange. These teams continued their work this year to ensure architectural compatibility and seamless flow to allow JHASIR longitudinal functionality (sharing of hearing loss data across the two Federal Departments) once JHASIR is fully functional.

Partnering with the National Intrepid Center of Excellence (NICoE), the HCE informatics management directorate led development of a standardized hearing and balance AIM form to facilitate data input and coding within the Armed Forces Health Longitudinal Technology Application, AHLTA. HCE informatics leaders also are exploring direct delivery of ECAA data to populate the Health Artifact Imaging Management System, (HAIMS) which will further standardize data entry while improving provider efficiency.

The HCE improved the functionality of a primary data source for Service member audiograms, the Defense Occupational and Environmental Health Readiness System for Hearing Conservation (DOEHRS-HC). The HCE funded efforts to strengthen DOEHRS-HC capabilities. File analysis, data processing optimization tasks, and defect corrections were completed.

In FY 2014, HCE provided analytical and expert support to help craft policy enabling purchase of hearing aids for active duty Service members through the VA's Remote Order Entry System (ROES), for a potential cost avoidance of \$7 million per year.

Prevention

HCE launched a Comprehensive Hearing Health Program (CHHP) in order to prevent and mitigate hearing loss and auditory/vestibular system injuries caused from hazardous noise for the military. The CHHP's focus is to provide hearing health services to all Service members (not just those routinely exposed to noise in their military jobs). This program is designed to prevent and ultimately eliminate noise-induced hearing loss through effective and consistently delivered education, monitoring of hearing and hearing protection use, and fitting and use of hearing protection. The DoD-wide implementation of CHHP will ensure all Service members are provided annual hearing health services to reduce and eliminate avoidable, preventable hearing loss. Implementation of the CHHP across DoD and in VA clinical care will help to promote hearing as a critical sense that is worthy of protection and preservation over the course of a lifetime.

In support of CHHP, HCE worked closely with the Air Force Surgeon General's Center of Excellence for Medical Multimedia (CEMM) to develop educational and outreach materials and social media. These tools should increase Service member awareness of the devastating

effects of noise on hearing and job performance and motivate them to adopt prevention practices – both on and off the job.

The HCE continues to work as a unified team with DoD and VA representatives to develop acquisition strategies for the central purchase of hearing protection devices (HPDs) and tactical communication and protective system (TCAPS) devices. Also, HCE examined potential acquisition strategies that would allow procurement of HPDs for both Service members and Veterans.

The HCE is working with the Navy as lead Service in sponsoring a large scale “fit check” pilot to define the logistics necessary to assess how well the hearing protection equipment fits Marine Corps candidates training at Paris Island. This collaboration includes joint service assessment and fitting for this Marine Corps training with the intent that it will translate and transition to fit testing members of all Services.

The HCE developed an Exercise in Communication and Hearing Operation (ECHO) delivered by Special Forces operatives as a means to demonstrate the functionality that communication through TCAPs offers. Through a combination of didactic and field scenarios, attendees learn firsthand how unity of effort and unity of command are enhanced through communication provided by available protective technology. Six such ECHO events were held at Fort Campbell, Aberdeen Proving Grounds, Nellis Air Force Base (AFB), and Quantico Marine Corps Base.

HCE completed an analysis and report entitled, “Military Hearing Critical Task Review by Service.” These hearing critical tasks (HCTs) may involve one or more of the hearing functionalities of understanding speech and detecting, identifying, and/or localizing sound. The report identified how military occupational specialties have HCTs and what required functional hearing capability is needed by personnel for specialties across the Services.

The HCE continues to look across the Military Health System and VA for enhancement opportunities with an eye towards value. It is in the third year of a large scale analysis of the epidemiology and economic burden of hearing loss on DoD. This analysis is a cross cutting effort of all HCE directorates to examine the impact of hearing and hearing loss on prevention programs, care organizations, and individual outcomes and expenses. By its conclusion in FY 2015, this analysis should help to identify those areas that may be optimized with the highest potential to yield cost savings and/or improved access to care.

Clinical Care and Auditory Care Optimization

Clinical Care and Auditory Care Optimization (ACO) are a primary focus of the HCE mission. Through advocacy and outreach efforts, HCE is putting its clinical care/ACO outcomes into the hands of providers to enhance the hearing health of Service members and Veterans.

The HCE guided the implementation of the Separation Health and Physical Exam (SHPE)⁶ program and facilitated continued discussions across VA and DoD to streamline the audiology portion of the separation process for Service members. By the end of FY 2014, all Military Services had plans (in varying stages of execution) for baseline and termination hearing tests. In preparation, HCE through its collaboration with the CEMM, created an online ordering system via the HCE Web site and absorbed the workload of storing and disseminating recorded speech materials for compensation and pension exams, as well as clinical audiology data for all DoD and VA audiologists.

Additional partnerships between DoD and VA continued to develop with the increased use of the VA Denver Acquisitions and Logistics Center's ROES by DoD audiology and otolaryngology services for hearing aid, hearing aid supply, and cochlear implant contracts. This partnership has resulted in large cost savings to DoD as they are able to purchase hearing aids at VA's contract price. The HCE continues to work in this area to address the issue of purchasing hearing aids through VA contracts for TRICARE network providers.

Over this past year HCE developed and disseminated a tinnitus questionnaire for DoD and VA providers to better understand practices and education. The results of that questionnaire showed that among 192 survey participants (126 VA providers, 66 DoD providers), 82 percent are offering tinnitus evaluations and 87 percent are offering tinnitus treatment and management service. Of the 157 participants who responded to the question regarding progressive tinnitus management (PTM), which was developed in the VA's National Center for Research in Auditory Rehabilitation (NCRAR), 75 percent reported they used PTM as their treatment method with the majority of respondents reporting treatments consisting of two to four clinic visits. As expected, coding for tinnitus evaluation and treatment was inconsistent with participants using multiple different codes to capture their workload. Over 75 percent of respondents requested on-line training in tinnitus treatment. The HCE continues to work with VHA EES to allow sharing of the Training Management System training modules with DoD and civilian audiologists.

The HCE coordinated publication of a series of six articles developing the issues, diagnosis, and management of polytraumatic TBI for Psychiatric Annals. HCE staff then followed up with a podcast interview outreach to primary care, psychiatric and psychological care providers to increase awareness of how the isolation created by hearing loss compounds other TBI and PTSD conditions. As a valued source of hearing and balance expertise, the HCE participated in reviewing guidelines and standards for the American Academy of Otolaryngology (Tinnitus Clinical Practice Guidelines), the Agency for Healthcare Research and Quality (AHRQ - Tinnitus CER), and the Institute of Medicine (Long Term Effects of Blast Exposure). The HCE also contributed to the VA/DoD collaborative research guidebook revision.

Research Coordination

In April 2014, HCE hosted the annual meeting for the Collaborative Auditory/Vestibular Research Network (CAVRN) group at the Army Research Laboratory and at the NICoE at

⁶ Also known as the Separation Health Assessment (SHA) Program.

Walter Reed National Military Medical Center. This was a two-day meeting to review current projects and explore future multi-site research studies. The CAVRN's Scientific Advisory Board fills Scientific Advisory capacities for Defense Health Program programmatic research reviews and development of research roadmaps (gaps and priorities) for the research activity directorates for Military Operational Medicine, Combat Casualty Care and Clinical and Rehabilitative Medicine.

The HCE Auditory Fitness For Duty Working Group (AFFD WG) initiated development of auditory standards required for specific military occupations. This will enable confirmation of necessary hearing function and hearing protection prior to deployment in order to meet critical job and mission requirements. In FY 2014 AFFD studies continued with a target of FY 2015 for completion of the work that will align hearing profile standards to operational performance. These are intended to improve the evidence basis for decisions made by the Accessions Medical Standards Working Group, disability Working Group, Service readiness reviews, and medical evaluation boards. Future work will provide the evidence basis for guiding the disposition of hearing deficient Service members with various rehabilitative and protective devices.

The HCE has organized the Pharmaceutical Interventions for Hearing Loss (PIHL) Working Group as a collaborative group of DoD, VA, National Institutes of Health (NIH), academic, and industry interests. The PIHL Work Group is focused on standardizing research methods and reporting standards, and coordinating DoD interests as they relate to pharmaceutical developmental strategies. PIHL Working Group white papers were presented at the Annual PIHL Working Group Meeting held in August 2014. They will be developed into full articles for publication as a peer-reviewed journal special edition of *Otology & Neurotology* in FY 2015.

The HCE leads a Surgical Therapeutic and Prosthetic Evaluation council with annual meeting and ad hoc discussions as a DoD/VA working group focused on evaluating and translating emerging trends and technologies that improve surgical outcomes and advance therapeutic strategies. Such interaction has led to decreased morbidity and improved outcomes, and novel rehabilitative options for members with hearing loss and auditory vestibular dysfunction.

The HCE augmented the U.S. Army Medical Research and Materiel Command (MRMC) Institutional Review Board (IRB) Office with a DoD IRB administrative scientist funded by HCE. This established a single IRB strategy that will facilitate multi-site research projects across the CoE and its DoD partners. During its first full year of operation in FY 2014, the new IRB received six protocols submitted for multi-site research; the HCE is tracking additional protocols planned for submission to the centralized IRB office.

HEC Extremity Trauma and Amputation Center of Excellence

The Extremity Trauma and Amputation Center of Excellence (EACE) serves as the Nation's premier center for promoting excellence in the identification, mitigation, treatment, rehabilitation, and research for traumatic extremity injuries and amputation for our Service members and Veterans.

Significant efforts in FY 2014 focused on recruiting quality staff and enhancing organizational practices, while building on previous years' activities. The EACE successfully recruited a number of talented clinicians and scientists, whose scientific publications and presentations have vastly expanded the amputation and extremity trauma body of knowledge. The year concluded with 33 of 41 positions filled for an 80 percent overall staffing ratio. The Research and Surveillance Division, the largest of four divisions, has 21 of 26 positions filled, including senior positions at the three research sites. The four VA positions within the EACE are now filled.

The EACE commenced several initiatives in FY 2014 to meet the goal of promoting measurable, safe, effective, timely, efficient, and equitable patient-centered quality healthcare for all Service members, Veterans, and their beneficiaries. The first Federal Advanced Amputation Skills Training (FAAST) Symposium was held in July 2014. The theme was "Care for the Individual with Multiple-limb Amputation." The FAAST Symposium, sponsored by the VA EES, was jointly planned by a VA and DoD committee and attended by more than 90 clinicians and researchers from across VA and DoD. The FAAST Symposium fostered interaction and sharing of knowledge between clinical experts and researchers from both VA and DoD. Attendees were provided with hands-on clinical skills to immediately use in their clinics, as well as education on evolving "state-of-the art" clinical topics such as hand-transplantation, targeted muscle reinnervation, and osseointegration. Details of the research funded by DoD and VA were presented, along with information on upcoming clinical trials. The interdisciplinary team of DoD speakers focused on care of combat amputees that are transitioning into the VA system of care, while VA staff presented on topics relating to life-long care for Veterans living with limb-loss. The success of this joint collaborative effort was confirmed by a 95 percent response rate of overall satisfaction with the training.

The EACE partnered with the VA Amputation System of Care (ASoC) to deliver the first EACE/ASoC Virtual Grand Rounds presentation. Virtual Grand Rounds is now conducted bi-monthly for a large range of DoD and VA clinical staff members. This program provides continuing medical education for both DoD and VA providers on the most current topics relating to limb-loss and extremity trauma rehabilitation and care. This program averages 120 attendees per session and is also available for digital replay on VA's Content Distribution Network for those VA clinicians unable to attend the live session. Overall satisfaction for the training is 88 percent, with more than 90 percent of the respondents reporting that they obtained new knowledge from the training, which they will apply in their clinical setting.

The total amputation population cared for within DoD advanced rehabilitation facilities and VA health care since 2001, has included a significant number of patients with upper limb involvement compared to the U.S. upper limb amputation population. Variations in rehabilitative care for patients with upper limb amputation were observed, with limited expertise for upper limb amputation care noted in some professional disciplines. In an effort to address these findings, the EACE obtained authorization in FY 2012 for a DoD/VA Upper Extremity Amputation Rehabilitation (UEAR) Clinical Practice Guideline (CPG). During FY 2014, the first clinical pathway/standard of care for this population of patients was completed and published

for national and international utilization⁷. The goals of this CPG are to reduce practice variance, enhance the standard of care, accelerate research translation into clinical practice, and ultimately lead to improved health, quality of life, and satisfaction for the population of patients with upper limb amputations.

The EACE continues to promote the prescription of and training on “state-of-the-art” technologies. This includes the X3® microprocessor knee and BiOM® microprocessor controlled powered ankle prosthesis. Component prescription in DoD and VA remains driven by patient need, based on goals and physical evaluations, and not driven by reimbursement from third party payers. This assures Service members and Veterans are provided the most appropriate technologies to facilitate independence in their individual environment.

EACE staff, in coordination with VHA, supported efforts to improve acquisition of prosthetic components and supplies through use of the Denver Acquisition and Logistics Center. The goals of this initiative, currently in the development phase, are to provide enhanced services for patients and providers, improve efficiency, and decrease costs for Veterans and Service members with lower limb-loss.

The EACE acknowledges the recognition of VA and DoD amputation rehabilitation facilities by external accrediting organizations. The three DoD Advanced Rehabilitation Centers are accredited by the American Board for Certification in Orthotics, Prosthetics and Pedorthics. The seven VA Regional Amputation Centers and 15 of the 18 Polytrauma Amputation Network Sites (PANS) sustained or acquired their amputation specialty certification from the Commission on Accreditation of Rehabilitation Facilities (CARF). The three PANS not accredited are newly designated sites and are working on acquiring their CARF certification.

Patient satisfaction with amputation care was collected from patient feedback in VA facilities. It captured perception of the quality of services as well as their level of satisfaction during hospitalization. Reported quarterly in VA, overall satisfaction for FY 2014 ranged from 98-100 percent. An outpatient survey tool was developed during FY 2014 and is currently being piloted in VA.

During FY 2014, multiple areas of investigation have continued to mature and produce scholarly work, especially in the specialized area of biomechanics and gait optimization. This year, EACE supported 76 ongoing active research projects, to include eight new research studies. Additionally, there were 21 publications in peer-reviewed journals and 33 platform and podium presentations at national and international conferences. The EACE diligently pursued an infrastructure of data networks by leveraging longitudinal, prospective cohort studies with the DoD Deployment Health Research Command and utilizing VA/DoD integrated data, such as the Expeditionary Medical Encounter Database and Millennium Cohort Study (MCS). This collaborative effort will enable future research of critical longitudinal outcomes data regarding casualty events, medical encounters, clinical care, and functional outcomes from point of injury into life-long Veteran care.

⁷ <http://www.healthquality.va.gov/guidelines/rehab/uear/index.asp>

HEC Medical Research Working Group

The DoD/VA Medical Research Work Group (MRWG) ensures coordination through the identification of new research directions and approaches, and identification of gaps in scientific knowledge. DoD and VA identified several high priority medical research areas that impact Service members and Veterans, including: PTSD and other psychological conditions, TBI, multidisciplinary treatment of polytrauma, pain management, rehabilitation, advanced prosthetics, and the long-term health effects of deployments. VA scientists compete very successfully for funding from DoD, resulting in hundreds of DoD-funded research projects in the VA system. These DoD-funded projects, which are performed by VA scientists, cover several high-priority topics, including: PTSD; alcohol abuse; resilience to mitigate combat stress and post-deployment reintegration problems; treatment of TBI and spinal cord injuries; treatment of amputations and improved prosthetics; visual and hearing impairments; and rehabilitation.

In FY 2014, senior DoD and VA research managers and scientists collaborated in six joint comprehensive program reviews. Each of these comprehensive portfolio reviews included hundreds of projects on treatment of acute traumatic injuries; rehabilitation medicine and orthopedics; PTSD, suicide prevention, and other psychological conditions; TBI; infectious diseases; and operational medicine. Comprehensive reports on the program reviews were written for each of the reviews. These joint reviews identified complementary research projects, new research approaches, and gaps in scientific knowledge. These reviews contributed to improved interagency coordination through the direct linkage of DoD and VA scientists working in the same medical specialty.

The MRWG continued to develop a monthly update of a bibliography of medical articles related to Service members and Veterans deployed to Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn. This monthly bibliography, focusing on the health of deployed Service members and Veterans, was distributed to senior DoD and VA research managers and scientists to improve their situational awareness. These monthly bibliographies included 2,445 articles during FY 2014, far exceeding the WG's goal of 600 articles per year in the VA/DoD JEC Joint Strategic Plan (JSP). As a result of this continuous information flow, the response times of senior research leaders to new findings were considerably shortened.

