MAR 29 2010

The Honorable Joseph R. Biden, Jr.
President of the Senate
United States Senate
Washington, DC 20510

Dear Mr. President:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to the Speaker of the House, as well as the leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 29 2010

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, DC 20515

Dear Madam Speaker:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to the President of the Senate, as well as leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Daniel K. Akaka
Chairman
Committee on Veterans Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the joint Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Richard M. Burr
Ranking Member
Committee on Veterans Affairs
United States Senate
Washington, DC 20510

Dear Senator Burr:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the Joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Joint Annual Report.

The statement of cost for preparing the Joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the Joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Tim Johnson
Chairman
Subcommittee on Military Construction,
Veterans' Affairs, and Related Agencies
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the Joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Joint Annual Report.

The statement of cost for preparing the Joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the Joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 29 2010

The Honorable Kay Bailey Hutchison
Ranking Member
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Senator Hutchison:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the joint Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Bob Filner
Chairman
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the joint Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 29 2010

The Honorable Steve Buyer
Ranking Member
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Buyer:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the joint Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Michael H. Michaud
Chairman
Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the joint Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 29 2010

The Honorable Henry E. Brown, Jr.
Ranking Member
Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Brown:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the joint Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable John J. Hall
Chairman
Subcommittee on Disability Assistance
and Memorial Affairs
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the joint Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Doug Lamborn
Ranking Member
Subcommittee on Disability Assistance
and Memorial Affairs
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Lamborn:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the joint Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Stephanie Herseth Sandlin
Chairwoman
Subcommittee on Economic Opportunity
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the Joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Joint Annual Report.

The statement of cost for preparing the Joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the Joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable John Boozman
Ranking Member
Subcommittee on Economic Opportunity
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Boozman:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the joint Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Harry E. Mitchell
Chairman
Subcommittee on Oversight
and Investigations
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the Joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Joint Annual Report.

The statement of cost for preparing the Joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the Joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable David P. Roe
Ranking Member
Subcommittee on Oversight and Investigations
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Roe:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the Joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Joint Annual Report.

The statement of cost for preparing the Joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the Joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Chet Edwards
Chairman
Subcommittee on Military Construction,
Veterans Affairs and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Edwards:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Joint Annual Report.

The statement of cost for preparing the Joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the Joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Zach Wamp
Ranking Member
Subcommittee on Military Construction,
Veterans Affairs and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Wamp:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the joint Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Carl Levin
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable John McCain
Ranking Member
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Senator McCain:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 29 2010

The Honorable Daniel K. Inouye
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees Appropriations, on Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Thad Cochran
Ranking Member
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Senator Cochran:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 29 2010

The Honorable Ike Skelton
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the Joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Annual Report.

The statement of cost for preparing the Joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the Joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 29 2010

The Honorable Howard P. "Buck" McKeon
Ranking Member
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Congressman McKeon:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 2 9 2010

The Honorable Norman D. Dicks
Chairman
Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

MAR 29 2010

The Honorable C. W. Bill Young
Ranking Member
Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Young:

In accordance with the requirements of 38 U.S.C. 8111, we are pleased to submit the joint Annual Report for Fiscal Year 2009 regarding the activities and accomplishments of the Department of Veterans Affairs and Department of Defense Joint Executive Council, as well as the Joint Strategic Plan for Fiscal Years 2010-2012. The Joint Strategic Plan is contained in Appendix A of the Annual Report.

The statement of cost for preparing the joint Annual Report and the Joint Strategic Plan, as required by 38 U.S.C. 116, is contained in Appendix C of the joint Annual Report.

Similar letters have been sent to other leaders on the House and Senate Committees on Appropriations, Veterans' Affairs, and Armed Services.

Sincerely,

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Enclosure: as stated

VA/DoD Joint Executive Council
Annual Report
FISCAL YEAR 2009

VA/DoD
Joint Executive Council
Membership List

(as of September 30, 2009)

Department of Veterans Affairs

W. Scott Gould (Co-Chair)
Deputy Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Gerald M. Cross, M.D.
Acting Under Secretary for Health
Veterans Health Administration
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Patrick W. Dunne
Under Secretary for Benefits
Veterans Benefits Administration
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Roger Baker
Assistant Secretary for
Information & Technology
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Department of Defense

Gail H. McGinn (Co-Chair*)
Deputy Under Secretary of Defense (Plans)
Performing the Duties of the
Under Secretary of Defense
(Personnel and Readiness)
4000 Defense Pentagon
Washington, DC 20301- 4000

Ellen P. Embrey
Deputy Assistant Secretary of Defense
Force Health Protection and Readiness
Performing the duties of the
Assistant Secretary of Defense
Health Affairs
1200 Defense Pentagon
Washington, DC 20301-1200

Allen W. Middleton
Director Financial Plans & Policy
Acting Principal Deputy Assistant
Secretary of Defense, Health Affairs
1200 Defense Pentagon
Washington, DC 20301-1200

David M. Wennergren
Principal Deputy Director CIO
Department of Defense
6000 Defense Pentagon
Washington, DC 20301-6000

---

*The Under Secretary of Defense for Personnel and Readiness and the Deputy Secretary of Veterans Affairs co-chair the JEC by statute However, for purposes of high priority initiatives or issues, the Deputy Secretary of Defense will serve as the Department of Defense co-chair of the JEC as indicated in the revised JEC charter, dated 9/28/2009.

Department of Veterans Affairs

L. Tammy Duckworth
Assistant Secretary for
Public &Intergovernmental Affairs
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Karen W. Pane, MPA, RN
Acting Assistant Secretary for
Policy and Planning
Department of Veterans Affairs
810 Vermont Avenue
Washington, DC 20420

Rita A. Reed
Acting Assistant Secretary for
Management
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Glenn D. Haggstrom
Director, Office of Acquisition
Logistics, and Construction
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Will A. Gunn
General Counsel
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Joan Evans
Assistant Secretary for
Congressional and Legislative Affairs
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Department of Defense

Thomas R. Lamont
Assistant Secretary of the Army
(M&RA)
Department of Defense
1111 Army Pentagon
Washington, DC 20310-1111

Juan M. Garcia
Assistant Secretary of the Navy
(M&RA)
Department of Defense
1000 Navy Pentagon
Washington, DC 20350-1000

Daniel Ginsberg
Assistant Secretary of the Air Force
(M&RA)
Department of Defense SAF/MR
1660 Air Force Pentagon
Washington, DC 20330-1660

Dennis McCarthy
Assistant Secretary of Defense
Reserve Affairs
1500 Defense Pentagon
Washington, DC 20301-1500

Richard Ginman
Deputy Director, Program and
Contingency Contracting
Department of Defense
3015 Defense Pentagon
Washington, DC 20301-3015

RADM Gregory A. Timberlake
Acting Director, Interagency Program Office
1700 N. Moore St.
Rosslyn, VA 22209

VA/DoD Joint Executive Council
Annual Report
FISCAL YEAR 2009

W. Scott Gould
Deputy Secretary
Department of Veterans Affairs

Clifford L. Stanley
Under Secretary of Defense
(Personnel and Readiness)

Table of Contents

VA/DoD Joint Executive Council Fiscal Year 2009 Annual Report

SECTION 1: INTRODUCTION

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Joint Executive Council (JEC) has completed its seventh year and is pleased to submit this *VA/DoD JEC Fiscal Year* (FY) *2009 Annual Report* (AR) to Congress and the Secretaries of VA and DoD. 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) for the period of October 1, 2008 to September 30, 2009. This report does not contain recommendations for legislation related to health care resource sharing.

