VA/DoD Joint Executive Council
Annual Report
FISCAL YEAR 2011

VA/DoD Joint Executive Council Membership List

(as of December 2011)

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SECTION 1 – INTRODUCTION

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Joint Executive Council (JEC) has completed its ninth year and is pleased to submit this *VA/DoD JEC Fiscal Year (FY) 2011 Annual Report (AR),* for the period of October 1, 2010 to September 30, 2011, to Congress and the Secretaries of Defense and Veterans Affairs as required by law[1]. The intent of the AR is to provide Congress with the collective accomplishments between the two Departments and highlight the current efforts to improve resource sharing. This report does not contain recommendations for legislation related to health care resource sharing.

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

The JEC continues to invite other Federal Departments and agencies to meetings as appropriate. In 2011, representatives from the White House, Office of Management and Budget, and Department of Labor attended for awareness and information sharing.

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

The *VA/DoD Joint Executive Council Joint Strategic Plan* (JSP) is the primary means to advance performance between VA and DoD, and is continuously evaluated, updated, and improved. Historically, the JSP has been attached as an appendix to the AR; however, on May 26, 2011, the JEC Co-Chairs decided to permanently separate these documents and realign the publication timelines. The intent of this decision was to improve the ability of the

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

JSP to drive JEC activities while still allowing the AR to be published by the Congressional deadline. The JSP for FY 2011-2013 was developed using a new strategic framework (mission, vision, goals) approved by current Department leadership and was published September 9, 2011. The next publication of the JSP for FY 2013-2015 is expected by September 30, 2012.

SECTION 2 - ACCOMPLISHMENTS

This section highlights the Fiscal Year (FY) 2011 accomplishments of the Health Executive Council (HEC), Benefits Executive Council (BEC), and Independent Working Groups (WGs). These accomplishments reflect the efforts of the Department of Veterans Affairs (VA) and the Department of Defense (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 Council (JEC) FY 2011 Annual Report (AR)* links the year's accomplishments to the Sub-goals and performance measures established in the *VA/DoD Joint Executive Council Joint Strategic Plan* (JSP) FY 2011-2013. This approach clarifies the connection between strategic planning and outcomes achieved through VA and DoD's coordination, collaboration, and sharing efforts. The report also demonstrates achievements beyond planned activities.

GOAL 1
Benefits and Services

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

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

BEC Pre-discharge Working Group

The BEC Pre-Discharge WG continued its efforts to improve the participation rate in the Pre-discharge Program; a joint endeavor between VA and DoD consisting of the BDD and Quick Start programs. The Pre-discharge Program affords Service members the opportunity to file VA disability compensation claims up to 180 days before separation, demobilization, deactivation, or retirement from active or full time duty. This includes Reservists serving on Active Duty in an Active Guard Reserve (AGR) role.

DoD continues to expand BDD and Quick Start information on the TurboTAP Web site (TurboTAP.org) and the TAP Facebook social media site. In FY 2011, DoD placed the BDD and Quick Start brochures on the TurboTAP Web site, which provides online access to Service members transitioning from military service and is intended to supplement the services offered by TAP. There is now unlimited access to BDD and Quick Start information for all Service members to include demobilization/deactivating National Guard and Reserves. On October 1, 2011, DoD added BDD and Quick Start mandatory counseling for all transitioning Service members who are eligible for TAP. Historically, pre-separation counseling is required for all Service members leaving the military. Now, with adding the mandatory counseling for BDD and Quick Start, over 250,000 transitioning Service members are expected to receive counseling on the BDD and Quick Start programs in FY 2012. DoD also provided BDD and Quick Start program information to over 120 Recovery Care Coordinators (RCCs) that provide nonmedical transition support to selected Wounded, Ill, and Injured Service members.

VA continues to maintain its Pre-discharge Program Web site and Pre-discharge video as part of the American Veteran Series currently available on the VA Web site. The Veterans Benefits Administration (VBA) also redesigned the TAP Briefing on VA Benefits to effectively communicate VA benefits and services that are available to transitioning Service members. This briefing includes an in-depth explanation of the BDD and Quick Start program to include claims filing procedures. The TAP Briefing on VA Benefits is also now online at the eBenefits Web site and available to all Service members. The redesign of the classroom and online versions of the TAP Briefing on VA Benefits were implemented on July 31, 2011. VBA provided training to over 230 VA briefers, representing 44 regional offices, on the revised and updated classroom briefing. Additionally, VBA conducts a monthly conference call, hosting subject matter experts from the various benefit business lines to provide direct information to VA briefers. These initiatives are needed to achieve the goal of providing the TAP Briefing on VA Benefits to 100 percent of transitioning Service members prior to separation.

VA also developed and implemented a survey instrument on August 1, 2011, to measure the quality and track attendance of VA's portion of TAP and provide this information to DoD. VBA provided training to over 270 VA employees, representing 50 regional offices on administration of the classroom survey.

Both Departments began developing communication plan recommendations to encourage participation in the Pre-Discharge program and TAP Briefing on VA Benefits. The Pre-Discharge WG will establish BDD and Quick Start program marketing requirements for inclusion into the strategic communications plan developed by the BEC Communications of Benefits and Service Working Group (CBSWG). Additionally, VBA and Office of Secretary of Defense (OSD) jointly agreed to establish a BDD awards program to publically recognize BDD military intake sites with high participation rates.

In FY 2011, as a result of these efforts, 59,845 claims were received at BDD intake sites with a Memorandum of Understanding (MOU) in place. Out of these claims, 32,104 were Pre-discharge claims (53.65 percent). For these Pre-discharge claims, 16,325 were BDD claims (27.87 percent) and 15,779 were Quick Start claims (26.37 percent). The WG continues to pursue efforts to increase participation to meet its goal of 65 percent participation by the end of FY 2012.

In response to the Government Accountability Office (GAO) Report 08-901, a BDD and Quick Start Standing Operating Procedure Guide for joint site visits was drafted in March 2011. Due to logistic and resourcing issues, the joint site visits were postponed for FY 2011. A new plan is being developed for implementation during the 2nd quarter of FY 2012.

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

BEC Communications of Benefits and Services Working Group

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

The CBSWG achieved many beneficial outcomes in FY 2011 through leveraging both DoD and VA communication outlets to share benefits information. This was evidenced by the increase of registered eBenefits Premium accounts from approximately 165,000 users to over one million.

The CBSWG surpassed its goal of a 25 percent increase in information sites available to Service members and Veterans that addressed the benefits and services provided by VA and DoD. One impact of this increase was demonstrated in the effort to provide awareness to Service members and Veterans of the new changes affecting the Post 9-11 GI Bill and upcoming changes to the Traumatic Servicemembers' Group Life Insurance program. The Departments were able to increase awareness of these changes by making the information available on an additional 10 information sites.

VA and DoD quarterly reviews were conducted on various VA and DoD Web sites to verify and assess the validity and accuracy of the content pertaining to benefits related information.

The CBSWG will look to increase the availability of a number of VA and DoD benefits to the Service member, Veteran, and the Retiree population by incorporating benefits information into existing DoD benefits sites and capabilities. These capabilities will include the calculators for Basic Allowance for Housing (with or without dependents), Basic Allowance for Subsistence, Temporary Duty Pay, promotion point calculators, and Special Pay/Hazardous Duty Pay. Also, a continued effort will be made to develop, incorporate, and market new applications such as a Deployment Pay Calculator, Time in Service and Time in Grade specific Special Pay calculators, and Permanent Change of Station (PCS)/Relocation budget planners and calculators on numerous VA and VBA Web sites.

Between October 2010 and September 2011, CBSWG promoted the awareness and use of the eBenefits site, and the Benefits Assistance Service (BAS) supported over 30 outreach and advertising activities to ensure that information about new benefits were disseminated to Servicemembers, Veterans, and their families as mandated by law.

Throughout FY 2011, eBenefits provided targeted information to separating Service members through such programs as BDD, Quick Start, Vocational Counseling, and an early notification capability provided within eBenefits. Service members are eligible for many VA benefits prior to separation or retirement; therefore they are receiving information when they become eligible for those benefits as opposed to waiting until separation from military service. This notification

occurs throughout their military life cycle, from accession through separation.

The cross promotion of similar VA and DoD benefits was demonstrated in FY 2011 when the new changes in the eligibility for Post 9-11 GI Bill benefits occurred, specifically the inclusion of National Guard Title 32 service. These changes were disseminated through both DoD and VA media outlets, enhancing awareness of the new changes.

Additional collaborative efforts between VA and DoD were established with both agencies' Public Affairs and Legislative Affairs offices. This collaboration sought to improve communications by the creation of joint communication plans. These plans involved providing Service members and Veterans up to date information on many initiatives such as changes regarding the Integrated Disability Evaluation System (IDES) as well as the Disability Review Board.

In FY 2011, the WG was not able to accomplish the goal of producing at least two joint media-related products due to budget constraints. However, a contract has been developed that will allow for these products to be created in FY 2012.

Sub-goal 1.3: Coordinate Federal and private sector resources and services needed by Recovering Service Members (RSMs) and their families through the Recovery Coordination Program (RCP).

Recovery Coordination Program

The RCP is aligned to the Office of Wounded Warrior Care and Transition Policy (WWCTP) and supports recovering Service members and their families through the phases of recovery, rehabilitation, and reintegration to their communities or return to Active Duty.

Wounded Warrior Care Coordination Summit

The mission of the Wounded Warrior Care Coordination Summit held March 28-31, 2011, was "to determine high priority wounded warrior issues and best practices' to identify actionable recommendations to be worked by four chartered working groups." Additionally, participants were asked to focus their discussions around Sub Goal/Priority Initiative 3 of the WWCTP, to "improve the recovery care coordination process by creating a unified VA/DoD and Services system that establishes 'best practices' in care coordination with the Services and industry leaders, and deploy a unified system by the end of FY 2011."

The Wounded Warrior Care Coordination Summit consisted of four chartered working groups, each focused on a key area:

1. Education and Employment
2. Federal Recovery Coordinator (FRC)/RCC Collaboration
3. In Pursuit of Excellence—Documenting Best Practices
4. Wounded Warrior Family Resilience

WG participants were leaders from across the public and private sectors, including participants from multiple Federal agencies (VA, Department of Labor (DOL), Military Community and Family Policy), as well as representatives from each of the Military Services.

As outlined in the table below, several recommendations are currently being carried out by the RCP or its component programs. Additional recommendations are being carried out by other participating agencies.

Sub Group	Recommendation	Current Status	Details
Education and Employment	Across the continuum of care and transition, prepare warriors who are ready to be successful in employment and education opportunities.	In progress	Addressed by Recovery Coordination Program (RCP) Education and Employment Initiative (E2I)
	Maximize Federal employment opportunities for transitioning wounded, ill and injured Service members through innovative approaches.	In progress	Addressed by E2I/Operation War Fighter(OWF)
	Maximize Non-Federal Entity /commercial sector employment opportunities for transitioning wounded warriors by empowering them through innovative approaches	In progress	Addressed by E2I/OWF
	Facilitate a framework for positive community engagement for transitioning wounded warriors and community organizations	In progress	Addressed by E2I
	Match developmental goals of recovering Service members with quality education and professional training opportunities	In progress	Addressed by E2I/OWF

The outcomes of the Education and Employment WG efforts are expected to be: the achievement of a comprehensive strategy to provide recovering Service members career-focused transition support early in their rehabilitation; development of policy and guidance, including the provision of resources when necessary; and establishment of outcome measures and synchronization and leveraging of existing efforts to ensure a consistent experience by all recovering Service members who seek education or employment opportunities.

Sub Group	Recommendation	Current Status	Details
Best Practices	Expand the requirement that every recovering Service member have an RCC	Completed	Completed by RCP, Services
	Ensure all recovering Service members have an active Comprehensive Recovery Plan (CRP) once they have met enrollment criteria	Completed	Completed by RCP, Services
	Define recovering Service member entrance criteria to a Wounded Warrior Program	Not started	Will be addressed by Case Management Working Group
	Refine the recovering Service member exit criteria	Not started	Will be addressed by Case Management Working Group
	Institutionalize the use of an electronic CRP	In progress	Recovery Coordination Program Support Solution designed by RCP/WWCTP and implemented by Services
	Require all Recovery Care Coordinators to be Health Insurance Portability and Accountability Act compliant	In progress	Carried out based on Service-specific requirements, processes
	Shift the focus from a 40:1 caseload ratio to a manageable workload	Not started	Will be addressed by Case Management Working group/Services
	Recognizing that separate DoD and Service-specific training represents a best practice, all RCCs will attend both trainings	Completed	Completed by RCP
	Convene the Service Recovery Coordination Program Directors Forum	Ongoing	First Forum held June 2011 and second Forum tentatively scheduled for October 2011

	Reconvene the Case Management Working Group	Ongoing	First meeting will be held after October 2011 Service Recovery Coordination Program Directors Forum
	Services routinely conduct Service member and family care coordination assessments and share common results	Ongoing	Conducted by the Services; topic is an agenda item for Service Recovery Coordination Program Directors Forum
	Develop a system or process that will allow RCCs to coordinate the plethora of non-medical care managers/providers assisting Wounded, Ill ,and Injured Service members and their families	Ongoing	Facilitated by Case Management Working Group, National Resource Directory (NRD)

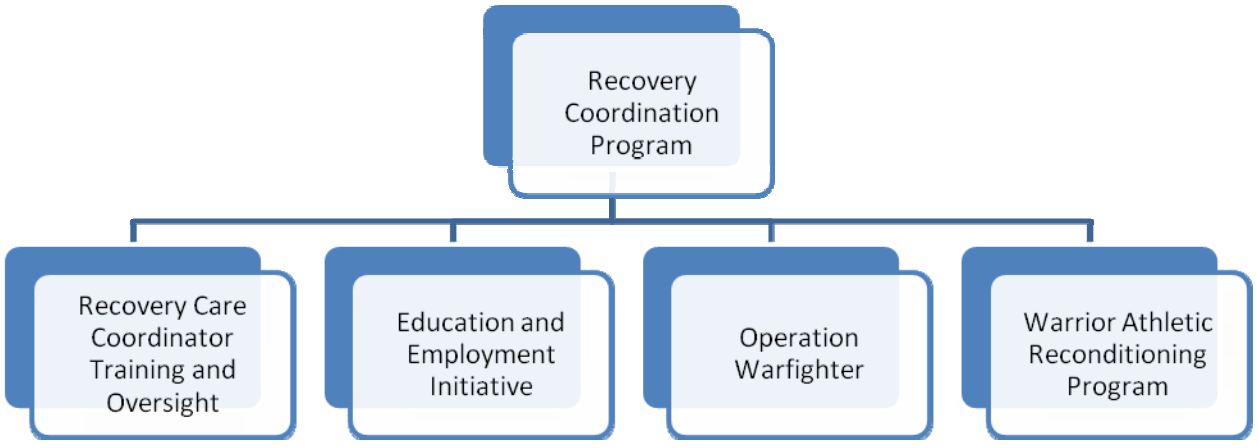
Recommendations of the Best Practices WG are being implemented with the goal of achieving a consistent experience for all recovering Service members across the continuum of care, including equal access to resources; and the adaptation of support services to meet the potential changing needs of Service members and families as the force draws down.

Sub Group	Recommendation	Current Status	Details
FRC/RCC Collaboration	Improve education and develop the strategic communications process	Ongoing	A training module outlining the Federal Recovery Coordination Program (FRCP) has been added to quarterly RCC training; a presentation on the RCP is also given at trainings for Federal Recovery Coordinators (FRC)s
	Access to interagency Information Technology systems	In progress	Addressed by Information Sharing Initiative work group, co-chaired by VA Director of FRCP

			and DoD OSD WWCTP and attended by all Military Services and National Security Space Architecture
	Develop and implement a standardized referral and intake process for the RCP	Completed	Addressed by work group, co-chaired by VA Director of FRCP and DoD OSD WWCTP and attended by all Military Services
	Consider geographic alignment of FRCs	In progress	FRCP, Services
	Continue to enhance and expand NRD	Ongoing	NRD

The outcomes of the FRC/RCC Collaboration WG efforts are expected to provide a smooth transition for recovering Service members who require support; and coordination of services by a FRC.

Other Resources Coordinated and Provided by the RCP
The RCP offers four programs to support wounded warriors; three of the programs were assigned to the RCP in the second half of FY 2011.



Education and Employment Initiative (E2I):
The Wounded Warrior E2I engages recovering Service members early in the recovery process to identify skills they have, career opportunities matching those skills, and any additional skills they will need to be successful. This process operates on a regional basis and involves an innovative collaboration with the Department of Veterans Affairs to provide VA's vocational

rehabilitation services earlier in the recovery process than before. Regional managers overseen by WWCTP identify and coordinate existing resources to ensure a consistent experience for recovering and transitioning Service members.

Operation Warfighter (OWF):
OWF is a Federal internship program open to all wounded, ill and injured Service members assigned to a Service Wounded Warrior Program (WWP). Each Service member must be medically cleared to participate and the internship assignment must not interfere with a participant's medical profile or adversely affect his or her well-being and recuperation.

OWF is a wellness and rehabilitation program designed to help Service members better prepare for a smooth transition into the workforce. OWF statistics for FY 2011 are as follows:

- 725 total placements
  - 500 Army
  - 125 Marine Corps
  - 50 Navy
  - 50 Air Force
- 36 National Capital Region (NCR) outreach events per year
  - Three NCR outreach events per month
- Approximately 75 Federal agencies and sub-components are actively participating, including and not limited to:
  - Department of Homeland Security
  - Department of Transportation
  - Department of Interior
  - VA
  - Department of Justice
  - Office of Director of National Intelligence
  - DoD

All the resources and programs discussed above, as well as all other programs and services required for a successful recovery, rehabilitation, and reintegration are documented in each recovering Service member's Comprehensive Recovery Plan (CRP). The CRP is monitored and updated as needed for increased effectiveness as each Service member moves through the three phases of recovery, rehabilitation, and reintegration. Through the training and oversight provided by the RCP, RCCs are prepared to successfully support Service members and families through the provision of tools (ex: CRP and Recovery Coordination Program Support Solution and the coordination of available resources and services (ex: NRD, E2I, OWF, and others).

RCC Training and Oversight;
The RCP provides more than 40 hours of comprehensive, standardized training for RCCs, including RCC roles and responsibilities, concepts for developing and maintaining the CRP, and practical exercises to ensure a successful transfer of information. The RCP trained 75 RCCs in FY 2011:

- Army: 20
- Navy: 8
- Air Force: 7

- Army Reserve: 5
- Marine Corps: 14
- United States Special Operations Command: 21

In addition, the team trained nine Non-Medical Case Managers and 20 other participants from various Service WWPs, and opened training events to observers from other Federal agencies that support recovering Service members and their families.

At the conclusion of each training event, RCCs are provided the opportunity to offer feedback and rate their satisfaction with the training experience. For the entire FY 2011, the overall satisfaction rating of RCCs was 96 percent. Statistics from the quarterly training held in October 2011 are as follows:

RCP Training Metrics	Target	Results
85 percent of RCC training OSD Modules will result in an overall "excellent" rating for instruction	85 percent	90 percent
85 percent of RCC training course evaluations will result in an overall "excellent" rating for instruction	85 percent	90 percent
85 percent of RCC training course evaluations will result in an overall "excellent" rating for training materials	85 percent	90 percent
Not more than 30 days will lapse between an RCC's date of hire and the date they attend OSD Training	≤ 30 days	55 percent <30 days

The RCC training curriculum has been continually updated over the past three years based on feedback from RCCs and course evaluation results. New topics, material, and training modules are added based on the availability of new resources, as well as to inform RCCs of new legislation, policies, and requirements. The RCC training curriculum has been updated to ensure RCCs are trained in a way that continually improves care provided to Service members and families. Recent briefings added to the RCC training curriculum include:

- The National Intrepid Center of Excellence (NICoE) orientation. NICoE is a treatment planning and research facility dedicated to advancing the clinical care, diagnosis, research, and education of Active Duty Service members (to include National Guard and Reservists on orders) and families experiencing combat-related Traumatic Brain Injury (TBI) and psychological health (PH) conditions.
- FRCP overview. An FRCP overview enables RCCs to understand the implementation of the FRCP, the enrollment criteria and the assessment process. RCCs gain a better understanding of the FRCP's clients and how both the RCP and the FRCP provide care management to recovering Service members and their families throughout the continuum of care.
- VA Caregiver Support Program Overview. Education Includes the roles and functions of the Caregiver Support Coordinators located at each VA medical center. Details are provided on the application process and eligibility for the program, which provides additional services and benefits that include a stipend and health insurance. The RCCs gain an understanding of the similarities and key differences of the Caregiver Programs

in DoD and VA in order to ensure a smooth transition of Caregiver services and benefits across the continuum of care.

Other enhancements to the RCC training include:

- A standard outreach template that can be personalized, or combined with Service-specific briefings, so that information about the RCP and the RCC role is communicated accurately and consistently across audiences.
- The Resource Exhibition, introduced in the first half of FY 2011, provides RCCs with an opportunity to learn about a variety of resources (ex: NRD, America's Heroes at Work, Yellow Ribbon Reintegration Program) in an interactive, self-guided environment allowing for open dialogue with program representatives
- Recent distance learning topics include Post Traumatic Stress Disorder (PTSD) 101 and Suicide Awareness.

Specific training modules of the RCC training are required by National Defense Authorization Act (NDAA) 2008. These specific modules cover signs and symptoms of PTSD, TBI, and the effects on wounded warriors and their families. Other modules focus on the warning signs of suicide, risk factors, intervention techniques and resources. RCCs are provided an overview of the Disability Evaluation System (DES), so they can best assist the recovering Service member as they progress through the DES. RCCs are trained on the development and purpose of establishing attainable, realistic goals for recovering Service members using the CRP. The module also covers the importance of monitoring and updating the CRP as Service members' needs and circumstances change. RCCs are provided with an education that focuses on multiple levels of collaboration between VA Liaisons for Healthcare, both medical and non-medical (who are stationed at MTFs). RCCs are also trained on the processing of transitioning Service members' health care from DoD to VA. An overview of VA's OEF/OIF/OND Care Management Teams, located at every VA Medical Center, is also provided at each RCC training.

Outreach and Communication Efforts

Several approaches to outreach and communication efforts and resulting outcomes include: the Warrior Care Web site, which includes regularly updated information about the RCP and currently experiences 4,000 visits and 15,000 page views per week; social media pushes of RCC success stories which have been included in blog posts, Twitter feeds, and leadership speeches and talking points. Several success stories from RCP programs, particularly OWF, have been included on other Federal agencies' blogs and social media sites, and on the Warrior Care Facebook page which has 243 monthly users with posts viewed by 15,981 people. The RCC training team has also made presentations to other DoD agencies such as the Inspector General's office.

Sub-goal 1.4: Improve the use of Federal and private sector resource information regarding coordination of care and benefits for Recovering Service Members (RSMs), Veterans, and their families.

Recovery Coordination Program/Federal Recovery Coordination Program

To facilitate efforts to deliver comprehensive benefits and services through an integrated client centric approach that anticipates and addresses clients' needs, the DoD, DOL, and VA joined together in 2008 to create the National Resource Directory (NRD). The NRD is part of a larger effort to improve wounded warrior care coordination and access to information on services and resources. NRD provides information on and access to services and resources for Wounded, Ill, and Injured Service members, Veterans, and their families and caregivers. NRD provides access to more than 14,000 quality reviewed resources.

The NRD unique visitors increased from less than 50,000 per month in August 2010 to more than 150,000 per month in September 2011. By the end of FY 2011, NRD was averaging more than 4,900 hits per day.

During FY 2011, the number of resources on the NRD has grown from 12,000 to nearly 14,000. A major focus over the past FY has been to re-vet all nonprofits that are currently listed on the NRD. An extensive quality assurance review has also been conducted to ensure all resources listed on the NRD truly provide support for Service members, Veterans, and their families.