In FY 2014, DoD and VA worked to increase coordination on studies of the long-term health effects of military service, and to improve collaboration on epidemiological studies, to include the MCS, that follow Service members from active-duty through Veteran status. Scientists in DoD Health Affairs and the VA Office of Research and Development (ORD) provided leadership in the development of two jointly-funded Program Announcements on TBI and PTSD. DoD and VA are funding two consortia studies designed to investigate the long-term health effects of PTSD and TBI. These two awards were funded in FY 2014. These consortia represent an unprecedented collaboration by DoD and VA, in terms of joint oversight and total funding of \$107 million during a five-year period.

The MCS includes more than 200,000 Service members, who started enrollment in 2001. The health of the cohort will be evaluated every three years until 2022, to determine the course of diseases over time. Forty percent of the cohort have already separated from the military and are eligible for VA medical care. DoD has funded the MCS since its inception, and the Naval Health Research Center in San Diego performs the research. In 2014, VA ORD and the VA Office of Public Health launched a major collaboration with DoD in the MCS, through the provision of substantial VA funding and dedicated VA research staff, who work on-site in San Diego. Increased DoD/VA collaboration on long-term cohort studies will build on the effectiveness of the existing foundation of interagency research.

On August 31, 2012, an Executive Order, titled "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families" was issued with focus on PTSD, TBI, and suicide prevention. Section 5 of the Executive Order required DoD and VA to develop a National Research Action Plan (NRAP). The NRAP is a 10-year blueprint for interagency research to enhance the diagnosis and treatment of PTSD and TBI and to improve suicide prevention, including immediate, short-term, and long-term initiatives. The NRAP outlines coordinated research efforts to accelerate discovery of the causes and mechanisms underlying PTSD, TBI, and other comorbid conditions, including suicide, depression, and substance abuse disorders. This includes collaborative research on safe, effective treatments to improve function and to promote community reintegration. The NRAP also describes research to accelerate the implementation of proven methods, through the rapid translation of new findings into effective prevention strategies and clinical innovations in the DoD and VA medical systems.

In August 2014, the agencies launched 24 initiatives that were required in year two through four of the NRAP. A progress report on the NRAP was provided to the White House in June 2014. In July 2014, an Executive Review was organized to report on the progress on the 46 initiatives in the first year, and to plan the 24 initiatives in year two through four. This Review characterized the initiatives that were complete, well underway, delayed or facing challenges, or not started yet. The Director of the DoD Medical Research Program, the VA Chief Research and Development Officer, and the Director of the National Institute of Mental Health participated in this Review; and they provided valuable feedback on the efforts that were going well and the efforts that were facing challenges.

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

HEC Psychological Health/Traumatic Brain Injury Working Group

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

DoD Instruction (DoDI) 6490.11, "DoD Policy Guidance for Management of Mild Traumatic Brain Injury/Concussion in the Deployed Setting," dated September 18, 2012, mandates Service members involved in potentially concussive events in the deployed setting be screened, identified, and treated promptly for concussions. The policy seeks to prevent long-term problems associated with concussions by providing early treatment and reducing the possibility that Service members could be exposed to further injury. The DoDI also identifies specific reporting requirements so that Service members who have been exposed to potentially concussive events are identified and tracked. Through January 2014, a total of 16,517 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, 2,661 of those exposed received concussion diagnoses identified in their medical records with 16.1 percent of all exposures during the period having diagnosed concussions. During the third quarter FY 2014 there were only 38 concussions reported by the Army, a significant decline from the second quarter of FY 2014 when there were 84 concussions reported. For both the Army and the Marines, these numbers represent 10 percent or less of the peak quarterly rates from the third quarter of FY 2011. The base majority of exposure events were classified as either 'presence within 50m of a blast' (48.9 percent) or 'involvement in vehicle blast event, collision, or rollover' (45.8 percent).

In FY 2014, VA screened 96 percent of all Veterans from the OEF/OIF/OND cohort who received services at VHA at their entry to the VA health care system for a possible mTBI. From April 2007 through September 2014, VA screened 883,883 Veterans from OEF/OIF/OND for possible mTBI with a resultant 159,220 positive screens consenting to further evaluation. Of those Veterans who completed follow-up comprehensive evaluations, a total of 70,043 were confirmed to have incurred an mTBI through May 2014. The length of time between the initial positive screen and completion of the comprehensive evaluation averaged about 23 days, well below the 30 day target.

In FY 2013, VA established a protocol for completion of TBI tele-consultations. The goal of this pilot project is to increase clinical accessibility to specialty care assessment for Veterans with a history of TBI, who live in geographically remote regions, or otherwise experience challenges accessing this specialty care. This pilot project began in December 2012 with 16 sites. A total of 41 sites have now been added to the pilot. Thus far, 801 unique visits and 306 follow-up visits have been achieved through this tele-rehabilitation pilot program. Training for

this program has been developed and is available on-line. The findings of this pilot will be shared with DoD for potential adoption in FY 2015.

“A Head for the Future”⁸ is a DCoE/DVBIC initiative launched in FY 2014 that is designed to promote TBI awareness, education and prevention for Service members and their families. The principle tenets of the program are to promote recognition of the signs and symptoms of a possible TBI, report it to a medical provider, and then follow the treatment program. This initiative will also focus on taking proper safety precautions for high-risk activities, including sports, military training, and operating motor vehicles. As part of this initiative DVBIC has developed programs and educational tools for back to school guidance, brain basics, an interactive brain model, a TBI overview for military providers, online courses for the identification and treatment of concussion, and for recognizing co-occurring conditions. Additionally, DVBIC has identified several smartphone apps that can assist providers in diagnosing and caring for TBI patients.

There are two TBI mobile applications available as additional educational resources. The mTBI Pocket Guide mobile app, designed by DCoE/DVBIC and developed at The National Center for Telehealth & Technology (T2) for health care providers, offers instant access to a comprehensive quick-reference guide on improving care for mTBI patients. It was launched in May 2011, and as of August 31, 2014, had 22,619 cumulative downloads, with 4,308 downloads in FY 2014. Concussion Coach, collaboratively developed by VA Rehabilitation and Prosthetic Services, National Center for PTSD, and T2, is designed for Veterans, Service members, and other individuals who experience physical, cognitive, and emotional symptoms that may be related to mild to moderate TBI. It provides users with information about concussion, tools to help users build resilience and manage symptoms, and recommendations for community-based resources and support. Launched in November 2013, this app has been downloaded 2,624 times through August 2014.

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

Facilitating Connections with Care

The *inTransition* Program is a voluntary and confidential program that ensures continuity of care as Service members and Veterans move between DoD and VA health care systems or providers. Personal coaches facilitate and encourage Service members and Veterans in making needed behavioral health connections during transitions. The *inTransition* coaches also provide telephonic behavioral health care support and guidance on psychological health concerns with motivational coaching, resources, and tools that will assist Service members and Veterans during the transition period by empowering them to make healthy life choices. Since its inception in February 2010, the *inTransition* program opened 5,663 cases, with 1,600 cases opened in FY 2014. On August 26, 2014, the President announced new EAs to improve Service members’ transition from DoD to VA and civilian health care providers. To fulfill this requirement, DoD will now automatically enroll all Service members leaving military service who are receiving care for mental health conditions in the *inTransition* program.

⁸ <http://dvbic.dcoe.mil/AHeadForTheFuture>

National Efforts to Reduce Mental Health Stigma

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

The "Make the Connection" campaign experienced substantial high volume growth throughout FY 2014: 2,651,837 Web site visits⁹ during FY 2014 (excluding September) for a total of 5,497,024 since the launch of the campaign and a 107.8 percent increase over the previous fiscal year. For FY 2014, DoD's Real Warriors Campaign¹⁰, averaged 27,173 visits per month, reflecting traffic consistent with FY 2013 (decrease of 0.1 percent).

Technological Innovations to Reduce Barriers to Care

There are a range of strategies being utilized in both DoD and VA to leverage technology in ways that reduce barriers to care, and educate and empower Service members, Veterans, and their families. These innovations provide increased access to information online, the ability to complete screening and self-assessments, and ready access to information and assistance via mobile tools. DoD and VA have collaborated through the IMHS, to develop Web-based resources to reduce barriers to care.

During FY 2014, technological enhancements to reduce barriers to care are:

- 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 ability to track usage for AfterDeployment was affected by the required removal of Google Analytics so FY 2014 numbers for AfterDeployment are not available. The Military Pathways® Web site was established to assist Service members and their families who are facing various mental health challenges.¹¹ Service members, Veterans, and family members can answer questions on a variety of mental health issues and receive feedback when further evaluation is needed, as well as guidance on where to seek assistance. The average monthly visits to militarymentalhealth.org increased in FY 2014 (through July 2014) by 3.6 percent going from an average of 18,035 per month in FY 2013 to an average of 18,705 per month in FY 2014.
- In FY 2014, DoD and VA continued to exceed the metric of increasing the number of downloads of psychological-health related mobile smartphone apps by 10 percent each year and plan to persist in a variety of communication strategy efforts to increase mobile application usage in the coming fiscal year.

⁹ <http://maketheconnection.net/>

¹⁰ <http://realwarriors.net/>

¹¹ <http://www.militarymentalhealth.org>

- As part of the IMHS, two new DoD/VA mobile applications, Moving Forward and Parenting2Go, were developed in FY 2014. Both mobile apps launched January 31, 2014, to complement the web-based self-help courses described above. Moving Forward provides on-the-go tools and teaches problem solving skills to overcome obstacles and deal with stress. Parenting2Go provides convenient tools to strengthen parenting skills. Through August 2014, the Moving Forward app has been downloaded 1,354 times, while the Parenting2Go app has been downloaded 662 times.
- In addition to the IMHS apps, DoD and VA jointly released three other psychological health-related mobile applications in 2014: Acceptance and Commitment Therapy (ACT) Coach, Mindfulness Coach, and CPT Coach. ACT Coach offers exercises, tools, information, and tracking logs to practice skills associated with the therapy. CPT Coach is designed to help manage treatment, including between session assignments, readings, PTSD symptom monitoring, and mobile versions of CPT worksheets. Mindfulness Coach helps Veterans, Service members, and others learn how to practice mindfulness through exercises, information, and a tracking log. Between when three applications were launched in February 2014 and the metric collection in August 2014, these applications have been downloaded 2,549 times, 6,898 times, and 2,969 times respectively.

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 DoD/VA Integration of Mental Health Services into Primary Care Task Group was established to address common issues related to integrating behavioral health care into primary care programs.

DoDI 6490.14 outlines the minimum staffing requirements for DoD of at least one full-time behavioral health provider at each primary care clinic with 3,000-7,499 adult enrollees. Clinics with 7,500 or more enrollees are required to have at least one full-time behavioral health provider and one full-time behavioral health care facilitator. Per minimum staffing policy, 311 MHS direct care primary care clinics will be staffed. Through June 2014, 216 (69 percent) of clinics are staffed with 216 full-time behavioral health providers and 83 behavioral health care facilitators. This is an increase of one full-time behavioral health staff from September 2013. The total numbers of full-time staff have remained flat with an overall loss of nine full-time behavioral health care providers and an increase of 10 behavioral health care facilitators. Service behavioral health in primary care leads are working with contracting experts at the Deployment Health Clinical Center on a plan to improve the human resources recruitment and hiring processes for these positions. The new plan is expected to reduce staff turnover. Percent of clinics staffed is expected to be at 80 percent by March 2015.

VA's Primary Care-Mental Health Integration Programs combine co-located collaborative care and care management functions to support primary care providers within the Patient Aligned Care Teams in treating common mental health conditions within the primary care setting. Growth of these activities continued in FY 2014, as did support of virtual education and

regional-based training of integrated mental health and Patient Aligned Care Team staff. Through July 2014, 335 (94 percent) of the 358 VAMCs and Community-Based Outpatient Clinics (CBOC) classified as large and very large have integrated behavioral health programs, compared to 93 percent at the end of FY 2013. Furthermore, seven percent of all primary care patients at these sites were directly served by the program.

HEC Pain Management Working Group

In FY 2014 the HEC Pain Management Working Group (PMWG) continued to focus on major lines of effort to improve pain management for Federal medicine beneficiaries. Activities centered on developing a standardized pain screening and assessment, clinical pain policy support, the creation of a new VA/DoD pain management curriculum, and integration of non-pharmacologic treatment options into the Federal medicine system or integrative medicine (formally complementary and alternative medicine). Additionally, the stepped care pain management model continues to evolve in both systems as the standard approach to pain care. VA/DoD efforts are in line and complementary to the IOM report on pain and the forthcoming National Pain Action Plan being developed by the Interagency Pain Research Coordinating Committee through the NIH.

Standardized Pain Screening and Assessment

The Pain Assessment Screening Tool and Outcomes Registry

The Pain Assessment Screening Tool and Outcomes Registry (PASTOR) tool set was completed in 2014 under the direction of the Defense and Veterans Center for Integrative Pain Management (DVCIPM) with collaboration with NIH PROMIS[®] through Northwestern University. Validation and internal consistency research testing of PASTOR has been ongoing at three major DoD centers, Walter Reed National Military Medical Center, Madigan Army Medical Center (AMC), and Naval Medical Center San Diego. Results from these research pilot programs are expected in 2015.

Defense and Veterans Pain Rating Scale

Further validation of the new Defense and Veterans Pain Rating Scale (DVPRS) was completed in both VHA and DoD hospital systems in FY 2014. The DVPRS is also integral to the PASTOR program and is being validated with PROMIS standards in the ongoing PASTOR research program. The tool continues to be adopted independently by civilian and federal healthcare systems at the local level. The DoD Tri-Service Pain Management Work Group is developing the plan to expand utilization of the DVPRS across the Military Health System.

Clinical Pain Policy Support

Chronic Opioid Therapy Safety

The PMWG has been developing a coordinated program for long-term opioid therapy (LOT) principles of practice to include prescribing practices and provider/patient LOT agreement standards. This information has been forwarded for Uniformed Service and DHA review and approval. A similar VA-wide program has been launched to provide standard guidance for providers on managing patients on LOT who are at risk for complications, misuse, or abuse. These programs depend on improvements in patient reported outcomes data that will be provided by systems such as PASTOR.

Suboxone

Suboxone is a combination medication (buprenorphine and naloxone) and has been used to manage patients with dependence and addiction issues with other opioids. It can be very effective as part of a physician directed pain management plan with a goal of limiting opioid use. DoD and VHA share standards for the use of Suboxone via VA/DoD Clinical Practice Guidelines on the Management of Long-Term Opioid Therapy for Chronic Pain and on the Management of Substance Use Disorders. The PMWG began work in FY 2014 to develop a plan to ensure provider concordance with common policy for Suboxone between VHA and DoD.

Therapeutic Drug Testing

Standards of therapeutic drug testing in pain patients, particularly those requiring LOT, are presently not available to providers. In FY 2014, the PMWG provided recommendations to the DoD Tri-Service Pain Management Work Group and VHA for establishing therapeutic drug testing standards across the DoD and VHA. These standards will define testing parameters, establish how the information can and cannot be used medically, and inform potential corporate contracts with the DoD and VHA to provide urine and/or saliva medication testing.

Acupuncture Credentialing

The Departments continue to expand utilization and availability of acupuncture and have been coordinating on acupuncture training for all levels of providers. Credentialing guidance concerning acupuncture standards has not been established; hindering the widespread application of this non-pharmacologic pain management modality within federal medicine. A panel of VHA and DoD acupuncture and pain experts, leveraging a policy instruction on acupuncture provided by the Navy, created the first draft for an acupuncture credentialing document defining levels of acupuncture practice within federal medicine. This document is presently under review by the Uniformed Services, DHA and VA Central office.

Education Curriculum

VA and DoD invested \$4.7 million beginning in 2013 to establish the Joint Pain Education Project (JPEP) that is managed through DVCIPM. This project is designed to provide a standardized foundational curriculum specifically for primary care providers to improve their knowledge and capabilities in managing pain patients. A group of VA and DoD experts jointly identified four core training areas: pain management, subspecialty pain care, patient education, and pain care transition. A total of 62 modules are planned under these topic headings; 32 are completed to date. Recently the material was piloted during the Navy sponsored Pain Care Skills Week in September 2014 and feedback from the primary care community was extremely positive. This program is essential for success of ECHO in building pain care networks. VA will be utilizing this JPEP curriculum as content for VHA mini-pain residencies for primary care.