The *VA/DoD Joint Executive Council Joint Strategic Plan* (JSP) for FY 2010-2012 is appended to the AR. The JSP is the primary means to advance performance between VA and DoD and is continuously evaluated, updated, and improved. The JSP FY 2010-2012 contains substantial revisions to the strategies, objectives, and performance measures found in the previous JSP FY 2009-2011.

The JEC provides senior leadership for collaboration and resource sharing between VA and DoD. The Co-Chairs approved a revised JEC Charter on September 28, 2009, which defines its structure and procedural guidelines. The Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness Co-Chair the JEC by statute. However, for purposes of high priority initiatives or issues, the Deputy Secretary of Defense will serve as the Department of Defense Co-Chair of the JEC. Presently, the Virtual Lifetime Electronic Record (VLER) is a high priority item. JEC membership also includes the Director of the Interagency Program Office (IPO), and other senior leaders, as designated by each Department.

The JEC provides leadership and oversight of the Health Executive Council, the Benefits Executive Council, the IPO, and all of their working groups (WGs). These Sub-councils ensure that the appropriate resources and expertise are directed to the areas of health, benefits, and information technology. The Joint Communications WG and the Construction Planning Committee report directly to the JEC.

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.

SECTION 2: ACCOMPLISHMENTS

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Joint Executive Council (JEC) Working Groups (WGs) highlight their Fiscal Year (FY) 2009 accomplishments here in Section 2. These accomplishments helped to propel VA and DoD forward in their mission to improve resource sharing. The structure of the *VA/DoD JEC FY 2009 Annual Report* (AR) links the *VA/DoD JEC Joint Strategic Plan* (JSP) FY 2009-2011 Strategies and Performance Measures back to the WG's stated objectives. This approach to the AR clarifies the connection between strategic planning and the resulting outcomes achieved through VA and DoD's coordination and sharing efforts. The report also demonstrates achievements and collaborations beyond planned activities.

GOAL 1
Leadership, Commitment, and Accountability

OBJECTIVE 1.1
Improve the access, quality, cost effectiveness, and efficiency with which benefits and services are provided to VA and DOD beneficiaries through increased resource sharing and organizational collaboration.

VA/DoD Joint Executive Council (JEC)

The JEC's role in providing strategic direction for VA/DoD collaboration received new emphasis in 2009. VA and DoD each expanded their permanent support systems that are devoted to monitoring coordination efforts. VA established the VA/DoD Collaboration Service in October 2008 within the Office of the Assistant Secretary for Policy and Planning and DoD established the Executive Secretariat under the Deputy Under Secretary (Plans) in December 2008. The VA/DoD Collaboration Service and the Executive Secretariat, respectively, are the VA and DoD leads for managing a new approach to setting priorities, monitoring performance, and improving accountability. The JEC met on October 29, 2008; January 8, 2009; June 26, 2009; and August 21, 2009.

In June 2009, VA and DoD applied a performance-based methodology to redesign the VA/DoD JSP FY 2010-2012 to make it more outcome oriented than previous plans. The new Sub-goals, objectives, and milestones are intended to be outcome oriented and measurable. This plan will allow the JEC to track progress and ensure the VA/DoD joint successes are transparent to senior leaders in the Departments and Congress, as well as Veterans, Service members, and other stakeholders. The AR in 2010 will also be modified.

The Departments did not wait until 2010 to reflect increased accountability in the AR. This year's JEC AR was restructured in FY 2009 to highlight the JEC's achievements in direct response to the FY 2009-2011 JSP. This approach to the AR helps to increase leadership's accountability for achieving its stated objectives.

The JEC updated the Interagency Program Office (IPO) Charter. The Charter was signed by the Deputy Secretaries on September 24, 2009. It expands the scope of responsibilities and addresses specific Virtual Lifetime Electronic Record (VLER) execution.

The JEC remains committed to using the JEC quarterly meetings to make decisions and resolve issues jointly. For instance, at the June 26 meeting, both Departments agreed to the strategy for implementing the VLER initiative as mandated by the President. This will be a long-term program endeavor between VA and DoD, with progress reports to be provided to the JEC membership on a regular basis. The Departments have also used the JEC forum to overcome impediments to achieving stated goals and objectives. For example, a decision was made to allocate more funding for the North Chicago Federal Health Care Center (FHCC) when the need for additional resources was identified. As a result of this JEC intervention, VA and DoD are expected to remain on schedule and open the facility in a timely manner.

Finally, the JEC continues to invite other Federal departments and agencies to the JEC meetings as appropriate. Representatives from the Office of Management and Budget (OMB) and the White House attended JEC meetings in 2009 for awareness and information.

OBJECTIVE 1.2
Improve stakeholder awareness of sharing and collaboration initiatives, and communicate and promote results and best practices throughout the two Departments and to external stakeholders.

VA/DoD JEC Communications Working Group

As a result of the changes to the leadership of the Communications Working Group (CWG), the priorities of the CWG were amended during the fiscal year. By the fiscal year's end, CWG leaders from both Departments were actively engaged and had plans in place for coordinated communications and planning efforts.

Updates on communication efforts were reported to the JEC. These efforts primarily focused on good news stories being reported and disseminated via the electronic newsletter published by DoD support staff. Included in these efforts were reports on the Warrior Care month, suicide prevention, the Safe Driving Campaign, and the Business of Government Hour which was devoted to VA/DoD information sharing. The Departments reported an increase in satisfaction concerning patient transfer to the VA from both Walter Reed Army Medical Center and the National Naval Medical Center.

VA and DoD began to develop Department level strategic communications plans as an initial step in developing a Joint Strategic Communication Plan. This work continues in FY 2010 and should show results of a strengthened concerted effort.

Content analysis of news articles was completed by members of the CWG. VA's Office of Public and Intergovernmental Affairs recently added a tracking requirement to its clipping service. This service will provide two graphic presentations showing the number of stories appearing on VA-related issues and the general "tone" of stories published under broad categories.

GOAL 2
High Quality Health Care

OBJECTIVE 2.1
Be leaders in developing and delivering innovative clinical processes and programs that enhance the quality of health care.

Health Executive Council (HEC) Patient Safety Working Group

VA/DoD Patient Safety WG enhanced the quality of health care to patients through their efforts to improve the safety of care. The WGs focused on the design, development, and distribution of joint patient safety initiatives and the establishment of Data Use Agreements (DUA). The DUAs allowed the Departments to develop shareable adverse events summary reports to include data such as; patient falls, inpatient suicides, pressure ulcers, unintentionally retained surgical items, and incorrect or invasive procedures.

The WG also automated the process in FY 2009 for sharing patient safety alerts and advisories. As a result, VA now routinely receives Medical Materiel Quality Control reports and DoD receives VA Patient Safety Alerts and Advisories. In addition, DoD began sharing alerts and advisories with VA, which was previously restricted, and agreed to continue to share in the future.