Each non-government resource listed on the site has undergone a four-step process of review prior to inclusion. The steps are designed to confirm each resource complies with Federal and industry standards. The resource is added to the NRD once the resource has passed through the process successfully.

Currently, the NRD provides a state widget which allows individuals and organizations to display resources tailored by state and subject matter to their own Web sites. In FY 2011, NRD launched a mobile version of the Web site to further increase accessibility. As part of a continuous improvement philosophy, NRD conducted user testing in FY 2011 and continues to make improvements to the Web site and search features based on the feedback from the user testing. Having a single directory that contains quality checked public and private resources ensures that Service members, Veterans, and their families can quickly and easily locate and access needed resources.

As part of its outreach efforts, NRD has a presence at national and local conferences where NRD targeted audiences may be gathered. NRD training and information is now a standard part of quarterly RCC trainings in the form of a booth at a Resource Exhibition, where RCCs can see the site live, and receive instructions about how to log in and create an account. NRD also conducted three Congressional outreach briefings this year, one of which was webcast to allow Congressional district staff to view the briefing.

Sub-goal 1.5: Improve FRCP program performance.

Federal Recovery Coordination Program

The FRCP is a joint VA and DoD program designed to coordinate access to Federal, state, and local programs, benefits, and services for severely Wounded, Ill, and Injured Service members, Veterans, and their families. Services are provided through recovery, rehabilitation, and reintegration into the community. Federal Recovery Coordinators (FRCs) are Masters prepared nurses and clinical social workers who provide for all aspects of care coordination, both clinical and non-clinical. FRCs are located at select military treatment facilities, VA medical centers, and WWP headquarters.

FRCs work together with other programs designed to serve the Wounded, Ill, and Injured population including clinical case managers and non-clinical care coordinators such as RCCs. FRCs are unique in that they provide their clients a consistent point of contact regardless of where they are located, where they receive their care, and regardless of whether they remain on Active Duty or transition to Veteran status. FRCs provide integrated care and services for the Wounded, Ill, and Injured population.

FRCs assist clients in the development of a Federal Individual Recovery Plan (FIRP) and then ensure that resources are available, as appropriate, to assist clients in achieving stated goals. At the end of FY 2011, FRCP had 781 active clients and authorization for 25 FRCs.

In FY 2011, FRCP successfully ensured that all those who were referred to the program were evaluated and assigned appropriately. In cases where it was not appropriate for an individual to be enrolled in FRCP, the evaluation process identified what assistance a Service member or Veteran needed and an FRC facilitated access to that service or benefit. This ensured that any Service member or Veteran referred to the program was not without resources to resolve outstanding issues.

The FRCP program met its established goal of 100 percent participation in targeted educational activities for the FRCs. Education and training contribute to overall FRCP performance as well as client satisfaction. Well trained FRCs are better able to assist clients in achieving goals, identifying resources, and solving problems. A consistent knowledge base across FRCs means that a client or caregiver receives the same high quality service regardless of where he or she is located or to whom he or she is assigned. Continuous learning enables FRCs to maintain comprehensive, up-to-date knowledge of programs and services available in DoD and VA, as well as the private sector which may benefit the client or caregiver. FY 2011 training contributed to, among other things, the ability of FRCs to refer appropriate client families to the new caregiver benefits and to inform Service members and Veterans of significant changes in Post 9-11 GI Bill benefits. New FRCs are educated about the collaboration between VA Liaisons for Healthcare (who are stationed at MTFs) and FRCP in transitioning health care for Service members from DoD to VA. An overview of VA's OEF/OIF/OND Care Management Teams, located at every VA Medical Center, is also provided at each new FRC orientation. Continued education and training ensure that FRCs can provide the best care coordination possible for clients and caregivers.

In FY 2011, FRCP implemented a series of program improvements recommended by the GAO in its March 2011 program evaluation. VA improved internal controls regarding FRCs' enrollment decisions to ensure that referred Service members and Veterans who need FRC services are enrolled in the program. FRCP also launched the first phase of a service intensity tool designed to add further consistency to the enrollment decision process. FRCP is conducting further testing and analysis to expand the functionality of the service intensity tool to include workload management.

Sub-goal 1.6: Improve FRCP outreach.

Federal Recovery Coordination Program

Program participation continues to grow. FY 2011 referrals to FRCP increased by more than 10 percent over FY 2010. At the end of FY 2011, FRCP had 781 active clients. Of these, more than 50 percent were Active Duty Service members. These increases are the result of increased program awareness and high levels of client satisfaction.

The FRCP participated in more than 100 outreach activities at the national and local level during FY 2011. Based on increased outreach, FRCP continues to explore new strategic placements in FRCs. In FY 2011, FRCP placed an FRC at Navy Safe Harbor headquarters.

Sub-goal 1.7: Improve integration with VA/DoD programs and services.

Federal Recovery Coordination Program

In FY 2011, VA worked with DoD at all levels to ensure program integration between its complementary care coordination programs. Twice in FY 2011, VA together with DoD, participated in hearings with the House Veterans Affairs Committee. During both times, the Departments came together to discuss the importance of the FRCP and the RCP and how the programs complement each other.

FRCs work closely with RCCs throughout the United States. FRCs are located at select Military Treatment Facilities (MTF)s, VA medical centers, and WWP headquarters. The strong relationships at the care coordinator level ensure that Service members and Veterans are receiving the right service, from the right people, at the right time.

During FY 2011, VA and DoD care coordination programs came together in two major endeavors. The first was through a Senior Oversight Committee (SOC) directed action to convene an Executive Committee to review the care coordination activities of the two Departments. The Executive Committee held several meetings and developed seven recommendations that were shared with the leadership of both Departments. The Committee also completed a survey of care/case managers/coordinators across both Departments. Additionally, DoD hosted a Wounded Warrior Summit in March 2011 which included VA participants and had a designated break out group focused on program integration. The results of the Summit were briefed to DoD leadership. Collaboration and partnerships cultivated through these activities ensured that the care coordination services provided to Service members, Veterans, and their families were thorough and seamless.

VA and DoD continue to actively engage in discussions and explore proposals on how to better integrate. The results of the FY 2011 activities were designed to improve integration and inform these decisions. In FY 2012, Line of Action three is scheduled to report to the SOC on its recommendations to improve program integration.

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

The VA and DoD HEC Patient Safety WG (PSWG) continued to enhance the overall quality of care to Service members and Veterans through collaborative efforts in strengthening and coordinating safe patient care. The PSWG exceeded its goal to increase lessons learned sharing by 25 percent. Exchanges in which lessons learned are shared include forums, virtual or in-person, where PSWG members or invited guests offer insights/resources for the purposes of preventing adverse events. Lessons learned sharing increased in FY 2011 by 50 percent (six exchanges over FY 2010's four exchanges). These exchanges centered on data analyses techniques, education and training programs, medication reconciliation tools, patient falls, and leveraging patient safety resources across Departments.

- In FY 2011, the PSWG implemented a new process to set expectations for timely sharing of patient safety notifications. Resulting from the process implemented, as of the third quarter, 100 percent of the nine patient safety initiated alerts and advisories were shared across Departments within five business days.
- Through timely sharing of alerts and advisories, each Department's patient safety group leveraged lessons learned from each other, aimed to prevent similar events. Specifically, the alerts and advisories encompassed tactics to prevent suicides and processes to reduce risks associated with the use of medical devices along with medical equipment. These efforts aim to translate into safer care for Service members, Veterans, and their beneficiaries.

The PSWG continued pursuing collaborative efforts across Departments' subject matter experts (SMEs). Those joint efforts included medication safety, patient falls prevention, data analysis, and education efforts. In FY 2011, these efforts achieved the PSWG's goal to increase collaboration by 25 percent, with five sharing activities, over the previous year.

Medication-related events are one of the most frequently occurring types of patient-specific adverse events. Evidence supports that initiatives promoting medication reconciliation, as well as improving medication health literacy, protect against medication-related adverse events. Toward that end, VA and DoD experts collaborated around these two areas. VA initiated plans to kick-off "May is Medication Reconciliation Month" to support the effort of reducing medication errors by comparing a patient's medication orders to all of the medications the

patient has been taking, and invited DoD to jointly participate. The collaborative effort supported VA and DoD facilities' efforts to implement The Joint Commission's National Patient Safety Goal. DoD invited VA's medication reconciliation expert to present VA's initiatives at a DoD patient safety leadership meeting to continue advancing potential combined efforts. Additionally, DoD's medication expert joined VA's pharmacy label WG to offer recommendations to formulate evidence-based, patient-centered outpatient prescription labels. The WG's broader objective focused on improving Veteran's health literacy. Together, VA and DoD experts presented to the DoD Pharmacy Board of Advisors on opportunities to improve health literacy by standardizing prescription medication labels in a more patient-centric format.

Patient falls remain a leading cause of preventable harm events in the civilian and military sectors. Since 2010, DoD routinely participates in quarterly VA meetings to impart tactics and strategies to limit these adverse events.

VA's patient safety data analysis team shared with DoD their expertise in new methods to process large volumes of unstructured data. The results of this collaboration allowed DoD to eliminate a contracted effort to develop a data analysis tool; instead, DoD now aims to utilize a forthcoming VA-developed text mining tool.

In FY 2011, VA and DoD forged an education oriented relationship when VA accepted one detailed Air Force military billet into the VA patient safety fellowship program. Stemming from that relationship, DoD re-engaged discussions to develop a VA/DoD fellowship program, potentially saving costs to both Departments while advancing understanding of patient safety improvement efforts beneficial to its common patient population. In 2012, these discussions will aim to develop requirements to pilot a joint fellowship.

In FY 2011, the PSWG identified strategic areas to convene routine learning forums across Departments. The first set of areas for 2012 learning forums include research, data analysis, education/training, and root cause analysis functions. Through these routine forums, individuals contribute ideas and challenges freely, developing trust across Departments and building efficiencies from shared learning experiences resulting in lower costs and safer care for Service members, Veterans, and their families.

The PSWG continued discussions to convene a VA/DoD patient safety conference. The blended conference would bring together patient safety stakeholders from VA and DoD facilities, regions, and headquarters levels to systematically build lessons and leverage resources available across Departments. Recognizing the immense benefit of such a conference, in FY 2011, the PSWG drafted an outline mapping requirements associated with a joint conference. Given the current Federal budgetary environment, the PSWG did not request the funding required to begin any substantive planning efforts for a joint conference. As an interim tactic, DoD invited VA to its annual Military Health System (MHS) Conference's patient safety and quality sessions in 2012.

In FY 2011, the PSWG brainstormed ideas to develop a joint publication, focusing on high-impact areas determined by patient harm, frequency of occurrence, or factors which may have contributed to the event's occurrence. In the upcoming FY, the PSWG aims to release a joint internal publication utilizing shared datasets to address a mutual patient safety issue. This will

promote a deeper understanding of the shared and unique datasets and offer more comprehensive lessons to be learned, facilitating safer care for Service members, Veterans, and their families.

HEC Evidence Based Practice Working Group

The Evidence Based Practice WG continued to improve the health of VA and DoD beneficiaries by collaborating in the development of Clinical Practice Guidelines (CPGs), using clinical and epidemiological evidence. The CPG development process is scientifically rigorous and includes a multidisciplinary expert group, representing all Military Departments and VA staff. The process entails an exhaustive literature review, as well as peer and world-renowned SMEs who review draft documents. The process includes ensuring all participants are free of pharmaceutical or other industry bias. During FY 2011, the WG completed Management of Post-Traumatic Stress Disorder and Stroke Rehabilitation CPGs. Contractual challenges prevented the WG from completing the annual target of four CPGs. Dissemination of CPGs assist VA/DoD health care teams by providing evidence-based treatment recommendations which lead to improved quality of clinical decisions, improved consistency of care and reduced variation in clinical practice for Veterans, Service members, and their families. CPGs are posted on both the VA's Web site[2] and the Army's Quality Management Web site[3].

One hundred percent of completed CPGs were submitted to and met the inclusion criteria by the National Guideline Clearinghouse (NGC). The NGC's mission is to provide physicians and other health professionals, health care providers, health plans, integrated delivery systems, purchasers, and others an accessible mechanism for obtaining objective, detailed information on evidence based CPGs and to further their dissemination, implementation, and use. The Evidence Based Practice WG is committed to educating health care teams on evidence based clinical practices. VA/DoD staff exhibited at 17 VA, DoD, and national medical conferences and provided multiple formal podium presentations on a variety of CPGs at 15 VA, DoD, and national medical and nursing conferences. These efforts resulted in educating thousands of VA and DoD health care team members regarding the availability of the 23 VA/DoD CPGs, the medical evidence behind the CPG recommendations, and the value of implementation.

Marketing efforts also included providing information and education regarding processes for ordering and shipping CPG tools directly to the medical facilities. The tools offer health teams valuable support materials to assist with CPG implementation and ultimately facilitate improved care delivery for patients and families across VA and DoD. A recent review published in the monthly journal *Brain Injury*[4] rated VA/DoD's mild Traumatic Brain Injury (mTBI) CPG as one of the best when compared against seven other mTBI CPGs in overall quality. Two live broadcasts, with subsequent multiple rebroadcasts, were provided via MHS Learn on chronic kidney diseases and diabetes mellitus CPGs. This effort facilitated educating VA/DoD health care providers on the evidenced based clinical recommendations for these two CPGs. The multiple broadcasts allowed maximum participation throughout the year. The broadcasts also provided continuing medical educations (CME) credits for the participating medical teams.

[2] https://www.healthquality.va.gov
[3] https://www.qmo.amedd.army.mil/pguide.htm
[4] Brain Injury, July 2011 25 (7-8), 742-751

The WG continued to share information with outside national professional organizations to include the Interorganization Guideline Forum, Agency for Healthcare Research and Quality, Institute of Clinical System Improvement, and Kaiser Permanente. Information sharing continues with the American Pain Society on the peri-operative pain CPG. These efforts resulted in the ability to produce a greater number of CPGs while at the same time conserving valuable personnel and monetary resources.

During FY 2011, VA and DoD received 910,698 CPG internet requests. This represented a dramatic 525 percent increase when compared to FY 2010 totals and included six months of data reported by VA. Future reports will include annual VA data. There is growing evidence showing that health care teams across VA and DoD are increasingly accessing CPG information via the internet to enhance the delivery of quality health care. Over 170 different CPG tools are available to medical facilities, providing health care teams with needed patient, family and provider support tools to assist with CPG implementation. DoD had 1,202,812 CPG tool kits items ordered from the Army's Quality Management Web site during FY 2011. This represents a 21 percent increase from FY 2010.

HEC Health Professions Education Working Group

The Health Professions Education (HPE) WG promotes effective, timely, and efficient health care for all Service members, Veterans, and their beneficiaries through educational sharing opportunities. The WG focuses on collaborative HPE and shared trainee affiliation programs between VA and DoD. The WG successfully established three HPE trainee exchange programs. A new training program between the San Antonio VA Medical Center (VAMC) and Brook Army Medical Center (BAMC) began in Academic Year (AY) 2009-2010. During AY 2010-2011, a HPE trainee exchange program was established between the Hampton VAMC and the Naval Medical Center Portsmouth. The WG also facilitated the establishment of a new psychology trainee exchange program between the San Antonio VAMC and Wilford Hall Medical Center at Lackland Air Force Base (AFB) beginning AY 2011-2012. The impact on quality health care is enhanced through these trainee experiences. Some of the major strengths of trainee exchanges include the following:

- Provides exposure to a variety of patient populations and clinical material not possible in a single institution. For example, civilian trainees see a younger patient population in DoD, while military trainees see an older population with a heavier disease burden in VA.
- Provides trainees a greater holistic experience when they see the continuity of care from Active Duty Service to Veteran status.
- Promotes trainee awareness and understanding of the capabilities of both health care systems.
- Promotes enhanced trainee awareness and understanding of the differing cultural aspects and goals of the VA and DoD health care systems.

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

consolidation of some NCC GME programs and BRAC ending in September 2011, it will take another seven to ten months to determine if BRAC has had any impact on GME training capacity in the NCR.

The HPE sub-WG continues to collaborate toward the development of a standard template for National VA/DoD Training Affiliation Agreements. Once complete, this agreement will facilitate HPE trainee exchanges between both Departments to provide high-quality trainee experiences with a diverse mix of patients and clinical problems that addresses evolving patient and population health care needs and expectations.

HEC Deployment Health Working Group

The Deployment Health WG (DHWG) ensures VA/DoD coordination to maintain, protect, and preserve the health of Armed Forces personnel. The DHWG focuses on the health of Active Duty, Reserve members, and Veterans during and after combat operations and other deployments. The primary emphasis is on Service members returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). The DHWG also coordinates initiatives related to Veterans of all eras.

In FY 2011, the DHWG facilitated VA and DoD efforts to identify situations in theater that could place military personnel and Veterans at risk, and to ensure that VA and DoD responses were appropriately coordinated. The DHWG coordinated DoD's identification of major environmental and occupational exposure incidents in theater, DoD's data sharing with VA, and development of appropriate VA and DoD follow-up activities. The DHWG took concrete steps to improve the sharing of Service member and Veteran health information between VA and DoD, by developing a Data Transfer Agreement (DTA), as described below. The DHWG coordinated VA and DoD responses to environmental exposure incidents during every monthly committee meeting, and the DHWG provided updates at nearly every HEC meeting in FY 2011.

The DHWG facilitated closer collaboration between VA and DoD scientists by organizing a full-day workshop in December 2010 on the VA and DoD responses to three large environmental exposure incidents in Iraq. This workshop also reviewed the potential health effects of drinking water contamination at Camp Lejeune, NC. The goals of the workshop were to stimulate communication among VA and DoD scientists and policy makers who are responsible for health studies related to environmental exposures in the military, and to improve the partnership between VA and DoD related to the decision making process about responses to environmental exposures. The workshop topics included environmental risk assessment, medical surveillance, epidemiological research, risk communication, and outreach efforts.

The DHWG also organized several other meetings in FY 2011 to coordinate VA and DoD responses to six specific environmental exposures in Iraq, Afghanistan, and the U.S.:

- Potential health effects of exposure to burn pit smoke in OEF/OIF;
- Potential health effects of exposure to the fire at the Mishraq State Sulfur Mine in Iraq in 2003;
- Potential health effects of high ambient concentrations of particulate matter in OEF/OIF;
- Potential health effects of chromate exposure at Qarmat Ali, Iraq in 2003;

- Potential health effects of exposure to the radiation release from the damaged Japanese nuclear power plant in 2011; and
- Potential health effects of contaminated drinking water at Camp Lejeune, NC.

Exposure to smoke from the burn pits in OEF and OIF could potentially impact tens of thousands of deployed Service members. In 2010, VA funded an Institute of Medicine (IOM) study, entitled "Long Term Consequences of Exposures to Burn Pits in Iraq and Afghanistan." DoD provided considerable health and environmental data to IOM for this study. This IOM report will be published in FY 2012.

The DHWG coordinated outreach efforts and risk communication products to Active Duty Service members and Veterans on environmental exposures to ensure consistency between VA and DoD. In 2003, several hundred members of the National Guard and Army Corps of Engineers worked at an industrial plant in Qarmat Ali, Iraq, where they were potentially exposed to sodium dichromate, a carcinogen. In FY 2011, the DHWG facilitated VA and DoD coordination of a joint medical surveillance program. VA and DoD sent a joint letter to these military personnel and DoD civilians inviting them to participate in a medical evaluation. VA's and DoD's examination results will be collated and analyzed in the future for any health effects that may be attributable to exposure to sodium dichromate.

In March 2011, a nuclear power plant in Japan was damaged in an earthquake and tsunami, which caused the release of low levels of radiation for months. The closest U.S. military base is about 150 miles from the power plant. Since March, DoD has collected daily location reports on all U.S. Service members in Japan, as well as their family members, DoD civilians, and DoD contractors, a total of approximately 65,000 individuals. DoD collected environmental data on air, water, food, and soil. As of September 30, 2011, the radiation measurements and dose assessments indicated that the radiation exposures are extremely low with no expectation of long-term health effects. DoD is developing an exposure registry, which will include radiation dose assessments for individuals that are being worked on by the Armed Force Radiobiology Research Institute and the Defense Threat Reduction Agency. Registry data will be useful for surveillance, research, diagnosis, treatment, and claims adjudication. The DHWG quickly coordinated VA and DoD communication related to the Japanese radiation release, including DoD plans to share registry data with VA. The DHWG also discussed DoD risk communication efforts to keep Service members and families in Japan informed. VBA and Veterans Health Administration (VHA) staff described the procedures to determine disability claims related to radiation exposure. VA and DoD members of the DHWG also participated in a three-day scientific workshop to plan the registry and other VA and DoD follow-up activities.

During the 1950s to 1980s, some of the drinking water at Marine Corps Base Camp Lejeune was contaminated with low levels of industrial chemicals. In FY 2011, the DHWG held many meetings that focused on VA and DoD responses to the exposures at Camp Lejeune. The DHWG requested two briefings by epidemiologists from the Agency for Toxic Substances and Disease Registry (ATSDR) in Atlanta. ATSDR is conducting four health studies related to Camp Lejeune, which are funded by the Navy. The DHWG organized a meeting of senior scientists from the Navy, Marines, VHA, and VBA to discuss how to streamline procedures to transfer DoD paper and electronic personnel records to VBA related to Camp Lejeune. The DHWG facilitated DoD coordination and revisions on two VBA training letters, which included

the potential health effects related to Camp Lejeune. The purpose of the letters was to educate VBA staff nationwide who process disability claims related to the health effects of environmental exposures. The DHWG also provided updates on its actions on Camp Lejeune during three meetings between the Deputy Secretary of VA and the Under Secretary of the Navy.

In FY 2011, the DHWG developed a DTA, which will provide two-way data exchange between VA and DoD. This improved exchange of data will facilitate the identification of deployment-related hazards that could lead to long-term adverse health effects. Recent DHWG actions on environmental exposure issues have reinforced the need for increased sharing of environmental health data between VA and DoD. The purpose of the DTA is to improve the delivery and management of health care and the process for determination of benefits for Active Duty military personnel, including activated National Guard/Reserve members, and Veterans. The DTA is intended to facilitate the exchange of personnel, medical, and environmental data to enable VA and DoD to make the best clinical care decisions, to establish levels of exposures, and to support the determination of services and benefits. The DHWG and other members of VA and DoD worked to identify the full spectrum of data that VA and DoD would need to support quality health care and that the VBA needs to support timely determination of benefits for Veterans involving environmental exposures. There are numerous stakeholders in both Departments in the data sharing process, including program offices, data users, legal and privacy offices, and the information management/information technology (IM/IT) offices. The DTA is currently being coordinated for approval. The DHWG will work to complete the approval process for the DTA by the deadline of September 2012.

HEC Psychological Health/Traumatic Brain Injury Working Group

The HEC chartered the VA/DoD Psychological Health/Traumatic Brain Injury (PH/TBI) WG in May 2010 to replace and expand the function and activities of the VA/DoD Mental Health WG. The PH/TBI WG's goal is to increase and sustain communication and collaboration between VA and DoD on issues related to PH and TBI. This includes identification, evaluation, and provision of services for both VA and DoD beneficiaries with PH conditions and TBI. Also covered, is the promotion of PH and resilience from the time of enlistment throughout the adult lifespan.

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

1. Expand access to behavioral health care in VA and DoD;
2. Ensure quality and continuity of care across the Departments for Service members, Veterans, and their families;
3. Advance care through community partnership, education, and successful public communication; and

4. Promote resilience and build better behavioral health care systems for tomorrow.

Each of the 28 SAs has defined end states by which the success of the activity is determined. SAs were developed with corresponding metrics (some of which are outcome, some are process, depending on the structure of the activities) to be used when the SAs are mature. A VA lead and DoD lead have been designated for each SA of the IMHS. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) serves as the DoD lead for 18 of the 28 SAs.