Integrative Medicine

VA and DoD invested \$5.4 million beginning in 2013, managed through DVCIPM, to introduce Battlefield Acupuncture (BFA) to the federal medicine community. BFA is an auricular acupuncture protocol developed by the Air Force Acupuncture Center at Joint Base Andrews that has been used extensively on the battlefield and throughout all roles of care in the management of pain. It is a unique program in federal medicine due to its ease of application, tremendous safety, and accessibility to all levels of healthcare provider (medic to physician). It represents an introduction to our federal medicine community to the potential of acupuncture as a routine, non-pharmacologic treatment modality to complement current standards of care. This program is also working to establish credentialing guidance for federal medicine on integrating all levels of acupuncture providers into the system (see Acupuncture Credentialing). To date, 19 additional medical acupuncturists (have been added to the DoD system to serve as leaders. The program has trained 771 new BFA clinical providers and 38 new BFA instructors. The program represents the first major commitment by VHA and DoD into integrative medicine on a national scale.

HEC Telehealth Working Group

The Telehealth Working Group's (THWG) mission is to identify opportunities to expand the joint telehealth program and optimize joint capabilities between VA and DoD. During FY 2014, the WG improved standardization and integration of telehealth activities between the Departments on three tasks:

- Credentialing and Privileging Procedures – streamlining process in and between Departments.
- Training – developing options for sharing existing telehealth training resources between Departments.
- Joint Demonstration Projects – fostering existing joint telehealth collaborations between Departments, and implementing new collaborations.

In FY 2014, the PMWG created a MOU that streamlined Credentialing & Privileging (C&P) processes to enable privileging by proxy for VA providers. This enabled VA pain specialists to

deliver tele-behavioral pain services to beneficiaries at Joint Base Anacostia-Bolling and Cannon Air Force Base. This standardized C&P process was also applied to a tele-insomnia demonstration project between providers at the VA's National Center for Tele-mental Health and beneficiaries at Naval Hospital Camp Lejeune. In FY 2015, the WG will develop an implementation plan for expanding this process to an established target number of locations.

In FY 2014, the established DoD and VA collaboration site was shifted from SharePoint to an 'All Partners Access Network'. The THWG plans to meet with the HEC's Continuing Education and Training WG in FY 2015 to continue work in this area.

In FY 2014, the DoD asked VA's Planning System Support Group to geo-map several medical specialties to determine overlap between areas of VA beneficiary need and areas of potential support for DoD medical readiness. Geo-mapping compares geographic maps of both Departments' beneficiaries' location overlaid by both Departments' clinical facilities to identify possible opportunities for inter-agency care origination. The THWG subsequently determined that the geo-mapping results could potentially augment the locally identified projects approach to identifying future Joint TH Projects while also supporting the goals of medical readiness and access to care. In FY 2015, the THWG will review the results of geo-mapping to determine whether telehealth is an applicable and feasible solution to increasing medical readiness and beneficiary access in the identified geo-mapped specialties. The WG will update the HEC in FY 2015 on initial findings from its review of geo-mapping and possibilities for inter-agency telehealth expansion opportunities.

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

HEC Vision Center of Excellence

The Defense Veterans Eye Injury and Vision Registry (DVEIVR) is a joint DoD/VA initiative that was created as the technical solution in response to Section 1623 of the National Defense Authorization Act (NDAA) 2008 to support the mission of guiding research and treatment for improved vision care and restorative innovations for those injured in battle. It provides a repository of Service members' and Veterans' longitudinal eye care data to aid in this effort. With DVEIVR, DoD and VA's vision community has computable, aggregated data with fact-based evidence to better guide how we care for our Service members and Veterans. It is scheduled to meet full operational capability by the third quarter of FY15.

In FY 2014, efforts continued in abstraction of DoD vision and related theater and garrison data into the Vision Registry with data abstraction quality consistently at the 98 percent level, exceeding the 96 percent accuracy requirement. The program achieved several key milestones ahead of schedule, including:

- Completed documentation to transition Vision Registry to acquire a milestone decision;

- Completed submission of documentation for the full deployment phase milestone decision by June 30, 2015;
- Implemented the registry's data management informatics governance; and
- Inclusion of other communities of interest in registry's data management informatics governance.

In addition, pending inclusion of VA data into the DVEIVR, the program is in the process of initiating analysis of abstracted DoD Theater and garrison data, and VA longitudinal data from the Vision Registry to support VCE's mission.

DVEIVR was named a finalist in two categories, Health Information Technology (IT) and Collaboration, for the 2014 American Council for Technology-Industry Advisory Council (ACT-IAC) Excellence.Gov Awards and one of the top eight finalists for the American Council for Technology and Industry Advisory Council (ACT-IAC) Igniting Innovation 2014 Showcase and Awards. Also, the DVEIVR Program Manager was recognized as a Federal 100 in Information Technology.

VA awarded a Data Abstraction Support Services contract in July 2014 for the manual extraction of clinical ocular and related information from VA medical records into a computable database that will be electronically transferred to DVEIVR.

VCE continues ongoing efforts through the optimal vision care prototype research project to develop vision-related clinical data definitions to facilitate harmonization between the DoD's future Electronic Health Record and vision registry efforts.

HEC Interagency Clinical Informatics Board

The Interagency Clinical Informatics Board (ICIB) continued through FY 2014 in serving 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. While the Departments' acquisition strategy changed from joint acquisition of a single integrated Electronic Health Record (iEHR) solution to ensuring complete interoperability of the Departments' respective EHR solutions, the ICIB continued to emphasize the requirements for achieving a comprehensive and interoperable health record to support Veterans and Service members.

The WG's objective of achieving six additional iEHR Capabilities in FY 2014 was superseded by the new focus on interoperability specified in the NDAA for 2014. The ICIB quickly re-focused its efforts, defining and prioritizing multiple information domains supporting the sharing of interoperable information between the Departments. This work ultimately concluded in recommendation of 28¹² specific data domains which were subsequently approved by the HEC:

¹² Although the ICIB approved 28 clinical data domains in FY 2014, they subsequently reduced the number of approved domains to 25 in early FY 2015.

- Allergies (multiple types)
- Medications
- Immunizations
- Problem Lists
- Vital signs
- Document
- Results (lab chemistry & hematology)
- Results- Lab Anatomic Pathology
- Results- Lab Microbiology
- Other Past Medical History (e.g. travel)
- Encounter Data – Appointments
- Encounter Data – Admissions
- Procedures
- Demographics
- Social History
- Family History
- Scanned & Imported Paper Records & non-radiology images
- Plan of Care- Pending Orders (multiple types)
- Radiology Images
- Payers
- Questionnaires (general & Standard Instruments)
- Pre- & Post-Deployment Health Assessments
- Functional Status
- Providers
- Advance Directives (metadata only)
- Medical Equipment
- Additional CCDA Clinical data elements
- Results- Radiology Reports

In addition to defining and prioritizing the data domains for interoperability, the ICIB facilitated the alignment of clinical informatics SMEs to conduct initial mapping of data from native DoD and VA EHRs to standardized clinical terminologies endorsed at the national level to support heightened levels of semantic interoperability. Further interoperability achievements supported by the ICIB in 2014 included the following:

- Drove analysis into data losses to VA providers caused by interagency systems issues resulting in the restoration of health information access to support care to Veterans;
- Advanced the dialogue and understanding of the different “types” of interoperability put forward by Health Level 7 (Technical/Semantic/Process);
- Developed and received approval of the Joint Legacy Viewer (JLV) deployment strategy;
- Developed JLV access control requirements enhancing the privacy controls to Service members’ and Veterans’ health information;
- Sunsetting several ICIB sub-working groups following the change in iEHR program strategy (all iEHR Capability IPTs, Functional Capabilities Group; and Business Process Group and its four subgroups, Information Exchange IPT);
- Oversaw and reviewed the Memorandum of Agreement Between the DoD, DHA and VBA for Sharing Data through the Joint Legacy Viewer, as developed by the ICIB’s Health Information Policy Subgroup; and
- Reviewed and provided DoD/VA clinician input on multiple Interagency Program Office (IPO) documents (Information Interoperability Technical Package, Health Data Interoperability Management Plan, etc.).

DoD/VA Interagency Program Office

Ensuring that American Service members, Veterans, and their families receive world-class healthcare is of the utmost importance for both the DoD and VA. Modernized Electronic Health Record (EHR) systems and information-sharing between providers are both key to improving access, quality, and safety in healthcare.

In FY 2014, DoD and VA continued to pursue two distinct goals pertaining to their EHR efforts:

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

Throughout FY 2014, the DoD/VA Interagency Program Office (IPO) worked with the Departments in the pursuit of standards-based data interoperability between the Departments' EHR systems.

Progress on Goal 1: Interoperability

As of October 2014, the Departments and the DoD/VA IPO continued to adhere to interoperability directives and worked to improve upon the more than 1.5 million elements of data exchanged between the Departments daily by:

- Establishing data domains and clinically-relevant data-mapping domains in cases where national standards for computable exchange have been identified, and for which data is available in structured form;
- Developing and issuing technical and governance guidance for the Departments as well as a Joint Interoperability Plan (JIP) that defines a short-term vision for interoperability among both of the Departments;
- Executing additional enhancements to the Departments' interoperability tools; and
- Continuing to lead the industry through engagement with the Office of the National Coordinator (ONC) for Health IT and standards organizations, and supporting the development and execution of the vision for national health data interoperability.

Data Mapping

This year, to establish a framework for implementing the Departments' data compliance with the NDAA for FY 2014, P.L. 113-66, the DoD/VA Interagency Clinical Informatics Board (ICIB) endorsed 28¹³ prioritized data domains. The DoD/VA IPO worked with the Departments in an attempt to identify existing national standards associated with each domain, which is documented in the Information Interoperability Technical Package (I2TP). For both Departments, one domain is in a common native exchange format, one domain has a common standard developed, three domains have no structured data to map, and one domain is not defined. For the remaining 22 domains, the DoD/VA IPO has identified national standards applicable to both Departments' EHR

¹³ Although the ICIB approved 28 clinical data domains in FY 2014, they subsequently reduced the number of approved domains to 25 in early FY 2015.

systems as required per section 713 (b)(1) of P.L. 113-66. This process is documented in the DoD/VA IPO's Health Data Interoperability Management Plan (HDIMP).

Technical and Governance Guidance and Joint Interoperability Plan

This year, the DoD/VA IPO developed several iterative versions of the I2TP, which identifies the DoD/VA IPO-required and DoD/VA IPO-recognized national health data interoperability standards for acquisition programs and technical solution developers in both Departments. The I2TP is being used as a reference for both Departments' modernization plans. The next update is anticipated to be released in the first quarter of FY 2015.

The DoD/VA IPO also developed the HDIMP, which outlines the strategy, guidance, roles, responsibilities, activities, and processes of the DoD/VA IPO that are necessary to achieve optimal Health Data Interoperability (HDI) data exchange and terminology standardization for the Departments' EHRs. It describes the products necessary for documenting agreements and plans, and the intended audience includes DoD/VA IPO leadership and staff as well as external partners. The document was released on October 1, 2014.

Additionally, to help guide the Departments towards their long-term goals, the Departments developed the JIP. This plan defines what interoperability means for the two Departments and lays out the short- and long-term actions that will be taken to achieve computable health data. The JIP is updated regularly by the DoD/VA IPO, and the next update is scheduled for the first quarter of FY 2015.

Engagement with ONC and Standards Organizations

ONC has developed a strategic plan to achieve an interoperable health IT infrastructure, which includes 3, 6, and 10-year agendas to support an interoperability roadmap designed to improve the interoperability of existing health information networks. The DoD/VA IPO has been an essential partner in the effort.

The DoD/VA IPO has also been actively involved in ONC Federal Health Architecture (FHA) Workgroup meetings discussing use cases for each Department and the technical and non-technical (i.e. policy) support required to support those use cases. Meeting participants from the Departments also shared their own interoperability experiences with the group via best practices and lessons learned, providing valuable input that helped shape decision-making.

Progress on Goal 2: Modernization

In FY 2014, the DoD/VA IPO provided technical leadership for the Departments modernization efforts in accordance with its updated charter.

For the DoD, the DoD/VA IPO was directly engaged and supported the DoD Healthcare Management System Modernization (DHMSM) to ensure a successful Request for Proposal (RFP) release in the fourth quarter of FY 2014 with a focus on providing support to the DHMSM Acquisition Strategy and the DHMSM Interface Strategy. In addition, the DoD/VA IPO has

supported the DoD on the interoperability efforts through the Defense Medical Information eXchange (DMIX) throughout the program office Design Reviews and testing events to ensure alignment with industry best practices and national standards with respect to interoperability.

These efforts will continue to ensure DoD's procurement solution seamlessly integrates with legacy systems, VistA Evolution, and private health care providers. Further, the IPO's efforts will assist in the VA's efforts to adhere to data standardization requirements, as defined by P.L. 113-66 under the Interagency Program Office (IPO), and how testing will be conducted in order to ensure interoperability between current and future VA and DoD electronic health record systems.

Moving Forward

The Departments and DoD/VA IPO remain fully committed to supporting the goals of modernization and interoperability to improve access, quality, and safety of healthcare to their beneficiaries. The Departments and DoD/VA IPO will continue to collaborate extensively as they pursue this common vision.

GOAL 3

Efficiency of Operations

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

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

BEC Disability Evaluation System Working Group

The VA/DoD DES Pilot program was instituted under the Senior Oversight Committee (SOC) in 2007 and was incorporated into the JSP for FY 2009-2011. As of January 2012, when the SOC was consolidated into the Joint Executive Committee (JEC), the JEC and subordinate Benefits Executive Committee (BEC) began overseeing the DES. The BEC DES Working Group (WG), an action officer-level joint oversight body officially chartered August 24, 2012, provides briefings as required to the BEC, which in turn informs the JEC.

The Integrated Disability Evaluation System (IDES), compared to the previous DoD and VA disability evaluation processes, provides a more streamlined, transparent, and efficient process for making disability determinations for seriously ill or injured Service members. Service members in IDES undergo a single disability examination and VA provides a proposed rating for use by each Department. They receive more consistent DoD and VA disability ratings and anticipated benefits information simultaneously, prior to separation, which enables them to make better informed decisions about their future.

In July 2010, the co-chairs of the SOC agreed to expand the November 2007 DES Pilot program in the NCR and rename it IDES. Senior leadership of DoD, VA, the Services, and the Joint Chiefs of Staff strongly supported this plan and the need to expand the benefits of this

improved process to all Service members. Expansion and full implementation of IDES was completed by September 30, 2011. Currently, there are 139 IDES sites operational worldwide, including the original DES pilot sites.

Since November 26, 2007, DoD has enrolled 124,701 Service members in IDES. A total of 90,768 Service members completed IDES by either returning to duty or being medically separated or retired and receiving VA benefits. Another 5,962 were removed for other reasons (e.g., additional medical treatment, administrative discharge). As of September 30, 2014, there were 27,971 Service members enrolled in IDES.

Active Component Service members who completed IDES in September 2014, by returning to duty or receiving VA benefits, averaged 316 days. This 316-day average is seven percent slower than the IDES goal of 295 days established for Active Component Service members. The 316 days include an average of 58 days for proposed ratings and 48 days for benefit notifications. Reserve Component and National Guard Service members who completed IDES averaged 396 days from entry to receipt of VA benefits, which is 30 percent slower than the IDES goal of 305 days. Overall, IDES has been 30 percent faster in FY 2014 than the 540-day benchmark for the sequential pre-IDES DoD and VA disability evaluation processes. As of September 30, 2014, 45 percent of Active Service members and 29 percent of Reserve Service members met the overall timeliness goal.

The Department of Veterans Affairs completed the following number of cases in the four core areas of responsibility in FY 2014:

- Claims Development – 29,467 (cases developed)
- Medical Exams – 29,645 (exams)
- Proposed Ratings – 35,071 (ratings)
- Final Ratings & Benefit Notifications to Veterans – 31,316 (benefits letters)

As of September 2014, overall DoD IDES timeliness continued to improve for all portions of the DoD core stages: referral, Medical Evaluation Board (MEB), Physical Evaluation Board (PEB), and transition. DoD has met the 105-day average Active Component core processing timeliness standard and the 125-day average Reserve Component standard. As of September 30, 2014, 76 percent of Service members completed the DoD core process steps (referral, MEB, informal PEB, and transition) within the established timeliness goals.