In FY 2009, through the National Center for Patient Safety and DoD Patient Safety Center, the WG started direct VA/DoD sharing of patient safety data. The data includes: information and analyses, incorrect surgery or invasive procedures, unintentionally retained foreign objects, patient falls, and suicide prevention. Further, the WG initiated plans to share suicide-prevention-related data with the Mental Health WG to supplement their work on suicide risk reduction.

VA and DoD collaborated on several additional patient safety initiatives in FY 2009. This work included the nationwide TeamSTEPPS (team skills training) initiative and working with the Agency for Healthcare Research and Quality (AHRQ) on the development of Common Formats for nationwide reporting of adverse events affecting patients in compliance with the Patient Safety and Quality Improvement Act of 2005. Finally, DoD co-sponsored VA's 2009 Transforming Fall Management Prevention Practices Conference.

HEC Evidence-Based Practice Working Group

In FY 2009, VA and DoD worked collaboratively to develop, update and/or adopt Evidence-Based Clinical Practice Guidelines (CPGs). CPGs reduce variation in care, optimize patient outcomes, and improve the overall health of our populations. During FY 2009, the Mild Traumatic Brain Injury (mTBI), Major Depressive Disorder, Chronic Heart Failure and Substance Used Disorder CPG's were completed. Six additional CPGs are at different stages of development: Stroke Rehabilitation, Bipolar Disorder, Post Traumatic Stress Disorder (PTSD), Diabetes, Chronic Opioid Therapy, and Asthma. These CPGs were developed in collaboration with professional organizations and health systems including the American Pain Society, American College of Physicians, American Heart Association, the American Stroke Association, and the Inter-organization Guideline Forum, which is a consortium that includes Kaiser Permanente, Geisenger

Health Plan, AHRQ, Institute for Clinical System Improvements and the Institute of Medicine (IOM).

VA and DoD received National Guidelines Clearinghouse approval and recognition on all CPGs; achieved 100 percent usage of CPGs; developed marketing strategies that culminated in a 137 percent increase in CPG Web views on the Quality Management Office Web site; increased by ten percent the number of toolkit items shipped to DoD sites in support of CPG implementation; and migrated to a new VA Web site that received over 31,000 Web view requests. The Low Back Pain Guideline was also published in the *Annals of Internal Medicine and t*he Low Back Pain tool kit was completed and submitted for mass production.

The Amputation Rehabilitation Patient Manual was developed and is being printed for pilot testing at VA and DoD facilities. Strong evidence-based recommendations from VA/DoD CPGs have been incorporated into VA performance measures. DoD began work to measure performance outcomes as well through the Military Health System (MHS) Population Health Portal.

HEC Traumatic Brain Injury and Psychological Health

In FY 2009, VA and DoD made improvements in the prevention, identification, treatment, recovery, and reintegration of Service members and Veterans who are at risk for, or are experiencing, mental health (MH) conditions or Traumatic Brain Injury (TBI).

The Traumatic Brain Injury and Psychological Health (TBI/PH) members developed the mTBI CPG through collaboration with the HEC Evidence-Based Practice WG, the Defense Centers of Excellence (DCoE) TBI Clinical Standards of Care (CSoC) Directorate, the Defense and Veterans Brain Injury Center (DVBIC), and the Psychological Health (PH) CSoC. They also began work on CPGs for several other PH conditions, including co-occurring TBI and PTSD.

The Office of the Assistant Secretary of Defense (Health Affairs) (OASD (HA)) policies on clinical training were updated to include VA/DoD requirements for dissemination, training, education, consultation, and policy guidance for evidence-based clinical practices. The Departments drafted the clinical training policies for PTSD and acute stress disorder, and TBI. The Center of Deployment Psychology trained a total of 368 DoD behavioral health providers during the third quarter of FY 2009. The Veterans Health Administration (VHA) trained over 2,000 providers in Cognitive Process Therapy and Prolonged Exposure Therapy for PTSD. Other training programs focused on Cognitive Behavioral Therapy, Acceptance Commitment Therapy, and Motivational approaches for other conditions.

VA and DoD supported the TBI code revision proposal with the National Center for Health Statistics (NCHS), which resulted in approval of the revised International Classification of Diseases, 9th Edition (ICD-9) codes. The codes scheduled to be published in October 2009, include two new, specific codes for TBI. The TBI/PH WG assisted in the development of medical record query requirements for the updates to AHLTA, DoD's electronic health record. VA and DoD clinicians continued to use Bidirectional Health Information Exchange (BHIE) to collect and link operational and health data. Information regarding the occupational and environmental

exposures that put Service members at risk for PH and TBI sequelae is now available using the Deployment Occupational and Environmental Health Surveillance Portal.

TBI and MH assessment tools were evaluated and monitored through quarterly reports from the Military Departments regarding screening procedures to, as specified in the "Deployment Health Quality Assurance Program" OASD(HA) policy. Program updates were reported annually to Congress, in accordance with the National Defense Authorization Act (NDAA) FY 2005. A Transition of Care policies and procedures handbook was also developed to support Service members affected by TBI/MH conditions undergoing transition of duty status.

DoD launched the "Real Warrior Campaign[1]" in May 2009 to promote the processes of building resilience, facilitating recovery, and to support reintegration of returning Service members, Veterans, and their families. Activities include Public Service Announcements and video profiles designed to combat stigma and counter perceived barriers in seeking MH care. DCoE established a process to collect data on the Campaign's outreach tactics, including detailed Web site metrics, number and tone of media stories, partnership requests, and social networking metrics.

VA initiated and began enrolling Veterans in the Assisted Living Pilot Program, which is designed to assess the effectiveness of providing assisted living services to Veterans with TBI. In February 2009, VA and DoD established an interdisciplinary and interagency collaborative group called "Building Bridges to Support the PH/TBI Needs of Military and Veteran Families" consisting of more than 30 organizations/agencies/departments with established long-term neurobehavioral rehabilitation and recovery programs. Additionally, the DVBIC developed and delivered standards of assessment, care, and best practices to assist its sites in establishing long-term neurobehavioral rehabilitation and recovery programs. Site visits were performed to monitor compliance.

In late FY 2009, VA and DoD coordinated efforts to host a joint MH summit in October. The Summit will bring together MH providers and experts from all over the world to discuss PH care, treatment, and efforts.

HEC Mental Health Working Group

In FY 2009, the Mental Health WG continued its collaboration to improve the psychological health[2] of Service members and Veterans.

VA and DoD have worked closely to improve collaborative efforts for conducting the Post-Deployment Health Reassessments (PDHRAs). Local VA Medical Center and Vet Center staff continued to attend Reserve Component PDHRA assessment events that are conducted in group settings, informing and enrolling Veterans as well as facilitating appointments for Service members referred to VA. PDHRA assessment events for Reservists and Guardsmen within VA facilities are slowly increasing in number as they appear to be a valuable mechanism for timely enrollment and appointment setup.

---

[1] www.realwarriors.net

[2] Psychological health is overall psychological well-being, including mental health and behavioral health.