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

Common Standard of Care to Support TBI

Joint VA/DoD training in TBI care is primarily coordinated through the Defense and Veterans Brain Injury Center (DVBIC) national network. The DVBIC organized and hosted the 5th Annual TBI Military Training Conference in August 2011. The conference provided updates and training on TBI to over 1000 attendees. The attendees included personnel from VA, OSD, Military Departments, academia, and the private sector.

Through the DCoE, DoD produced the first four in a series of 12 planned Web-based case studies in a grand rounds style presentation that feature actual mTBI cases on Talent Management System (TMS) in VA and MHS Learn in DoD. One free continuing education credit/unit is available upon completion of each course. The Web-based case studies are used as a tool with which to teach providers and other health care personnel about the VA/DoD CPG for the management of concussion/mTBI (2009), the updated DoD mTBI clinical guidance (2008) document, International Classification of Diseases, 9th edition, and other clinical support tools. Between September 2010 and February 2011, the first two mTBI Web-based case studies were released to TMS and MHS Learn so that VA and DoD, as well as other civilian providers, can access the cases. The next two will be available on TMS and MHS Learn in early FY 2012. As of July 2011, a total of 7,089 participants signed up for cases one through four, and 3,767 (53 percent) had completed cases via MHS Learn. The case topics addressed thus far are: Diagnosing Mild Traumatic Brain Injury; Assessing the Individual with Persistent Symptoms; Use, Administration, and Interpretation of the Military Acute Concussion Evaluation; and Assessing the Individual with Persistent Headaches. In addition, Navy has several TBI-related training initiatives underway and has released a TBI education policy that will standardize the training for all Navy providers related to assessment and treatment of TBI. In June 2011, the Army released a comprehensive campaign plan that addresses TBI education and training requirements to all Soldiers, leaders, medics, and health care providers. Training consists of a hybrid approach (standardized video and a live instruction component), which is required one time initially at pre-deployment, and on an annual basis.

DoD's mTBI Pocket Guide smartphone application is a portable reference tool for all providers, including those not primarily trained in TBI health care. By making information on assessing,

treating, and managing common mTBI symptoms readily available to all health care workers, this mobile application improves care for mTBI patients. The mTBI Pocket Guide was downloaded 1,053 times in FY 2011.

Common Standard of Care to Support Psychological Health

Ongoing work to develop consistent standards across VA and DoD for training in Evidence-Based Psychotherapy (EBP) for PH conditions is in progress. In response to the IMHS SA on this topic, VA and DoD are working to increase the availability of effective psychological treatments for PTSD, major depression, and other PH conditions consistently across both Departments. VA and DoD training program staff are working in close collaboration to implement the training and ensuring comparable training content.

- In FY 2011, VA provided training to over 600 staff in the delivery of Cognitive Processing Therapy (CPT) and/or Prolonged Exposure Therapy (PE). VA added over 40 trainers/consultants to these programs.
- In addition, VA continued efforts in Cognitive Behavioral Therapy for Depression (CBT-D), Cognitive Behavioral Therapy for Insomnia (CBT-I), Motivational Interviewing, and other evidence-based psychotherapies throughout FY 2011. VA provided training through these programs to over 400 staff, and additional training consultants have been added.
- In FY 2011, DoD provided training in CPT and/or PE to 1,362 mental health providers from DoD, VA, and community based clinics, who then provide services to Service members and Veterans. The Center for Deployment Psychology is developing processes for identifying and training consultants for these EBPs.
- In addition, DoD continued efforts in CBT-I and CBT-D. DoD provided training through these programs to 193 mental health providers and added seven trainers/consultants to the CBT-I program.
- Data indicating numbers of providers and instructors determined competent in delivering EBPs and training providers in EBPs respectively will be gathered in FY 2012.

Through another one of the IMHS SAs, VA and DoD are working together to develop a comprehensive multimedia training for providers that focuses on military culture, signs and symptoms of deployment-related mental health conditions, and effective methods for the treatment and prevention of mental health conditions. The target audiences will include VA and DoD primary care and mental health providers, civilian primary care and mental health providers, and non-provider care providers (e.g. chaplains, case managers, etc).

Suicide Risk and Prevention Strategies

The joint suicide prevention activities described here are elements of one of the IMHS SAs. VA and DoD continue to participate in ongoing meetings of the Suicide Prevention and Risk Reduction Committee (SPARRC) to discuss effective mechanisms to share resources, develop programs, and monitor best practices related to suicide prevention across the two Departments. The SPARRC includes participation from DoD Personnel and Readiness, each of the Military Departments, National Guard Bureau, Reserve Affairs, VA, DCoE, and other entities such as the Department of Health and Human Services (HHS).

The PH/TBI WG established the Suicide Nomenclature and Data Work Group in FY 2010, which made several important contributions in FY 2011. For example, the Centers for Disease

Control and Prevention suicide nomenclature was adopted in VA and DoD, and implementation of the nomenclature is underway, to include training of all VA clinicians and development of documentation standards and requirements that will go into effect early in FY 2012. DoD is piloting the nomenclature in the DoD suicide surveillance program, known as the DoD Suicide Event Report.

In March 2011, the VA/DoD Suicide Prevention Conference was attended by approximately 1,000 participants (roughly 1/3 VA and 2/3 DoD personnel). This annual conference provides a platform to disseminate practical tools and innovative practices and research related to suicide prevention for Service members, Veterans, and family members in distress. The conference also serves as a forum to collect feedback on community needs. The VA/DoD Suicide Prevention Conference is now an internationally recognized annual suicide prevention conference. Individual evaluations from the 2011 conference were overwhelmingly positive and indicated both that learning occurred and that participants were satisfied. The planning committee for the 2012 conference has been formed and is in the process of developing the conference agenda.

Web-based suicide prevention training modules for clinicians caring for women and older Veterans were completed and are available for all VA staff. VA also adopted the American Association of Suicidology training for primary care providers. A list of tools and trainings in use by both Departments has been compiled and will be widely distributed once cleared.

In March of 2011, the Veterans Suicide Prevention Hotline was re-named the Veterans Crisis Line (VCL) to be more proactive in suicide prevention and reach people before they get to the point of being actively suicidal. An online chat function is also now available to enhance the availability of this confidential resource for Veterans, Service members, and their families. The initial message was modified to increase access of the VCL to Service members and their families. VA is working with each Military Department to develop Service-specific promotional materials and availability of toll-free calling is being developed for locations outside of the continental U.S. Toll-free lines will open in early FY 2012 for six European countries. In FY 2011, there were 164,101 total calls to the VCL, as compared to 134,528 total calls in FY 2010. In FY 2011, there were 18,438 online chats with the VCL, as compared to 8,471 online chats in FY 2010. Since its launch in 2007, the Suicide Prevention Hotline/VCL has received 494,342 calls and has initiated more than 18,000 rescues of suicidal callers. A rescue occurs when a caller communicates an immediate suicidal intent and the crisis line respondent contacts local emergency services to attend to the caller and ensure his or her safety.

The VA/DoD Suicide Outreach Web site[5] provides suicide prevention resources for Service members, Veterans, family members, and staff of both Departments. The Web site was launched in October 2010 and is continually updated with relevant content. In FY 2011, the total number of visits to the site was 16,137. The number of visits to informational resource pages was 4,034. This metric references individual page visits tapping educational information about suicide and warning signs, and links to self-assessments. In addition, the number of

[5] www.suicideoutreach.org

immediate contacts that were accessed from the Suicide Outreach Web site was 1,163, which includes 'visiting' the hotline, DCoE's Outreach Center, and the resource locator.

Vision Center of Excellence

The Vision Center of Excellence (VCE) was established for the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries and diseases. The VCE receives operational support from the Navy within DoD, and from the Office of Patient Care Services within VA. A VA and DoD MOU established the collaborative support between VA and DoD. The VCE is jointly staffed, and the leadership team includes the Executive Director (DoD), Deputy Director (VA), and Executive Officer (Public Health Service).

The VCE was established as a virtual and distributed organization for VA and DoD, with the headquarters located in the Walter Reed National Military Medical Center, Bethesda, Maryland. The VCE received a 2009 Congressional military construction project to establish the headquarters in Bethesda, which is on target for occupation in the second quarter of FY 2012. The desired end state is that VCE mission areas are fully operational by the first quarter of FY 2014. The overall impact of the VCE's mission area activities is to optimize operational readiness and enhance quality of life by improving vision health for Service members and Veterans.

During FY 2011, the VCE directed its efforts toward a number of significant activities to enhance the quality of health care to Service members, and Veterans:

- Established a VCE regional center with vision service care coordination capability at Madigan AMC in collaboration with the nearby American Lake VAMC. The VCE is evaluating the requirements for establishing the next VCE regional center in FY 2012.
- Implemented the monthly Worldwide Ocular Trauma Teleconference program that joins theater-based and garrison-based VA and DoD vision care providers to discuss the surgical, medical, and rehabilitative care to Service members and Veterans with eye injuries and diseases in a case conference format.
- Worked with the Joint Military Combat Eye Protection Program toward improving eye protection and mitigating traumatic eye and visual systems injuries.
- Worked with the Committee on Tactical Combat Casualty Care to include eye shields in the Individual First Aid Kit and achieved concurrence for this in the Air Force and Marine Corps.
- Led the initial efforts to develop the functional requirements of a joint DoD and VA electronic eye note for the integrated Electronic Health Record (iEHR).
- Led a joint team of VA and DoD SMEs to develop standardized eye care assessment templates and clinical guidance for the management and rehabilitation of vision dysfunction associated with ocular and neurological trauma. These standardized assessment templates offer the opportunity to create a common standard of care across the VA and DoD continuum of care.
- Supported education and training initiatives for VA and DoD health care providers to enhance clinical competency and promote synergy with the private, public, and academic sectors. The VCE co-hosted a conference with the Army Surgeon General's Office on providing care to Service members with visual dysfunction.

- Hosted a consensus workshop with VA/DoD and community interdisciplinary providers in order to develop a practice pathway for ocular trauma, disease, and vision dysfunction across the continuum of care.
- Convened a workshop to develop recommendations to address technology gaps associated with visual impairment related to driving, mobility, sports and recreation, and communications.
- Collaborated with the other congressionally mandated Centers of Excellence (CoEs) in a variety of processes and efforts including, but not limited to, registry efforts, governance, communication strategies, and other operational activities. Collaborative efforts included integration for clinical care and research to better leverage capabilities and affect a more holistic approach to DoD's medical home and VA Patient Aligned Care Team initiatives.
- Partnered with Military and Veterans Service Organizations (VSO)s to facilitate access to a broad range of vision rehabilitation and education services across the MHS and VHA.
- Established a communications network between MTFs and VAMCs in the NCR for vision and blind rehabilitation services, and developed strategies for better coordination of vision and blind rehabilitation and restoration services across VA and DoD.
- Led the prioritization for DoD vision trauma research and coordinated the execution of the congressionally directed Vision Research Program with the DoD Telemedicine and Advanced Technology Research Center and the Defense Medical Research and Development Program.
- VCE initiated discussions with U.S. Army Institute of Surgical Research and the Joint Theater Trauma System on the processes required for data entry into the Ocular Trauma Module.

Hearing Center of Excellence

The Hearing Center of Excellence (HCE) continued to work toward its goal of improving the prevention, diagnosis, mitigation, treatment, and rehabilitation of hearing loss and auditory system injuries for Service members and Veterans. In FY 2011, the HCE collaborated with DCoE to develop a CPG for primary care of patients with chronic dizziness. Partnerships are being established to develop CPGs for tinnitus, asymmetric hearing loss, and sudden hearing loss. The HCE's Active Duty Separations WG added tinnitus questionnaires to separation surveys. Tinnitus assessments on pre- and post-deployment health surveys are under development to improve accounting and benefit determinations. On August 31, 2011, the HCE finalized a comprehensive plan to address prevention of noise-induced hearing loss in the Military Departments. Implementation will begin in FY 2012.

The HEC collaborated with various agencies, organizations and industry in FY 2011:

- HCE delegates representing the U.S. participated in a North Atlantic Treaty Organization exploratory team to address rehabilitation and reintegration of Service members with hearing loss and auditory system injuries. A proposal for a formal research team organization has been submitted.
- The HCE hosted the Military Vestibular Assessment Rehabilitation Course which trained specialists in the rehabilitation of patients with chronic dizziness.

- The HCE identified emerging implant technologies to treat selected hearing loss cases. A group of DoD neurotologists in partnership with international colleagues, identified promising techniques for hearing restoration with the goal of Service member reintegration.

Additionally, the HCE started development of an Advisory Board charter.

The HCE Joint Hearing and Auditory System Injury Registry (JHASIR) concept of operations (ConOps) was approved by the Clinical Portfolio Management Board. Efforts are underway to integrate existing audiogram data and meet system security requirements. The JHASIR pilot project is expected to launch in FY 2012 utilizing the system architecture developed by the VCE for their eye injury registry.

The HCE assumed the organizational leadership role for auditory and vestibular issues for DoD. The headquarters (HQ) location was selected at Wilford Hall Medical Center, Lackland AFB. An interim Executive Director has been appointed, pending ConOps approval. The timeline for full operating capability is targeted for December 2013. Initial Operating Capability (IOC) was established May 31, 2011, when the key core “hub” positions were staffed via contract positions. The HCE Web site is scheduled to be online December 2011. A ConOps outlining HCE functions and relationships was developed and is pending approval. The HCE completed facility, manpower and budget planning to house, staff and resource a hub-and-spoke system to integrate VA and DoD resources across five functional directorates: prevention, clinical care, research, information management, and global outreach. The HCE appointed directorate Chiefs, established WGs, and contracted a HQ development team to address strategic planning commitments and to prepare hiring actions for staffing HCE HQ and regional affiliates. Evidence of full operating capability will be demonstrated through stand up of the JHASIR. The JHASIR will build on lessons learned from the VCE registry pilot, existing clinical data warehouses, VA data capabilities, and the addition of digitized audiograms (Noah and Audbase). HCE and VA representatives have worked closely to establish cross-departmental support and an executive decision memorandum has been sent to the VA Under Secretary for Health requesting funding for positions to support the HCE.

The desired end state of the HCE is defined as having a fully operational, bi-directional JHASIR. This data registry will be VA/DoD’s central data warehouse for Service members who have been diagnosed with hearing loss and/or auditory system injury. The JHASIR meets key requirements as cited in Public Law 110-417, Section 721.

Overall impacts of the HCE are multifaceted but are targeted to increased return to duty rates among the Services and a reduction in hearing loss claim rates through VA. First and foremost will be the prevention of hearing loss through increased awareness of the impact of noise and blasts and the use of proper hearing protection among all the Services. Standardized and improved treatment protocols will be developed for use across VA and DoD. Implementation of these evidence-based protocols will improve clinical outcomes. The HCE completed standardization of hearing device purchasing processes. This will uphold the quality of hearing aids issued to patients throughout VA and DoD as well as reduce the cost per unit through volume purchasing, better accounting, and streamlined processing strategies. DoD fitness-for-duty standards will address hearing requirements for critical occupational fields thereby facilitating rapid return-to-duty determinations. For Service members with "significant hearing

loss or auditory system injury or with auditory dysfunction related to Traumatic Brain Injury," DoD will notify VA's National Center for Rehabilitative Auditory Research and the auditory system impairment services of VA to ensure coordination of the provision of on-going follow-up for VA rehabilitation benefits and services. The HCE serves as the 'unified voice' for VA, DoD, and other Federal agencies to help develop funding, regulation, and directives for issues regarding the prevention, diagnosis, mitigation, treatment, rehabilitation, and research of hearing loss and auditory system injuries. VA and DoD acquisition centers and industry partners are aligned with the HCE to develop, acquire, and field new technology and systems that address prevention through noise and blast injury mitigation.

In addition to the milestones outlined above, the HCE developed a full scale strategic communication plan that will network clinicians, researchers, Active Duty Service members, Veterans, families, and commanders. Implementation of the plan, which will begin October 2011, will entail a multimedia effort to add synergy to HCE efforts. Key messages will focus on education and awareness, promoting hearing health, facilitating research and attracting strategic partnerships with industry and academic institutions. The HCE completed a comprehensive prevention plan in conjunction with the Hearing Conservation WG that will increase educational opportunities and platforms for Service members, families, and commanders. This plan will fulfill several of the recommendations that the GAO had for the Military Departments' hearing conservation teams.

In conjunction with the VA Acquisition and Logistics Center, the HCE is restructuring the purchasing process for ordering rehabilitative devices. Standard ordering will be online by the end of first quarter FY 2012, eliminating purchase orders and credit card fees and improving accounting and utilization measures.

A fitness-for-duty seminar was held to address disparities in Military Department standards for hearing requirements. The seminar addressed identification of occupational groups at risk in order to assess current research to determine what amount of hearing is required for various duties and what effect hearing deficits have on mission accomplishment. A WG was organized to facilitate and prioritize this process.

The Defense Occupational and Environmental Health Reporting System (DOEHRS) developers were provided funding to sponsor VA access and facilitate integration of DOEHRS data into the JHASIR. The VA/DoD Collaboration Guidebook for Healthcare Research was officially launched with input and review from HCE members.

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

HEC Psychological Health/Traumatic Brain Injury Working Group

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

In FY 2011, DoD initiated the comprehensive revision of the three deployment health assessment forms: the Pre-Deployment Health Assessment, Post-Deployment Health Assessment (PDHA), and Post Deployment Health Reassessment (PDHRA). The requirements of FY 2011 NDAA, Section 712 will also be addressed in the revision of the PDHA. Modified screening questions on the PDHA are designed to improve TBI screening sensitivity and better identify those Service members who sustained TBI during deployment. This is important as a history of TBI is a risk factor for subsequent brain injury, psychiatric disorder, suicide, headaches, cognitive problems, and other negative health outcomes.

The Directive Type Memorandum (DTM) 09-033, "Policy Guidance for Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting," was signed on June 21, 2010. The goal of this policy is to ensure Service members who are involved in potentially concussive events in the deployed setting will be screened and treated promptly for concussion. The policy outlines the potentially concussive events that will trigger a mandatory medical evaluation. In addition, the policy has four clinical guidelines embedded that outline the concussion care rendered from a medic/corpsman through to those who may sustain multiple concussions. The policy seeks to prevent long-term problems associated with concussions by providing treatment earlier to lessen the possibilities that Service members could be exposed to further injury. The DTM also outlines specific reporting requirements so that Service members who have been exposed to potentially concussive events are identified and tracked. The program launched on August 1, 2010. For four months, much of the data obtained via this program was done without an automated process. In January 2011, the Blast Exposure Concussion Incident Report was launched and automates the data on a monthly basis. Currently, there are over 8,000 Service members who have been identified through this program as being exposed to a potentially concussive event. Furthermore, for those Service members who had an electronic medical record (EMR) to review, on average, approximately 15 percent were found to have sustained a concussion. The DTM will transition to a DoDI which is now in formal staffing. It is anticipated the DoDI will take effect in FY 2012.

The Assisted Living TBI (ALTBI) pilot program is designed to assess the effectiveness of providing assisted living services to Veterans with TBI. As of September 2011, 48 Veterans with TBI were enrolled into the program and placed in assisted living settings. Satisfaction with the program and program effectiveness are monitored for each patient on an ongoing basis. The patient satisfaction survey is administered to all enrollees at admission and every six months thereafter. The survey was given to 100 percent of enrollees with 89 surveys completed, including initial and follow-up surveys. This data will continue to be collected and analyzed so that it can be included in the final summary report and evaluation of the program.

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

There have been a number of efforts in FY 2011 to improve access to and reduce the stigma associated with seeking mental health care in both VA and DoD. They include a variety of approaches that focus on facilitating connections with available services, providing services outside of traditional specialty mental health care settings, utilizing technological approaches to reduce barriers to care, and engaging in national efforts to reduce the stigma associated with mental health problems and seeking mental health care.

Facilitating Connections with Care

The *inTransition* program, launched on February 1, 2010, offers a program to assist Service members requiring behavioral health treatment and who are transitioning between health care systems, status, or location. *inTransition's* mission is to support continuity of care for the Service member during transition. A transition coach provides support and guidance on psychological health concerns, resources, and healthy living, while motivating the Service member to connect with a treatment provider post-transition. The coach assists the Service member with connecting to his or her post-transition gaining provider. VA and DoD developed and provided joint training to promote referrals from VA and DoD providers to the *in Transition* program. This program is also one of the SAs of the IMHS.

Since the program began in February 2010, there have been a total of 918 coaching cases. Service members are asked to complete a voluntary satisfaction survey at the end of the program. Of the 35 completed surveys, 91 percent of responders reported overall satisfaction and 91 percent would recommend the program to others. Data collected from 24 providers who returned surveys indicated that 100 percent reported overall satisfaction with the program and 100 percent would recommend the program to others.

Providing Care in Alternative Settings

Integrating mental health care into primary care settings is a critical element of improving access to and reducing stigma associated with seeking mental health care. Through the IMHS, considerable work is underway to develop consistent models of care, and a VA/DoD WG was established to address common issues related to behavioral health care integrated into primary care programs. In addition, this WG hosted a face to face joint VA/DoD conference on September 13-15, 2011, to share best practices in clinical services, administration functions, and implementation of mental health services in primary care settings. Over 300 VA and DoD staff attended this conference. VA's Primary Care-Mental Health Integration Programs combine co-located collaborative care and care management components to support primary care providers in treating common mental health conditions within the primary care setting. As of September 30, 2011, 243 of the 317 VAMCs and Community Based Outpatient Clinics (CBOCs) classified as large and very large have integrated behavioral health programs. Work continues with administrative data and program surveys to better define the specific co-located collaborative care and care management components down to a similar level of site detail. This work will assist in defining the baseline progress metrics in a manner that identifies the specific program development needs of each site, and will also inform the identification of appropriate trajectories for target increases in program components during successive FYs. DoD programs include both co-located collaborative approaches such as the Behavioral Health Optimization Program within the Air Force, and care management approaches such as the Re-engineering Systems of the Primary Care Treatment (of depression and PTSD) in the Military (RESPECT-Mil) program within the

Army. Currently, there are part- or full-time collaborative care and care management components to support primary care providers in 191 of the estimated 336 direct care MTF primary care clinics within DoD. Common standards for blending these approaches within each Military Department are presently underway.

National Efforts to Reduce Mental Health Stigma

In keeping with a public health model of mental health, there are national efforts underway in both VA and DoD to reduce the stigma associated with mental health problems and with seeking mental health care. The efforts in each Department are consistent and complementary with each other and comprise one SA of the IMHS. Anti-stigma efforts that are addressed by this WG are also consistent with other efforts within each Department (e.g., DoD released the DoDI 6490.08 that clarified notification requirements to dispel stigma in providing mental health care to Service members).

During FY 2011, VA initiated significant efforts to develop "Make the Connection," a national public awareness campaign to connect Veterans and their families with information and services about mental health resources and services to discover ways to improve their lives. Testimonials from Veterans of all eras, genders, and backgrounds are at the heart of the campaign. The campaign goals are to reduce the stigma Veterans and their families associate with seeking mental health services, educate Veterans and their families about the signs and symptoms of mental health issues, increase awareness of and trust in VA's advances in mental health services and its commitment to delivering accessible, high quality, patient-centered care, and to promote help-seeking behavior for those who need care. The official launch of the campaign will be in FY 2012.

The Real Warriors Campaign[6] is an initiative launched by DoD to promote the processes of building resilience, facilitating recovery, dispelling stigma, and supporting reintegration of returning Service members, Veterans, and their families. The Real Warriors Campaign promotes help-seeking behavior among Service members and Veterans with invisible wounds and encourages Service members to increase their awareness and use of these resources. To reach the broadest audience possible, the campaign utilizes a variety of strategies including outreach and partnerships, print materials, media outreach, an interactive Web site and social media. The campaign features stories of Service members who have sought treatment and are continuing to maintain successful military or civilian careers. In FY 2011, there were 302,959 visits to the Real Warriors Campaign Web site. This reflects a 120 percent increase over the 137,810 Web site visits in FY 2010. Additional FY 2011 accomplishments for the Real Warriors Campaign:

- Produced four video profiles, four television public service announcements (PSAs), and three radio PSAs.
- Confirmed 50 participants in FY 2011 for a cumulative 165 campaign participants (DoD, Federal, national, and community groups) to offer the most relevant and updated resources to members of the military community and spread campaign communications and information to our target audience worldwide.