The Departments continue to refine and improve the IDES with numerous efforts, both independently and in close collaboration. In FY 2014, major efforts in this area included:

- VA IDES Program Office continued to conduct monthly internal video teleconferences with all VA senior executives involved in the execution of IDES. VA also conducted bi-weekly teleconferences with DoD and the Military Departments to monitor performance, resolve problems, and collaborate on improvement strategies.
- VA and DoD continued pursuing the development of a bi-directional data exchange capability between VA's Data Access Service (DAS) to Veterans Benefits Management System (VBMS). Interfacing both systems will reduce redundancies and increase the

speed, accuracy, and transparency of the IDES process by synchronizing the systems to allow for automatic transfer of case documentation, real time case updates, and required notifications to the appropriate users from each Department. In December 2013, DoD tested a unidirectional interface between its electronic case file transfer system (eCFT) and DAS, and also tested a bi-directional capability in September 2014, which allowed the transfer of files electronically to VA. Currently, VA does not have development funding available to complete the bi-directional interface between VBMS and DAS, estimated at \$10 million. VA has included the development of bi-directional capability in the FY 2016 VBMS development roadmap.

- The Office of Warrior Care Policy, in collaboration with the Defense Health Agency and the Military Departments, is developing business requirements for a DoD DES IT solution, with a targeted initial operating capability in FY 2016. The DoD DES IT solution will enable the Department to leverage existing IT capabilities where appropriate, and include new capabilities to support end-to-end case management: tracking, reporting, and electronic IDES case file transfer between the Services and Departments. The electronic case file transfer capability will be included in Phase 1 of the DoD DES IT implementation.
- VA is using a phased approach to eliminate excess inventory and improve IDES timeliness. The first phase was to meet the benefit notification timeliness standard by March 2014. The second phase was to meet timeliness standards for proposed rating by October 2014. To achieve timeliness standards, VA trained and promoted 36 raters at the Seattle Disability Rating Activity Site (DRAS); continued mandatory overtime; and implemented Disability Benefits Questionnaires (DBQs) at all sites. As of March 2014, VA eliminated the excess inventory in the benefits notification stage from a peak of more than 9,000 cases to less than 2,500 cases, and achieved the 30-day timeliness standard in April 2014. Since that time, VA has focused efforts on eliminating the excess inventory in the proposed rating stage of the process. Recent progress has reduced the proposed rating inventory from a peak of over 10,000 to 3,243 cases and reduced the average days to complete cases from a high of 141 days to 58 days in September 2014. VA is still working to meet the timeliness standard for completing the proposed rating.
- VA continued to refine DBQs, which are streamlined medical examination forms used to capture Veterans and Service members essential medical information. The enhancements should decrease the number medical examination reports that are insufficient for rating purposes and allow VA to produce digital images of exams for input to VBMS. Additionally, monthly assessment meetings are held to monitor the progress and effectiveness of the DBQ form.
- "VA Pays First" Phases 1 and 2 were implemented, which allow VA to initiate the VA compensation award before the Defense Finance and Accounting Service (DFAS) completes its accounting processes for Veterans entitled to military retired pay. A final decision on Phase 3 is to be determined by DFAS at a later date.
- DoD began using an improved IDES customer satisfaction survey in July 2013 to ensure better coverage and to provide more actionable results. Service members in DES who

were surveyed from January 2014 – June 2014 indicated 85 percent overall satisfaction with the IDES process. Generally, Service members expressed greatest satisfaction with customer service, both from Physical Evaluation Board Liaison Officers (PEBLO) and VA Military Services Coordinators (MSCs). The IDES Stakeholder Satisfaction Survey for the period November 2013 through March 2014 indicated the majority of stakeholders (82 percent) reported they were satisfied with IDES. Stakeholders are defined as IDES personnel including PEBLOs, the Judge Advocate General Corp, MSCs, and others.

- In December 2012, DoD assumed responsibility to download DD Forms 214 from the Defense Personnel Records Information Retrieval System (DPRIS) and upload them into Virtual VA to assist VA in completing IDES final benefit determinations. As of September 30, 2014, DoD has provided VA with over 16,000 DD Forms 214, enabling VA to complete its disability benefit notifications for those cases sooner.
- In August 2014, DoD completed the first comprehensive revision of DES policy since 1996; combining 13 separate policy documents, disability evaluation issuances, and directive-type memoranda. The Military Departments are now able to work from a much improved set of policy documents that provide simpler, clearer guidance to the individuals administering the program and should result in more consistent interpretation and implementation of policy, and more consistent outcomes.
- DoD established policy for Service-specific ratios of PEBLO's-to-cases for the IDES, tailored for each Military Department, based on their unique IDES case load, case complexity, and staffing requirements. This improved case management for IDES helps ensure Service members, their families, and caregivers receive more frequent and meaningful communication about IDES and awareness of where they are in the process at any given point. This makes the significant life event of transitioning to Veteran status somewhat easier.
- DoD formalized a DES Quality Assurance Program (QAP) that standardized the way DoD compares and reports on the accuracy and consistency of DoD disability determinations. The DES QAP enables DoD and the Military Departments to monitor the performance of Medical and Physical Evaluation Boards and the analysis enables DoD to identify best practices as well as areas needing improvement.
- The Departments collaborated to implement IDES case file content guidance to ensure all available medical information is available to conduct Medical Evaluation and Physical Evaluation Boards and provide proposed disability ratings; enabling both Departments to deliver timely disability determinations without delaying the IDES process due to missing medical documents.

DoD collaborated with VA and Army leadership to continue Army Reservists' support to VA's Seattle Disability Rating Activity Site to help expedite the delivery of VA disability benefits to discharged Service members, reducing the time these Service members waited to receive their VA final disability benefits determination from 66 days in February 2014 to 45 days in September 2014.

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

BEC Medical Records Working Group

The BEC Medical Records Working Group (MRWG) was established to oversee the entire life-cycle of the paper military STR, with an emphasis on ensuring accurate and complete STR related information for all Service members is available to VA and DoD designated benefits adjudicators. In FY 2014, the working group intensified its focus on enhancing and improving collaborative efforts in managing paper records in support of improving Veterans' disability claims processing, and oversight of the transition making digitized copies of STRs electronically available to VBA with the deployment of the Healthcare Artifact and Image Management Solution (HAIMS).

In FY 2014, the MRWG oversaw the implementation of a new standard for providing VBA with "certified and complete" STRs. The standard for STRs is the complete Medical Record (to include military treatment facility care, contract civilian treatment facility care (TRICARE), inpatient discharge summaries, entrance and exit examinations, radiology and laboratory results reports), Complete Dental Record, DD Form 214 "Certification of Release or Discharge from Active Duty"/Separation Orders, and the DD Form 2963 "STR Transfer or Certification." This effort was undertaken in order to assist VBA in meeting its duty to assist requirements under the Veterans Claims Assistance Act of 2000, and is anticipated to have a large impact on preventing future claims backlogs. The Military Services steadily improved their performance in meeting the standard, and at the end of the calendar year 2013, had improved from 18 percent compliant to 82 percent. This metric was discontinued when DoD ceased mailing hardcopy STRs to VA and instead started transferring them electronically on January 1, 2014. From January 1, 2014 through September 30, 2014, VBA submitted 29,212 electronic STR requests. 19,696 of those requests were completed. 22.6 percent of the completed STR requests were compliant within the VBA 45 day timeliness standard.

The MRWG was responsible for ensuring that the Services were prepared to begin transferring all STRs to VA electronically through HAIMS by December 31, 2013. In addition to successfully obtaining the needed funding (~\$40 million) via the JIF process to ensure the Services had the resources to hire required staff and procure needed equipment, the MRWG also documented and provided the functional requirements to the IT community to ensure new automated systems met the business needs of the end users. As part of the leadership team overseeing the establishment of the automated interface, the MRWG monitored and assisted the Services in preparing to operationalize the digitalization of STRs on time. The group also submitted nightly situation reports to Senior Leaders on all the status of progress.

The MRWG also collaborated with a DoD medical records transition policy working group to develop and promulgate Interim Guidance to ensure consistent and appropriate use of HAIMS at the field sites that are doing the digitization. As of September 30, 2014, the Services were uploading over 9,000 STRs per week and had successfully provided VBA with 18,905 of 28,444 STRs requested from HAIMS in support of Veterans claims.

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

BEC Information Sharing/Information Technology Working Group

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

DoD Self-Service (DS) Logon

DS Logon is a secure identity (username and password) that is used by eBenefits and various DoD and VA websites. The BEC IS/IT successfully implemented the capability to provide all Service members DS Logon accounts, which are being provided to all new accessions and all Service members that are separating or transitioning from the Service. A key BEC IS/IT WG objective was to provide all Service members access to the eBenefits Web site (see next section). This goal has been achieved through combination of both DS Logon and common access card (CAC) as credentialing capabilities for eBenefits. As of September 30, 2014, there were over four million registered eBenefits users in over 180 countries. This growth of registered users represents a growth rate of over 26 percent in FY 2014 as compared to the previous fiscal year. DMDC is now working with the DoD CIO office to publish an Enterprise Self-Service memo to ensure all self-service applications across the DoD will implement DS Logon capability within a specified date.

eBenefits

eBenefits, a joint VA/DoD initiative, currently provides access to both a public website and a secure portal that connects Service members, Veterans, their beneficiaries, and/or other designees to health, benefit, and other services to support their needs. The eBenefits portal continues to deliver new capabilities each quarter, and as of September 30, 2014, the more than four million registered users exceeded the WG's annual goal of 3.8 million registered users. The BEC IS/IT WG has provided proactive and transactional self-service capabilities through 18 quarterly releases since October 2009. In FY 2014, the WG deployed additional eBenefits self-service features and major enhancements, bringing the total number of self-service capabilities to over 55. The BEC IS/IT developed the fourth consecutive yearly eBenefits Roadmap for calendar year 2014, showing the scheduled releases of enhancements and new capabilities, for each quarter. The quarterly releases in FY 2014 provided users with new or improved access to information and resources as follows:

Features of the April 13, 2014, release

- Personal Contact Information Update (PCIU) Enhancements – Implemented various enhancements and corrections to personal contact information.
- Medicare Part D Creditable Coverage – Allows users to generate and print Creditable Coverage Letters.
- Fully Integrated VA Form 21-526 Phase 2 – Navigation changes to support Forms 21-0781 / 21-0781a (Statement in Support of PTSD Claim) and 21-8940 (Unemployability) sub-flows in the 526Form.
- National Resource Directory (NRD) Integration – Integrated the NRD into eBenefits. The NRD is now fully migrated into eBenefits.
- DBQ Generation and Selection – Allows users to view and select recommended DBQs based on contentions entered. This enhancement also included full integration with the automated form, which allows users to upload documents for DBQ submission.

Features on the July 20, 2014, release

- Enhancement to NRD – Alphabetized resources beginning with lower case character in line with upper case.
- New Person Lookup – Implemented orchestration services that compare identity information from various sources and return a single, unique identity for the claimant, or create one if it does not already exist.
- VDC 526EZ (VA Form 21-526 – Updated interview and PDF with updated instructional guidance.
- VDC usability enhancements – Various enhancements to the VDC form process, based on usability study.
- Pre-Discharge Compensation Claim – System determines pre-discharge eligibility and entrance criteria, based on separation date.
- Unauthenticated Chat – System to enable real-time communication between two users.
- Employment Center (EC) Phase II – VA for Vets and VetSuccess are now part of the Employment Center.

Features on the September 21, 2014, release

- Enterprise Content Management System (eCMS) – Inline editing (incremental implementation).
- Rules-Based Processing System (RBPS) Off-ramp Messaging – Generates a message to the user and in Modern Awards Processing – Development (MAP-D) when a dependency claim is off-ramped.
- VDC Dependent SSN Missing – Does not allow submittal unless a social security number (SSN) is submitted or there is an attachment from the Social Security Administration (SSA) stating no SSN is needed.
- Claim Status (Cancelled EP 400 Messaging) – Deployed content to users pertaining to cancelled end product (EP) 400s.

- Archived Account History – Implemented changes to provide account activity history for specific periods of time.
- Refresh Military Module in VDC – Deployed changes that refresh military service history module if a change is made in the Corporate database after the user has visited that page.
- Veterans Claim Intake Process (VCIP)-Centralized Mail support – Updated Regional Office (RO) address references to present centralized mail locations.
- Added the Debt Management Center's phone number to Payment History.
- Added the Board of Veterans' Appeals phone number to Claim Status.
- Technical Analysis of Claim Status (Upload Document Status) – Updated status to reflect that documents were submitted, reducing users' calls to the call center and/or users' resubmissions of evidence through the mail.

VA and DoD deployed over 60 "Early Communications Messages" based on "life-changing" events through eBenefits. "Early Communications Messages" are sent via email to notify Service members and Veterans of potential eligibility for health, education, and disability benefits. This proactive approach encourages them to use online self-service features such as applying for benefits, checking claims or appeals status, obtaining home loan certificates, and generating self-service letters (e.g. civil service preference). The frequency of logged-in users for specific key features from October 1, 2013, through September 30, 2014 is as follows:

As of September 2014:

- Compensation and Pension Claims Status Views - 13,498,215
- VA Home Loan Certificates of Eligibility - 591,822 (since inception)
- Official Military Personnel File - 639,313 (since inception)
- Chapter 33 Post 9/11 GI Bill Enrollment - 2,355,108
- Payment History - 14,140,854
- Appeals Status - 3,355,933
- Letter Generator - 2,381,524

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

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

The following accomplishments were made in FY 2014:

- Completed USMC SOES testing (May 22, 2014 – June 4, 2014) using the DMDC test environment;
- Closed or addressed 37 of the 43 issues raised during the USMC SOES testing;
- Completed development and testing of interfaces between SOES and the Marines' personnel and pay system and Services Official Military Personnel File Systems.

DoD worked on implementation planning with the Marine Corps to allow them to begin using SOES in calendar year 2015. In preparation for their use, the SOES development team is planning a final round of testing to validate application updates made as a result of initial testing.

DFAS and DMDC have finalized requirements for the transfer of premium information from SOES to the Defense Joint Military Pay System (DJMS). DoD is currently coordinating an implementation plan for all Services to begin utilizing the SOES application.

Interagency Paperless DD Form 214

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

Since the publishing of the August 2013 report, and in order to ensure a paperless DD Form 214/215 distribution process is in place by December 2014, the following progress has been made:

- Developed policy recommendations and initiated a policy change to DoD Instruction 1336.01 to transition the Military Services to a paperless environment.
- DoD enterprise Web Service capability has been developed to enable interagency partners to retrieve DD Form 214/separation data.
- Conducted functional and technical discussions with Department of Labor (DOL) to plan for Web Services implementation to transition to a paperless environment by December 2014. Currently finalizing the data requirements that DOL needs to adjudicate the Unemployment Compensation for Ex-Service members (UCX) benefit.
- United States Marine Corps and Air Force are currently providing electronic DD Form 214 separation information to DMDC.
- Improving the accuracy of data being shared with VA regarding Medals and Awards, Dental Indicator, Character of Separation, and Narrative Reasons. DMDC developed a reconciliation process to automate discrepancy reporting between electronic DD Form 214 data and Service personnel transaction data. DMDC completed the initial reconciliation process testing against Active Duty Marine Corps data in FY 2014, achieved greater than 95 percent overall accuracy and 98 percent accuracy for the key data elements of Character of Service and Narrative Reason for Separation. DMDC will continue reconciliation testing with the other Services' data in FY 2015.
- Working with eight State Department of Veterans Affairs to obtain an enterprise list of information requirements for use in conducting Veteran outreach.
- DMDC continues to collaborate with State Directors of Veterans Affairs to provide electronic access to the Official Military Personnel File (OMPF) via the Defense Personnel Records Information Retrieval System (DPRIS) to support more timely benefits processing for Veterans. Thirty four states have now obtained electronic

OMPF access, an increase of eight states from last year. The 34 states serve 80 percent of the Veteran population.

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

HEC Continuing Education and Training Working Group

The Continuing Education and Training WG leverages sharing opportunities to improve continuing education and in-service training quality for VA and DoD health care professionals. In FY 2014 the WG coordinated and/or managed the sharing of 347 clinical or clinically related programs between VHA and DoD; 214 trainings from VHA and 133 from DoD. The WG reports an overall increase of 67 shared training programs between the Departments and a 31 percent increase in the programs shared from the DoD to VHA in FY 2014. These shared programs offered 276 continuing medical education hours of learning and with a focused outreach to physicians, nurses, dentists, social workers, psychologists, occupational therapists and counselors.