Veterans have many choices as to where they receive further evaluation and care after completing the PDHRA, including the Military Health System (MHS) with both direct and purchased care[3], Veterans Health Administration (VHA), private insurance, Military OneSource for problem-focused psychosocial counseling, and other community resources. Although Veterans who are National Guard and Reserve Component members should keep their units informed of medical issues affecting medical readiness, Privacy Act and Health Insurance Portability and Accountability Act (HIPAA) considerations preclude easy military access to health care information outside the MHS and VHA systems. Realizing the importance of getting Veterans the care they need, the Military Departments are working to enhance their ability to follow-up on referrals from the PDHRA.

The WG examined 119,001 PDHRAs completed by Veterans (50,837 Active Duty and 68,184 Reserve Component) between February 7, 2008, and September 7, 2009, and found the following:

- 30 percent had a referral for further medical evaluation and of those, 60 percent were seen at VA;
- 11 percent were referred for behavioral health[4] or substance misuse evaluation and of those, 64 percent were seen at VA;
- Many (21,072, or 18 percent of the 119,001) Veterans came to VA after the PDHRA but without a referral from the PDHRA (possibly because they were already under care there, as a result of enrollment at a PDHRA event, following VA outreach, or for other reasons); and
- Conclusions reached from this data include:
  - VA is a major health care resource for both Veterans referred via the PHDRA and those who are not formally referred;
  - Many who are referred either seek help elsewhere or do not seek it at all; and
  - A higher proportion of those who screen positive for PTSD and depression are seen at VA than those who screen negative

There were significant enhancements in FY 2009 in MH[5] staffing for both DoD and VA. From May 2007 through May 2009, DoD increased MH staffing in its medical treatment facilities (MTFs) by 1,697, from 4,129 to 6,070. In addition, the TRICARE purchased care network increased its MH providers from 39,587 to 49,807, for a net increase of 10,220, over the same period. From January 2007 through March 2009, VA MH staffing grew by 4,283 full time equivalent employees, from 14,560 to 18,444. The increase in staffing allowed VA to enhance access to MH services. For new requests or referrals for MH services, VA provided a preliminary evaluation within 24 hours to identify those in urgent need for services. For others, VA provided MH diagnostic and treatment planning evaluations within 14 days for more than 95 percent. At the same time that it has accommodated substantial numbers of returning Veterans with increased access, VA maintained the frequency of encounters for treatment of PTSD and other MH conditions in Veterans of prior eras.

[3] Direct care is care provided directly by the Military Health System and purchased care is care purchased by the Military Health System from the civilian sector.

[4] Behavioral health is defined as observable behaviors (e.g., alcohol, spousal, or substance abuse) and may include mental health.

[5] Mental health refers to clinically related treatment for a disorder.

To forecast future needs of DoD for psychological health services and to estimate the number and mix of health care providers required, the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) developed a population-based psychological health risk-adjusted staffing model (PHRAMS). A user application of the model is designed for use by Military Medical Departments and OASD(HA) as a planning tool. Through the application, users can modify selected demographic, clinical and administrative parameters to model their likely effects on psychological health staffing requirements.

PHRAMS can forecast the total staffing requirements to meet the annual need for psychological health services by beneficiaries over a five-year period for each type of specialty MH provider (e.g., psychiatrists, psychologists, psychiatric nurse practitioners, and clinical social workers). It can forecast for others who also provide psychological health services as part of the care they offer (e.g., primary care providers and chaplains).

DoD clarified and reinforced its standards for access to MH care in an October 2007 policy for TRICARE Prime beneficiaries. The policy reinforced that access to care standards for initial MH care are equivalent to those for primary care services. The data available permits the evaluation of the degree to which behavioral health care initial access standards are met in DoD MTFs.

TRICARE Prime beneficiary requests for behavioral health assessments at the MTFs are seen within the following timeframes:

- Emergency – On an immediate basis as directed by the threat.
- Urgent – Within 24 hours or less.
- Routine – Provided within one week.
- Specialty Referral – Occurs within four weeks (or, if more urgent care is indicated, within 24 hours or within 72 hours).

Overall, approximately 90 percent of initial TRICARE Prime appointments to MH providers in MH clinics are seen within seven days. This includes all individuals categorized as in need of emergent, urgent, or routine appointments. Of those, 82 percent are seen within 24 hours. For Active Duty beneficiaries (all Military Departments), approximately 93 percent are seen within seven days for an initial appointment, and of those, 85 percent are seen within 24 hours.

Limitations to the data include that the analysis is based only on the date the patient completed a call for the appointment or the date of the planned appointment, and does not account for possible multiple attempts to call in for appointment. The analysis is exclusive to evaluating compliance with policy for initial appointments only. Even with these limitations, the large majority of TRICARE Prime and Active Duty beneficiaries are able to access MH assessment within standards set by DoD.

OBJECTIVE 2.2
Actively engage in collaborative Graduate Medical Education (GME), joint in-service training, and continuing education activities, which will enhance quality, effectiveness and efficiency of health care.

HEC Graduate Medical Education Working Group

A new charter for the GME WG was approved on April 16, 2009. The WG's name has become the "Health Professions Education WG" to signify an expansion of its scope to include GME as well as other health professional education and training programs. The WG's new charter includes explicit authority for trainee exchange programs. A Memorandum of Agreement (MOA) titled "Creating Opportunities for Exchange of Healthcare Professionals to Promote Cross Cultural Awareness" has enhanced health professional exchanges between the two Departments.

The impact assessment of the Base Realignment and Closure Commission on GME programs is still in progress. A final report will be available once all base realignments are completed. The Seamless Transition for Trainees Program in San Diego, CA has just been completed which will make the GME program more efficient for this large geographic area.

HEC Continuing Education and Training Working Group

The Continuing Education and Training WG is committed to refining the shared training programs between both Departments. In FY 2009, the WG shared 305 education and training programs between VA and DoD, which generated a cost avoidance of $12,775,116 exceeding its target of $8 million. The WG exceeded its Web-based training target of 105 shared programs by sharing 201 Web-based programs. Utilizing MHS Learn Learning Management System (LMS), the WG met its shared training development technology leveraging objective by facilitating the Tri-service deployment of a Content on Demand Web-based training system. This system is now operational and allows Military Department personnel to access selected training programs at any time.

The WG successfully completed a pilot project to test the use of on demand video as a shared training modality in DoD. This Content on Demand deployment of training is now operational in DoD utilizing the MHS Learn LMS. The WG began development of a pilot to utilize both Department's LMSs to quantify participation in VA and DoD personnel shared training. Work is also in progress to develop a pilot to later assess that participation.

The WG also developed a strategy to integrate the training acquired from Federal agencies other than VHA and DoD into the resources being shared by the VHA/DoD shared training partnership. The Interagency Shared Training partnership is managed by the VHA Employee Education System (EES). The implementation of the strategy is in progress. The WG continued efforts to align the distributed learning architectures within VA and DoD. The goal of this initiative is to support increased shared training between the Departments by utilizing distance learning modalities while minimizing the additional resources necessary to support shared training.

After exploring the development and refinement of the Shareable Content Object Reference Model Conformant (SCORM) Web-based training standards and practices, it was determined that

a more thorough review under the authority of the VHA EES is needed in order to proceed. SCORM serves as architectural elements for shared training between VHA and DoD. The activities of the Continuing Education and Training WG with regard to this project were completed on February 28, 2009.