[6] www.realwarriors.net

- The Real Warriors Campaign has potentially reached more than 6,503,000 Service members, Veterans, and military families through 152 campaign articles in blogs, newsletters, and publications since its launch.
- Won 17 industry awards in FY 2011 for the Web site, video profiles, PSAs, integrated marketing communications, e-card and social media pages, including induction into the PR News 2011 Hall of Fame.

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

Afterdeployment.org is an information and self-help resource available to Service members and Veterans and also includes a variety of tools and information for providers. In FY 2011, the total number of visits to the afterdeployment.org site was 63,968. Since the site was launched in August 2008, the total number of visits is 183,253. Through FY 2011, of the site's 18 modules, the top five most frequently visited in descending order were: post-traumatic stress; families and friendships; depression; anger; and sleep.

Military life presents challenges related to deployments or mobilizations for Service members, Veterans, and their families. Military Pathways[7] was established to meet these challenges with web-based, anonymous, and voluntary self-assessments and screening for common mental health issues. Service members, Veterans, and family members can answer questions on a variety of problems including PTSD, depression, anxiety, and alcohol problems, and receive feedback when further evaluation is needed, as well as guidance on where to seek assistance.

In FY 2011, 38,852 screenings were completed online compared to 32,109 screenings in FY 2010. This reflects a 20 percent increase in screenings, which far exceeds the FY 2011 goal to increase the number of screenings by 3 percent. In FY 2010, there were 195,803 visits to the Military Pathways Web site. In FY 2011, the total number decreased by 1.9 percent to 192,080. The primary goal of the program is online screening, so the conversion rate (i.e. number of visitors to the Web site who complete a screening) is more accurate than Web site visits as a measure of the program's effectiveness. Typical conversion rates for most Web sites are between 1 percent and 3 percent. In FY 2011, the conversion rate was 20.3 percent. Compared to a conversion rate of 16.5 percent in FY 2010, this reflects a 22.4 percent increase.

In addition to innovative Web-based approaches described above, VA and DoD are leveraging smartphone technology to enhance access to mental health information and care for Veterans and Service members. For example, VA and DoD jointly launched the PTSD Coach smartphone application in April 2011. As of the end of FY 2011, the PTSD Coach app was downloaded over 28,000 times in 53 countries. The app lets users track their PTSD

[7] www.militarymentalhealth.org

symptoms, links them with public and personalized sources of support, provides accurate information about PTSD, and teaches helpful strategies for managing PTSD symptoms. The application is one in a series of jointly designed resources by VA's National Center for PTSD and DoD's National Center for Telehealth and Technology (T2) which helps Service members and Veterans manage their readjustment challenges and receive anonymous assistance.

DoD's T2 Mood Tracker is a mobile application that allows users to self-monitor, track, and reference their emotional experience over a period of days, weeks, and months using a visual analogue rating scale. Users can self-monitor emotional experiences associated with common deployment-related behavioral health issues like post-traumatic stress, life stress, depression and anxiety. Self-monitoring results can be a self-help tool or they can be shared with a therapist or health care professional, providing a record of the patient's emotional experience over a selected time frame.

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

The total number of FY 2011 downloads are as follows:

- PTSD Coach 28,232
- T2MoodTracker 25,788
- Breathe2Relax 25,682

Pain Management Working Group

Since being chartered in December 2010, the Pain Management WG (PMWG) has begun developing strategies and processes to ensure eligible beneficiaries receive the highest standards of pain care, delivered seamlessly across both Departments. This includes developing and deploying education and training programs for clinicians and beneficiaries, and creating, testing, and implementing a pain data registry that will assure the development and dissemination of outcomes-driven, evidence-based pain management and continuous quality improvement for use within VA and DoD. In addition, the PMWG is developing standardized assessment and treatment guidelines for use in a stepped care pain management model throughout both Departments.

Standardizing Pain Measurement

The use of a common tool across VA and DoD for pain assessment is both appropriate and desirable. The most commonly used tool to measure pain in both VA and DoD facilities is an 11-point, 0-10 Visual Analog Scale (VAS). Although this scale is widely used, even in the civilian community, the vast majority of health care providers find VAS to be inconsistently administered, and subjective without any functional anchors, and feel assessments recorded in patient medical records have little value. Therefore, a new, validated tool is needed to assess factors that impact clinical decision making, such as pain intensity, pain interference, mood, stress, and psychosocial and functional impact. The tool must also be objective and useful in evaluating treatment effectiveness: practical and adaptable to multiple clinical settings and scenarios throughout the continuum of care (e.g., battlefield, transport, combat support hospital, primary

care, medical center, pain medicine specialty services), easily adapted and integrated into VA and DoD computer medical databases, standardized into all levels of medical training across all roles of care (e.g. useful for the medic, the ward nurse, the Primary Care Providers (PCP), the pain researcher, and the pain management specialist), and consistent with current validated pain research tools.

Given the above background and requirements, the PMWG endorsed pursuing a more in depth analysis of an alternative pain assessment tool known as the Defense/Veterans Pain Rating Scale. This tool, developed by the Defense and Veterans Center for Integrative Pain Management (DVCIPM), has undergone a preliminary validation study and appears to be promising. However, it requires additional testing and validation before it can be considered reliable for routine use throughout VA and DoD. If proven to be scientifically valid, it will be a much stronger tool for clinicians to utilize in their evaluation and treatment of acute and chronic pain. The PMWG is currently working with DVCIPM to field the tool for additional testing at several VA and DoD sites with the goal of deploying the tool globally as soon as it is proven safe and reliable for routine use.

The Patient Centered Medical Home

To ensure a patient's care needs are coordinated and/or integrated across the entire health care system (acute and subspecialty care, inpatient care, home health care, skilled nursing care) as well as the patient's community (family, public, and private community-based services), the PMWG fully endorses the concept of the Patient Centered Medical Home (PCMH). In the PCMH model, the PCP leads a team of health care professionals who collectively take responsibility for the ongoing care of the patient. The PCP is responsible for either personally providing care for the patient, or for appropriately arranging treatment by other qualified health care professionals. The PCMH facilitates education of both the patient and his or her family on the etiology and management of acute and chronic pain, which may reduce the likelihood of disability, address the under-treatment of pain, and provide for patient participation in decision-making and in the tailoring of treatment plans to the individual patient. Both VA and DoD fully endorse the concept of the PCMH. The PMWG has stood up a sub-WG to continue exploring how to further integrate pain management treatment and education for providers and beneficiaries into the PCMH model. This sub-WG will report its findings monthly to the PMWG to ensure full integration with other ongoing efforts.

Clinical Practice Guidelines

CPGs provide guidance on the diagnosis, treatment and management of patients based on clinical evidence obtained from an intensive, comprehensive review and analysis of the published medical literature. The HEC Evidence Based Practice WG selects topics for the development of CPGs based on high cost, high volume, high risk, and problem prone conditions. To date, three CPGs have been developed related to the treatment of acute and chronic pain: opioid therapy for chronic pain, lower back pain, and post-operative pain. The perioperative pain control CPG was under development in FY 2011; it is anticipated that it will be available for distribution sometime in the next two to three years. Work on the degenerative joint disease CPG was approved in FY 2011 and will begin in FY 2012.

While it is important to develop and implement CPGs as educational tools to align medical practice patterns with the most currently available clinical evidence, it is also important to make

them easy to use and integrate into routine provider practice. The chronic opioid therapy CPG is now available in a dialogue box that can be accessed in the VA's EMR, Veterans Health Information Systems and Technology Architecture (VISTA). The PMWG formed a subgroup to develop electronic solutions to embed in both VISTA and DoD's computerized patient medical record, Armed Forces Health Longitudinal Technology Application (AHLTA), that would simplify the use of these CPGs by both military and VA providers. In addition, this subgroup will strive to ensure that the future iEHR EMR system is embedded with the CPG pain algorithms, enabling providers to follow these evidenced-based practices more easily. The subgroup will also examine whether additional CPGs for pain management should be developed.

Pain Management Education and Pain Medicine Training

Many health care professionals have little or no training in pain management and are unable to effectively respond to the pain care needs of their patients. Recent reports from IOM and the American Medical Association concluded that pain management receives very little attention in the curricula of many U.S. medical and allied health professions schools. In fact, health care professional programs at most major medical educational and training sites do not include a dedicated pain management curriculum. The lack of a consistent approach to pain management education results in considerable variation in pain management understanding and practice within all medical professions. The PMWG formed a subgroup to look at provider and patient education for acute and chronic pain management, including improving provider awareness of medication misuse. To this end, the Uniformed Services University of the Health Sciences (USUHS) developed interactive, Web-based videos to educate providers about risk factors, risk stratification, and mitigation strategies for medication misuse. In addition, they developed a core-curriculum for medical students and physicians in training on pain management and medication misuse. The subgroup will work with USUHS to make these training aids available through the internet for all military providers and subsequently to VA providers by early 2012. They also developed a series of PSAs regarding medication misuse to air at a future date in cities with high concentrations of military and VA beneficiaries. Additional educational efforts will focus on identifying patients with PTSD and other psychological injuries which frequently co-occur with painful injuries and chronic pain conditions that may pre-dispose them to experience increased pain post-operatively, increased requirements for pain control, and an increased risk for medication misuse.

The subgroup will continue to work with VA on its Specialty Care Access Networking/Extension for Community Health Care Options project which offers education to providers on pain management. VA implemented this program in five regional (Veterans Integrated Service Networks [VISN]) projects: Cleveland, Greater Los Angeles, Connecticut, Albuquerque, and Denver. A sixth site, Virginia, will be running by early 2012. VA approved a curriculum of 35 pain topics for which lectures are being developed and approved for Continuing Medical Education (CME) through a peer review process. Presently, eight lectures in this curriculum are CME approved and can be offered for use in training primary care clinicians. The remaining topics are in various states of development for CME approval. The Greater Los Angeles VA Health Care System (HCS) is working with VA's National Pain Office and VA's Employee Education Service to create a set of instructional videos for regional pain physical examinations that will be integrated into the pain training series. The goal for the PMWG is to

work with VA to integrate their current work with efforts by DoD into a comprehensive, national educational program.

The Pain Assessment and Outcome Registry

The PMWG will continue to collaborate with the DVCIPM on further development and deployment of the Pain Assessment and Outcome Registry (PASTOR), which was initially launched as a demonstration project as part of the Chronic Pain Impact Network between Walter Reed National Military Medical Center, Madigan AMC, and the University of Washington. PASTOR is a patient self-reported, internet-based information system that is being designed to support PCPs and pain specialists in their day-to-day clinical work with patients. Presently, a subcommittee of the PMWG is working with the National Institute of Health Patient Reported Outcomes Measurement Information Systems (PROMIS) at Northwestern University and various assets in DoD with coordination provided through DVCIPM. The subcommittee completed an extensive business process analysis of the PASTOR program and its integration into the PCMH. In September 2011, the subcommittee convened a conference in San Antonio, Texas of tri-Service VA, DoD, and civilian pain experts to finalize the content requirements of the PASTOR registry. The requirements document is presently undergoing a review and development process with PROMIS to create a prototype program in FY 2012. This prototype will provide the foundation example of the 'to-be' state as this technology is integrated into existing VA and DoD medical information systems. Additionally, PASTOR will provide vital pain management outcomes data to drive pain resource decisions and best treatment protocols. Efficient for both patient and provider, the system will generate information that can assist the provider in enhancing care by increasing awareness of real or potential pain-related health problems. Questions within the system explore substance abuse issues, mental health, and pain therapy effectiveness to name just a few.

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

HEC Interagency Clinical Informatics Board

The Interagency Clinical Informatics Board (ICIB) serves as the primary source of input from clinical stakeholders in recommending priorities for enhancing information sharing in support of the care delivery process for common beneficiaries of VA and DoD. The identification of clinical requirements for both Departments' interagency health information sharing needs is necessary to support the provision of health care and to better support Veterans and Service members. This initial definition of a business or clinical need is officially recorded in DoD as a System Change Request (SCR), while VA refers to this record as a New Service Request (NSR). Development of SCRs and NSRs initiates the process for prioritization and funding of Information Technology (IT) projects. During FY 2011, the ICIB completed three such need statements between the two Departments. Interagency collaboration was initiated on a fourth activity, the use of common clinical and quality of care performance measures, which was also identified for transition to a new framework under the iEHR initiative.

The ICIB completed the following SCRs/NSRs in support of its FY 2011 strategic objectives:

- Exchange of Standard Inpatient Data Record files;
- Exchange of TRICARE Encounter Data – Institutional/Non-Institutional files; and
- Bidirectional exchange of family health information.

Standard Inpatient Data Record (SIDR)

Current health information exchanges between VA and DoD provide very little historical data from Service members on the inpatient care they received over the course of their military service. The SIDR provides an exceptional resource for creating awareness of Service member admissions dating back to the early 1990s, providing a nearly 20 year history of care for complex conditions requiring inpatient treatment. The absence of this information not only forces providers to make clinical decisions in the absence of this information, it also precludes the ability of the electronic health record (EHR) to provide effective Clinical Decision Support (CDS) based upon the diagnosis and procedure codes that are available with this information. To facilitate closing this gap, the ICIB defined resolution of this as a high priority need for our nation's Veterans. In fulfilling its task, the ICIB facilitated work sessions between the Departments that resulted in the completion of both the NSR and SCR that will support the process for beginning the sharing of this health information.

TRICARE Encounter Data – Institutional/Non-Institutional (TED-I/NI)

Current health information exchanges between VA and DoD provide very little data from Service members regarding care they received from the private sector over the course of their military service. The TED – for both institutional and non-institutional claims - provides an exceptional resource for creating awareness of Service member treatment in the private sector. This information is particularly important for Reservists and National Guard members as they are often not stationed near MTFs throughout their career, and must seek treatment in the private sector for service-related conditions. Absence of this information not only forces providers to make clinical decisions in the absence of this information, it also precludes the ability of the EHR to provide effective CDS based upon the diagnosis and procedure codes that are available in this information. The TED records provide detailed information for each treatment encounter including date and facility of treatment, diagnoses treated, and clinical procedures undertaken. These records are subsequently sent as claims for reimbursement to TRICARE Management Activity (TMA) and are then available for sharing to support clinical care. It is vital for VHA clinicians to have treatment encounter information available in order to make the most accurate and appropriate clinical decisions for their patients in a timely manner. Ensuring VHA providers have this information not only supports continuity of care for Veterans, but also supports VBA in the management of Veterans' claims, as this information would automatically be available to VBA personnel as well.

Family Health Information Sharing

Family Health History (FHH) is increasingly used in clinical practice as an indicator of patient health risks and in supporting patient diagnosis in the health care setting. While both Departments collect some FHH information now, it is not standardized and has been difficult to share as information distinct from the overall encounter. Understanding the importance of gathering FHH data as more discreet and standardized elements better supports the provision of high quality care to Service members and Veterans. The ICIB identified closing this information gap as a high priority.

In FY 2011, the initial documentation of business needs was completed for sharing FHH information. The needs focus on the following:

- Standardized collection of FHH data across the Federal and private health sector;
- Allowing for portability of the identified core data set to be exportable to external EHRs and personal health records; and
- Supporting the integration of FHH information with the patient's EHR.

The objective of this effort is the ability to share the data between the two Departments such that it could be revealed in the application(s) of each individual Department's choosing. The method of data collection would also be up to the individual Department. The identification of FHH data to be collected and the mode of transmission between VA and DoD will be based on national standards.

Common Clinical and Quality of Care Performance Measures

The ICIB determined that VA and DoD clinical systems do not currently have capabilities facilitating the effective capture of enterprise-wide, standardized, computable data to support effective benchmarking or comparative analytical applications to assess clinical performance metrics across the two Departments. Labor intensive, manual records reviews, searches, and data abstraction and compilation are currently required to assess performance from a quality of care perspective. Many of the VA and DoD legacy health information systems do not have robust capabilities for data collection across clinical quality domains built into the software. As the ICIB approached the task of defining the collection of quality of care performance measures from the legacy systems, the iEHR initiative was also being defined by senior leadership of both Departments. Refocusing this task as the Departments design the new iEHR provides an exceptional opportunity to design data capture for quality measures into the new system acquisition strategy. The ICIB will continue to support the definition of common clinical and quality of care performance measures as specifications for the new iEHR.

Business Requirements Documentation

Once the clinical requirements are defined, the ICIB will further refine the business requirements and identify changes to business practices to frame the scope of desired functionality. The output of this process is officially recorded in DoD as a Business Requirements Specification (BRS), which was formerly known as a ConOps. The output is recorded in VA as a Business Requirements Document (BRD). The BRS and BRD documents are used to lay the foundation for prioritization and funding of IT projects. The ICIB facilitated the necessary interdepartmental coordination and succeeded in completing the BRS and BRD documentation for the exchange of SIDR data files during FY 2011. Collaborative efforts are currently underway and on schedule to complete the BRS and BRD documentation for TED-I/NI and FHH activities.

Beyond the JSP Objectives

As the Departments engaged the iEHR initiative in 2011, health care providers in the ICIB were identified as key functional stakeholders to lead the initial focus teams defining the program. ICIB members were Co-chairs of focus teams in the areas of systems capabilities, mission requirements and performance outcomes, business requirements, and the iEHR presentation layer. These members also supported the data interoperability focus team.

Ultimately, ICIB providers Co-chaired or were key members in five of the six focus teams dedicated to the iEHR. These teams from both VA and DoD defined a list of over 30 functional capabilities to support an integrated health record, as well as the governance structure to guide the capability development life cycle. The ICIB are key players in the iEHR governance structure that highlights processes, roles and responsibilities, and artifacts required to support functional stakeholder activities. ICIB members established a process for prioritizing iEHR capabilities in collaboration with the Interagency Program Office (IPO) and the IT community that is supported by the Departments' iEHR senior coordinating group.

An important part of this effort is the establishment of WGs, or Capability Integrated Product Teams (C-IPTs), to analyze each capability and support the requirements definition process. The iEHR C-IPTs bring together SMEs from all three Military Departments, TMA, and VA to perform architecture, requirements engineering, and business process re-engineering activities. This approach is the culmination of months of planning to identify a standard process that will guide each capability through the development life cycle, and meet the needs of both VA and DoD functional end-users. Products from the C-IPT will help both VA and DoD leadership assess and select the best iEHR IT solution that meets the needs of both Departments.

ICIB providers, members, and staff supported the full C-IPT for the first iEHR clinical capability (pharmacy) through analysis, decision, documentation, and completion of an initial Request for Information to industry. The joint immunization capability began its C-IPT activities in September 2011 and began developing functional requirements and business process models. As an iterative process, these working sessions are building a foundation for the remaining C-IPT activities, scheduled to run through the end of the calendar year. The staggered completion of each functional capability's development life cycle tracks toward the greater goal of a VA and DoD fully-integrated iEHR.

Vision Center of Excellence

The VCE developed functional requirements to support the development of the Defense and Veterans Eye Injury and Vision Registry (DVEIVR) pilot that will facilitate the tracking of eye and vision injuries' longitudinal clinical data. Data collected and analyzed from the DVEIVR pilot will identify opportunities to optimize operational readiness and enhance quality of life by improving vision health for Service members and Veterans through the development of best practices in vision care and guide research. The DVEIVR will be the first registry to combine VA and DoD clinical information into a single data repository for assessing longitudinal outcomes. The pilot application was completed September 30, 2011.

To meet the rigid DoD requirements for development and deployment of the DVEIVR application, the VCE developed the documentation requirements for deployment of the DVEIVR Pilot. The documentation includes a System of Record Notification that was published in the National Register in the third quarter of FY 2011; an approved Privacy Impact Assessment; jointly executed memoranda of agreements (MOAs) with multiple VA and DoD agencies to ensure transfer and use of data to the registry; an Authority to Operate certificate for the DVEIVR as a pilot; and secured Defense Information Assurance Certification and Accreditation Process approval for the registry.

VA developed the VA Eye Injury Data Store, also called the Defense and Veterans Eye Injury Registry, to send the clinical data of Veterans with eye and vision injuries to the DVEIVR from the VA Eye Injury Data Store 3.0 application. The VA's Defense and Veterans Eye Injury Registry is located in the VA Eye Injury Data Store 3.0 application. This registry is one registry within the Converged Registries Solution. Convergence is designed to maintain and enhance the structure to integrate the design and development of all VA Registry programs in a manner that minimizes duplication of effort among the various VA registries, and maximizes VA's ability to support the rapid development of new registries.

VCE awarded two vendor contracts in support of the DVEIVR:

- Data abstraction support services; and
- DVEIVR Pilot IT support services.

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

Extremity Injuries and Amputations Center of Excellence

VA and DoD have worked closely together since 2001 to coordinate and provide comprehensive care for patients with extremity trauma and limb loss. This has positioned both Departments to build upon existing collaborations that meet congressionally mandated responsibilities for provision of clinical care, and for conduct of basic, translational, and clinical research that contributes to provision of science-based medical treatment for this population.

The Extremity Injury and Amputation Center of Excellence (EACE), established in 2009, operates under a proposed ConOps developed by interim leadership. The ConOps describes a strategic vision, identifies core staff requirements, and proposes a comprehensive plan and strategy to optimize extremity trauma and amputee care across VA and DoD. On May 6, 2011, the Assistant Secretary of Defense for Health Affairs (ASD (HA)) approved the Surgeon General and Commanding General U.S. Army Medical Command's recommendation that the headquarters for the EACE be located in San Antonio, Texas. On June 10, 2011, the MHS CoE Oversight Board was chartered. This board will recommend CoE policies, establish guidelines for CoE ConOps, and provide advice to the ASD (HA) and the Senior Military Medical Advisory Council on activities of the various CoEs. The EACE is currently awaiting approval of the EACE ConOps. Funding for the EACE was requested in the FY 2012 President's Budget Request. In addition, EACE funding was included in the FY 2012 – FY 2016 Program Objective Memorandum (POM) cycle.

The Executive Agency Office, while awaiting approval of the ConOps, took preliminary steps during FY 2011 to determine staffing level projections and develop position descriptions. To date, the Director's position has been identified and five other hiring actions are in staffing at the Civilian Personnel Advisory Center. The hiring actions are being processed through the Army Medical Command and the Office of the Surgeon General. In FY 2011, an interim Research Director was appointed to direct activities and milestones under the Research and Surveillance Directorate. Funding for the EACE was requested in the FY 2012 President's Budget Request. In addition, EACE funding was included in the FY 2012 – FY 2016 POM

cycle.

Coordination of care between VA and DoD treatment facilities continues to focus on optimizing care for wounded Service members and Veterans. In support of this objective, VA and DoD continue to work collaboratively on research efforts aimed at saving injured extremities, avoiding amputations, and preserving and restoring function of injured extremities.

In FY 2011, the goal was met to participate in a minimum of three collaborative research activities.

- Results from a collaborative research effort between the Providence VAMC and the DoD Center for the Intrepid (CFI), designed to validate a community reintegration measurement tool within a population of military patients with extremity trauma, was published in FY 2011.
- VA and DoD worked together to develop a VA/DoD Collaboration Guidebook for Healthcare Research. Published during FY 2011, this guidebook was an initial effort undertaken to facilitate successful research outcomes, and paves the way for successful collaborative opportunities. A copy can be obtained at http://www.research.va.gov/va-dod/va-dod-guidebook.pdf.
- A VA/DoD collaborative research effort completed during FY 2011, performed clinical laboratory assessment of the DEKA arm, an upper extremity prosthetic device developed under the Defense Advanced Research Projects Agency Revolutionizing Prosthetics Program. This effort was conducted at the DoD CFI in collaboration with the Providence VAMC, and led to an optimized version of the DEKA arm.
- An optimized version of the DEKA arm will be assessed in a home use environment in FY 2012. This follow on VA/DoD research was approved and funded during FY 2011. The results from this study will lead to a final version of the DEKA arm that will lead to improved options available for individuals with upper limb loss.