In FY 2014, the WG continued to utilize enhanced Learning Management capabilities in VHA and DoD and optimize resources with archived e-learning programs accessed by health care professionals from VA and DoD via the electronic learning systems Military Health System¹⁴ (MHS) and the VA TMS. The MHS hosts training programs developed by the VHA Interagency Health Care Training consortia, and in FY 2014 reports 17 contributing partners. These shared trainings are available for DoD and the Military Departments in training their personnel. The FY 2014 average annual report from MHS reported 523 archived training programs with 4,032 page views and 2,964 unique page views to the Web site. The archived programs (FY 2013) VA TMS reports over 400 programs available to VA and DoD health care professionals at James A. Lovell Federal Health Care Center (JAL FHCC) with over 2,900 DoD course completions.

In an effort to leverage special initiatives to develop and deploy high value education and training programs, the WG ensured the coordination of technical upgrades to the VA Knowledge Network and the Content Distribution Network and across DoD Service facilities for the Medical Interagency Satellite Training—Next Generation (MIST-NG) program. The FY 2014 reports from Content Distribution Network Admin Page and PROTRACK systems for MIST-NG are: 63 MIST programs shared; 8 programs from VHA and 55 programs from the DoD; with 1,963 VA and DoD completions and over 71 hours of training.

In FY 2014, the WG exceeded its goal by successfully deploying 85 virtual clinical grand rounds training programs to VHA and DoD health care providers with more than 5,800 staff members participating. More than 2,665 health care providers received continuing education credits to meet licensure and certification requirements to practice. The WG, in collaboration with VHA and DoD

¹⁴ <http://www.health.mil>

clinical officials and staff, successfully identified, designed, and developed high priority clinical topics relevant to the health care of Service members and ongoing care of Veterans in areas such as: extremity trauma and amputation, medication/pharmacy, polytrauma/TBI, prevention and management of disruptive behavior (PMDB), mental health, radiology, cardiac care, oncology, infectious disease, diabetes, respiratory/pulmonary, women's health issues, geriatric care, patient safety, prosthetic, medication use crisis, clinical practice guidelines and interventions.

The WG continued to refine the pre-arrival, orientation, and post-arrival continuing education and in-service training deployed at the JAL FHCC and joint venture sites in FY 2014. The FY 2014, continuing education and in service training to JAL FHCC reported from VA TMS is 35 courses and over 98,000 course completions. In FY 2014, 136 *Prevention and Management of Disruptive Behavior (PMDB) Level 2-4* trainings were delivered to VHA/DoD integrated and joint venture sites with over 980 course completions. The WG successfully coordinated the completion of the *VA-DoD Leadership Guide* for joint venture site training with the WG steering committee.

In FY 2014, the WG coordinated activities to decrease redundancies between VA and DoD for mandatory training programs. In particular, the WG is currently working to eliminate duplicative computer security training between the Departments. This issue is in the final stages of resolution and will be resolved in FY 2015.

The WG recommended the development of new processes within the DoD with the emerging DHA Education and Training Directorate. These new approaches require review across/beyond each Service and efforts are being coordinated with the consolidation of DoD Learning Management Systems for the development of a comprehensive DHA course catalog. VHA is exploring efficient ways to address other mandatory training for non-VA health care providers.

HEC Information Management/Information Technology Working Group

The Information Management (IM)/Information Technology (IT) WG provides executive oversight of joint integrated legacy health information sharing activities and ensures that commonly accepted government IT program management practices are utilized. DoD continued to provide VA with one-way historical health information on separated Service members through the Federal Health Information Exchange. Sharing electronic health information at the time a Service member separates allows VA providers and benefits specialists to securely access data for use in delivering health care and making claims determinations.

VA and DoD continued to maintain the jointly developed Bidirectional Health Information Exchange (BHIE). Using BHIE, VA and DoD clinicians are able to securely access health data in real-time for patients being treated in both healthcare systems and for benefits and claims assessments. VA and DoD continued to use the Clinical Health Data Repository to share computable outpatient pharmacy and medication allergy data. Exchanging computable electronic health data supports improved patient care and safety through the ability to conduct drug to drug and drug to allergy interaction checks using data from both VA and DoD systems.

In FY 2014, the HEC IM/IT WG successfully completed 100 percent of JSP metrics to support the bidirectional exchange of electronic health data between the Departments. The benefit is that more providers than ever have more health data available, electronically, securely, and in real-time, to support the provision of health care and the adjudication of benefits claims:

- The number of DoD Service members with historical data available to VA increased from over 6.1 million to over 7.2 million.
- The number of deployment health assessments available to VA increased from over 3.7 million to over 4.0 million.
- The number of individuals with deployment health assessments available to VA increased from over 1.6 million to over 1.7 million.
- The percentage of DoD inpatient beds providing VA providers access to inpatient documentation was maintained at 100 percent.
- The number of DoD beneficiaries with viewable data available real-time to VA and DoD providers increased from over 5.0 million to over 5.5 million.
- The number of data queries by VA and DoD providers increased from over 36.6 million to over 46.7 million.
- The number of shared patients flagged as ADCs for computable pharmacy and allergy data exchange increased from over 1.8 million to over 2.2 million.

HAIMS is a MHS program that enhances medical informatics through integration of medical digital artifacts and images (A&I) with the DoD EHR. HAIMS is fully deployed and gives health care providers global awareness and access to essential A&I throughout the continuum of care from theater to garrison to VA, and from VA to DoD when needed. HAIMS provides an enterprise-wide data sharing capability for multiple types of A&I, including radiographs, photographs, waveforms, audio files, video, and scanned documents. As of August 2014, 145 VA sites and 152 DoD sites have access to A&I through HAIMS, 26,376 DoD users have been trained, and over 26,500 artifacts and images have passed through the HAIMS interface.

The DHA Health Information Technology Directorate, Infrastructure and Operations (I&O) Division (formerly Enterprise Infrastructure) provided quarterly and ad hoc briefing updates regarding bandwidth utilization and network performance of the north, south, east, and west multipurpose VA/DoD network gateways to the HEC IM/IT WG. I&O continues to monitor traffic analysis reports to identify traffic levels, types, and patterns (including protocol type and distribution of imaging traffic) and overall bandwidth demand levels for inbound and outbound wide area network traffic. The current assessment is that the existing FY 2014 network infrastructure and available bandwidth is more than adequately supporting current data traffic based on the established JSP metric: DoD/VA network bandwidth utilization did not exceed 90 percent and network availability was maintained at 98.5 percent or better across the four multipurpose gateways.

Health Architecture Review Board

The DoD/VA Health Architecture Review Board (HARB) continued to provide architecture oversight and influence on joint DoD/VA health programs to facilitate interagency cooperation on interagency Health Information Technology (HIT) initiatives. In FY 2014, the HARB

remained on track to support this mission, with the only caveat being that the Secretary of Defense and Secretary of Veterans Affairs decided to no longer pursue an iEHR. With the February 2013, decision from the Secretaries to pursue two separate but interoperable EHR systems, the HARB readjusted its focus to achieving interoperability while the Departments pursue the acquisition and development of different EHR systems. This new focus for the HARB supports *interoperability* as one of the three cross-functional foundational elements fundamental to all DoD/VA efforts, the others being *client centric focus* and *partnerships*.

This shift in focus toward interoperability led the HARB to create, validate, and use a health information interoperability alignment framework to determine if data exchange specifications for DoD/VA health information exchange are complete relative to this interoperability alignment framework. This HARB sponsored analysis identified and validated data exchange specification gaps and developed recommendations for gap closure. These recommendations informed process improvements accomplished by the re-chartered DoD/VA IPO.

As mentioned, FY 2014 also saw the re-chartering of the DoD/VA IPO in December 2013; resulting in the IPO being recognized as the leader and authoritative resource on health data interoperability standards for data sharing between the DoD and VA, and between the Departments and private and other governmental health care organizations. The HARB responded to this re-chartering by working with the IPO to develop a joint forum to provide top-down guidance for the development, maintenance, and monitoring of information interoperability plans between the two departments. This forum, led by the DoD/VA HARB co-chairs and IPO Deputy Director, resulted in agreement on the need for a joint framework to transparently capture and share the set of artifacts that pertain to interoperability and that are produced by the exchange partners for the implementation and deployment of information interoperability capabilities. These artifacts pertain to the touch points between exchange partners to deliver a given health data interoperability capability set. Because the artifacts must be transparent and accessible to all exchange partners, this group also agreed that a mechanism for transparent sharing and access to authoritative artifacts on information interoperability is needed and is working with the DoD/VA IPO to operationalize an information interoperability artifact repository. Such a repository is intended to satisfy a mandate for transparent execution of the interoperability mission. The joint forum also obtained DoD, VA, and IPO concurrence on the use of an Integrated Master Plan to capture key milestones and interoperability touch points between the Departments. These accomplishments address the need to establish a standard methodology for the development and sharing of needed DoD/VA joint HIT interoperability artifacts.

The NDAA for FY 2014 assigned the responsibility for identification of required national standards and reporting progress of DoD/VA Health Data Interoperability (HDI) achievements to the DoD/VA IPO. Therefore, responsibility for the activities associated with external advocacy shifted from the HARB to the DoD/VA IPO. However, the HARB collaborated with the DoD/VA IPO on the review and approval of key standards guidance documents.

The HARB participated in the review and approval of the DoD/VA IPO Information Interoperability Technical Plan (I2TP). The I2TP provides a top-level description of the DoD/VA IPO clinical and technical standards determination process as well as technical

implementation guidance for DoD/VA IPO-approved national health data standards for acquisition programs and technical solution developers in the DoD and VA. The HARB also influenced changes to the DoD/VA Health Standards Profile to add consideration of emerging standards to allow for future interoperability capability planning. This change allowed the inclusion of rapidly emerging standards such as the Health Level Seven Fast Healthcare Interoperability Resources Specification, an emerging standard for health data exchange.

The HARB recommended information interoperability address Veteran and Service Member needs more holistically rather than treating health and benefits information exchange independently. The recommendation resulted in consideration of this broader view as part of a HEC sponsored review of HEC Information Management (IM) and Information Technology (IT) subgroups for recommendations in FY 2015 on the most effective and efficient HEC subgroup structure.

HEC Acquisition and Medical Materiel Management Working Group

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

Identifying and Leveraging Spend

During FY 2014, VA awarded four follow-on radiation therapy contracts. In radiology, DoD awarded three new contracts from the last open season solicitation. VA and DoD are working on the solicitation for the next generation of joint contracts. There are currently 45 contracts in place and the earliest of them expires in December 2016. The new long-term contract awards for radiation therapy and radiology, and in the future, the next generation radiology program, will expand the vendor base and product offerings for all VA and DoD customers. Both the VA National Acquisition Center and DoD DLA-Troop Support are awarding joint national contracts for pharmaceuticals. During FY 2014, a total of 27 joint national contracts were awarded.

As evidenced in the chart below, total joint pharmaceutical and equipment sales showed an increase from FY 2013 to FY 2014. Total joint sales increased by 10.7 percent; joint equipment sales increased by 16.8 percent; and joint pharmaceutical sales increased by 9.4 percent.

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

Commodity	FY 2013	FY 2014	Change
Pharmaceuticals	\$1,962.26	\$2,145.95	+9.4 percent
Equipment	\$415.86	\$485.60	+16.8 percent
Total	\$2,378.11	\$2,631.55	+10.7 percent

VA and DoD cost avoidance from using acquisition programs based on the use of joint requirements approached \$28.4 million for VA in high tech medical equipment and exceeded \$563.4 million in pharmaceuticals.

Medical Surgical Business Intelligence

In FY 2014, The VA/DoD Data Synchronization Program focused on integrating the Product Data Bank (PDB) business intelligence data into enterprise processes, improving internal data to synchronize with external systems, providing key business intelligence reports and data sets as needed by the enterprise teams, integrating new commercial benchmark data and helping to clarify/define readiness data.

Cost saving and pricing effectiveness are key themes for the DLA and the PDB is providing reports that allow leadership to evaluate past decisions and justify future acquisition strategies. One of these reports is a program report developed to confirm that negotiated contract discounts are being received on Electronic Catalog purchases. The program also produced pricing effectiveness analysis data based on commercial benchmark data to enable DLA Troop Support Medical and the VA Program Management Office to better understand enterprise pricing as it relates to benchmarks. The program participated in preparatory discussions for the decommissioning of a readiness system soon to be replaced by newer technologies to capitalize on enterprise assemblage data.

The program streamlined business name and alias updates to the DLA Troop Support Medical Supplier Directory, and the PDB prepared an incremental research data extract to update the enterprise Medical Master Catalog (MMC), providing more accurate and timely business and item name resolution in FY 2014. The program collaborated to identify and resolve item and packaging differences between the enterprise electronic catalog, the MMC and the PDB, resulting in the discovery of ways to enhance package data storage so that packaging can be more easily reconciled between the systems. PDB data is now used in the administration and reporting of DLA Blanket Purchase Agreements for reviewing the contract coverage of a given supplier's set of items at a particular site, accruing valuable business intelligence. DLA

Research and Development (R&D) is applying to study the potential of PDB data in meeting DLA challenges in assembly management.

VA endorsed and reiterated the importance of Veterans Integrated Service Network (VISN) Directors' use of the eZSAVe price reduction identification tool once again in FY 2014, to achieve cost savings as well as to track and report cost avoidances monthly. The program worked with VHA program managers to identify and track standardization candidate workflow. The PDB produced 90 reports including over \$500 million in spend detail for standardization consideration by National Standardization Medical/Surgical Integrated Product Team (IPT) in the creation of their Contract/Acquisition Plans. VA program management reported that the only approved Acquisition submissions have been based on information gleaned from the PDB reports and that IPT member plan development time has been greatly reduced. The program developed metric reports to report the flow of purchases to VA Prime Vendor contracts, as well as for monitoring socio-economic compliance. The program is currently working to supplement VA Strategic Acquisition Center VISN level spend analysis for prior fiscal years with PDB data by Budget Object Class codes, product categories, and by contract item.

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, to include shared oversight of the DoD/VA Joint Incentive Fund (JIF).

DoD/VA Joint Incentive Fund

The JIF offers incentives for VA and DoD field activities to increase and engage in creative health care coordination and sharing initiatives. In FY 2014, DoD Health Affairs and VHA leaders embarked on an intensive and exhaustive internal review of the JIF program and its initiatives with the goal of making meaningful improvements that would ultimately improve the access, quality and safety of care provided to DoD and VA beneficiaries.

The DoD and VA Program Coordinating Office worked in concert with the FMWG co-chairs to investigate improvements for internal management of all JIF initiatives. The discovery process highlighted \$32.6 million in unobligated funds being dedicated to older JIF projects. As a result, HA and VA leadership initiated an in depth assessment for FY 2008-2012 JIF projects, with an expected completion by the end of FY 2015. In addition to reducing the number of active projects older than three years, the discovery process has identified several planned improvements and work products. During FY 2015 and FY 2016, HA and VHA leadership will revamp JIF policy and guidance approvals, increase submission and evaluation cycles, improve JIF program manager training, and implement an improved financial management reporting system. JIF de-obligated funds just go back into the JIF general fund and become available for more projects.

The National Reimbursable Sharing Agreement and Streamlined Billing Practice

Throughout FY 2014, DoD and VA senior leadership have actively engaged in pursuing meaningful improvements to the DoD/VA reimbursement process. This was driven partly in response to GAO Report 12-992 as well as OMB Passback language directing both Departments to collaboratively devise and agree to a simplified reimbursable billing solution for the exchange of healthcare and other related services and then to pilot the approach at specific medical facilities. In response, the FMWG briefed the HEC in October 2014 on a proposed way forward. The HEC approved a concentrated effort by both Departments that resulted in an agreement to pursue a national reimbursement sharing agreement based on prospective payment with local flexibilities.

The National Reimbursable Sharing Agreement places an emphasis on simplicity and efficiency while ensuring that medical documentation is provided to the referring facility. The working solution is based upon a traditional Intra-agency Agreement in which payment is made in advance on a quarterly basis. The amount of the payment is based upon historical workload, with quarterly reconciliations, to ensure accuracy. Thresholds will be established to guide payment adjustments, with the potential use of "bundled rates" to further simplify the process.