The Continuing Education and Training WG is also pursuing the establishment of a committee to coordinate the identification, vetting and distribution of shared training within DoD and between VA and DoD. Formal approval of a committee to coordinate this effort has been completed. A three phase pilot project to assess the optimal vetting and distribution strategy for sharing training within DoD and the Military Departments was initiated in collaboration with the DoD Health Care Interservice Training Office. Phase I of this pilot was completed on March 31, 2009 and resulted in identifying subject matter experts. During Phase II, subject matter experts in each of the Military Departments reviewed and vetted potential shared training programs for their respective Departments. Subsequent to that review, programs that were found acceptable for deployment were authorized. This was completed on September 25, 2009. Phase III is currently in progress and will establish a stable architecture and procedure for marketing and deploying shared training approved by each Military Department's subject matter experts.

The Continuing Education and Training WG continued to facilitate the development and management of a VA/DoD Facility Based Educators community of practice to increase shared training initiatives between VA health care facilities and DoD MTFs. The WG completed several efforts during FY 2009, including:

- Expanding the community of practice composed of local VA and DoD Facility Based Educators and provide them with in-service training in the area of shared training utilizing a virtual forum.
- Developing a strategy to identify high priority clinical or clinical related training clients in VHA and DoD and determining their in-service and continuing education needs.
- Launching special training initiatives for selected high priority clients who can benefit from shared training.
  - Developed and deployed a strategy for providing continuing education and in-service training to the leadership, managers and staff of the VA/DoD integrated FHCC in North Chicago. Designed a comprehensive in-service and continuing education training program for FHCC leaders, managers and staff.
- Establishing a Virtual Grand Rounds clinical training program to serve VHA and DoD clinical staff.
- Deploying a suite of Compensation and Pension training courses and a Suicide Prevention Training for Physicians course to DoD.

The WG continues to work on the following efforts:

- Managing and facilitating a virtual forum (email group, knowledge management site and suite of virtual meetings) for the members of the Facility Based Educators community of practice to increase communications and the development of shared training between VA and DoD health care facilities.

- Deploying the pre-arrival, orientation, and on-going components of the comprehensive in-service and continuing education training program for FHCC North Chicago leaders, managers and staff.
- Receiving approval of a pilot for FY 2010 to reduce the overlap in mandatory training requirements between VHA and DoD.

The WG increased the membership of the VA/DoD community of practice, incorporating the members of existing Facility Based Educator communities of practice in VA, DoD and the Military Departments, and providing three virtual on-line meetings for the VHA/DoD Facility Based Educators Community of Practice. All of these addressed high priority facility based training issues.

OBJECTIVE 2.3

The HEC Deployment Health Working Group shall identify and foster opportunities for sharing information and resources between VA and DoD in the areas of deployment health surveillance, assessment, follow-up care, health risk communication, and research and development.

HEC Deployment Health Working Group

The VA/DoD Deployment Health WG (DHWG) was established to ensure coordination and collaboration to maintain, protect, and preserve the health of Military personnel and Veterans. The DHWG focused on the health of Active Duty Service members and Veterans, during and after combat operations and other deployments. The primary emphasis was on Service members returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). In addition, the DHWG coordinated initiatives related to Veterans of all eras, going back to the 1940s. Under the scope of the DHWG, VA and DoD shared information and resources in the areas of deployment health surveillance, follow-up medical care, research, and health risk communication.

In FY 2009, the DHWG worked to share information between VA and DoD on deployment health surveillance and assessment. VA and DoD coordinated efforts on identification of and outreach to Veterans who participated in chemical and biological agent testing from 1942 to 1975. The DHWG reviewed DoD's progress to identify Veterans, the transport of data to VA, and VA's outreach efforts to these Veterans. DoD compiled databases on three cohorts: Mustard/Lewisite, Project 112/Shipboard Hazard and Defense, and the Chemical Biological Follow-on Database. In September 2009, DoD launched a new Web-enabled database to improve the transfer of this data from DoD to VA, which is designed to enhance timeliness and accessibility of information. In addition, VA performed targeted outreach to these three cohorts of Veterans. The Veterans Benefits Administration (VBA) identified current addresses and sent notification letters to Veterans about their participation in the tests and about the availability of VA medical care and benefits. As of September 2009, VBA mailed more than 8,200 letters to Veterans in the three cohorts.

The DHWG evaluated VA and DoD efforts on the identification and surveillance of Service members and Veterans who were injured and have embedded metal fragments. The DHWG reviewed the progress of the DoD Embedded Metal Fragment Registry, DoD's identification of

these individuals, and progress of the VA Toxic Embedded Fragment Surveillance Center, including VA's medical follow-up activities. Fragments from 344 Service members have been submitted for analysis from 2003 to July 2009. The DoD Registry to identify this group is being developed in phases. The first phase, which is almost complete, involves the identification of cases using Theater medical records and transferring the data to VA. A later phase will identify cases using DoD inpatient and outpatient databases, which will identify potential cases after their return home.

The DHWG monitored the initiation of a program to identify and track Service members diagnosed with TBI on a systematic basis by the OASD(HA), the Armed Forces Health Surveillance Center (AFHSC), and the DVBIC. This program was designed to determine the number of Service members who have been diagnosed with TBI by using inpatient and outpatient medical records to identify cases. The AFHSC analysis provided the number of TBI cases in DoD from 2000 to 2009, to date. The numbers gradually increased each year, from about 11,000 cases in 2000 to about 27,500 cases in 2008. The cases were categorized into four groups: penetrating, severe, moderated, and mild. Almost 80 percent of the TBI cases were mild.

The DHWG monitors progress on the Millennium Cohort Study (MCS) on an ongoing basis. The objectives of the MCS are: "to evaluate chronic diagnosed health problems, including hypertension, diabetes, and heart disease, among military members, in relation to exposures of military concerns; and to evaluate long-term subjective health, including chronic multi-symptoms illnesses, among military members, especially in relation to exposures of military concern." The first 77,000 personnel enrolled in 2001; as of 2010, a total of 150,000 personnel will be enrolled. The health of the cohort will be evaluated every three years until 2022 to determine the course of diseases over time, which will require continued collaboration with VA.

The DHWG also evaluated the establishment of the VA National Veterans' Registry. VA and DoD staff, including DHWG members, started planning the data collection for this database in 2008. The VA Office of Policy and Planning compiled the database, which was renamed the United States Veterans Eligibility Trends and Statistics. The purpose of the database is to provide the most comprehensive picture of the Veteran population possible to support statistical, trend, and longitudinal analysis. This includes Veterans who have used VA medical care and benefits, as well as Veterans who have never sought VA services. The database also includes uniquely identifiable living and deceased Veterans, including demographic and socioeconomic information, for as far back as data is available. Several existing VA and DoD databases were combined, and duplications were removed. Almost 24 million living and 14 millions deceased Veterans with unique social security numbers were identified and included. The final validation procedures for the database were completed in 2009 and will be updated annually.

Additionally, the DHWG initiated sharing of DoD information with VA on 24 documented environmental exposure incidents in OEF and OIF. The WG invited scientists from the U.S. Army Center for Health Promotion and Preventive Medicine (CHPPM) to provide an overview of these 24 incidents, including the type of chemical contamination, the exposed population, the possible long-term health effects, the environmental risk assessment, medical surveillance, and risk communication efforts for each incident.