EACE leadership placed a high priority on the goal to disseminate knowledge to the scientific community through publications and professional presentations of work accomplished at the research centers. During FY 2011, 12 manuscripts were published and/or accepted for publication in leading peer-reviewed journals. These articles are the first to publish normative data, establish values to determine meaningful clinical significance, and identify key clinical indicators of performance in a population of military Service members with extremity injury. An additional 40 abstracts (five international and 35 national) were presented as platform or poster presentations at 12 leading national and international scientific conferences.

In FY 2011, the JSP goal was met to provide data that supports evidence based changes to VA/DoD CPGs:

- VA and DoD began to jointly provide patients with the Genium/X2 knee prosthetic device and the iLimb power ankle. These technologies are a culmination of years of advanced development research, and were clinically tested under approved research protocols completed in FY 2011 at the CFI and Walter Reed National Military Medical Center's Military Advanced Training Center sites. Clinical assessment of these advanced prosthetic devices within a population of combat injured Service members with above-knee amputations revealed that functional performance was optimized for these patients by providing improved stance stability and decreased physical demands.

This effort provided evidence-based functional outcome metrics to suggest that use of these devices within the clinical setting enhanced functional outcomes for individuals with lower limb amputation.

- EACE funding improved the research equipment at three DoD centers, enhancing the ability to perform standardized, collaborative, multi-site research efforts.
- A multi-site collaborative study to establish reliability and validity of the measures utilizing the new equipment was spearheaded by the Comprehensive Combat and Casualty Care Center at the Naval Medical Center, San Diego, and the protocol was submitted for funding in FY 2011.

The EACE funded several international collaborative efforts. This effort included a meeting at Headley Court, England to work with British, French, and Canadian SMEs to standardize outcome measures for patients with extremity trauma and limb loss across international defense forces. Additionally, the EACE sent rehabilitation teams to the Republic of Georgia to assist in developing in-country capabilities for caring for injured coalition forces, and to Estonia to help in developing the plans for a rehabilitation facility for the care of their wounded warriors.

GOAL 3
Efficiency of Operations

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

Sub-goals 3.1 and 3.2: Jointly refine the improved Integrated Disability Evaluation System (IDES) process, and jointly expand the improved IDES process to new locations, as directed.

BEC Disability Evaluation System Working Group

The VA/DoD Disability Evaluation System (DES) Pilot program was instituted under the SOC in 2007 and was incorporated into the JSP FY 2010-2012. The BEC initiated oversight of the DES Pilot during FY 2009. The DES Pilot, now renamed IDES, continues to operate under the oversight of the SOC and the JEC. The BEC DES WG provides quarterly briefings to the BEC.

The DES Pilot began in FY 2008 in the NCR at three MTFs: Walter Reed Army Medical Center, Bethesda National Naval Medical Center, and Malcolm Grow Air Force Medical Center. During FY 2009, the Pilot expanded to an additional 18 MTFs. Prior to each location beginning DES Pilot operations, the Departments verified the site was prepared to meet Pilot staffing and system support requirements. A training team from VA and DoD traveled to each site to conduct Pilot training and identify any remaining issues or problems. On September 17, 2009, the SOC approved expansion to an additional six locations. This phase of expansion began January 4, 2010, and was completed March 31, 2010.

Building upon the success of the DES Pilot, particularly the ability to rapidly and effectively assist a larger number of Service members and their families, the Departments set a goal to expand the IDES to all Service members by the end of FY 2011. During the first quarter of FY 2010, VA and DoD held collaborative meetings to design a joint expansion strategy to achieve

this goal. The Departments considered several different models, but agreed that further expansion of the IDES would be implemented by region because it provided the opportunity to consolidate resources and minimize duplication of effort. VA and DoD conducted two conferences on September 27-28 and September 29-30, 2010, in preparation for the next stage of IDES expansion. Fifty-five additional sites reached IOC within the first quarter of the FY. Each quarter thereafter, the Departments phased in additional sites, to culminate in the 139 sites currently operating IDES. On September 30, 2011, the Departments achieved IDES coverage for 100 percent of Service members.

The IDES process is simpler and more transparent from the perspective of a Service member being evaluated for disability, as they receive their proposed VA and DoD disability ratings simultaneously, prior to separation, and they are able to make more informed decisions about their future. The process is also more efficient because Service members undergo a single disability examination instead of separate examinations by each Department. During FY 2011, the DES WG had continued success in achieving a single examination that meets the needs of both Departments and executed a cost sharing agreement that is fair and equitable to both Departments.

Since November 26, 2007, 32,804 Service members were enrolled in the IDES. A total of 11,805 Service members completed the program by returning to duty, separation, or retirement and 1,581 were removed for other reasons (additional medical treatment needed, case terminated pending administrative discharge processing, etc.) At the end of FY 2011, a total of 19,418 Service members remain enrolled in the IDES.

Active Component Service members who completed the IDES in the month of September 2011, averaged 404 days from IDES entry to VA benefits decision. Active Component Service members who completed the IDES since November 26, 2007, (including pre-separation leave) averaged 367 days. This 367-day average is 19.6 percent slower than the IDES goal of 295 days, established for Active Component Service members.

Reserve Component and National Guard Service members who completed the IDES averaged 350 days from entry to issuance of the VA Benefits Letter, which is 12.9 percent slower than the IDES goal of 305 days.

Surveys of over 18,000 Service members in the DES continue to show that IDES participants are more satisfied with their overall experience and fairness of the process than participants in the legacy DES (pre-IDES) process.

On October 1, 2008, VA initiated a “paperless” program to electronically process all IDES claims initiated in the NCR. VA worked with these MTFs to provide access to VBA’s Virtual VA Web-based application, the electronic warehouse where imaged documents are stored. In May 2011, VA revised Disability Rating Activity Site (D-RAS) operating procedures, including adding Providence, Rhode Island as a third D-RAS. This change generated improvements in overall timeliness as the additional site shared the claims workload. The change addresses timeliness concerns with the preliminary proposed rating, rating reconsideration, and VA Benefits stages of IDES, and allows better management of the IDES rating workload. The

Providence D-RAS is where paperless IDES cases are now scanned and rated, versus the slower process of scanning at one site (St. Petersburg) and rating at another (Baltimore).

DoD authorized the temporary implementation of a two-member Informal Physical Evaluation Board (IPEB) on July 21, 2010, in response to a request from the Department of the Air Force. This authorization was in effect until June 15, 2011, and allowed all Military Departments to use two-member IPEBs to improve their IDES processing rate.

Another procedural change within the IDES process was the modification to the VA Compensation and Pension Records Interchange (CAPRI) system, which now allows the system to recognize substation codes. Substation codes allow batch printing of IDES examination reports at the Military Services Coordinator (MSC) locations rather than the supporting Regional Offices. The Departments identified and addressed a required IT enhancement that pulls the Veterans' separation date from one system to another, i.e., VA/DoD Identity Repository to Veterans Tracking Application (VTA). The interface was activated in September 2011, and allows the D-RAS to be aware of the separation date so that they can take final rating action and issue the benefits letter. These procedural and technology enhancements will better support smooth and unhindered operations of the IDES.

One significant item to be addressed in the coming FY is the post-separation/retirement survey of DES Pilot/IDES Veterans. The VA is marshalling this effort and the JEC looks forward to reviewing results this year and making appropriate adjustments as needed.

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

BEC Medical Records Working Group

The BEC Medical Records WG (MRWG) was established to oversee the entire life cycle of the paper military STR. In FY 2011, the WG concentrated its energy on enhancing and improving collaborative efforts in managing paper records as described below.

DoDI 6040.45, developed by the MRWG to govern the paper, outpatient medical record across its entire life cycle, was signed into effect on October 28, 2010. The specific impact of this new guidance is not yet known, but it is expected to yield better consistency in how medical and dental records are maintained and transferred to VA upon a Service member’s discharge, separation, or retirement.

The MRWG is well on track to attain the goal of a 95 percent reduction in the volume of loose and late flowing medical documentation by the end of FY 2012, as established in the VA/DoD JSP. However, measuring the actual availability of the STR within 10 days of request at a 95 percent frequency continues to prove elusive for the MRWG. Numerous data systems were queried within VBA; however, in each case, the data generated had significant limitations and could not be used as a reliable indicator for this metric.

The Air Force has established a centralized office that is responsible for compiling and transferring a complete STR to VA. The Army briefed the MRWG that a similar centralized

operation would occur by second quarter of FY 2012. The MRWG will work with the Military Services to establish a mechanism for them to track and report the number of STR's transferred and the timeliness of this transfer to the VA.

In FY 2011, the Military Departments exceeded the goal of a 50 percent reduction in the amount of loose and late flowing medical documentation to the VA Records Management Center. The baseline at the end of FY 2010 was 1,328,000 documents, and at the end of this FY the amount of loose and late flowing medical documentation was 390,000 documents for a decrease of 61 percent.

To monitor performance related to the second metric, the Military Departments reported on the status of their backlogged STRs and efforts underway to clear the backlog at each of the MRWG's quarterly meetings. The term "backlog" refers to any STR that is not in the appropriate location and/or medical record documentation that has not been interfiled into the service member's STR jacket. Each of the Military Services continued to process backlog, but only to the level that new STR documentation was received into inventory. Although the DoD is making improvements in providing less late flowing medical documentation to VBA, the backlog STRs within DoD have not been significantly reduced. This is largely due to an increasing amount of MHS treatment being provided through TRICARE. The EHR is only used within MTFs and not in the private sector, so every consult in the community results in paper documentation. The MRWG views scanning as the bridge to address this backlog until a fully interoperable EHR is available. Accordingly, the MRWG has also been working closely with the MHS Chief Information Officer's (MHS CIO) office as they are preparing to release a scanning capability that, once implemented, will provide the opportunity for designated field level units within the Military Departments to scan loose medical documentation into dedicated repositories. This will make the documents globally accessible to support VA benefits decision makers and the continuity of health care.

The second milestone for the MRWG included the issuance of new DoD policy and procedures for the creation, maintenance, use, transfer, and disposition of the STR. The STR disposition schedule was submitted to the National Archives and Records Administration (NARA) for approval last FY, was assigned a dedicated job number (N1-330-10-03), and is currently in NARA's internal review and appraisal process. The MRWG responded to several requests for more information this year and VA Records Management Center hosted a site visit from NARA staff and several MRWG members for the purposes of conducting an appraisal of the STR. At the end of FY 2011, NARA informed the MRWG that the disposition was entering the final phase and that a decision, which will require being posted in the Federal Register, should be made sometime in the first half of FY 2012.

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

BEC Information Sharing/Information Technology Working Group

The objective of the VA/DoD BEC Information Sharing/Information Technology (BEC IS/IT) WG is to use VA and DoD enterprise architectures to foster an environment that ensures appropriate

Departments, Agencies, Service members, Veterans, their beneficiaries, and/or other designees have immediate and secure access to reliable and accurate personnel and beneficiary data that support their needs.

eBenefits Registered User Accounts

The eBenefits portal was launched in FY 2009 for Service members and Veterans as directed by the President's Commission on the Care of America's Returning Wounded Warriors in July 2007. The eBenefits portal currently provides a secure Web site focused on the health, benefits, and support needs of Service members, Veterans, their beneficiaries and/or other designees. The eBenefits portal is a single information source providing access to both a public Web site and a secure portal that connects the user with customized benefit information based upon his or her personalized profile.

During FY 2011, the WG achieved its goal of increasing eBenefits registered user accounts quarterly by 10 percent or more. As of the fourth quarter of FY 2011, the number of registered eBenefits users was 1,009,891. In FY 2011, from the first quarter (201,966) to the second quarter (278,532) the number of registered eBenefits user accounts increased by 38 percent, followed by a 32 percent increase from the second quarter to third quarter (368,156), and over 174 percent increase from the third quarter to the fourth quarter. The average rate of increase for FY 2011 was 67 percent. The annual rate of increase from FY 2010 to FY 2011 is 518 percent. This year's increase in registered eBenefits users suggests that VA/DoD outreach efforts were successful in spreading awareness of this powerful tool. The eBenefits site redesign, scheduled for release in the first quarter of FY 2012, will also aid in ensuring Service members and Veterans are aware of the benefits to which they are entitled.

Defense Self Service Logon

The BEC IS/IT WG effectively and proactively implemented many helpful self-service features available to eBenefits users. All of these self-service features require a level of authentication so the portal can provide secure personalized benefit information. This authentication is the Defense Self-Service (DS) Logon. The DS Logon is a secure, self-service logon ID (user name and password) that allows beneficiaries affiliated with the VA or DoD access to several Web sites using a single username and password. eBenefits has single sign on (SSO) capability with several other sites that also accept the DS Logon for access. Since DS Logon credentials are mutually authenticated, users can navigate between provided site links after logging in to eBenefits.

In November 2010, the Under Secretary of Defense for Personnel and Readiness published a Memorandum directing all newly accessed Active Duty, National Guard and Reserve members of the military services, in possession of a Common Access Card (CAC), to obtain a DS Logon. In order to ensure all Service members and Veterans obtain a DS Logon, the Departments will work the implementation strategy and Plan of Action and Milestones in three segments: 1) new accessions – implementation that is straight forward and easily measured; 2) current Service members – implementation that may be complex, not easily measured, and will be over a three-year period; and 3) Veterans – VA and DoD are working on strategies to address this issue. Joint discussions for how best to leverage Defense Finance and Accounting Services (DFAS) myPay to increase the number of Veterans accessing the eBenefits portal are in progress. Additionally, with the automation of the Servicemembers'

Group Life Insurance (SGLI) application, once available, will require the establishment of the DS Logon and then allow CAC access.

In 2011, through the implementation of mandatory DS Logons for eBenefits premium accounts for Service members at accession, both Departments can seamlessly communicate the right benefits information at the right time throughout the Service member's career life cycle.

The WG has implemented several options for establishing the proof of identity required to obtain a DS logon. Currently, in-person validation for DS Logon is available at all VA Regional Offices. There are 85 TRICARE Service Centers that provide in-person validation using the DS Access Station software. VA is also working with VSOs to support in-person validation of Veterans and promote the use of self-service features. Military retirees can use their DFAS MyPay logon and password to self-authenticate and obtain their DS Logon online. Users holding DoD CACs (Service members/Contractors/DoD Employees) may obtain a DS Logon online. Authenticated MyHealtheVet users can obtain a DS Logon online through the Account Request Portal.

An ongoing telephone-validation pilot enables Veterans, in receipt of monetary benefits from VA via direct deposit, to obtain a DS Logon account by telephone. DoD is developing a National Institute of Standards and Technology 800-63 compliant online authentication process for the Level 2 DS Logon scheduled for a November 2011 deployment. VA continues to work on expanding telephone proofing nationwide via VA National Call Centers.

A Level 2 DS Logon Premium account is given to users who have registered using their CAC or DFAS myPay Login Identification or who have completed an in-person proofing process by an agency official. This level enhances security to personal information and increases the assurance that the user is who they claim to be since they have been verified in-person.

A Level 1 DS Logon Basic account is an entry-level user account established online that provides limited view access to personal information. This level of account is only provided to individuals who have registered online through the eBenefits portal without being in-person proofed.

<u>eBenefits Self Service Features</u>
The BEC IS/IT WG introduced proactive and transactional self-service capabilities in each quarterly release since the first quarter of FY 2010. In FY 2011, over 20 eBenefits self-service features and enhancements were deployed. The quarterly releases for FY 2011 provided users with new or improved access to information as follows:

- Winter 2010 (Release 2.6)
    - Live Chat
    - SGLI, Education, Loan Guaranty Early Communications of Benefits
    - Customer Feedback
    - Post 9/11 GI Bill Electronic Funds Transfer Payment Update
    - Letter Generator (e.g. Commissary Letter, Civil Service Preference Letter, Benefit Verification Letter)
    - TRICARE Online Redirect for Eligible Participants

    - State VA Director Resident Separation Notification

- Spring 2011 (Release 3.0)
    - VGLI
    - BDD, Quick Start, Vocational Rehabilitation &Education, and Health Early Communication – Phase II
    - Benefit Explorer
    - Mobile Payment History
    - Secure Messaging
    - Online Patient Authorization

- Summer 2011 (Release 3.1)
    - TAP Online Training-Phase I
    - TURBO Benefits (VONAPP II)
    - Life Events Early Communication-Phase III
    - VetSuccess
    - Representative Search (VSO)

- Fall 2011 (Release 3.2)
    - IRIS Authenticated Integration (Education Only)
    - Mobile Feature (Appeals Status)
    - Education Enrollment Status (Chapter 33)
    - eBenefits Site Redesign
    - VONAPP Direct Connect (VDC)

By allowing online self-service features such as applying for benefits, checking claims or appeals status, obtaining home loan certificates and generating self-service letters (e.g. civil service preference), resources and efficiencies can be realized.

The frequency of logged-in users for specific key features from October 1, 2010, through September 30, 2011, is as follows:

- Compensation and Pension (C&P) Claims (2,366,044)
- Certificate of Eligibility (48,205)
- Defense Department Form 214 (34,118)
- Payment History (712,307)
- Appeals (419,185)
- Letter Generator (148,659)

The constant and rapid growth in the increase of registered eBenefits users enhances access to information and the application process for the delivery of benefits and health care. The eBenefits portal constantly evolves in response to customer feedback. As of the fourth quarter FY 2011, 50 percent of users providing feedback indicated they were able to get what they needed from the eBenefits Web site and were less likely to call a contact center for service. Twenty-five percent of users provided feedback specifically to praise their eBenefits experience.

New capabilities are being added every quarter and thousands of new users are registering daily. eBenefits, as a joint VA/DoD initiative, is already providing unprecedented capabilities for all Service members, Veterans, and their families to access and update VA and DoD information from a single portal.

The BEC IS/IT eBenefits WG continues to enhance the eBenefits portal with access to benefits information for Service members and Veterans with a DS Logon. Efforts are ongoing to improve the eBenefits portal with personal based benefits information delivery.

eBenefits and Virtual Lifetime Electronic Record (VLER)

VLER enables DoD, VA, and their partners to proactively provide the full continuum of services and benefits to Veterans through Veteran-centric processes made possible by effective, efficient, and secure standards-based information sharing. VLER is a multi-faceted business and technology initiative that includes a portfolio of health, benefits, personnel, and administrative information sharing capabilities. VLER provides Veterans, Service members, their families, care-givers, and service providers with a single source of information for health and benefits in a way that is secure and authorized by the Veteran or Service member.

The eBenefits portal supports the overall strategy of VLER by which users can access personnel and health records information throughout their entire career without redundancy.

The VLER Initiative is broken down into iterative capability deliverables that direct the actions and milestones necessary to achieve the VLER desired end state in 2014. These deliverables are called the VLER Capability Areas (VCAs) and will deliver scalable and secure data exchange capabilities between VA, DoD, other Federal agencies, and private health care providers.

BEC IS/IT Requirements WG (RWG) for VLER benefits

The BEC IS/IT initiated the RWG for VLER benefits in January 2011. As of September 30, 2011, the BEC IS/IT RWG developed and validated a total of 36 use cases to document requirements, data, and associated processes with respect to VA and Social Security Administration (SSA) disability adjudication, education, housing, insurance, and memorial benefits. Additionally, a detailed gap analysis is in progress.

The BEC IS/IT RWG Use Cases and the gap analysis information will feed into a Business Requirements process for VLER development in support of VCAs 2 and 3. VCAs 2 and 3 are envisioned to provide electronic disability adjudication and education, housing, insurance, and memorial benefits adjudication functionalities. Benefits adjudicators within VA and SSA will be able to conduct electronic benefits adjudication. Service members and Veterans at large will directly benefit from the expected efficiencies in claims processing due to the implementation of VCA 2 and 3 functionalities.

eBenefits and Reengineered Veterans Briefing and online TAP

In June 2010, the JEC directed the development of an implementation plan to ensure that 100 percent of transitioning Service members has access to VA benefits information prior to separation and to establish a program that evaluates the quality of the TAP services. A self-service, on-line mechanism was developed to enable Service members to complete the VA

benefits briefing electronically within their own time frame prior to discharge. Audio and storyboards were developed to support online TAP. As a result, VA information for TAP is available online through the eBenefits portal as of July 31, 2011.

In FY 2011, the Departments launched the first survey mechanism to specifically gather input regarding the VA portion of the TAP. As of August 1, 2011, the VA TAP Surveys were available for the classroom curriculum. The surveys will be used for recording attendance and for the continued improvement of the TAP program.

For the month of August 2011, preliminary results from the survey mechanism reported TAP respondents rating all aspects of the new re-engineered classroom TAP briefing very high. The overall Satisfaction Index Score was 923, with a total of 4,036 attendees completing the TAP classroom survey. This score reflects a high level of satisfaction with VBA's TAP Briefing and is among the highest rating of any study measured by JD Power and Associates.

Analysis of the survey information showed that nearly all TAP respondents reported an understanding of how to apply for VA benefits and nearly all TAP briefing participants reported an understanding of the benefits to which they are entitled.

VTA in support of IDES

The VTA for the IDES or VTA IDES Module, replaced the original DoD database hosted on Army Knowledge Online as the primary tracking and metrics reporting application in FY 2009. VTA is a tracking application that allows VA and DoD non-clinical case managers to monitor Service member and Veteran progress through the IDES process. Personnel from both Departments utilize the application. VA users include: MSCs, D-RAS, Regional Office Management, and Central Office Management. DoD users include: Physical Evaluation Board (PEB) Liaison Officers, PEB Staff, Personnel /Transition Centers, and DoD and Service Leadership.

For FY 2011, VTA IDES deployed four releases. These releases provide maintenance and enhancements to existing user groups such FRC, VHA, VBA, and IDES. Enhancements are tailored to improve the VTA architecture and ability to accommodate future expansion of the IDES. These enhancements will continue to improve reporting functionality and capability.

VTA enhancements included an IDES Discrepancy Reporting capability to support the identification and correction of missing and/or errant information and improve the overall data quality. Also included in the enhancements were additional PEB Administration and Regional Office Rating capabilities, a VBA casualty module which provides authorized users access to Veteran casualty information to assure prompt access to available benefits, and additional VBA interfaces and upgrades that allow more functionality based on recommendations from the 2010 VTA Systems Engineering Analysis.

Sub-goal 3.5: Ensure the highest level of economic and organization efficiency, effectiveness, and productivity of VA and DoD health care systems while utilizing systematic measurement that leverages information technologies and data sharing efficiencies.

HEC Continuing Education and Training Working Group

The Continuing Education and Training WG leverages sharing opportunities to improve continuing education and in-service training quality for VA and DoD health care professionals. In FY 2011, the WG accomplished a number of significant activities which increased continuing education and in-service training programs shared between VA and DoD. Significant among these were a number of enhancements to the shared training distributed learning architecture, which are various information technologies that assist in educating health care professionals. These improvements optimized clinical and clinically related training by:

- Developing a content on demand distribution system for MHS Learn in DoD;
- Enhancing the scope of training deployed via the VA/DoD Virtual Clinical Grand Rounds program;
- Improving the process for vetting and deploying satellite training from DoD to VA;
- Implementing a strategy for deploying training to DoD; and
- Increasing the number of participants in the VA/DoD Facility Based Educators Community of Practice while enhancing the communication strategies utilized to share information with the community.

These enhancements resulted in exceeding the FY 2011 direct cost avoidance target of $13,500,000 by 123 percent, generating $30,306,119 in shared training direct cost avoidance; $21,148,854 in DoD and $9,157,265 in VA. The WG also exceeded the FY 2011 volume of shared training target of 415 programs by 100 percent, coordinating 830 shared programs; 598 programs were deployed from VA to DoD and 232 programs were deployed from DoD to VA at no cost to either Department.