Integrated Disability Evaluation System (IDES)

At the end of FY 2014, approximately 95 percent or better of IDES billing claims were submitted without noted errors. The VHA/Disability and Medical Assessment Office (DMA) IDES staff continued its ongoing training efforts, actively working with all VAMCs via one-on-one instruction and group training events to further improve the quality of claims submitted to the Managed Care Support Contractors (MCSCs) IDES staff. Along with VHA TRICARE Liaisons, the DMA IDES staff is now working on developing a method for conducting quarterly continuous internal Quality Assurance reviews of claims submitted by VHA VAMCs. These reviews will focus on denied claims by utilizing reports provided by the MCSCs to identify trends and potential areas of improvement.

The DMA, working collaboratively with DHA, identified common reasons for denial of IDES Claims. The DHA acknowledged these reasons and recognizes that policy adjustments and additional guidance is required for their fiscal Intermediaries and MCSCs.

HEC Joint Venture & Resource Sharing Working Group

The Joint Venture/Resource Sharing Working Group (JV/RS WG) mission is to explore, identify, and make recommendations on opportunities for increased collaboration between VA and DoD to maximize care available to beneficiaries of both health care systems.

In FY 2014, the JV/RS WG collaborated with the FMWG to develop a draft revision to the current JIF business process that will go through continued review, approval and planning during FY 2015, for implementation in FY 2016. The revised JIF business process will provide

better guidance to sites seeking funding for joint projects; improve the proposal review and scoring process; and provide improved information and instructions on proposal expectations and performance metric development.

The workgroup also began enhancing the Resource Sharing Database which houses over 132 VA/DoD resource sharing agreements. Final modifications to the database will include the ability to identify and provide alert notices on expiring agreements every 30 days beginning 180 days before expiration, and the ability to conduct ad-hoc report queries. Additionally, the workgroup was involved with identification and review of military base access concerns for Veterans seeking care from MTFs. The workgroup assisted the VA Office of Operations, Security, and Preparedness, and the DoD Physical Security Program and Policy Division, to develop standard DoD base access language specifically for Veterans receiving care from MTFs.

A comparative study to identify opportunities for efficiencies between the VA and DoD direct health care systems was directed by the 2014 OMB Passback. Selected pilot sites with identified goals to improve access to care, military medical readiness, and management of purchased care will be monitored and evaluated by the workgroup beginning the first quarter FY 2015, with reports back to OMB.

James A. Lovell Federal Health Care Center Advisory Board

The JAL FHCC is an optimally integrated five-year medical facility demonstration project, begun on October 1, 2010, with VA and DoD staff working together toward a single, combined VA and Navy mission serving active duty Service members, Veterans, and TRICARE dependents (military families, including infants and children). The JAL FHCC Advisory Board functions as the link between the JAL FHCC and the HEC/JEC and serves as the Board of Directors for strategic and operational decision making. A JAL FHCC Stakeholder Advisory Committee meets quarterly to advise the Director and Commanding Officer on how well the JAL FHCC is meeting the needs of local VA and DoD beneficiaries.

In January 2013, a JIF project was approved for a contract to perform an enterprise evaluation of the JAL FHCC five-year demonstration as required by the NDAA 2010. The contract evaluation of the JAL FHCC began in FY 2014. The VA's Product Effectiveness team is also conducting an independent evaluation of JAL FHCC IM/IT. The contractor will draw upon the Product Effectiveness team's evaluation to support its IM/IT findings. The final Report to Congress is due October 2015.

The year 2014 marks an important time of transition and growth for the JAL FHCC. In April 2014, the JAL FHCC completed a major reorganization of the hospital and moved from six to 11 Directorates. The reorganization created a governance structure with four new clinically-focused directorates and one new nursing practice directorate coming to the leadership decision-making table.

The JAL FHCC is in the process of closing out a budget of \$425 million for FY 2014 with a projected execution rate of 99.9 percent. Identified efficiencies within the interagency financial reconciliation process resulted in the early return of \$12.9 million to the VA and DoD. In the patient safety arena, the JAL FHCC is one of the first hospitals in either VA or DoD to have its entire 3,400 member staff trained in TeamSTEPPS, a nationally recognized safety program designed to improve the quality, safety and efficiency of health care delivered to patients by enhancing communication and mutual support between team members. As part of the national access focus within VA, JAL FHCC has been audited and found to have no discrepancies in scheduling practices. To ensure sustained success, JAL FHCC trainers have provided staff education on scheduling policies and use of the Electronic Wait List.

Clinical Care

The JAL FHCC provides care to over 95,000 individuals per year including Veterans, active duty service members, students, and their families, and over 31,000 new Navy recruits. The JAL FHCC consistently leads the Navy with an IDES Medical Evaluation Board average completion time of 57 days, 43 days below the DoD standard. The FHCC was one of the first government health care facilities in the nation to provide a Caregiver Support Center for patients' families, and the second facility to open Green Homes for 40 geriatric patients in need of skilled care. A recent innovation is the development of a fully integrated West Campus dental clinic where both active duty and veteran patients are treated.

The JAL FHCC supports a 16 state regional area for military active duty and reserve members. The integration expanded the services and programs previously available to DoD and VA beneficiaries in the prior two independent facilities. As a result of combining Veteran and DoD patients, the total number of patients seen in the emergency department has more than doubled. JAL FHCC active duty and civilian staff now provide inpatient and outpatient ears, nose, and throat, orthopedic, and general surgical services, including pediatric procedures.

IT Capability Delivery to Support Information Resource Management (IRM)

In order to safely exchange data between VA and DoD IM/IT systems and allow health care providers and administrative personnel to deliver high-quality services at the JAL FHCC, the IRM Department continued its efforts in the development and refinement of numerous IT capabilities to support JAL FHCC during FY 2014. After years of significant challenges, and after the majority of capabilities and requirements have been met, efforts led the transition into a sustainment effort and sustainment funding to support the complex and unique IM/IT environment at JAL FHCC. The team focused on the critical fixes and the local and development sustainability of these capabilities. In addition, the testing team completed deployment of Consults Increment 2C, Lab AP Non-GYN, GYN and Surgical Pathology capabilities deployed/incorporated into Orders Portability solution, Financial Management and Reconciliation enhancements, Single Sign-On and Context Management, Maintenance Release's and Orders Portability Laboratory/Radiology. Product development efforts beyond FY 2014 are still required to support both the health IT framework and the ability of providers to provide seamless health care to VA and DoD beneficiaries in the JAL FHCC integrated environment.

DoD/VA Interagency Program Office

Throughout FY 2014, the IPO Development Team and the DoD and VA Pharmacy functional communities continued identification and analysis of interim solutions for implementation to support the JAL FHCC Pharmacy. The VHA PE Office began development of a performance assessment framework in FY 2014 to conduct an evaluation of the IM/IT investments made to enable JAL FHCC integrated operations. The performance assessment will continue to analyze information and data through FY 2015.

Activities and Milestones Progress

Fisher House

JAL FHCC was approved for a Fisher House to be built in 2017. It will be a 16-bed facility to help families of wounded warriors and Veterans stay free of charge.

Business Process Reengineering

A contractor team has been tasked to conduct business process modeling and analysis, and provide consulting to strengthen and improve the FHCC's ability to utilize IM/IT solutions developed and deployed supporting clinicians and other health care providers. The scope of work and work products are inclusive of analyses of "as-is" and "to-be" business process states and develop into coherent analysis useable for promoting informed decisions by stakeholders, and incorporate the recommendations into an action plan as part of the JAL FHCC process improvement program. The team shall evaluate workflows and use of integrated solutions for the redesign of business processes to achieve value and calculate improvements in critical contemporary measures of performance of cost, quality, service and speed. This Business Process Reengineering analysis has yielded many process improvements, thus increasing the effectiveness of health data sharing.

Lean Six Sigma

The JAL FHCC continued to implement a Lean Transformational Plan of Care with two identified Value Streams: Inpatient Flow (Medical/Surgical ward, Intensive Care Unit, and Inpatient Mental Health) and Outpatient Flow (all East Campus military clinics, excluding Dental). Through the Value Stream Analysis (for both Value Streams) 10 Rapid Improvement Events, four Problem-Solving Events, eight 5S Projects, and three 2P (Process-Preparation) Projects were conducted. The Lean Six Sigma team provided training to all staff on Lean concepts. Through Lean initiatives, JAL FHCC has improved Medical Home Port metrics, decreased medical hold time for Recruits, improved shared decision-making, and increased patient satisfaction scores. Through engagement in projects across the hospital, Lean Six Sigma has been an excellent resource for staff development.

Patient Centered Care

The JAL FHCC has been working towards transforming Patient Centered Care to improve practices and educate staff on the best techniques and processes to achieve quality, patient centered care for every patient, every time. Over the course of the last year the JAL FHCC has been successful in carrying out the following initiatives:

- The JAL FHCC participated in a four-part engagement with the Office of Patient Centered Care and Cultural Transformation, during which staff was trained on patient-centered care concepts, Listening Sessions were held with patient, employees and stakeholders and facilitators were trained to carry out staff engagement sessions focusing on empathy and connection with the patient experience.
- The GetWellNetwork was implemented as a patient engagement tool. Interactive patient care allows for real time customer feedback, hospital information, over 400 health education videos available on the patient's television as well as enhanced entertainment options such as internet and on-demand movies. The GetWellNetwork is currently in over 200 JAL FHCC beds.
- 98 percent of staff completed one of many trainings focusing on concepts related to patient centered care and patient engagement.

Integrated Police Force

JAL FHCC successfully integrated Navy Master-At-Arms (MAs) with the VA Police force. Navy MAs attend the Veterans Affairs Law Enforcement Training Center in Arkansas and fully participate in JAL FHCC law enforcement activities. The integrated police team has developed a Standard Operating Procedure which describes how military police function on a VA compound.

Logistics

In the logistics arena, JAL FHCC supported efforts of a National VA/DoD Defense Medical Logistics Standard Support (DMLSS) Work Group chartered by the Deputy Surgeon General of the Navy and the Assistant Deputy Under Secretary for Health for Administrative Operations. An important result is the approval of a JIF proposal to pilot utilization of the DMLSS at the JAL FHCC and will require evaluation of potential use throughout VA. This pilot project has the potential to create one logistics, facilities, supply and equipment system across both DoD and VA healthcare systems.

Information Resource Management

As part of the comprehensive evaluation plan for the JAL FHCC, some key IT related initiatives include the following:

- Determine the costs associated with the workarounds required due to Information Technology capabilities at the JAL FHCC for each year of the demonstration, including the costs of hiring additional staff and of managing the administrative burden due to the workarounds, by October 31, 2012, and annually, thereafter.

Status: Ongoing and to be finalized FY 2015. During FY 2014, an independent team was brought on board to evaluate the cost effectiveness of the IM/IT capabilities and staffing associated with the support of these capabilities. This product effectiveness team will be working on this report with all the different business units which support and use the capabilities.

- Fix pharmacy capability at JAL FHCC to address current operational issues.
Status: Both development teams are currently engaged in this activity through the end of calendar year 2014; they were able to identify comprehensive enterprise enhancements to alleviate pharmacy pain points, completed two phases of Health Data Dictionary Terminology Mapping and received approval for the Governance Process.
- As an interim solution, the Janus joint Graphical User Interface Write-back of Allergies Data pilot project was installed and became operational. This allows practitioners to update patient electronic health records with allergy information and allow the pharmacy to determine drug-drug interactions prior to dispensing, thereby improving patient safety.
Status: Janus is implemented and operational to address allergies and patient safety issues. VA is due to roll out Joint Legacy Viewer in 2015 which is a web based Janus system.

Performance Metrics and Data Disparity

JAL FHCC data is segregated amongst DoD and VA data systems and not uniformly visible to both agencies or available in a meaningful form at the operational or headquarters level. A JAL FHCC Data Summit convened for three days in August 2014. The Summit initiated interagency collaboration to resolve underlying data requirements, system challenges, and concerns impacting workload capture, labor reporting, and financial reconciliation. The Departments continue to focus on targeted action items that may yield development of solutions and strategies to address the data disparities that prevent leaders at all levels from generating meaningful performance metrics.

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

JEC Strategic Communications Working Group

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

- FY 2014 communications activities in support of the specific objectives in the JEC JSP included:
- Regular coordination with representatives from the HEC, BEC, IPO, Transition Assistance Program Redesign (Transition GPS), Camp Lejeune Working Group, Gulf War Task Force,

VA-DoD legislative affairs, and VA-DoD public affairs to enable ongoing collaboration between subject matter experts and communications professionals.

The JEC SCWG continued to build on outreach activities in FY2014, and conducted:

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

Joint VA and DoD communication efforts facilitated several collaborative events with major news organizations and stakeholders on a myriad of issues. The Secretaries of Defense and Veterans Affairs met to focus on priority issues. VA-DoD public affairs worked to jointly communicate significant issues, including increasing access to care, PTSD joint research investments, and health record transitions and management.

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

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

JEC Construction Planning Committee Working Group

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

Progress was made through FY 2014 with respect to the CPC's Activities and Milestones as outlined in FY2013-2015 JSP Objective 3.6.A as follows:

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

- Update the CPC Charter to modify the scope statement in recognition of its efforts beyond physical construction to include leasing and to expand membership to include Service representation.
Status: The CPC charter revision was drafted to include the proposed committee name change from the Construction Planning Committee (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 draft revision also expands the committee membership to include field-level representation for both Departments. This Charter draft revision is concurrent through the DoD Services; however, finalization was delayed by the DHA reorganization. The CPC has identified revisions required to reflect this organizational change. In addition, given recent leadership changes at the VA, the CPC determined it would be wise to wait until the end of first quarter FY 2015 before revising the Charter to ensure that any potential VA organizational changes could also be reflected in the new charter.
- Document a standardized, repeatable process for ongoing data sharing to inform annual SCIP and CIDM processes.
Status: In 2011 the CPC developed a concept for a common approach to capital asset management planning through identification and sharing of planning data. The CPC continued this data sharing work in FY 2013 with the addition of new data elements. In FY 2014, the CPC took the lead to develop a JIF proposal that would leverage the VA's existing geographic information system (GIS) tools to support joint market and joint operations planning between VA and DoD at the local market level. To that end the CPC coordinated with facility and planning program offices within VHA and DoD to develop and submit a JIF proposal for FY 2015 to create the Joint Use Market Planning (JUMP) Enterprise Web Portals ("The Portals"). The CPC has been coordinating its effort with respect to this JIF in order to minimize any duplication with the OMB directed Comparative Study and the related HEC analysis on enterprise-standards for joint market planning. The proposed Portals will provide enhanced access to the VA and DoD shared data sets and provide both DoD and VA facility as well as operational planners in the field with a powerful and efficient means to visualize and analyze individual healthcare markets in detail in a collaborative environment to best leverage existing VA and DoD resources. This capability will facilitate joint VA/DoD planning and decision making; improve the quality and timeliness of the data required to support joint facility planning processes; and optimize the investment of staff time and other contract resources that are currently required to support these joint planning efforts.
- Re-submit like legislation to leadership if appropriate for submittal in FY 2014 NDAA. If proposed legislation is approved, communicate no later than 90 days after bill enactment, the benefit of legislation changes to field planners and other interested parties.
Status: VA resubmitted the legislative language in FY 2014 in its FY 2015 budget.

- Advance VA/DoD joint market planning efforts.
Status: In FY 2014, the CPC identified joint market planning as an appropriate future focus for its efforts in order to meet its goal of optimizing capital asset planning for both Departments. In FY 2014, VA initiated its Integrated Master Planning (IMP) initiative at the VISN level and the DoD initiated its enhanced Multi-Service Market (e-MSM) planning efforts. During FY 2014, VA initiated local market planning processes in three VISNs, each of which included outreach to and participation by local market DoD providers; and the DoD conducted e-MSM planning efforts in the San Antonio and Seattle markets, each of which included VA representation. Coordinating the active involvement of each Department within these ongoing joint market planning efforts will be a CPC imperative going forward.

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

JEC Separation Health Assessment Working Group

Based on the SHA pilot, on December 4, 2012, DoD and VA agreed to share responsibility for ensuring that each departing Service member receives a Separation Health Assessment (SHA) according to a common standard. A Memorandum of Agreement outlining the standards for the assessment and how DoD and VA will share the responsibility for completing it was signed in December of 2013. The SHA will be mandatory for all separating Service members, to include Reserve Component members who have been on Title 10/32 orders for longer than 180 days or 30 days in a contingency operation. The agreed upon processes include the completion of DD Forms 2807-1 and 2808 (or their electronic record equivalents) by the DoD on all Service members not making a disability claim and by VA for those who submit a disability claim prior to discharge. The exam will include a threshold audiogram (with full audiology evaluation required if the threshold test is abnormal) and any appropriate or required ancillary testing. The DoD published Directive Type Memorandum 14-006, "Separation History and Physical Examination (SHPE)" on July 7, 2014, specifying policy and procedures to be fully implemented by January 1, 2015.