The DHWG also organized separate information sharing meetings on two of the exposure incidents in Iraq: the potential chromate exposure at Qarmat Ali, and the burn pit at Joint Air Base Balad. In 2003, CHPPM performed a comprehensive occupational and environmental health assessment at Qarmat Ali, and concluded it was "unlikely" that any current symptoms or health problems could be related to this past exposure or that future problems from this exposure are expected. However, Veterans have expressed concern about the possible long term health effects. In FY 2009, VA started planning an in-depth medical surveillance program for Veterans who were at Qarmat Ali. The Secretary of Veterans Affairs requested VA send letters to the Veterans who were at Qarmat Ali inviting them to participate in a medical evaluation. The DHWG organized a meeting of physicians and scientists from VA, CHPPM, and the Army National Guard to improve the coordination of VA and DoD responses related to Qarmat Ali. Exposure to the smoke from the burn pit at Joint Air Base Balad could potentially impact tens of thousands of Service members who were stationed there. The DHWG is continuing to facilitate this collaboration between VA and DoD scientists and organized a day-long workshop in November 2009 on the VA and DoD responses to the largest environmental exposure incidents in Iraq. They also organized a meeting on the potential health effects of exposure to emissions of the incinerator at the Naval Air Facility in Atsugi, Japan. This could potentially impact the health of 5,600 U.S. Service members and 11,000 family members who lived there.

The DWHG identified a group of VA and DoD scientists to draft and coordinate a joint VA/DoD response to an IOM study that was published in December 2008, entitled *Gulf War and Health, Volume 7: Long-Term Consequences of Traumatic Brain Injury.* The response highlighted ongoing VA and DoD programs that addressed five major clinical and research recommendations from the study.

The DHWG requested an analysis of the results of referrals from the DoD PDHRA program to VA for medical care. The DHWG reviewed an analysis related to a group of 29,835 Reserve Component (RC) and National Guard members, who completed the PDHRA and who were referred to the VA. Seventy nine percent of the Veterans made a VHA clinic visit after the PDHRA. The most common diagnosis in this group of Veterans was PTSD at 42 percent. The other top four diagnoses were low back pain (31 percent); other counseling (25 percent); depression disorder (24 percent); and tobacco use disorder (22 percent). "Other counseling" is a code used for marriage counseling or other non-clinical visits. This analysis provided the first VA feedback to DoD on medical evaluations that resulted from PDHRA referrals.

During the past year, the DHWG shared information on deployment health research projects and progress. A noteworthy example was the planning of a research conference held in January 2009 on prevention and treatment of drug and alcohol abuse in Active Duty personnel and Veterans. The conference was co-sponsored by the National Institute on Drug Abuse, DoD, and VA. More than 200 scientists attended the conference.

The DHWG also developed an inventory of 932 VA and DoD research projects related to the health of deployed Service members and Veterans. DHWG members compiled this comprehensive inventory of projects for FY 2007 (the last year for which complete project data was available) in FY 2009. The members worked with centralized offices in VA, Health and Human Services (HHS) and many DoD research offices to establish a reporting system. The

reporting system has been institutionalized to collect data on completed, ongoing, and new projects on an annual basis. The majority of projects focused on injuries and MH. Injury research included TBI and spinal cord, musculoskeletal, and other types of injuries. Most of the MH research focused on PTSD. Other research areas included infectious diseases, environmental and occupational exposures, vision and hearing, and pain management. Data collection on research projects funded in FY 2008 has been started. Descriptions of the projects are published in a user-friendly format on a DoD Web site, DeployMed ResearchLINK.

In 2009, VA and DoD continued their coordination of risk communication and outreach to Service members and Veterans related to deployment-related exposures. Members of the DHWG developed and coordinated two products: a pocket card for clinicians in VA and DoD on the screening, diagnosis, and treatment of TBI, and a fact sheet for Veterans on amyotrophic lateral sclerosis (also known as Lou Gehrig's disease).

GOAL 3
Seamless Coordination of Benefits

OBJECTIVE 3.1
To improve participation in the Benefits Delivery at Discharge (BDD) program nationwide and ensure Service members are afforded the single cooperative examinations where available.

OBJECTIVE 3.4
VA and DoD will coordinate to respectively implement and market the Quick Start program to ensure maximum awareness and participation by all separating or retiring Service members, especially National Guard and Reserve members who are demobilizing or separating/retiring from Service, who do not meet the timeline to participate in the BDD program.

BEC Benefits Delivery at Discharge Working Group and Quick Start Program

The BDD and Quick Start objectives and strategies were combined in FY 2009 into the new Pre-Discharge WG. The Pre-Discharge Program is a joint endeavor between VA and DoD consisting of the BDD and Quick Start programs, which afford Service members the opportunity to file disability compensation claims up to 180 days before separation, demobilization/deactivation, or retirement from active or full time National Guard duty. Pre-discharge applications can be submitted to any location where VA accepts claims, including all VA regional offices, military installations (intake sites) and demobilization/deactivation sites that have a VA presence, and all VA health care facilities. Through the first three quarters of FY 2009, BDD participation rate was 36 percent. Fourth quarter participation rate was 40%.

To promote greater awareness and facilitate the use of the BDD and Quick Start programs, the Pre-Discharge Program Homepage (http://www.vba.va.gov/predischarge) was launched on June 9, 2009. On this Web site, Service members can find information about pre-discharge programs, locate local intake sites, and apply for benefits online. The site also provides links to DoD sites

that provide transition assistance. The Web site has been marketed through announcements printed on all Service members' Leave and Earning Statements (LESs).

Pamphlets promoting the BDD and Quick Start programs were jointly developed and have been distributed to VA personnel. VA also updated the Veteran's Online Application Web site to include information about pre-discharge programs. In an effort to provide commanders with indications of BDD program participation, the first annual VA Recognition Certificate was awarded in January 2009 to the military installation with the highest BDD participation rate. Finally, to simplify the application process, VA developed a two-page Pre-Discharge Claim Application (currently with OMB), designed specifically for Active Duty applicants.

OBJECTIVE 3.2
Jointly develop, test, and expand to new locations, as directed, an improved Disability Evaluation System (DES) process that is faster, seamless, and transparent to Service members and Veterans, and that improves the Departments' disability systems to the degree allowed by current law.

BEC Improve the Disability Evaluation System

The VA/DoD DES Pilot program was instituted under the oversight of the Senior Oversight Committee (SOC) in 2007. The DES was incorporated into the JSP FY 2010-2012 and brought under the BEC in FY 2009. The DES Pilot continues to operate primarily under the SOC and Overarching Integrated Product Team. The DES WG under the BEC provides quarterly briefings to the BEC and JEC.

The DES WG made significant progress in FY 2009. Since November 26, 2007, a total of 4,822 Service members entered the DES Pilot from 18 MTFs. Of those, 687 Service members completed the DES Pilot via returning to duty, separation, or retirement and 144 Service members were removed from the DES Pilot for other reasons (additional medical treatment needed, case terminated pending administrative discharge processing, etc.). Three thousand nine hundred and ninety-one Service members remain enrolled in the DES Pilot. Active Component Service members who completed the DES Pilot averaged 272 days from Pilot entry to VA benefits decision, excluding pre-separation leave. In addition, Active Component Service members completed the DES Pilot in an average of 289 days, including pre-separation leave. This is two percent faster than the goal established for Active Component Service members and is 46 percent faster than the current DES and VA Claim process.