Several enhancements to the learning management capabilities in VA and DoD improved participant data management and increased deployment of training between the Departments. This resulted in increased sharing and the ability to collect and analyze VA/DoD learner participation data for the first time. These enhanced capabilities include:

- More efficient training deployment from the VA learning management system now called Talent Management System (TMS) to both VA and DoD staff at integrated and joint venture sites, and with fewer resources;
- The collection and deployment of course completion data derived from the VA TMS to both Departments on VA and DoD learners, from integrated and joint venture health care facilities, while maintaining IT security;
- VA and DoD SME access to both VA and DoD courses prior to deployment to assure the content validity and technical compatibility with each Departments' TMS; and
- Tracking and reporting VA and DoD staff participation in shared training MHS Learn and the VA TMS.

In FY 2011, the WG implemented a process to share training programs developed by the VHA Interagency Healthcare Training Consortia (composed of 12 Federal agencies) with DoD for use

in training their personnel. This effort resulted in 216 additional programs shared with DoD and generated a potential direct cost avoidance for DoD of $7,560,000.

The WG coordinated and/or managed a number of special training initiatives that were leveraged to develop and deploy high value education and training programs in VA and DoD. In FY 2011, the deployment of these special initiatives resulted in more than 160 hours of instruction made available to VA and DoD personnel and generated more than $8,000,000 in direct cost avoidance. These programs include:

- Virtual Clinical Grand Rounds program;
- Managing Violent and Disruptive Behavior training program;
- Case Management Training program;
- C&P training initiative;
- Pharmacy Technician Training program;
- Clinical Practice Guidelines training program;
- InTransition training initiative;
- Managing Overweight and/or Obesity for Veterans Everywhere (MOVE) diet and fitness program; and
- Compliance training for VA and DoD staff.

The WG also managed or coordinated a number of activities intended to decrease redundancies of mandatory continuing education and in-service training programs for staff in both VA and DoD facilities, and for DoD personnel at integrated or joint venture sites. The WG first developed a strategy for reducing the overlap in mandatory training and developed a tactical plan for implementation. The WG implemented and completed a pilot project in FY 2011 that validated the effectiveness of the proposed strategy. During the pilot, DoD determined that none of the five courses reviewed warranted mutual exchange, while VA found that reciprocity was warranted for four courses. VA approved implementation of a process to grant course waivers for the four approved courses. The WG developed a tactical plan for implementing the course waiver process utilizing the VA TMS and is currently awaiting VA approval of the plan.

In FY 2011, the WG deployed 100 percent of requested training curriculum to the Captain James A. Lovell Federal Health Care Center (FHCC). This effort resulted in managers and staff at the FHCC achieving their health care mission through VA and DoD staff orientation, in-service, and continuing education training. Successfully implementing the training curriculum at the FHCC established a curriculum model that could be used as a basis for developing and deploying orientation, in-service, and continuing education training to other VA/DoD integrated or joint venture health care facilities, supporting their efforts to provide state of the art health care.

In FY 2011, the WG initiated two major initiatives expected to be implemented in FY 2012. The first initiative is a VHA Employee Education System Web-based Program Exchange which will allow all available Web based courses to be shared between VA and DoD. The courses will be reviewed for content and to assure that they meet the technical requirements of the Department seeking to deploy the training. The Web-based program exchange will allow sharable content objects to be accessed by those building new programs thus saving developmental costs, and provide a single source for training being downloaded to VA and DoD TMS. The second initiative will add the DoD MHS Health.mil Web site to the VA/DoD distributed learning architecture, which will allow deployment of all Web-based shared training from a single source

to all Federal workers including VA and DoD staff. This effort will dramatically increase the efficiency of sharing programs between the Departments and significantly reduce the resources necessary to deploy shared training in DoD. All shared courses will be accessible by Federal workers from government or private sector computers. It will remove the need to deploy shared training from either Department to the partner TMS, thus reducing the time and resources necessary to deploy training. It will also provide more accurate reports on Federal agency staff participation, allowing for better documentation of shared training impact. If successful, these initiatives will significantly enhance the distributed learning architecture and will have a substantial positive impact on the number of programs shared between VA and DoD in 2012 and thereafter.

HEC Information Management/Information Technology Working Group

The Information Management/Information Technology (IM/IT) WG provides executive oversight of joint integrated health information sharing activities and ensures that commonly accepted government IT program management practices are utilized.

Sharing of secured electronic health information

Since 2001, DoD has provided VA with one-way historic information on separated Service members through the Federal Health Information Exchange (FHIE). On a monthly basis, DoD sends laboratory results, radiology reports, outpatient pharmacy data, allergy information, discharge summaries, consult reports, admission/discharge/ transfer information, demographic data, PPDHAs, and PDHRAs. Sharing electronic health information at the time of a Service member's separation allows VA providers and benefits specialists to access secure data for use in delivering health care and making claims determinations.

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

Since 2006, VA and DoD have shared computable outpatient pharmacy and medication allergy data through the interface between the Clinical Data Repository (CDR) of AHLTA, DoD's iEHR, and VA's Health Data Repository (HDR). This initiative is called "CHDR." In September 2008, DoD automated a previously manual process to identify patients treated in both Departments and began setting an active dual consumer (ADC) "flag" which facilitates the exchange of outpatient pharmacy and medication allergy data. Exchanging computable electronic health data on patients supports improved patient care and safety through the ability to conduct drug-drug and drug-allergy interaction checks using data from both VA and DoD systems.

Between October 2010 and September 2011, the IM/IT WG successfully completed 100 percent of FY 2011 quarterly metric milestones to support the bidirectional exchange of electronic health data between the Departments. The benefit of this progress is that more

Service members and Veterans than ever have had more health data available, electronically and in real-time, to support the provision of care and the adjudication of claims:

- The number of Service members with historical data transferred to VA increased from over 5.3 million to over 5.7 million.
- The number of PPDHA and PDHRA forms transferred to VA increased from over 2.8 million to over 3.3 million.
- The number of individuals with PPDHA and PDHRA forms transferred to VA increased from over 1.2 million to over 1.5 million.
- The percentage of DoD inpatient beds providing VA provider access to inpatient documentation (e.g., discharge summaries) increased from 80 percent to 100 percent of total DoD inpatient beds.
- The number of DoD beneficiaries with viewable data available real-time to VA and DoD providers increased from over 3.8 million to over 4.1 million.
- The number of data queries by VA and DoD providers increased from over 11.2 million to over 16.8 million.
- The number of shared patients flagged as ”ADCs” for computable pharmacy and allergy data exchange increased from over 251,000 to over 1.2 million. ADCs have increased over 400 percent in the past year due to increases in the number of patients automatically flagged each day.

To increase the availability of clinical information on a shared patient population, VA and DoD collaborated to further leverage BHIE functionality to allow bidirectional access to inpatient discharge summaries from DoD’s inpatient documentation system. In 2008, additional DoD inpatient note types became available to all VA and DoD providers in the Puget Sound area including inpatient consultations, operative reports, history and physical reports, transfer summary notes, initial evaluation notes, procedure notes, evaluation and management notes, pre-operative evaluation notes, and post-operative evaluation and management notes. In April 2011, DoD completed implementation of its inpatient documentation system. Access to DoD inpatient documentation is now operational at DoD’s 59 inpatient facilities. In June 2011, VA expanded provider access to these additional inpatient note types enterprise wide.

DoD technical development supporting the capture and display of automated neuropsychological assessment data from the NeuroCognitive Assessment Tool (NCAT) is complete. Limited user testing (LUT) is now underway at Army and Air Force sites. Navy LUT is scheduled to begin in the first quarter of FY 2012. VA technical development efforts related to the Clinical Display Module, to enable viewing NCAT data, are complete and end-to-end testing is well underway. The NCAT capability is targeted for the production (live) environment by the first quarter of FY 2012. This module will support the initial capability for DoD to electronically capture baseline assessments on Service members and for VA and DoD clinicians to view and trend NCAT data electronically.

The IM/IT WG achieved the following activities in support of interagency electronic patient registries in FY 2011:

- Interagency registry collaboration with CoEs including DCoE, National Intrepid Center of Excellence (NICoE), DVBIC, VCE, HCE, and EACE;
- Registry collaboration and strategic synchronization with other data warehouses and data repositories, such as the Population Health Portal and the Health Services Data

Warehouse/Statistical Analysis System Computing Environment and the VA's data stores;

- DVEIVR pilot application was completed on September 30, 2011
  - BRD and ConOps documents complete
  - Contract awarded for registry pilot; technical documentation and reviews underway;
- JHASIR
  - ConOps finalized and approved
  - JHASIR will interface with the DVEIVR pilot as a community of interest;
- The ConOps, BRD, and registry interface requirements are being vetted with the EACE lead for the Interagency Extremities Injuries and Amputation Registry; and
- The Interagency TBI and PH registry is in the planning stages to develop and implement a charter to determine registry scope.

Collaborative registries will enable the Departments to capture and store data on patients affected by these conditions. As data in the registries becomes increasingly robust over time, the advanced data registry management capability will enable VA and DoD medical and research communities to conduct multidimensional and longitudinal studies, benefitting medical readiness, patient care services, and outcomes management.

VA/DoD IT activities supporting single patient registration, medical SSO for clinical systems with patient context management, and interoperability foundation at the FHCC were successfully developed and implemented in December 2010. The IM/IT goal of the FHCC demonstration project is to implement systems or capabilities that safely integrate VA and DoD EHR systems in a combined VA/DoD facility with multiple care locations. The radiology orders portability solution began implementation in June 2011. Additionally, VA and DoD began testing graphical user interface (GUI) solutions to improve viewing BHIE data and to identify a "common" GUI for providers at the FHCC. Going forward, the Departments will maintain delivered IT capabilities, however IT capabilities not yet delivered will be jointly coordinated with the iEHR effort.

In light of the current iEHR efforts, as well as the VLER initiative activities and lessons learned from IM/IT efforts supporting the FHCC, the Departments agreed to halt future development of the capability to share laboratory data through the CHDR interface. Simultaneously, VA continues current efforts to more fully standardize its laboratory data enterprise-wide. The goal is to ensure that future exchanges of computable data fully align with future systems.

<u>Improve electronic sharing of images and artifacts</u>
The IM/IT WG successfully completed 100 percent of FY 2011 quarterly milestones to increase the type and amount of electronic image data shared between VA and DoD.

The Healthcare Artifact and Image Management Solution (HAIMS) is a MHS project that will enhance medical informatics through seamless integration of medical digital artifacts and images (A&I) into the iEHR. The objective of HAIMS is to give health care providers global awareness and access to essential health care A&I throughout the continuum of care from theater to garrison to VA, and from VA to DoD when needed. When fully developed, HAIMS will provide an enterprise-wide image sharing capability for multiple types of A&I, including radiographs, photographs, waveforms, audio files, video, and scanned documents. The

following activities were completed in FY 2011:

- A joint VA/DoD testing schedule was completed in April 2011;
- DoD HAIMS Release I LUT in the production (live) environment at nine sites (three sites from each Military Department) was completed in June 2011;
- DoD System Qualification Testing was completed in August 2011;
- HAIMS Release II VA/DoD end-to-end testing was completed in August 2011; and
- VA's Advanced Web Image Viewer, a technical solution which enables VA providers to view DoD scanned patient records and related artifacts, is planned for enterprise-wide release in October 2011.

DoD completed development of the technical solutions that send radiological orders and patient demographics from the Theater Medical Information Program Composite Health Care System (CHCS) Cache system to the Deployed Tele-Radiology System (DTRS) and Theater Picture Archiving and Communication Systems (PACs). This capability was released to the Service Infrastructure Offices in September 2009 for deployment in theater. Additionally, the work necessary to push the corresponding radiological reports from DTRS into the Theater Medical Data System was completed and delivered to the Service Infrastructure Offices in September 2011. This capability will improve continuity of care from theater to garrison to VA by supporting the movement of radiology information and images with the wounded warrior during the provision of care. Further, by enabling ready access to theater radiology information, the risk of unnecessary exposure to radiation is reduced by negating the need for repetitive radiology services.

The DoD MHS Cyberinfrastructure Services (MCiS) directorate provided a quarterly briefing regarding bandwidth and network performance of the north, south, east, and west multipurpose VA/DoD network gateways to the IM/IT WG. MCiS developed traffic analysis reports to identify traffic levels, types, and patterns (including protocol type and distribution of imaging traffic) and overall bandwidth demand levels for inbound and outbound wide area network traffic. The current assessment is that the existing network infrastructure and available bandwidth more than adequately supports current VA/DoD data traffic based on the established FY 2011 metric: network availability was maintained at 98.5 percent or better across the four multipurpose gateways.

<u>Promote collaboration on architectural compliance</u>

The VA/DoD Health Architecture Interagency Group (HAIG), currently an advisory sub-WG to the HEC IM/IT WG, was established in January 2005, to facilitate interagency cooperation, and specifically to foster collaboration on enterprise architecture sharing initiatives between the Departments. The HAIG is being re-chartered as the DoD/VA Health Architecture Review Board, a sub-WG under the HEC.

The HAIG is a collaborative interagency board that oversees VA and DoD health data sharing efforts to ensure emerging technologies meet national interoperability standards. The HAIG's efforts facilitate the exchange of meaningful health data between the Departments to support health care delivery and claims adjudication.

In February 2011, the HAIG approved the updated architectural compliance review checklist. Updates focused on alignment to version two of the DoD Architecture Framework and the

Federal Enterprise Architecture Framework. This checklist is used in conducting VA/DoD electronic health data sharing architecture compliance reviews relating to various aspects of project architecture. The HAIG, guided by a joint VA/DoD revision team, restructured the 2009 checklist to include side-by-side VA and DoD input columns for ease of project comparison. The joint VA/DoD electronic health data sharing architecture compliance review submission received formal HAIG acceptance and approval.

The HAIG reviewed 2011 HHS National Health Information Technology (HIT) standards related to health data sharing and provided a briefing to the IM/IT WG in June 2011. Additionally, the HAIG reviewed and accepted the FY 2011 VA/DoD annual health data sharing architectural compliance review which included FHIE, BHIE, and CHDR initiatives. This activity supports VA/DoD electronic health data sharing by promoting architectural compliance, adoption of HIT standards, identification of new information exchanges, and combines separate VA and DoD reviews into one document. In March 2011, the information exchange (IE) tool was updated with SSA data exchanges including claims and benefits. In June 2011, the HAIG recommended that the IM/IT WG continue sustainment of the IE tool. The VA/DoD IE tool enables agency stakeholders to establish and prioritize measurable data sharing, determine IM/IT program compliance with interoperability standards, and approve the annual interoperability standards for the Departments in a more streamlined manner. In September 2011, the HAIG, working in collaboration with the Interoperability WG, updated the IE tool to integrate FHCC and VLER information exchanges. In FY 2012, the IE tool will be extended to include additional data exchanges between VA and DoD.

On September 19, 2011, the HAIG approved the latest version of VA/DoD Target Standards Profile which incorporated interoperability standards and identified current gaps. During this activity, members of the HAIG reviewed current standards profile and provided comments.

In support of iEHR activities, the HAIG began development of an Integrated Business Reference Model which will provide alignment between both Departments' business activities and will support collaborative capability development and implementation of new health data exchanges. Additionally, the HAIG will leverage the updated compliance review checklist and IE tool as a key reference for planning and implementation of iEHR capabilities.

Under the guidance of the HAIG, VA/DoD teams collaborated with the Office of the National Coordinator Standards and Interoperability Framework on refining specifications on the standards recommended by HHS for Meaningful Use Stage 1 criteria. In September 2011, the joint work on standards resulted in a new Health Level 7 Draft Standard for Trial Use and a Consolidated Implementation Guide for Clinical Document Architecture supporting the VLER delivery of patient care summaries.

The HAIG successfully completed 100 percent of FY 2011 proposed milestones. Completion of these goals resulted in identifying and documenting architectural compliance, maturity, and levels of interoperability standards in current VA/DoD health data sharing initiatives. In addition, HAIG products are serving to educate VA, DoD, and other stakeholders about current health data sharing strategies and statuses.

HEC Acquisition and Medical Materiel Management Working Group

The Acquisition and Medical Materiel Management WG (A&MMMWG) continued to identify, review and implement joint VA/DoD medical materiel management sharing initiatives to achieve joint operational and business efficiencies. During the reporting period, VA and DoD awarded eight of nine follow-on contracts for the Digital Imagine Network – Picture Archiving Communications System (DIN-PACS). For radiology, VA and DoD awarded seven new joint radiology contracts. In addition to these awards, the Departments received two new offers during this year's open season. These long term contract awards provide for continued contract coverage for DIN-PACS systems and expand the vendor base and product offerings for radiology to all VA and DoD customers.

As evidenced in the chart below, while pharmaceutical sales showed solid growth, a reduction in equipment sales placed significant downward pressure on total sales. The reduction in joint equipment sales is not directly proportional to the number of joint contracts, as the number of joint contracts for high tech medical equipment has increased over the last year. Equipment sales are more directly related to Department budgets and the need for high tech medical equipment.

Joint VA/DoD Sales
(Dollars in Millions)

Commodity	FY 2011 (through 2 Qtr)	FY 2010 (through 2 Qtr)	Change (through 2 Qtr)
Pharmaceuticals	$1,128.875	$1,115.64	$13.235
Medical/Surgical	$0.000	$0.0150	($0.015)
Equipment	$170.391	$223.500	($53.109)
Total	$1,299.266	$1,339.160	($39.894)

The WG's activities below contributed to the realization of established FY 2011 targets for cost efficiencies and savings.

During this reporting period, the VA/DoD data synchronization program completed the migration of the Product Data Bank (PDB) and the Medical Surgical Product Data Bank (MedPDB) application development process behind the government firewall. The objective of the migration was to certify the PDB system under the DoD Information Assurance Certification and Accreditation Process. The migration successfully enabled all PDB processes and activities with related Web tools and functionalities, including MedPDB and eZSAVe, a data synchronization pricing and site data enhancement application, to achieve final authority to operate in January 2011. The PDB/MedPDB is now compliant with all Federal information assurance requirements and enables protection of sensitive but unclassified data.

The VA/DoD data synchronization program is transitioning the PDB/MedPDB system from a research and development stage to the operation and maintenance life cycle phase. During FY 2011, the program was heavily involved in strategic planning for contracting, financial, and technical requirements for the transition. The support contract for major development of the PDB/MedPDB expired at the close of FY 2011, and the program is implementing the PDB life cycle sustainment plan through a competitive re-solicitation contracting action for FY 2012-

2013. Both the Defense Logistics Agency (DLA) Troop Support and VA committed to providing 50 percent each for program sustainment costs.

At the end of FY 2010, the VA/DoD data synchronization program completed an initial load of DoD pharmaceutical data and basic functionality for a pilot. Analysis conducted in FY 2011, identified the potential for significant savings in DoD pharmaceutical purchases by moving from brand name to generic drugs at the earliest opportunities. By the end of FY 2011, the pharmaceutical pilot worked on 24 specific pharmaceutical products and projected over $20 million in potential annual savings in brand name cost reductions and generic drug substitutions at the pilot sites.

The spend analysis capability in MedPDB has become a cornerstone in VA's health care efficiency initiative for commodity standards. The objective of this initiative is to develop an integrated approach to commodity standardization (equipment, supplies, and services). The initiative is designed to align processes, stakeholders, and resources across all organizational levels to achieve sustainable, measureable cost savings/avoidances, and efficiencies. The data synchronization program also studied the capabilities for VA national and regional standardization. VA's expenditure was analyzed by clinical categories for equivalent and similar items, and by manufacturer by reviewing open market purchases. The analysis presented top candidates for VA standardization, with potential cost reductions on five to ten clinical categories and open market buys in the range of $35-50 million. Regional standardization opportunities were identified on clinical item categories not nationally standardized. VA began to investigate and develop compliance reports to assist in monitoring compliance with committed volume and VA standardization contracts.

The data synchronization program's equipment pilot researched the availability of capital equipment taxonomies, in which classification schemas could enable the aggregation of VA expenditure for further cost and contract analysis. The market research revealed there are currently no mature categorization schemas in the commercial marketplace for capital equipment. The government's experience with one-off configurations on nearly every major capital equipment purchase (e.g. for Magnetic Resonance Imaging [MRI] and Computed Tomography [CT] scan machines) is more the rule than the exception in the commercial marketplace as well, making product analysis for standardization ineffective. The initial study confirmed the return on investment projection for the equipment pilot would take several years to materialize, given the small potential for this commodity's taxonomy to develop in the near term.

The data synchronization program conducted training for new users and refresher Webinars for existing users on a quarterly basis to promote the availability of contract and pricing data for procurement decisions. At the close of FY 2010, there were 864 active users. As of August 31, 2011, the last report available for FY 2011, there were 1,116 VA and DoD active users of the business intelligence (BI) tools, a 29 percent increase in users. This metric exceeds the WG's target of a 12 percent increase.

The data synchronization program was actively involved with field users, through Web site feedback and help desk calls, to explain product data queries and results as users were working purchase recommendations generated by the BI tools. The WG targeted $8 million in

product price reductions as a result of using the BI tool. As of September 30, 2011, VA and DoD users have accepted purchase recommendations that reduced medical/surgical product costs by a projected $19.42 million, exceeding the target increase by 140 percent (see chart below).

Data Synchronization Product Price Reductions

Quarter	DOD	VA	Total
1	$ 2,517,397	$ 2,206,344	$ 4,723,741
2	$ 3,611,931	$ 1,861,647	$ 5,473,578
3	$ 2,713,973	$ 2,057,828	$ 4,771,801
4	$ 2,605,398	$ 1,849,636	$ 4,455,035
Total	$ 11,448,700	$ 7,975,456	$ 19,424,155

The data synchronization program achieved the WG's target of participating in at least two industry forums, venues, and/or pilots to advance adoption of industry-wide use of medical surgical product data standards and data sharing networks. The Deputy Program Manager attended GS1 forums and program representatives participated in industry data standards WGs for the health care industry. Program personnel were active contributors to developing implementation guidelines and industry scorecards to measure readiness to meet standards implementation dates.

The WG is in the process of revising the 1999 VA/DoD MOA on combining buying power in accordance with the terms of the current MOA. The intent of the revised MOA is to lower material and administrative costs, evaluate better ways to promote maximum participation, and address new realities to extend opportunities for partnership and intra-agency program support.

HEC Financial Management Working Group

The Financial Management WG (FMWG) collaborates to improve business practices related to financial operations in VA and DoD and manages the JIF for health care sharing. In FY 2011, the FMWG revised the JIF templates to clarify and standardize the instructions for the preparation of proposals. In addition, the Air Force briefed the FMWG on their internal JIF application process and best practices. Additional briefings are planned with the other Military Departments. These actions contributed to a 100 percent increase in the number of proposals submitted from both Army and Navy; Army from six to 12 and Navy from two to four. The FMWG reviews Interim Progress Reports (IPRs) of all active JIF projects and monitors actual obligations on a quarterly basis. The IPR templates are being revised to include planned obligations on a quarterly basis. The results for this goal will be reported for newly funded projects beginning the first quarter of FY 2012.

TMA and VA IDES personnel conducted an intense review of claims billing and reimbursement over a nine month period. Claims submissions were validated and it is expected that there will be improved claim submittal using the VA Electronic Data Interface (EDI) process. At the onset, with paper claims, there was a baseline of 85 percent of "clean claims." With the submission of electronic claims, the target for "clean claims" is 98 percent, as long as VAMCs are provided the appropriate TRICARE authorizations. VAMCs initiated submittal of IDES claims via EDI on June

1, 2011.

VA IDES, in conjunction with the VHA Chief Business Office (CBO), continually reviewed and revised the IDES registration and billing guidance. Guidance updates were shared with VHA, VBA, DoD, and TRICARE managed care support contractor (MCSC) partners. In September 2011, VA IDES, in conjunction with key personnel from the VHA Allocation Resource Center and Decision Support Office, revised the guidance to include the proper IDES clinic set-up requirements.