VA developed and fielded an electronic SHA General Medical (SHA Gen Med) Disability Benefits Questionnaire (DBQ) template incorporating the elements of DD forms 2807-1 and 2808 specified in the MOA, including any appropriate or required ancillary testing; air conduction threshold audiogram; and full audiology evaluation using a hearing loss template, if the threshold test is abnormal.

VA has begun using the SHA DBQ for all examinations related to pre-separation claims, to include the Integrated Disability Evaluation System, Benefits Delivery at Discharge, and Quick

Start programs. The DoD and VA have modified the briefings provided in the Transition Assistance Program to include emphasis on the requirement for a face to face physical examination under the Separation Health Assessment program, and the DoD has added content (information and a fillable DD Form 2807-1) to the TRICARE OnLine system to help Service members prepare for their examinations. All Services are currently working to adopt the new standards to their existing separation health examination procedures. Four DoD facilities are currently working to implement the new procedures in cooperation with VA partners to determine the best means of accomplishing communication at the local level. Work is ongoing to address and refine information sharing procedures between the Departments to fully support this initiative electronically.

Additional Accomplishments

Interagency Care Coordination Committee

The Department of Defense / Department of Veterans Affairs (DoD/VA) Interagency Care Coordination Committee (IC3) oversees implementation of the November 2012 Secretaries' Intent memorandum, declaring One Mission, One Policy, One Plan, in response to ongoing stakeholder concerns about interagency complex care coordination of recovering Service member / Veteran care, benefits, and services. IC3 operates in accordance with guidelines established by the Joint Executive Committee (JEC) and completes assignments received from the JEC.

The IC3 is tasked with developing: (1) a common, interagency, overarching guidance; (2) a Community of Practice, connecting the DoD and VA clinical and non-clinical case managers of recovering Service members and Veterans receiving complex care coordination; (3) a single, shared comprehensive plan for each Service member / Veteran; and (4) guidance for the establishment of a Lead Coordinator for Service members / Veterans to better coordinate across all stages of recovery, rehabilitation, and reintegration.

The IC3 functions via its three standing work groups: Community of Practice; Policy and Oversight; and Technology, Tools, and Change.

In the past year, IC3 made significant strides towards its mission to implement a standard model for coordinating all aspects of interagency and interdisciplinary complex care, benefits, and services for Service members / Veterans.

One Mission

During FY 2014, IC3 supported its "One Mission," to provide care coordination to Service members / Veterans with complex care needs, by establishing the IC3 Community of Practice of DoD and VA care coordination programs and further developing and implementing the Lead Coordinator concept. On March 14, 2014, the IC3 Community of Practice officially launched with an initial group of leaders from 50+ care, benefits, and services coordination programs across DoD and VA. These leaders started to engage and communicate via smaller work groups that are driving IC3 tasks that support the Community of Practice, including member engagement, communications, and creating common tools and shared resources. Community of Practice members are starting to use the Co-Lab, a PIV and CAC secure website for interagency care coordinators to connect, find each other through a master directory, learn about each other's programs, and share information. In late FY 2014, the Community of Practice membership began a phased expansion to include more care coordinators within these Community of Practice member programs.

The Lead Coordinator role was introduced to the National Capital Region and San Antonio as a feasibility assessment from January 2013 – January 2014. Incorporating lessons learned from this assessment, the Community of Practice is in the beginning phases of a nation-wide

rollout to DoD and VA sites. All Service members or Veterans requiring complex care coordination will be assigned a Lead Coordinator who will serve as the primary point of contact for complex care and service coordination for Service members or Veterans and their families or designated caregivers, helping to reduce confusion and improve care coordination.

One Plan

The Comprehensive Plan Work Group sunset after it completed its goal of creating a merged Interagency Comprehensive Plan (ICP) and Checklist that can now be shared between DoD and VA. Based on these tools, the DoD and VA built consensus on an ICP Scope Statement, drafted a business justification package, and have started the development planning for a full scale electronic ICP. The electronic ICP will improve coordination, transparency, and interoperability across programs by allowing VA and DoD care coordinators to view and share client data from one place.

The new Technology, Tools, and Change Work Group will continue to oversee the development, deployment, and maintenance of this ICP technology solution.

One Policy

On July 29, 2014, the Honorable Sloan D. Gibson, Deputy Secretary for the Department of Veterans Affairs (VA), and the Honorable Jessica L. Wright, Under Secretary of Defense for Personnel and Readiness, Department of Defense (DoD), signed the *Memorandum of Understanding (MOU) between VA and DoD for Interagency Complex Care Coordination Requirements for Service members and Veterans*.

This IC3 MOU represents the Departments' commitment to implement a joint, standard model for coordinating all aspects of interagency and interdisciplinary complex care, benefits, and services for Service members and Veterans. As the IC3 continues to move to implementation, the MOU will serve as a catalyst to fully implement key initiatives throughout DoD and VA. Next steps include for DoD and VA to release a DoD Instruction and VA Directive, respectively, based on the MOU. IC3, through the Policy and Oversight Work Group, will work with the VA and DoD programs that support care coordination to align existing policies with the MOU and to create new, standardized joint policies, where needed.

Health Care Resource Sharing

Charleston-Beaufort Joint Venture

NHC Charleston, South Carolina (NHCC); Ralph H. Johnson VAMC (RHJVAMC); 628th Medical Group (MDG), Joint Base Charleston, South Carolina; NH Beaufort, South Carolina (NH Beaufort)

RHJVAMC shares spaces with NH Beaufort and NHCC to provide CBOC services to Veterans. In Charleston, services are shared at the Captain John G. Feder Joint Ambulatory Care Center

(JACC) and at the JIF-funded DoD/VA Joint Optometry/Ophthalmology Clinic. In FY 2014, the Charleston Joint Venture was awarded a JIF expansion project to the existing Physical Therapy Clinic to provide services to DoD family members and Veterans who receive services at the CBOC. In FY 2014, the JACC continued to provide mobile MRI services to both VA and DoD beneficiaries through equipment purchased through the JIF. Through resource sharing agreements, NHCC/628 MDG/RHJVAMC provided joint services in optometry, ophthalmology, cardiology, diagnostic radiology, phlebotomy, consultant pathology services, and shared training/clinical skills enhancement opportunities.

Joint Ambulatory Care Center, Charleston

Service	DoD Beneficiary Services	TRICARE Maximum Allowable Charges	VA Beneficiary Services	VA Value of Services
MRI	1,241* studies	\$601,543*	799 studies*	\$213,221*
Optometry	2,033 visits*	\$243,810*	1,516 visits**	\$308,273**
Ophthalmology (Part-time)	310 visits*	\$ 43,630*	1,291 visits**	\$252,688**
Outpatient Cardiology (RSA)	633* procedures	\$ 30,917*	377 visits**	\$281,671**
Reimbursed Diagnostic Radiology For Veterans provided by NHCC (RSA)			3,259**	\$69,051**
Total	4,217*	\$919,900*	7,242 services	\$911,683

*Workload/TMAC values based upon data from October 1, 2013 – September 19, 2014 (CHCS or Vista data)

**Workload/VA Value of Services based upon data from October 1, 2013 – July 31, 2014 (DSS)

In Beaufort, 4,200 enrolled Veterans and approximately 11,000 enrolled TRICARE Prime and TRICARE for Life patients received care in the Naval Hospital Beaufort facility. Two wings of the NH are dedicated to the CBOC and Veterans health services. Through a resource sharing agreement with RHJVAMC, DoD provided radiology, laboratory, podiatry, audiology, and optometry services to these beneficiaries. In FY 2014, NH Beaufort, along with RHJVAMC, continued MRI services through the FY 2012 JIF mobile MRI, providing 1,038 studies for

Veterans and 1,708 for DoD beneficiaries. This collaboration yielded a federal health care cost avoidance of \$1,324,432 (VA- \$724,316 and DoD- \$600,116) and \$35,840 in Veteran travel benefits in FY 2014. With a shared VA lab technician, the laboratory performed over 7,000 phlebotomy draws for VA patients saving time, travel dollars, and providing improved access to and ease of care. Navy podiatrists performed over 300 exams for Veterans in FY 2014 valued at \$28,645. Navy radiologists and technicians performed and read over 4,980 radiology procedures for VA patients valued at \$150,840 TMAC in professional fees and technical services. Additionally, the Beaufort-VA Joint Venture was awarded a JIF project to provide Dermatology services to DOD and VA CBOC patients at NH Beaufort.

Resource Sharing and JIF Initiatives, Beaufort

Service	DoD Beneficiary Services	TRICARE Maximum Allowable Charges (TMAC)	VA Beneficiary Services	VA Value of Services
MRI (JIF)	1708*	\$600,116*	1,038*	\$332,431*
Diagnostic Radiology including x-ray, CT, and US (RSA)	--	--	4,984*	\$150,840*
Podiatry (RSA)	--	--	335**	\$ 28,645**
Laboratory (RSA)	--	--	7,080*	\$212,400*
Total	1708	\$600,116	13,437	\$724,316

*Workload values based on data from October 1, 2013 – August 31, 2014 (M2 or CHCS data)

**VA Value of Services based upon data from October 1, 2013 – July 31, 2014 (DSS)

Benchmarking and communications are coordinated through the Lowcountry Federal Healthcare Alliance (LFHA), a coordination committee that meets monthly to discuss potential JIF initiatives, resource sharing agreements and other topics that increase the sharing of services and information between VA and DoD health care organizations in the Lowcountry/South Carolina area. LFHA was selected by the Charleston chapter of the Federal Employees Association for the annual “Team Award” for outstanding collaboration between federal agencies in 2013 and 2014, resulting in reduced costs and providing high quality care to Veterans and DoD beneficiaries.

Naval Medical Center San Diego and VA San Diego Healthcare System

DoD/VA Obstetric Program

Naval Medical Center San Diego (NMCS D) and the VA San Diego Healthcare System (VASDHS) continue a successful third year of sharing obstetric services. VASDHS does not offer obstetric services; therefore, NMCS D assists by providing obstetrics services at both the main hospital and two branch medical clinics for women Veterans. In addition to the obstetric services, NMCS D provides women Veterans any specialty care and emergency care needed during their pregnancy. The addition resulted from a request in FY 2013 by the VASDHS Women's Health Committee. In FY 2014, 78 women Veterans received obstetric services at NMCS D.

Ophthalmology Surgery

After the sequestration and furlough events of FY 2013, NMCS D started performing cataract surgeries via ambulatory surgery on Veterans in the third quarter of FY 2014 with a total of 24 Veterans treated. NMCS D anticipates continued capacity and ability to provide services to VA beneficiaries in FY 2015.

Comprehensive Medical, Surgical, Psychiatric Sharing Agreement

NMCS D has been instrumental in providing Veterans access to outpatient and inpatient services through the establishment of a comprehensive sharing agreement. VASDHS is able to rely on the NMCS D during episodes of decreased capacity due to high inpatient census or maintenance requirements. In FY 2014, there was an average of five VASDHS referrals for inpatient services such as Intensive Care and Mental Health units. In addition, the VASDHS refers patients to variety of specialty clinics as per the table below.

OUTPATIENT CLINICS	PATIENTS	VISITS
Breast Health Center	4	6
Cardiology	48	62
Obstetrics	78	744
Ophthalmology	24	48
Orthopedics	75	175
Radiation Oncology Therapy	93	1940

FY 2014 Outpatient Services to VASDHS Veterans

Radiation Oncology Joint Initiative

NMCS D and VASDHS implemented a joint initiative for a Linear Accelerator and staff to support radiation oncology services to DoD and VA beneficiaries. The goals are to

accommodate current and expected growing future workload for both NMCS D and VASDHS cancer stricken beneficiaries, and to reduce VASDHS fee-for-service costs.

JB Langley-Eustis, and the Hampton Veterans Affairs Medical Center

Master Sharing Agreement

The 633rd Medical Group (633 MDG) and Hampton VA Medical Center (HVAMC) in Hampton, VA have developed an agreement that establishes a mutually beneficial relationship between them with the intent of maximizing the capacity and services available to both DoD and VA beneficiaries. This Master Sharing Agreement serves as the core document for all VA/DoD resource sharing initiatives between the HVAMC and the 633 MDG. Local Operational Plans will address service specific processes and will serve as an extension of this agreement. The scope of care includes all medical, surgical, dental, and therapeutic services within the HVAMC and the 633 MDG, subject to a patient's eligibility, access priority to care, and the supplying facility's excess capacity/availability of that service. This long awaited agreement opens the door to limitless possibilities to sharing in the area and will enhance the clinical currency of 633 MDG providers as they care for VA patients.

Scott AFB and St. Louis VA Health Care System

Compensation & Pension Plan

The 375th Medical Group (375 MDG), Scott AFB, along with the St Louis VA Health Care System (SLVAHCS) have agreed to share up to 9,800 sq. ft. of space in the 375 MDG for the purpose of providing an Orthopedic Physician's Assistant, Orthopedic Health Technician, and Orthopedic Physician (PA remote supervision) to serve MDG patients and the VA's local Compensation & Pension (C&P) Clinic serving their local patient population. The agencies agree to provide integrated services to VA and MDG patients wherever possible and to strive toward increased integration. This is a no-cost agreement as the agencies have agreed to provide services of approximately equal value.

Seymour-Johnson AFB, NC and Fayetteville Veterans Affairs Medical Center (FVAMC)

Master Sharing Agreement

The 4th Medical Group (4 MDG), Seymour-Johnson, and FVAMC created a Master Sharing Agreement combining the following services:

- FVAMC shall provide Physical Therapy Full-Time Equivalent (FTE) Support and TRICARE Network Services to eligible 4 MDG beneficiaries on a referral basis, and Joint Committee POCs.
- The 4 MDG will provide Diagnostic X-Ray Service, Physical Therapy, Joint Committee POCs, Coumadin Clinic FTE Clinic, and FTE Support to eligible FVAMC beneficiaries (both dual eligible and VA eligible patients) on a referral basis. This agreement opens the door to additional opportunities in the future as their sharing relationship matures.

The Air Force Academy, CO, and Eastern Colorado Health Care System (ECHCS VA)

Ambulatory Care

The 10th Medical Group (10 MDG), USAFA, and ECHCS VA have combined resources to provide ambulatory surgical services for the ECHCS VA beneficiaries at the 10 MDG, US Air Force Academy, Colorado. The ECHCS and 10 MDG will integrate as many surgical operational functions as feasible. Recognizing the VA will be utilizing the minority of the 10 MDG space, this Sharing Agreement defines proportionate cost reimbursement methodologies for services and supplies. The 10 MDG will host ECHCS surgeons and support staff for the purpose of providing surgical specialty clinic and same day surgery for ECHCS Veterans. The 10 MDG will provide ancillary services, operating room space post-anesthesia care, recovery room, and all related activities for ECHCS staff and the ECHCS Veterans.

Pharmacy Ad Hoc Working Group

The VA/DoD Pharmacy programs continued to pursue joint contracting opportunities where appropriate and look for new opportunities to maximize efficiencies through joint efforts when possible. National contracts are at an all-time high with 113 existing contracts, of which 16 were new in FY 2014.

There are currently 18 joint contracts pending at the VA National Acquisitions Center (NAC) and 17 pending at DLA. In FY 2014, DLA awarded 13 new joint national contracts. The VA/DoD pharmacy team identified 37 commonly used pharmaceutical products and manufacturers for potential joint contracting action and continued to seek new joint contracting opportunities where practicable. Through the third quarter of FY 2014, VA spent \$215 million on joint national contracts, and DoD spent \$101 million. VA joint national contract prime vendor purchases represented 6.93 percent of total prime vendor purchases; DoD purchases represented 3.47 percent. VA identified 107 new molecular entities used in the ambulatory setting for contracting opportunities. All 107 have been reviewed or are currently under review. DoD performed 10 drug-class reviews, comprised of 75 molecular entities, representing \$997.6 million of the total spend with estimated cost avoidance and direct refunds of \$179.9 million.

Credentialing and Privileging Working Group

The Credentialing and Privileging Working Group (WG) evaluates VA and DoD policies, processes and systems related to the credentialing process to improve existing processes and reduce the time and cost associated when staff move or are shared between VA and DoD.