The Reserve Component/National Guard Service members who completed the DES Pilot averaged 270 days from Pilot entry to issuance of the VA Benefits Letter, which is 11 percent faster than the projected 305 day timeline. Surveys of over 2,500 Service members in the DES showed that DES Pilot participants were significantly more satisfied with their experience than were participants in the current DES process.

The highlights are as follows:

- The DES Pilot began in FY 2008 in the National Capital Region 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. VA and DoD signed a MOA for the single DES examination in the National Capital Region in November 2007. A new MOA regarding cost sharing for the single physical examination was in coordination at the end of FY 2009. The DES WG has been successful in achieving a single examination that meets the needs of both Departments.
- The St. Petersburg VA Regional Office was the initial site to provide all DES Pilot proposed and final ratings for the military services during the first phase of the pilot. As a result of lessons learned, on March 2, 2009, VA designated the Baltimore and Seattle VA regional offices to be the primary Disability Rating Activity Sites. In FY 2009, 1,337 proposed ratings were provided to the military services' Physical Evaluation Boards (PEBs) and 594 VA benefits letters were provided to separated Veterans.
- On October 1, 2008, VA initiated a paperless claims processing pilot for all DES claims initiated in the National Capital Region. VA worked with the MTFs in the National Capital Region to provide access to VBA's Virtual VA Web-based application, the electronic warehouse where imaged documents are stored. In FY 2009, 755 claims were scanned into Virtual VA and 321 VA rating decisions were stored in Virtual VA. The DES WG will continue to assess full implementation of a paperless system beyond the National Capital Region in FY 2010.
- The DoD Disability Advisory Council (which functions as DES WG) chartered the VA-DoD Veterans Affairs Schedule of Rating Disabilities (VASRD) WG to address changes, updates, or modifications to the VASRD. During FY 2009, VA promulgated amendments to the VASRD for burn scars, eye disabilities, and traumatic brain injury. The VASRD WG meets on a monthly basis and will continue to recommend changes that increase efficiency in the delivery of benefits or modifications to the VASRD.

OBJECTIVE 3.3
DoD Service members of all components are aware of and know how to obtain information about their VA and DoD benefits.

BEC Communication of Benefits and Services Working Group

The Benefits and Services Communications WG under the BEC, focuses on how to best communicate military and VA benefits-related information to Service members, Veterans, and their families. In FY 2009, the WG developed and implemented a comprehensive and effective strategic communications plan. To accomplish this task, the Benefits and Services Communications WG disseminated (through the use of VA and DoD Web sites, military service portals and military LESs) important, benefits-related information in support of high-visibility, high-demand benefit programs. Examples of these programs include the new Post-9/11 GI Bill, the Pre-Discharge Program, and the Family Subsistence Supplemental Allowance.

The WG was also successful in expanding its membership, having included permanent representation from the DoD Public Affairs Office and select VA benefits and services divisions.

As a result, the WG has been able to better leverage the various media outlets within VA and DoD. A YouTube-style video was released to provide Service members, Veterans, and their family members with valuable information about highlighted VA and DoD benefits and services. This was used to help understand and access this critical information. The Benefits and Services Communications WG assisted the eBenefits team, which is part of the BEC Information Sharing and Information Technology WG, in developing the content of this joint benefits portal. Through eBenefits, VA and DoD will create streamlined information on benefits and services for Service members, Veterans and their families. Over the next year, members of the Benefits and Services Communications WG will continue to serve as subject matter experts to ensure that the wealth of information regarding benefits and services is readily accessible.

The Benefits and Services Communications WG continues to develop a Service-wide alert notification system that will provide Service members with timely, accurate, and targeted benefits-related information. Although this initiative was originally scheduled to be completed by September 2009, the WG recently discovered that this effort may be more effectively and efficiently realized using existing technologies - primarily Defense Knowledge Online (DKO). This system will serve as a tool to notify Service members approximately one year prior to discharge about both military and VA benefits and services. When developed and implemented, the system will reach out to all active and reserve component Service members by email to provide valuable benefits related information before the final decision is made to separate from service. The WG believes the use of DKO will enhance customer service to Service members while minimizing start-up and maintenance costs. The WG continues to work with the DKO staff and projects an implementation date of September 2010.

OBJECTIVE 3.5
The BEC Medical Records WG will systematically examine all phases of the paper military Service Treatment Record (STR) Life-Cycle Management Process, with an emphasis on promptly providing accurate and complete STR related information for all Service members in all components and Veterans to VA and DoD designated benefits determination decision makers.

BEC Medical Records Working Group

The MRWG was established in FY 2007 to systematically examine all phases of the paper military STR Life-Cycle Management Process. There is an emphasis on promptly providing accurate and complete STR related information for all Service members, in all components, to VA and DoD designated benefits determination decision makers.

In FY 2009, the MRWG was responsible for facilitating the development and implementation of military Service policy and procedures to decrease the volume of loose and late flowing medical documentation to the VA and DoD designated benefits determination decision makers. Three goals were established to measure success: (1) decrease the volume of loose (documentation sent separately from the transfer of the official STR) and late flowing medical documentation by 95 percent; (2) increase the availability of STR information to the VA and DoD designated benefits determination decision makers within 45 days of separation by 95 percent; and (3) provide VA

access to accurate and complete STR information on all Service members and Veterans within 10 days of request at least 95 percent of the time.

During FY 2009, the Office of the Under Secretary of Defense Personnel and Readiness Information Management conducted an analysis of the entire life cycle of outpatient medical and dental records. The analysis team finalized its interim report of findings and recommendations in May 2009. The key recommendation from this report was to create an electronic repository for health treatment information as an interim step to the eventual deployment of a fully electronic health record. The report also confirmed the previously determined need to establish DoD policy and a disposition schedule to be approved by the National Archives and Records Administration (NARA) and contained over 20 recommendations for improvement in the business processes related to the STR. The MRWG incorporated these detailed recommendations into three new policy documents; a Department of Defense Instruction (DoDI), an MOA, and the NARA Disposition. As of the end of the fiscal year, formal coordination for all three documents was underway.

The following performance assessment metrics were related to the previously identified problems of loose and late flowing medical documentation and the delay in getting the official STR to VA upon a Service member's separation, retirement or release from active duty.

The BEC approved a goal of a 95 percent reduction in the flow of loose medical documentation from the Military Departments to the VA by the end of FY 2009. To track the performance for this metric, the VA Records Management Center (RMC) provided a monthly count of the actual volume of loose and late flowing documentation they received from all the Military Departments. Over the course of this past year, DoD collectively decreased the volume by 14.4 percent, which is well short of the established goal. At least part of the reason for the less than desired level of improvement is that the policies that would change the STR-related business processes were delayed pending the information from the DoD analysis of the entire life cycle of outpatient medical and dental records. Over the course of the fiscal year, the Air Force established a centralized cell to reconcile loose medical documentation with the STR prior to transfer to the VA within its Personnel Command. Guidance was issued to all Air Force medical facilities to cease the transfer of all medical documentation directly to the VA. Navy established an operation within the Bureau of Medicine and Surgery to work with their Medical Treatment Facilities (MTF) and Regional Commands to improve performance through an educational focus.