VA IDES personnel are monitoring a SharePoint Site and Demonstration Site Subgroup (DSS) reports to monitor both billing and collection data, as well as workload and no-show information. VA IDES, the Medical Sharing Office, and CBO personnel are reviewing the need for requesting a revision to the MOA as it relates to the registration and billing guidance, with particular attention to billing procedures.

The billing and reimbursement process will have no direct impact to Service members, however there will be an indirect impact to Veterans. According to Title 38, Section 8111, when reimbursements are received by the VAMC, they should be used to improve programs for Veterans or augment existing programs and staff.

TMA trained additional personnel to improve the time frame for processing paper claims. VA IDES will send final claims for dates of care prior to January 1, 2011, for final submission. The TRICARE MCSCs now process claims electronically with a date of care on or after January 1, 2011.

HEC Joint Facility Utilization and Resource Sharing Working Group

The Joint Facility Utilization and Resource Sharing WG (JFU&RS WG) works to identify opportunities and make recommendations for increased collaboration between the Departments. During the Joint Venture Conference in October 2010, the JFU&RS WG developed and presented a sample JEC charter for use as a tool to help newly formed multi-market areas formalize and provide local guidance on how to conduct joint business initiatives. Additionally, the WG introduced a modified performance-based objective template and sample as a means for sites to periodically summarize and communicate their initiatives in a comprehensive and concise manner to the JFU&RS WG.

In December 2010, the JEC required the JFU&RS WG to provide information on operational efficiencies and identify dollar targets related to performance metrics at all joint ventures and joint market sites. The JFU&RS WG was also tasked with identifying opportunities and making recommendations for joint utilization of facilities, sharing resources, and integration of activities that will streamline management and eliminate duplicative services.

To comply with the JEC mandate, the JFU&RS WG required that all joint ventures and joint markets discuss and develop performance metrics to quantify the efficacy of their unique sharing arrangements. In addition, facilities were expected to identify new or current sharing arrangements where a minimum five percent annual reduction in operational costs is realized. A coordinated memorandum was distributed to all affected VA and DoD facilities as guidance

through the VA Deputy Under Secretary for Health for Operations and Management, and the Principal Deputy Assistant Secretary of Defense for Health Affairs.

The WG focused on identifying sites with potential for developing new or increased sharing relationships and with the objective of achieving cost savings. In FY 2011, the WG used purchased care expenditures, proximity of facilities, area enrollment population, current working relationship, current/future resource sharing initiatives, and planned/current construction renovation as site selection criteria. Based on these criteria, the following markets were targeted and visited during the year: St. Louis, Missouri market area (St. Louis VAMC and Scott AFB) in March 2011; Columbia, South Carolina market area (Columbia VAMC, Fort Jackson and Shaw AFB) in June 2011; and Temple-Killeen market area (Central Texas VA HCS and Fort Hood) in August 2011.

The St. Louis market area continued to explore potential clinical and administrative sharing initiatives between Scott AFB (375th Medical Group (MDG)) and the St. Louis VAMC that will help reduce external purchased care expenditures. Services under review include dermatology, neurology, podiatry, physical therapy, and mental health. In addition, both facilities are exploring opportunities for shared education and training.

The Columbia market area had several VA/DoD sharing initiatives in general surgery, gastroenterology, ophthalmology, and podiatry. They also developed several successful joint services through the initial use of the JIF program for sleep lab services and mental health.

The Central Texas VA HCS and Fort Hood conducted active sharing relationships with the interest of improving patient care and reducing costs through their Central Texas Executive Council. The joint leaders in the Temple-Killeen market area expressed interest in exploring additional sharing opportunities in a number of areas, including mental health, cardiology, oncology, women's health, ophthalmology, orthopedics, general surgery, and pain management. Additionally, the Central Texas Executive Council is exploring shared space opportunities with the Copperas Cove proposed CBOC and the potential use of vacated space in Darnall AMC at Fort Hood.

In-progress reviews were conducted for most of the current and previously visited joint market sites that showed an interest in participating in joint initiatives, and have the potential to improve health care service efficiencies.

The discussions held during the site visits and in-progress reviews increased the level of communication among the sites, raised the level of awareness of opportunities for sharing, and provided greater access to specialized services for VA and DoD shared beneficiaries at a lower cost.

The Enhanced Document and Referral Management (eDR) business tool is a product of the Hawaii joint venture market site that was developed to improve health care related business processes. The local site developed three metrics that have shown positive results in FY 2011(from baseline data from FY 2010 and earlier). These metrics are patient consult processing time which is part of the referral management module; patient appointment compliance timeliness under the utilization review module; and billing process, accounts

receivables turnaround under the charge master based billing module. The data for all three metrics displayed improved timeliness and turnaround processing time. Additional eDR reporting metrics are under local development and analysis and will be discussed and reviewed with the JFU&RS WG.

JANUS, the front-end Web application of the eDR, is a common data viewer which is a GUI that links CHCS with VISTA. JANUS provides bi-directional exchanging and viewing of VA/DoD patient record data by authorized DoD CHCS users and VA VISTA users. Due to its local production success at the Hawaii joint venture site, the Janus interface is being installed and tested at the FHCC. This tool improves the exchange of health data between VA and DoD in a user friendly format while improving response time for patient consult referrals.

HEC Contingency Planning Working Group

The Contingency Planning WG works to maintain appropriate VA capability to support DoD contingency medical requirements. The objective established at the beginning of FY 2010 was to document VA capabilities in applicable DoD functional, concept, and operations plans. Addressing 2010 milestones, VA and DoD surveyed existing U.S. Northern and U.S. Transportation Command functional, concept, and operations plans to determine current DoD bed and patient transport flow requirements and to ascertain the combatant commands' contingency requirements that could be supported by VA. Neither combatant command identified any VA support requirements in their existing plans. For FY 2011, the Departments agreed to review the Aeromedical Evacuation analysis of the DoD Mobility Capabilities and Requirements Study (MCRS) upon its completion. The MCRS was completed in early 2010, but the Aeromedical Evacuation analysis, which included aeromedical evacuation requirements, was not completed until June 2011. Study assumptions regarding inpatients' lengths of stay, locations for final patient movement, and other critical details have yet to be confirmed. However, initial indications are that the Aeromedical Evacuation analysis has identified overall logistical requirements in sufficient detail to enable VA and DoD planners to estimate the level of VA support that may be required in a wartime contingency. A VA/DoD contingency plan currently exists to support established DoD contingency requirements. When the assumptions described above are confirmed, the WG will develop a revised plan.

In addition to addressing the objective described above, both Departments continued training and exercise programs geared to ensure the preparedness of current contingency assets. Education and training specialists from both Departments worked closely to conduct a comprehensive curriculum review of both the basic and the advanced courses available for VA and DoD personnel at Primary Receiving Centers (PRC) and Federal Coordinating Centers (FCCs). Both courses were conducted in 2011 and all PRC and FCC personnel are current on their training. Full scale patient reception exercises were independently conducted at various FCCs throughout the year. A nationwide medical regulating exercise was conducted by the U.S. Transportation Command to ensure the capabilities of all FCCs. All FCCs continue to conduct bi-monthly bed availability drills. Finally, the WG conducted a comprehensive VA and DoD patient movement system exercise in conjunction with the National Disaster Medical System and the Federal Emergency Management Agency's National Level Exercise in May 2011, involving exercise aeromedical missions to eight FCCs over a two day period.

Although the analysis of the results from the aeromedical evacuation follow-on study to the MCRS is not yet complete, DoD recognizes VA is an essential partner in supporting its medical requirements during major wartime contingencies. The medical activities of both Departments continue planning, training, and exercising together to be prepared to meet any potential contingency requirement.

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

JEC Communications Working Group

The JEC Communications WG (CWG) is responsible for the coordination of the legislative and public affairs activities between VA and DoD.

A Communications WG Charter, signed on October 28, 2010, by the JEC Co-Chairs, established the VA/DOD CWG and delineated the purpose, goals, and signatory party responsibilities, including implementation and coordination actions.

In accordance with the charter, a Congressional Outreach Implementation Plan was developed. VA/DOD Departmental concurrence and plan implementation was reported to the JEC in July 2011.

Outreach activities continued in FY 2011, with positive response from stakeholders. For example, VA and DOD program managers jointly briefed congressional staff from eight stakeholder committees on the status of the IDES program. The discussion of program successes and challenges was well received. In particular, program managers introduced the remodeled IDES project. Congressional staff expressed strong interest in continuing these forums. Additional joint VA/DOD Congressional outreach included the following:

- Multiple site visits (such as to the joint facility at North Chicago), to review the progress of joint information technology projects (e.g. VLER);
- Multiple briefings on the iEHR program;
- Two briefings on the IPO; and
- A briefing on a VA/DOD outpatient clinic in Monterey, CA.

VA and DoD Public Affairs activities include production of a Public Affairs Outreach Implementation Plan, signed and approved by both the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs. This plan is used as a foundational document for additional “layers” of specific plans for the various collaborative programs.

Joint VA and DOD communication efforts facilitated several collaborative interviews with major news organizations on controversial issues such as FRCP/RCP, military and Veteran suicides, and suicide prevention initiatives, and joint support after the 2011 Tsunami in Japan that severely damaged the Tamadachi nuclear power plant. This collaborative effort ensured message consistency throughout both departments and gained overall balanced media coverage on these controversial issues.

Environmental Exposures issues continued to grow in both significance and consequence in FY 2011, with VA working closely with DoD Public Affairs, the military services, and most closely with the Department of the Navy (DON) on projects such as the Camp Lejeune Historic Drinking Water project, burn pits, and Blue Water Veterans Agent Orange presumption.

These joint efforts between VA and DoD resulted in the establishment of a protocol for collaborative news releases, the most significant for this year being the August 30, 2011, release, "Over $2.2 Billion in Retroactive Agent Orange Benefits Paid to 89,000 Vietnam Veterans and Survivors for Presumptive Conditions," and the September 2, 2011, release, "VA Posts Online List of Ships Associated with Presumptive Agent Orange Exposure."

The VA and DON/U.S. Marine Corps established a formal coordination function to communicate on the Camp Lejeune Historic Drinking water project, to include a communications plan, and an online/social media outreach mechanism on VA and Marine Corps Web sites. The Web sites resulted in 175, 000 registrants comprised of current Service members, Veterans, dependents, and civilian employees. The VA and Marine Corps are postured to refine and continue joint communication efforts on this important topic in FY 2012.

The Secretary of Defense and Secretary of Veterans Affairs meeting in October, 2011, and senior Departmental visits to North Chicago resulted in refined guidance regarding the way ahead for iEHR project. The CWG established a more formal relationship with the IPO, to more closely coordinate iEHR communications efforts.

In FY 2011, the CWG also worked on joint media interview protocols, and joint products and programs such as brochures on TAP, Military Families, Yellow Ribbon Reintegration Program, Social Media, IDES, and eBenefits. An example of a communication effort was VA's Under Secretary for Benefits interview with the Defense Media Activity's Armed Forces Press Service. This interview reached a potential audience of 1.2 million Active Duty Service members through publication on Defense.gov and through additional publication in several military newspapers in posts, camps, bases, and stations around the world.

Another example of a joint outreach effort was VA's first major collaboration with the United States Army in the annual Association of the U.S. Army Convention in Washington, DC. VA accomplished a major outreach effort which included floor exhibits and a robust operations center to reach out to soldiers and Veterans attending the event. The effort resulted in signing up over 750 Soldiers and Veterans for eBenefits. Additionally, VA supplied information and products to many more Soldiers and Veterans on programs ranging from VA health care, home loans, burial benefits, GI Bill, disability compensation, pensions, and virtually every program contained in VA.

During the past year, coordination between the two Departments' Public Affairs offices has grown significantly and taken on a more habitual nature that will greatly assist the Service members who transition from the military and become part of the American Veteran population.

Sub-goal 3.7: Identify, propose, and increase collaborative opportunities for Joint Capital Asset Planning.

Construction Planning Committee Working Group

The VA/DoD Construction Planning Committee (CPC) provides a formalized structure to facilitate collaboration between the Departments to identify joint capital asset opportunities that enhance the delivery of services to Active Duty Service Members and Veterans. Types of capital initiatives include planning, construction (major and minor/military construction and unspecified minor construction), leasing, and other real property related activities. The CPC works to overcome budget and appropriation limitations that impede these efforts.

In FY 2011, the CPC improved the collaborative process through three major achievements: 1) initiated joint participation in each Department's capital investment decision making processes through the VA's Strategic Capital Investment Planning (SCIP) and DoD's Capital Investment Decision Model (CIDM); 2) completed a review of various Departmental planning tools and processes to identify potential shared projects; and 3) reached agreement ways to streamline funding challenges for joint projects. Ideally these efforts will result in a mechanism to provide early, systematic identification of joint opportunities and provide new flexibility that would allow the Departments to overcome previous budget limitations.

In VA's SCIP and DoD's CIDM process, both Departments have incorporated a mechanism that requires review of joint possibilities when submitting projects for consideration. Both Departments also provide a point incentive which helps joint projects compete for funding when compared to other projects submitted. This enhanced collaboration should increase the availability and delivery of services to Active Duty Service members and Veterans.

In May 2011, the CPC presented an information paper to the JEC with recommendations for improving joint construction planning and alignment of funding to facilitate the future development of plans for joint medical facilities and other joint ventures. In addition, the CPC Project WG collaboratively reviewed and identified a short list of near term joint construction opportunities with a focus on what can be done to expand joint capacity in FY 2013. Joint sessions that included representation from the DoD and the Services were held to understand the various tools and processes used by each agency to identify potential shared projects.

Through shared representation at the SCIP and CIDM sessions, specific projects that could benefit through joint sharing were identified. In addition, efforts to explore sharing of common data elements (e.g., population, utilization/workload, and purchased care) to aid in the early identification of possible future joint projects were started. In FY 2012, this concept will be explored and, if feasible, refined for long-term process improvement. These improved planning tools should aid in identifying additional joint opportunities.

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

JEC Separation Health Assessment Working Group

A Separation Health Assessment Work Group was formed by key VA and DoD leaders. This followed the JECs guidance to develop a common set of criteria, or process, for conducting separation/transition health assessments on eligible Service members prior to their separation from the military that would meet the requirements of both Departments. The Separation Health Assessment is intended to provide an objective baseline medical assessment that can be referred to when disease is suspected or claims are made months or years after leaving the Service. This will help VA make more accurate disability determinations and will help ensure Service members and Veterans receive a fair, evidence based disability decision. The WG reviewed existing Military Service's separation health assessment processes and determined that all Service members were covered by an examination policy regardless of separation status (i.e., voluntary or involuntary). However, the content of these examinations was not standardized, computable, or bi-directionally viewable by both the VA and DoD.

The Separation Health Assessment Work Group established a DoD-VA Tiger Team to develop a standardized Separation Health Assessment that would meet the needs of both VA and DoD. The Separation Health Assessment Work Group developed a pilot process to synchronize and coordinate all health related activities at discharge, thereby reducing duplication of efforts. Methods to make the Separation Health Assessment computable and automated were explored. However, it was determined that this is not currently possible due to multiple issues including file size and interoperability between AHLTA, VISTA, and CAPRI.

The Military Services identified pilot sites and prepared them to implement the Separation Health Assessment Pilot. Formal coordination and signing of the Memorandum of Understanding (MOU) between the two Departments was completed in October, 2011. The Pilot is expected to be completed in 180 days. Following completion, the data will be compiled and analyzed to determine any requirements or implications for policy changes. Analyses will also evaluate how well the Pilot met VA and DoD requirements for consistent, standardized information, workload and resource implications, and Service member perceptions of the process. A final report is expected within 30 days following completion of the pilot.

A review of FY 2009 baseline data reflected that of 153,037 total discharges, 49,898 (32.6 percent) Service members filed VA pre-discharge claims, which include BDD, Quick Start, and IDES discharges. The total number of claims filed within one year of discharge was 88,756 (57.9 percent). This information will be compared to the data collected from Pilot participants.

Additional Accomplishments

Integrated Electronic Health Record Agreements

Each year more than 150,000 military members separate from military service and transition to Veteran status. Transitioning their health care from one large health care system (DoD) to the other (VA) involves coordination of data and information between the two Departments. When complete, the Integrated Electronic Health Record (iEHR) will serve as a national model for capturing, storing, and sharing electronic health information for Service members and Veterans from the moment they enter Active Duty throughout their lifetime.

The Secretaries of VA and Defense committed their respective Departments to jointly develop and implement the next generation of Electronic Health Record (EHR) capabilities with integrated objectives towards implementing a common architecture, data and services, data centers, interface/exchange standards and presentation layer; and with a single joint common platform using sequentially ordered business rules. On March 17, 2011, the Secretary of Veterans Affairs and the Secretary of Defense reached an agreement to work cooperatively on the development of a common electronic health record and are planning to sunset corresponding legacy systems and transition to the new iEHR.

Throughout FY 2011, numerous agreements were reached for iEHR activities, including the implementation of a high-level governance structure with a Program Executive and an Interagency Program Office (IPO) Advisory Board. Under this governance structure, the IPO Director as the Program Executive will make decisions related to requirements, design methodologies, application priorities, implementation schedule, and deployment sequence. The IPO Advisory Board has the necessary authority to ensure program execution and oversight.

Other key agreements were reached in the following areas:

- ***Mission Requirements/Performance Outcomes.*** Common mission and vision for the iEHR; common functional compatibility model; common quality measures and transparency requirements; core common Measures of Effectiveness, Measures of Performance and Key Performance Parameters; transparency to industry in business requirements, process flows, architectural requirements, and data standards/approach.
- ***Business Processes.*** Common Integrated Business Reference Model; common, optimized “To Be” business process flow model.
- ***Data Interoperability.*** Common information and terminology models; common data exchange specifications and translation services; common data standards.
- ***Infrastructure and Enterprise Architecture.*** Common regionalized data centers; common enterprise service bus(ses); common identity management within iEHR will utilize the Department of Defense Eligibility and Enrollment Reporting System Identifier which is the Electronic Data Interchange Person Identifier linked to VA’s Master Veteran Indexes Integration Control Number which is integral to the common health information database.
- ***Systems Capabilities and Shared Common Core Services.*** Prioritized list of system capabilities; initial set of shared common core services; prioritization framework and list of common system capabilities for joint pursuit.
- ***Presentation Layer.*** Common presentation layer for both Departments.

Virtual Lifetime Electronic Record Capability Delivery

VLER will empower Service members and Veterans. The concept of universal registration will eliminate the gap that our Service members experience when they transition to Veterans status. When fully implemented, VLER will ensure that the two-way relationship between Veterans and their government begins at the oath of office and continues through the administration of the final benefit. Through various VLER sub initiatives, Service members and Veterans will have access to their information in the single, secure electronic record made possible by VLER and be able to control how that information is shared with VA and its partners via e8enefits.

In FY 2011 the Departments continued to demonstrate their shared commitment to the Virtual Lifetime Electronic Record (VLER) Initiative, enabling access to individuals' information in VA, DoD, other federal and state agencies, and private sector partners while facilitating proactive and improved delivery of services. VLER is rapidly becoming a mechanism for the exchange of comprehensive health, benefits, and administrative information for Veterans, Service members, and other eligible beneficiaries as envisioned by President Obama.

VA, DoD, and their VLER Health partners made progress toward interoperability by agreeing to use and comply with the Nationwide Health Information Network (NwHIN) standards propagated by the Department of Health and Human Services Office of the National Coordinator for Health IT. More than twenty federal and private partners have signed the Data Use and Reciprocal Support Agreement (DURSA), a multi-party trust agreement that provides a legal framework for participation in the NwHIN. Signing the DURSA formalized the NwHIN partners' mutual commitment to ensuring that information exchanges from their respective EHR systems will use standards that will enable secure interoperability

During the reporting period, VLER and DoD pilot sites were continued at VA, DoD, and private sector health care facilities in San Diego, California, and the Tidewater Area of Virginia, and new pilots were launched in the Spokane and Puget Sound areas of Washington. Activities at each location involved the testing of capabilities developed to achieve the safe and secure exchange of patient health care data between the EHR systems of two or more data exchange partners. VA and DoD are conducting a series of joint three-way pilots with increasing functionalities to test system and data capabilities. Each joint three-way pilot successfully achieved implementation of its planned allotment of data modules, leading to full implementation of the foundational health data set in September 2011. In addition, VA engaged with private sector partners in seven other communities where information exchange occurred using the same standards and specifications. As of this writing, more than 38,000 Veterans had provided authorization to share information with the NwHIN.

VLER is also implementing capabilities that enable the sharing of benefits, health and personnel information for purposes beyond clinical healthcare, such as disability claims processing, educational benefits, employment benefits, and other services critical to Veterans. VLER is already driving enterprise-wide transformation and generating results in these areas through expanded use of the e8eneifts.gov portal and its collaboration with external partners. VLER will continue to build on those early successes to achieve greater results for our Veterans by employing a proactive, Veteran-centric approach.

VLER's larger capability will provide access to all the information necessary to determine Veterans' eligibility for benefits and services and to proactively deliver those benefits and services to them. It will involve partnerships between not only 000 and VA, but also other federal agencies like the Social Security Administration, as well as state and local governments, private organizations, and non-profits. Health, benefits, personnel, and administrative information will be shared seamlessly and securely between VA and is partners to ensure that the right information is in front of the right people at the right time to best serve the needs of Veterans.

Captain James A. Lovell Federal Health Care Center

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

The FHCC is a fully-integrated facility with VA and DoD staff working together toward a single, combined VA and Navy mission. A FHCC stakeholder advisory group meets quarterly to advise the Director on the status of the FHCC mission to meet the needs of local Veteran and DoD beneficiaries. The FHCC is an alpha site for the iEHR way-ahead. Clinicians securely use both VA and DoD clinical systems.

The FHCC's Pediatric and Primary Care Clinics' adoption of the Medical HomePort approach for DoD eligible beneficiaries means normally seeing the same caregivers at each visit. These caregivers help plan care, now and in the future. This move to a "whole person" approach is designed to enhance access, strengthen communication, and build stronger relationships between the patient and his or her health care team.

In September 2011, the FHCC was named one of the nation's top performers on key quality measures today by The Joint Commission, the leading accreditor of health care organizations in America.

The FHCC is one of the sites participating in the IDES program. FHCC also has implemented a single discharge physical so that a Service member leaving the military and receiving a VA compensation examination now only has to undergo one physical. Results are shared between VA and the Navy.

Information Technology Capability Delivery to Support FHCC Operations

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

- ***Single Patient Registration*.** This IT solution supports the capability to register and update a patient via a single graphical user interface. Through native VA and DoD systems, the patient is registered, eligibility is verified, and updates are made. This common service is used by both VA and DoD.

- ***Medical Single Sign-on (MSSO).*** Users are now able to access the individual clinical applications presented via MSSO based upon the user's access rights for the individual systems available using a VA Personal Identity Verification Card or DoD Common Access Card.
- ***Clinical Context Management .*** VA and DoD context management solutions enable users to select a patient from one application, which then automatically selects the same patient when accessing another VA or DoD application.
- ***Testing Platforms*****.** Both agencies have individual testing platforms to facilitate joint end-to-end testing for all FHCC releases which supports joint IT capabilities and ensures interoperability.
- ***Orders Portability (OP).*** OP provides the ability for a provider, or authorized user on behalf of a provider, to place or enter an order in the VA and/or DoD clinical system and have the information available for an authorized user in either system.

DoD and VA successfully developed and implemented Single Patient Registration, MSSO, CCM, and other elements foundational to interoperability at the FHCC in December 2010. A joint DoD/VA Test Facility became fully operational in March 2011. Work continues on OP to allow health care providers to place and review radiology and laboratory orders.

Additionally, VA and DoD began testing GUI solutions to improve viewing healthcare data and to implement a common GUI for providers at the FHCC. Going forward, the Departments will maintain these delivered IT capabilities. Those IT capabilities planned but not yet delivered for the FHCC will be led by the IPO as part of the iEHR development effort.