In October 2013, the HEC directed the WG to expand the credentialing software system currently utilized by DoD, the Centralized Credentials Quality Assurance System (CCQAS), to meet the needs of both Departments. This decision resulted in an approved JIF project to develop a Joint Centralized Credentials Quality Assurance System (JCCQAS) which builds on the existing DoD platform. The JCCQAS will integrate VA and DoD credentialing processes

into one data system which will contain all provider verified credentials in one system for use across both Departments.

The JCCQAS project will be accomplished in two phases. Phase 1 has been funded through the original JIF proposal and includes a significant upgrade of CCQAS to an ASP.NET Web form in order to support scalability and sustainability of the system and ensure Section 508 compliance. Phase 1 will also include review and planning to ensure the JCCQAS infrastructure is developed to maintain a longitudinal provider record that retains retrievable historical records of provider data as currently exists in CCQAS and in VA's VetPro as well as planning for future expansion. Finally, Phase 1 will include the beginning of code changes to incorporate requirements that have been developed and approved by both Departments which are essential for migration to the JCCQAS. As funding permits in Phase 1, the prioritized list of the 41 approved requirements and user stories will be addressed with the start of code changes toward the building of a prototype that will include all identified requirements by the end of the JCCQAS project. Additional funds for Phase 2 have been requested through a second JIF proposal. The second phase will include the actual IT development, data migration and realization of the prototype solution.

At the time the Credentialing and Privileging Working Group was chartered, three subgroups were developed: Business Process, Policy and Regulation, and Information Technology Assessment. The work completed by these three subgroups was incorporated into the approved JCCQAS requirements and user stories. These three subgroups remain intact and provide expert guidance for each of the requirements and complete the joint VA/DoD ground work of how the systems and processes can be standardized. The Business Process subgroup focuses on the business requirements and necessary capabilities through the requirements, user stories, and acceptance criteria. The Policy and Regulation subgroup focuses on regulatory policy of both Departments to identify policies needing to merge in support of a joint credentialing platform and process. The Information Technology Assessment subgroup focuses upon the system infrastructure and taxonomy in support of a system that meets the needs and technology requirements of both Departments.

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) 2014 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 JSP framework for joint coordination and sharing efforts between VA and DoD. The Departments will continue to demonstrate and track progress toward defined goals, objectives, and end-states, and provide the continuum to successfully meet the needs of Service members and Veterans.

Appendix A

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

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

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

I. PURPOSE

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

II. AUTHORITY

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

III. JOINT EXECUTIVE COUNCIL (JEC)

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

B. Responsibilities: The JEC shall:

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

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

IV. SHARING AGREEMENTS

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

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

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

D. Scope of Agreements:

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

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

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

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

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

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

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

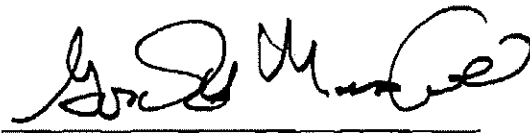
Enhanced Services (VA CARES) decisions or significant demographic changes. Sharing agreements shall provide for modification or termination in the event of war or national emergency, as necessary. Annual reviews of sharing agreements are required by all involved agencies for VA/DoD health care ensure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

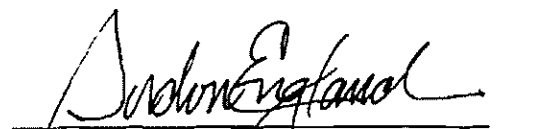
V. EFFECTIVE DATE AND MODIFICATION OF GUIDELINES

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

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

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


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


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

Appendix B

Cost Estimate to Prepare Congressionally-Mandated Report

Title of Report: VA/DoD JEC FY 2014 Annual Report
Report Required by: Public Law 108-136, National Defense Authorization Act

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

Direct Labor Cost	\$ 70,749
Contract(s) Cost	\$ 0
Production and Printing Cost	\$ 4,100
Total Estimated Cost to Prepare Report	\$ 74,849

Brief explanation of the methodology used to project cost estimate:

The estimated number of total direct labor hours expended was multiplied by the U.S. Office of Personnel Management's calendar year 2014 hourly rate structure for the metropolitan Washington, DC area. The calculated net labor costs were multiplied by the fiscal year 2014 fringe benefit amount of 36.25 percent. The reported information in the cost statement reflects the sum of direct labor hour costs and fringe benefits.

Glossary of Abbreviations and Terms

A&I – Artifacts and Images
AC – Access Control
ACO – Auditory Care Optimization
ADC – Active Dual Consumer
AFB – Air Force Base
AFFDWG – Department of Dense Auditory Fitness for Duty Working Group
AHLTA – Armed Forces Health Longitudinal Technology Application
AHRQ – Agency for Health Care and Research Quality
AIM – Alternate Input Method
AMC – Army Medical Center
ANRs – Audio News Releases
APPs – Applications
AR – VA/DoD JEC Fiscal Year 2012 Annual Report
ARWG – Auditory Research Working Group
ASoC – Amputation System of Care
ATACS – Acupuncture training Across Clinical Settings
ATO – Authority to Operate
ATSDR – Agency for Toxic Substances and Disease Registry
AY – Academic Year
BAMC – Brooke Army Medical Center
BCA – Business Case Analysis
BDD – Benefits Delivery at Discharge
BEC – Benefits Executive Council
BHIE – Bidirectional Health Information Exchange
BI – Business Intelligence
BJPs – Business Justification Packages
BOG – Board of Governors
BRAC – Base Realignment and Closure
BRD – Business Requirements Document
CAUT-Catheter Acquired Urinary Tract Infections
CAC – Common Access Card
CAPC – Capital Asset Planning Committee
CAREN – Computer Assisted Rehabilitation Environment
CARF – Commission on Accreditation of Rehabilitation Facilities
CBO – Veterans Health Administration Chief Business Office
CBOC – Community-Based Outpatient Clinic
CBSWG – Communication of Benefits and Services Working Group
CBT-D – Cognitive Behavioral Therapy for Depression
CBT-I – Cognitive Behavioral Therapy for Insomnia
CCQAS – Centralized Credentials Quality Assurance System
CDC – Centers for Disease Control and Prevention
CDP – Center for Deployment Psychology
CDR – Clinical Data Repository

CFI – Department of Defense Center for the Intrepid
CHHP – Comprehensive Hearing Health Program
C-IPT – Capability-Integrated Product Team
CM – Context Management
CMI – Chronic Multi-symptom Illness
CoE – Center of Excellence
CoEPE – Centers of Excellence in Pain Education
C&P – Compensation and Pension
CONOPS - Concept of Operations
CPC – Construction Planning Committee
CPE – Clinical Pastoral Education
CPG – Clinical Practice Guideline
CPT – Cognitive Processing Therapy
C-STARS – Center for Sustainment of Trauma and Readiness Skills
CT – Cardiothoracic
CY – Calendar Year
DBQ – Disability Benefits Questionnaire
DCoE – Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DD – Department of Defense Forms 214, 2807, and 2808
DDEAMC – Dwight David Eisenhower Army Medical Center
DES – Disability Evaluation System
DHA – Defense Health Agency
DHMSM – DoD Healthcare Management System Modernization
DHWG – Deployment Health Working Group
DLA – Defense Logistics Agency
DMA – Disability and Medical Assessments
DMDC – Defense Manpower and Data Center
DoD – Department of Defense
DOEHRS - Defense Occupational and Environmental Health Readiness System
DOEHRS-HC - Defense Occupational and Environmental Health Readiness System for Hearing Conservation
DoDI – Department of Defense Instruction
DOL – Department of Labor
DP – Design Principles
DPRIS – Defense Personnel Records Information Retrieval System
DRAS – Disability Rating Activity Site
DS Logon – Defense Self-Service Logon
DSPO – Defense Suicide Prevention Office
DSS – Decision Systems Support
DTA – Data Transfer Agreement
DTC – Development and Test Center
DU – Depleted Uranium
DVBIC – Defense and Veterans Brain Injury Center
DVCIPM – Defense and Veterans Center for Integrative Pain Management
DVEIVR – Defense and Veterans Eye Injury and Vision Registry

DVPRS – Defense and Veterans Pain Rating Scale
EACE – Extremity Trauma and Amputation Center of Excellence
EBP – Evidence Based Psychotherapy
EBPWG – Evidence Based Practice Working Group
eCFT – electronic Case File Transfer
ECAA-Enterprise Clinical Audiology Application
ED – Department of Education
eDR – Enhanced Document Referral
EES – Employee Education System
EHR – Electronic Health Record
FHCC – Federal Health Care Center
FHP&R – Force Health Protection and Readiness
FISIG-Federal Interdisciplinary Skin Integrity Group
FMWG – Financial Management Working Group
FOC – Full Operating Capability
FRS – Federal Resource Sharing
FTE – Full-Time Equivalents
FY – Fiscal Year
GAO – Government Accountability Office
GME – Graduate Medical Education
HACs – Hospital Acquired Conditions
HAIMS – Healthcare Artifact and Image Management Solution
HARB – Health Architecture Review Board
HCE – Hearing Center of Excellence
HCS – Health Care System
HCWG – Hearing Conservation Work Group
HDR – Health Data Repository
HEC – Health Executive Council
HIE – Health Information Exchange
HIT – Health Information Technology
HIPPA – Health Insurance Portability and Accountability Act
HPE – Health Professions Education
IC3 – DoD/VA Interagency Care Coordination Committee
ICD-9 – International Classification of Diseases, ninth revision
ICE – Interactive Customer Evaluation
ICIB – VA/DoD Interagency Clinical Informatics Board
IDES – Integrated Disability Evaluation System
IE – Information Exchange
IE-IPT-Information Exchange Integrated Product Team
iEHR – integrated Electronic Health Record
IMIMIHI-Institute of Healthcare Improvement Model
ILER – Individual Longitudinal Exposure Record
JCCQAS – Joint Centralized Credentials Quality Assurance System
IMHS – Integrated Mental Health Strategy
IM/IT – Information Management/Information Technology
IOC – Initial Operating Capability

IOGF – Inter-organizational Guideline Forum
IOM – Institute of Medicine
iPLRD – Integrated Project Level Requirement Document
IPO – Interagency Program Office
IPR – Interim Progress Reports
IRB – Institutional Review Board
IS/IT – Information Sharing/Information Technology
IT – Information Technology
IWG – Independent Working Groups
JAL FHCC – James A. Lovell Federal Health Care Center
JACC – Joint Ambulatory Care Center
JEC – Joint Executive Council
JFU&RS WG – Joint Facility Utilization and Resource Sharing Working Group
JHASIR – Joint Hearing Loss and Auditory System Injury Registry
JIC – Joint Immunization Capability
JIF – Joint Incentive Fund
JSP – VA/DoD JEC Joint Strategic Plan
JTTR – Joint Theater Trauma Registry
JV/RS WG – Joint Venture and Resource Sharing Working Group
Lab/AP – Laboratory/Anatomic Pathology
LINAC – Linear Accelerator
LINKS- Linking Information Knowledge and Systems
MCiS – Military Health System Cyberinfrastructure Services
MCL – Military Crisis Line
MCS – Millennium Cohort Study
MCSC – Managed Care Support Contractor
MDG – Medical Group
MDW – Medical Wing
MEB – Medical Evaluation Board
MedPDB – Medical Surgical Product Data Bank
MHS – Military Health System
MHS Learn – Military Health System Learning Portal
MHV – MyHeatheVet
MIST-NG – Medical Interagency Satellite Training - Next Generations
MMC – Medical Master Catalog
MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MP – Management Plan
MRI – Magnetic Resonance Imaging
MRMC – United States Army Medical Research and Material Command
MRWG – Medical Records Working Group (BEC)
MRWG – Medical Research Working Group
MSC – Military Services Coordinator
MSSO – Medical Single Sign-On
mTBI – Mild Traumatic Brain Injury
MTF – Military Treatment Facility

NATO – North Atlantic Treaty Organization
NCAT – NeuroCognitive Assessment Tool
NCC – National Capital Consortium
NCPS – National Center for Patient Safety
NCR – National Capital Region
NDAA – National Defense Authorization Act
NGC – National Guideline Clearinghouse
NH – Naval Hospital
NHCC – Naval Health Clinic Charleston
NIH – National Institutes of Health
NMCS D – Naval Medical Center San Diego
NPRC – National Personnel Records Center
NRAP – National Research Action Plan
NRD – National Resource Directory
(OASD(HA)) – Office of the Assistant Secretary of Defense for Health Affairs
OEF – Operation Enduring Freedom
OIF – Operation Iraqi Freedom
OIG – Office of Inspector General
OMB – Office of Management and Budget
ONC – Department of Health and Human Services Office of National Coordinator
OND – Operation New Dawn
ONR – Office of Naval Research
OP – Orders Portability
ORD – Office of Research and Development
OTR – Operation Tomodachi Registry
PAN – Polytrauma Amputation Network
PASTOR – Pain Assessment and Outcome Registry
PBI – Practice-Based Implementation
PBM – VA Pharmacy Benefit Management
PBRN – Practice-Based Research Network
PCMH – Patient-Centered Medical Home
PDB – Product Data Bank
PDHA – Post-Deployment Health Assessment
PDHRA – Post-Deployment Health Reassessment
PE – Prolonged Exposure Therapy
PEB – Physical Evaluation Board
PEBLO – Physical Evaluation Board Liaison Officers
PFA – Psychological First Aid
PH – Psychological Health
PHI – Public Health Information
PIDM – Patient Identity Management
PMO – Program Management Office
PMWG – Pain Management Working Group
PPDHA – Pre- and Post-Deployment Health Assessment
PSA – Public Service Announcements
PSC – Polytrauma System of Care

PSWG – Patient Safety Working Group
PT/BRI – Polytrauma/Blast-Related Injuries
PTSD – Post Traumatic Stress Disorder
QMO – Quality Management Office
QUERI – Quality Enhancement Research Initiative
RCA – Root Cause Analysis
RCP – Recovery Coordination Program
RHJVAMC – Ralph H. Johnson VAMC
ROES – Remote Order Entry System
RoG – Republic of Georgia
RTO – Research and Technology Organization
SA – Strategic Actions
SCAN-ECHO™ – Specialty Care Access Networks-Extension for Community
Healthcare Outcomes
SCORE! – Study for Cognitive Rehabilitation Effectiveness
SCWG – JEC Strategic Communications Working Group
SDSU – Same Day Surgery Unit
SGLI – Service Members Group Life Insurance
SHAWG – Separation Health Assessment Working Group
SMMAC – Senior Military Medical Advisory Council
SME – Subject Matter Expert
SOA – Service Oriented Architecture
SOC – Senior Oversight Committee
SOES – SGLI Online Enrollment System
SPARRC – Suicide Prevention and Risk Reduction Committee
SPC – Suicide Prevention Conference
SSA – Social Security Administration
SSO – Single Sign-On
STR – Service Treatment Record
STVHCS - South Texas Veterans Health Care System
T2 – Department of Defense’s National Center for Telehealth and Technology
TAA – Training Affiliation Agreement
TAP – Transition Assistance Program
TATRC – Telemedicine and Advanced Technology Research Center
TBI – Traumatic Brain Injury
TCAPS—Tactical Communication and Protective System
TED-I/NI – TRICARE Encounter Data – Institutional/Non-Institutional
TFMO – Theater Functional Management Office
THSP – Target Health Standards Profile
THWG-Telehealth Working Group
TMA – TRICARE Management Activity
TMS – Talent Management System
TSWF – Tri-Service Work Flow
USMC – United States Marine Corps
USMLE-United States Medical Licensing Exam
USTRANSCOM – United States Transportation Command

USUHS - Uniformed Services University of the Health Sciences UX – User Experience
VA – Department of Veterans Affairs
VA CARES – Veterans Affairs Capital Assets Realignment for Enhanced Services
VAMC – VA Medical Center
VAS – Visual Analog Scale
VASDHCS – Veterans Affairs San Diego Health Care System
VBA – Veterans Benefits Administration
VCE – Vision Center of Excellence
VCL – Veterans Crisis Line
VHA – Veterans Health Administration
VHCS – Veterans Health Care System
VHI – Veteran’s Health Initiative
VISN – Veterans Integrated Service Network
VISTA – Veterans Health Information System Technology Application
VLER – Virtual Lifetime Electronic Record
VONAPP – Veterans Online Application
VOW Act – Veterans Opportunity to Work Act
VSO – Veterans Service Organization
VTA – Veterans Tracking Application
VTA IDES – Veterans Tracking Application for the Integrated Disability Evaluation System
WG – Working Group