The following are notable figures from the FHCC's first year in operation:

- Total outpatient visits VistA and AHLTA: 829,399
- Total inpatient admissions: 4,489
- Total dental visits to West Campus: 5,644
- Total dental visits to East Campus: 639,020
- Pharmacy prescriptions (fiscal year 2011): 1,870,170
- Number of records integrated: about 90,000
- USS Red Rover processed more than 38,000 Navy Recruits; delivering more than 178,000 immunizations

HEC Telehealth

As a result of the JEC identifying joint telehealth expansion as a priority item, HEC leadership established a VA/DoD Telehealth WG in FY 2011. The WG's mission is to identify opportunities to expand the joint telehealth program and optimize joint capabilities between Departments. Senior representatives from VA and DoD were selected as Co-chairs of the WG.

In FY 2011, the Co-chairs made recommendations to the HEC and the JEC on how the WG could develop solutions for cross-Departmental telehealth programs. The Co-chairs also identified additional WG members that include senior telehealth representatives from all the Military Departments and from relevant VA offices. With the input of these additional representatives, the WG developed a draft charter that it presented for HEC review. An information paper on the new WG charter will be reviewed by the JEC in early FY 2012. The

WG identified the following areas of focus: improve telehealth service links across Departments, facilitate access to care in remote areas, promote continuity of care, allow for possible cost savings and increased efficiencies, investigate and provide suggestions on legal issues, advise on policy issues, and survey medical facility staff to gather information on the use of telehealth/teleradiology. Once the charter is approved, the WG will begin its work to improve standardization and integration of telehealth activities between VA and DoD.

Meanwhile, the Co-chairs have initiated the following:

- Regular bi-weekly joint VA/DoD telehealth meetings;
- An exchange and review of VA/DoD telehealth operation manuals;
- Exploration of sites for VA/DoD telehealth service collaboration; and
- Planning for a feasibility pilot to deliver tele-behavioral pain consultation from VA clinicians with specialized expertise to DoD patients through telehealth.

VA and DoD Collaborations on Medical Research, Including Activities of the Deployment Health Work Group

VA and DoD currently collaborate on many diverse medical research initiatives. VA and DoD research efforts have been responsible for major breakthroughs in many areas; VA and DoD have identified several high priority medical research areas that are shared. These high priority areas include PTSD and other psychological conditions, TBI, multidisciplinary treatment of polytrauma, pain management, rehabilitation, advanced prosthetics, and the health effects of deployments.

VA scientists successfully competed for funding from DoD, and there are hundreds of DoD-funded research projects in the VA system. DoD currently funds VA scientists to investigate several high-priority topics, including PTSD, alcohol abuse, mental health of female Veterans including military sexual assault, resilience to mitigate combat stress and post-deployment reintegration problems, treatment of TBI and spinal cord injuries, treatment of amputations and improved prosthetics, visual and hearing impairments, rehabilitation, telemedicine, and illnesses in Veterans of the 1990-91 Gulf War and OEF/OIF.

VA and DoD collaborate on the planning and evaluation of major research programs. During the past year, DoD invited senior VA research managers and other VA members of the DHWG to participate in full-day program evaluations of three DoD research portfolios. Each of these comprehensive portfolios included hundreds of DoD-funded projects on PTSD, suicide, other psychological conditions, TBI, combat casualty care, and clinical and rehabilitation medicine. Many of these projects provided funding to VA scientists. In addition, the knowledge resulting from the longstanding collaboration of VA and DoD researchers was recently assembled in a handbook, entitled “VA/DoD Collaboration Guidebook for Healthcare Research.” VA and DoD researchers wrote this handbook to improve interagency collaboration and to increase awareness of VA and DoD programs and funding opportunities. VA published the book on its research Web site[8] in February 2011.

[8] www.research.va.gov/va-dod/

In FY 2011, the DHWG analyzed research literature and government reports on environmental exposures during military service, and provided recommendations to the HEC to mitigate the effects of hazardous exposures. The DHWG reviewed scientific reports on drinking water contamination at Camp Lejeune, including a National Research Council (NRC) report. The DHWG requested a briefing from the study director of this NRC report, and the committee discussed Navy/Marine, VA, and ATSDR plans to respond to the recommendations in the report. The DHWG provided a briefing to the HEC on Camp Lejeune. VA formulated recommendations to the Secretary of the VA in response to this NRC report.

The DHWG held multiple discussions to increase collaboration between VA and DoD on studies of long-term health effects of deployments. The DHWG organized a full-day research workshop in July 2011, entitled "DoD and VA Longitudinal Cohort Studies, Focusing on Long-Term Health Effects of Deployments." The workshop purpose was to explore ways to improve collaboration on studies that follow Service members from Active Duty through Veteran status. The intent was to facilitate communication and coordination among VA and DoD scientists and research administrators who are responsible for conducting and funding longitudinal cohort studies on the long-term health effects of deployments. The workshop featured 13 large studies that included hundreds to 150,000 Service members and Veterans, which were funded by VA, DoD, or jointly. The focus was primarily on Service members and Veterans who have deployed to OEF/OIF.

The HEC approved the DHWG recommendation that VA and DoD should explore ways to collaborate on long-term epidemiological studies that follow Service members from Active Duty to Veteran status. This could improve early identification of long-term health effects and enable early treatment and prevention.

The DHWG monitors the progress of the Millennium Cohort Study (MCS) on an ongoing basis, which includes 150,000 Service members. DoD has funded the MCS since its inception in 2001. The health of the cohort will be evaluated every three years until 2022, to determine the course of diseases over time. Thirty percent of the cohort has already separated from the military and are eligible for VA medical care. The DHWG made a recommendation to the HEC that VA should consider increasing its collaboration with DoD in the MCS in terms of funding and research staff. VA is currently exploring possible mechanisms to increase its role in the MCS. Increased VA/DoD collaboration on long-term cohort studies would build on the effectiveness of the existing foundation of interagency research.

Health Care Resource Sharing

Sharing Agreement for Surgical Supervision Services

59th Medical Wing, Lackland AFB, Texas/South Texas VA HCS

In June 2011, the 59th Medical Wing (MDW) at Lackland AFB, Texas and the South Texas VA HCS (STVHCS) signed a no-cost sharing agreement that provides surgical supervision services for general surgery, urology, and cardio-thoracic surgery at the STVHCS. As the 59th MDW converts to an Ambulatory Surgical Center, the Air Force providers and surgical residents will need ample opportunity to work with and operate on the more complicated patients that VA presents. This sharing agreement places experienced Air Force surgeons as supervisors at the VAMC to provide educational as well as supervisory duties over both the Air Force and VA providers. In turn, the agreement also places experienced VA surgeons at the 59th MDW to provide ambulatory surgical services on both VA and DoD patients. This

agreement benefits both Departments and beneficiaries as the surgeons receive the best, well-rounded training and opportunities, and the beneficiaries the best care available.

Naval Hospital Pensacola and Branch Clinics

The JIF project between Naval Hospital Pensacola (NHP) and the VA Pensacola Joint Ambulatory Care Center (JACC) for sleep studies was a very successful project and a final report was submitted January 15, 2011. The JIF greatly benefited both parties in meeting their beneficiaries' sleep study needs. The NHP sleep lab has taken care of routine Veterans' medical requirements as well as reducing the sleep study backlog for the VA compensation and pension division. This project provided 1,613 sleep studies to VA/DoD patients with a cost avoidance of $1.2 million. The NHP sleep lab will continue with the VA JACC by an established and approved resource sharing agreement.

The JIF project between NHP Panama City Branch Health Clinic and the VA Panama City CBOC for renovations and establishing a joint dental clinic was completed with the final report submitted on April 15, 2011. The multiple renovations to the three buildings involved in this project made the facilities more efficient clinics in the delivery of outpatient health care. The joint dental clinic brought dentistry to both VA and Active Duty beneficiaries. The VA dentist is dually credentialed to provide dental service to both VA and Navy. This joint dental clinic service treated 1,426 Active Duty beneficiaries for a cost avoidance of $1.2 million. The total project had a cost avoidance of $1.9 million. The project will continue in the future. A resource sharing agreement is in the process of final review and approval.

The JIF project between NHP Mid-South Branch Health Clinic and the Memphis VAMC was completed as of April 15, 2011. The final project report was submitted on April 29, 2011. The project provided MRI services of 8,296 exams to VA/DoD patients with a cost avoidance of $4.4 million. A resource sharing agreement was established and approved for the continuation of MRI services.

The NHP resource sharing services have improved this FY due to the completion of major renovation project to the facilities' five operating room suites. This effort permitted the routine weekly schedules for the VA general surgeon and urologist to perform their more complex surgical cases at NHP. NHP provided workload in FY 2011 to VA through the existing resource sharing agreements with service increases to VA by 44.5 percent for inpatient and 38.5 percent for outpatient over FY 2010 levels.

Naval Branch Health Clinic Key West and the Miami VA HCS Key West CBOC

Naval Branch Health Clinic Key West (NBHC Key West) and the Miami VA HCS Key West CBOC continue to work closely as a team providing quality health care services to VA and eligible DoD beneficiaries on a permanent basis. NBHC Key West occupies a 57,000 square foot building with 10 percent of the total facility utilized by VA. Currently, there are 1,769 VA patients; the eligible population for TRICARE averages about 4,500 in the assigned area.

The sharing agreement provides mental health, physical therapy, pharmacy, laboratory, and radiology services to both VA and DoD beneficiaries. Optometry, spirometry, and audiology are provided by NBHC Key West on a space available basis. Housekeeping, utilities, and biohazard disposal are provided by NBHC Key West on a reimbursable basis. The Key West

CBOC also reimburses NBHC Key West for any repairs and maintenance performed on the spaces allocated to VA. NBHC Key West provides basic computer support in the form of technical assistance and access to CHCS with no surcharge. NBHC Key West actively engages in collaborative hands-on training with staff and Naval Air Station Key West (NAS Key West) personnel while complying with building security, safety, and environment of care provisions.

In FY 2011, NBHC Key West provided anti-terrorism and hurricane training to Key West CBOC personnel and together we successfully completed several interactive drills hosted by NAS Key West. The Key West CBOC provides annual training on prevention and management of disruptive behavior to NBHC Key West, assuring the utmost safety and security of all staff and patients. Daily communication between clinics and quarterly meetings with the Miami VA HCS and NBHC Key West leadership resulted in providing safe, high quality patient care for VA and DoD beneficiaries. Our joint clinic has enhanced our ability to provide services to both VA and DoD beneficiaries with the two Departments working closely together to make our work look and feel seamless.

Naval Health Clinic Charleston, Ralph H. Johnson VAMC, 628th MDG, and Naval Hospital Beaufort

On June 28, 2011, Naval Health Clinic Charleston (NHCC), the Ralph H. Johnson VAMC (RHJVAMC), 628th MDG and Naval Hospital (NH) Beaufort were approved by the HEC to be the newest joint venture site; sites identified by both VA and DoD to share facilities and services in an effort to reduce costs and improve patient access to care. This joint venture site is governed through the Lowcountry Federal Healthcare Executives Council, a council made up of senior leadership from Air Force, Navy and VA. The Council is looking forward to increased sharing opportunities in the market areas for many years to come.

On May 17, 2011, NHCC, 628th MDG and RHJVAMC celebrated the grand opening of a JIF funded optometry clinic designed to provide services to 47,900 VA beneficiaries and 35,000 Active Duty family members, DoD retirees, and their family members who are TRICARE Prime beneficiaries. RHJVAMC shares spaces at both NH Beaufort and the Captain John G. Feder JACC in Goose Creek, SC to provide CBOC services. The JACC continues to provide mobile MRI services to both VA and DoD beneficiaries using the 1.5 Tesla unit purchased through the JIF in April 2008. Through resource sharing agreements, NHCC/628th MDG/RHJVAMC provide joint services in cardiology, phlebotomy, and consultant pathology services and share training and clinical skills enhancement opportunities.

Naval Medical Center San Diego

Naval Medical Center San Diego (NMCSD) and the VA San Diego HCS (VASDHS) have a strong sharing arrangement which includes six reimbursable agreements. Under the comprehensive medical services sharing agreement, all health care resources are shared between NMCSD and VASDHS where demand and capacity exist. Currently, the VASDHS does not offer obstetrics services. NMCSD assisted the VASDHS by seeing their Veterans for obstetrics services at both the main hospital and at two branch medical clinics. The VA Consolidated Mail Order Pharmacy filling service provides high volume, centralized processing and mailing of refill prescriptions to NMCSD beneficiaries and has been an excellent vehicle for keeping cost down for NMCSD beneficiaries in the past FY. The radiation therapy sharing

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

NMCSD and VASDHS submitted and received FY 2010 JIF funding for $4.9 million to obtain a linear accelerator radiation therapy device for the treatment of VASDHS radiation oncology patients at NMCSD. Equipment has been ordered and construction and installation should be completed within the next six to seven months.

HEC Credentialing

The Credentialing Policy Ad Hoc WG (CPAHWG) is committed to increasing sharing of qualified health care professionals between the Departments while reducing the burden to the provider and the medical facilities. The CPAHWG successfully collaborated on a MOU between the Departments for the sharing of health care provider credentials that complies with the guidance established by The Joint Commission. The MOA was signed in December 2010 and guidance promulgated within each Department by May 2011.

In accordance with the MOU, the Credentialing Process Coordinating Committee was established and is comprised of one subject matter expert in medical staff process identified by VA, DoD, and each Military Department. This committee is charged with the following:

- Coordinate communication of information and issues related to this process from participating sites;
- Collect and analyze information related to this MOU to include, but not limited to, the number and type of providers who are shared between VA and DoD and issues related to the sharing of credentials data;
- Meet no less than every six months by conference call, and face-to-face when determined appropriate; and
- Report back to the HEC upon request.

The Committee has met more frequently than what is prescribed in the MOA in order to address MOA implementation guidance. Since the MOA was signed, 25 providers have been shared by VA with a DoD MTF (22 to Air Force and three to Army) and 25 shared by a DoD MTF with VA (10 from Navy, 14 from Air Force, and one from Army).

HEC Pharmacy

In FY 2011, the Pharmacy WG identified pharmaceuticals and commonly used products and manufacturers for potential joint contracting action and continued to seek new joint contracting opportunities. Additionally, eight potential joint initiatives other than contracting were identified for possible further development.

The WG achieved all performance measures related to joint contracts. A review of purchases for new and existing joint contracts yielded 84 joint national contracts, of which 22 were new

joint national contracts. As of the third quarter of FY 2011, VA spent a $117 million on joint national contracts, and DoD spent $27.4 million. In quarters one through three, VA joint national contract prime vendor purchases represented 3.83 percent of total prime vendor purchases; DoD purchases represented 0.78 percent. VA identified four drugs within the top 25 drugs as measured by VA's acquisition dollar volume that lost patent exclusivity. VA identified 43 new molecular entities used in the ambulatory setting for contracting opportunities. All 43 have been reviewed or are currently under review. DoD performed eight drug-class reviews with 16 sub classes and 161 drugs, representing $1.3 billion of the total spend with estimated cost avoidance and direct refunds of $79 million. Sixty-six joint national contracts expired in FY 2011. All 66 expiring joint national contracts were reviewed for renewal, re-procurement, or termination.

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

SECTION 3 – NEXT STEPS

The accomplishments described in this year's *Department of Veterans Affairs* (VA)/*Department of Defense* (DoD) *Joint Executive Council* (JEC) *Fiscal Year* (FY) *2011 Annual Report* demonstrate concerted efforts within VA and DoD to improve the multiple areas of joint responsibility that directly affect the care and benefits of Service members and Veterans. This report provides updates in strategic areas that will continue to evolve until these joint initiatives become fully institutionalized into everyday operations. Both Departments are sincerely committed to maintaining and improving the collaborative relationships that make this progress possible.

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

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

*** Memo will be inserted into final document**

Appendix B
Cost Estimate to Prepare Congressionally-Mandated Report

Title of Report: VA/DoD JEC FY 2011 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	$ 73,371
Contract(s) Cost	$ 19,926
Production and Printing Cost	$ TBD
Total Estimated Cost to Prepare Report	$ TBD

Brief explanation of the methodology used to project cost estimate:

The estimated number of total direct labor hours expended was multiplied by the U.S. Office of Personnel Management's calendar year 2011 hourly rate structure for the metropolitan Washington, DC area. The calculated net labor costs were multiplied by the fiscal year 2011 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

AFB – Air Force Base
AHLTA – Armed Forces Health Longitudinal Technology Application
AMC – Army Medical Center
AR – VA/DoD JEC Fiscal Year 2011 Annual Report
ATSDR – Agency for Toxic Substances and Disease Registry
AY – Academic Year
BEC – Benefits Executive Council
BDD – Benefits Delivery at Discharge
BHIE – Bidirectional Health Information Exchange
BI – Business Intelligence
BRAC – Base Realignment and Closure
BRD – Business Requirements Document
BRS – Business Requirements Specification
C&P – Compensation and Pension
C-IPT – Capability Integrated Product Team
CAC – Common Access Card
CAPRI – Compensation and Pension Records Interchange
CBOC – Community Based Outpatient Clinic
CBSWG – Communication of Benefits and Services Working Group
CDS – Clinical Decision Support
CFI – Center for the Intrepid
CHCS – Composite Health Care System
CHDR – Clinical Health Data Repository
CoE – Center of Excellence
CBO – Veterans Health Administration Chief Business Office
CBT-D – Cognitive Behavioral Therapy for Depression
CBT-I – Cognitive Behavioral Therapy for Insomnia
CFI – Department of Defense Center for the Intrepid
CIDM – Capital Investment Decision Model
CME – Continuing Medical Education
ConOPS - Concept of Operations
CPC – Construction Planning Committee
CPAHWG – Credentialing Policy Ad Hoc
CPG – Clinical Practice Guideline
CPT – Cognitive Processing Therapy
CRP – Comprehensive Recovery Plan
CWG – Communications Working Group
DCoE – Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DES – Disability Evaluation System
DFAS – Defense Finance and Accounting Services
DHWG – Deployment Health Working Group
DIN-PACS – Digital Imagine Network – Picture Archiving Communications System
DLA – Defense Logistics Agency

DoD – Department of Defense
DOEHRS - Defense Occupational and Environmental Health Reporting System
DoDI – Department of Defense Instruction
DOL – Department of Labor
DS Logon – Defense Self-Service Logon
DTA – Data Transfer Agreement
DTM – Directive Type Memorandum
DTRS – Deployed Tele-Radiology System
DURSA - Data Use and Reciprocal Support Agreement
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
EACE – Traumatic Extremity Injuries and Amputations Center of Excellence
EBP – Evidence Based Psychotherapy
EDI – Electronic Data Interface
eDR – Enhanced Document Referral
EHR – Electronic Health Record
EMR – Electronic Medical Record
FCC – Federal Coordinating Centers
FHCC – Federal Health Care Center
FHH – Family Health History
FHIE – Federal Health Information Exchange
FMWG – Financial Management Working Group
FRC – Federal Recovery Coordinator
FRCP – Federal Recovery Coordination Program
FY – Fiscal Year
GAO – Government Accountability Office
GUI – Graphical User Interface
HAIG – Health Architecture Interagency Group
HAIMS – Healthcare Artifact and Image Management Solution
HCE – Hearing Center of Excellence
HCS – Health Care System
HDR – Health Data Repository
HEC – Health Executive Council
HQ – Headquarters
HPE – Health Professions Education
HHS – Department of Health and Human Services
HIT – Health Information Technology
HPE – Health Professions Education
ICIB – VA/DoD Interagency Clinical Informatics Board
IDES – Integrated Disability Evaluation System
IE – Information Exchange
iEHR – integrated Electronic Health Record
IMHS – Integrated Mental Health Strategy
IM/IT – Information Management/Information Technology
IOC – Initial Operating Capability
IOM – Institute of Medicine

IPEB – Informal Physical Evaluation Board
IPO – Interagency Program Office
IPR – Interim Progress Reports
IRIS – Inquiry Routing and Information System
IS/IT – Information Sharing/Information Technology
IT – Information Technology
JACC – Joint Ambulatory Care Center
JEC – Joint Executive Council
JHASIR – Joint Hearing and Auditory System Injury Registry
JIF – Joint Incentive Fund
JSP – VA/DoD JEC Joint Strategic Plan
LUT – Limited User Testing
M&RA – Manpower and Reserve Affairs
MCRS – Mobility Capabilities and Requirements Study
MCS – Millennium Cohort Study
MDG – Medical Group
MHS – Military Health System
MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MCSC – Managed care support contractor
MCiS – Military Health System Cyber infrastructure Services
MDW – Medical Wing
MRI – Magnetic Resonance Imaging
MRWG – Medical Records Working Group
MSC – Military Service Coordinators
MSSO – Medical Single Sign-On
mTBI – Mild Traumatic Brain Injury
MTF – Military Treatment Facility
NARA – National Archives and Records Administration
NAS – Naval Air Station
NBHC – Naval Branch Health Clinic
NCAT – NeuroCognitive Assessment Tool
NCR – New Change Request
NDAA – National Defense Authorization Act
NCC – National Capital Consortium
NCR – National Capital Region
NGC – National Guideline Clearinghouse
NH – Naval Hospital
NHCC – Naval Health Clinic Charleston
NHP – Naval Hospital Pensacola
NICoE – National Intrepid Center of Excellence
NMC – Naval Medical Center
NMCSD – Naval Medical Center San Diego
NRC – National Research Council
NRD – National Resource Directory
NwHIN - Nationwide Health Information Network
OEF – Operation Enduring Freedom

OIF – Operation Iraqi Freedom
OP – Orders Portability
OSD – Office of Secretary of Defense
OWF – Operation War Fighter
PASTOR – Pain Assessment and Outcome Registry
PCMH – Patient Centered Medical Home
PCP – Primary Care Providers
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
PH – Psychological Health
PMWG – Pain Management Working Group
POM – Program Objective Memorandum
PPDHA – Pre- and Post-Deployment Health Assessment
PRC – Primary Receiving Centers
PSA – Public Service Announcements
PTSD – Post Traumatic Stress Disorder
RCC – Recovery Care Coordinator
RCP – Recovery Coordination Program
RCP-SS – Recovery Coordination Program Support Solution
RHJVAMC – Ralph H. Johnson VAMC
SA – Strategic Actions
SCIP – Strategic Capital Investment Planning
SCR – System Change Request
SGLI – Servicemembers' Group Life Insurance
SIDR – Standard Inpatient Data Record
SME – Subject Matter Expert
SOC – Senior Oversight Committee
SPARRC – Suicide Prevention and Risk Reduction Committee
SSA – Social Security Association
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
TAP – Transition Assistance Program
TED-I/NI – TRICARE Encounter Data – Institutional/Non-Institutional
TBI – Traumatic Brain Injury
TMA – TRICARE Management Activity
TMS – Talent Management System
USC – United States Code
USUHS – Uniformed Services University of the Health Sciences
VA – Department of Veterans Affairs
VAMC – VA Medical Center
VAS – Visual Analog Scale

VASDHS – VA San Diego Health Care System
VBA – Veterans Benefits Administration
VCA – VLER Capability Area
VCE – Vision Center of Excellence
VCL – Veterans Crisis Line
VDC – VONAPP Direct Connect
VGLI – Veterans' Group Life Insurance
VHA – Veterans Health Administration
VISN – Veterans Integrated Service Network
VISTA – Veterans Health Information System Technology Application
VLER – Virtual Lifetime Electronic Record
VONAPP – Veterans Online Application
VSO – Veteran Service Organization
VTA – Veterans Tracking Application
VTA IDES – Veterans Tracking Application for the Integrated Disability Evaluation System
WARP – Wounded Warrior Athletic Reconditioning Program
WG – Working Group
WWCTP – Wounded Warrior Care and Transition Program
WWP – Wounded Warrior Program