Finally, the BEC approved a metric to monitor the timely availability of the STR to VA with a goal of 95 percent within 45 days post discharge. Obtaining the necessary data to construct this metric proved to be extremely challenging. The Defense Manpower Data Center (DMDC) provided monthly lists of all individuals reported as being separated or discharged in FY 2009. These lists were then provided to personnel at the VA RMC for reconciliation against their database of all STRs received. This process demonstrated that the VA RMC was in fact receiving less than two-thirds of all the STRs. However, in the process of conducting the reconciliation, the MRWG became aware of differences between the data schemes employed by each of the Military Departments and DMDC. Further analysis is currently underway.

OBJECTIVE 3.6
Provide comprehensive, coordinated care and benefits to recovering Service members, Veterans, and their families from recovery through rehabilitation to reintegration. This comprehensive care is provided through a network of medical and non-medical care managers. The coordination of care, benefits, services, and resources is provided by the Federal Recovery Coordination Program (FRCP) and the Recovery Coordination Program (RCP).

JEC Federal Recovery Coordination Program

The mission of the FRCP is to coordinate and access Federal, state and local programs, benefits and services for severely wounded, ill and injured Service members, Veterans, and their families through recovery, rehabilitation, and reintegration into the community.

In FY 2009, FRCP developed and standardized policies and procedures for all aspects of the Program. FRCP developed standard operating procedures for administrative and field staff. These will be updated as necessary to provide additional operational guidance. Performance metrics for Federal Recovery Coordinators (FRCs) are included in the field staff standard operating procedures guide. The program's official VA handbook is in the final concurrence process and is scheduled to be published by June 30, 2010.

Progress was made in FY 2009 towards improving the FRCP Data Management System. In the effort to create a data element dictionary for its current Data Management System (DMS), FRCP standardized many of the required data elements. This was an iterative process throughout FY 2009. The most recent update to the DMS was released on November 16, 2009. In addition, the program developed a framework for future data management needs. A business requirements document was completed and a contract for developing the technical solution was recently issued. Version 1.0 of the new DMS is scheduled for release in the second quarter of FY 2010.

Work began in FY 2009 to develop and test tools for the purpose of measuring and recording intensity of services required by clients and to better balance FRCs workload. Several tools were tested and time categories of FRC effort expanded to better reflect actual activities. This activity will carry over into FY 2010 with anticipated completion by September 20, 2010.

Progress was made in FY 2009 towards developing a complete and long-term program evaluation strategy to include process and outcomes measures, as well as client and family satisfaction surveys. FRCP developed a satisfaction survey and obtained the required clearance from the OMB and DoD. The program worked with the relevant VA offices to complete the required scope of work documentation and privacy clearance for issuing a contract for administering the survey. The request for proposals was issued in FY 2009; the contractor will have 10 weeks to complete the survey, analyze, and present the results in FY 2010. Upon receipt of the survey results, an improvement target and a strategy to meet the target will be determined.

The Government Accountability Office (GAO) is currently conducting a program evaluation of FRCP with a report anticipated in early summer 2010. FRCP will use this report to develop additional process and outcome measures for the program. Performance metrics have been

established for FRCs and are identified in the field standard operating procedures guide and in their annual performance plans.

FRCP developed several new information and outreach strategies in FY 2009. Over the past year, FRCP was an invited participant in a number of activities at the local and national level. To assist in these efforts, the program has created program brochures, posters and banners for use at conferences. The brochures are also provided to potential clients and families, and to other groups for distribution upon request. The program also set up a 1-800 line for referrals. FRCP developed a strategy for hiring placement, and personnel support of FRCs. At the end of FY 2009, 15 FRCs were stationed at six MTFs and two VA medical centers. FRCP made plans to hire an additional five FRCs to supplement existing FRCs. Staffing models have been developed and standard support elements identified.

Program Interoperability

Key to the success of both the FRC and RC programs, and to the coordination of care, benefits, resources and services to recovering Service members, Veterans, and their families, is the interaction of policies, procedures, and personnel between FRCP and RCP. The VA FRCP Handbook was completed in FY 2009 and is in the final stages of concurrence. This is a step towards developing joint standard operating procedures, guidance and handbooks that define roles and responsibilities between the two programs and other medical and non-medical case and care managers. FRCP has also shared educational content with RCP as part of the effort to combine the programs' educational strategies to addresses initial and ongoing educational requirements for both programs. Work is ongoing to develop a joint framework for a common Data Management System.

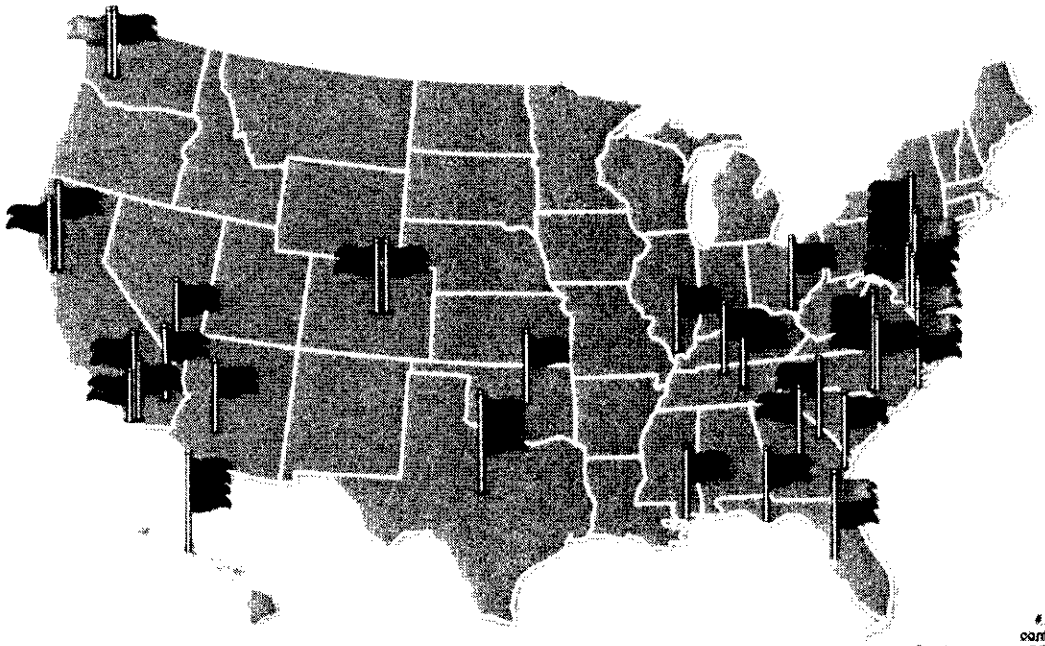
Communications Outreach Program

The National Resource Directory (NRD) provides information on, and access to, services and resources for wounded, ill, and injured Service members, Veterans, and their families and those who support them from recovery and rehabilitation to community reintegration. A business plan was established in FY 2009 to ensure ongoing content management. This initiative is ongoing in FY 2010.

JEC Recovery Coordination Program

The Recovery Coordination Program (RCP) is under the purview of the Office of Wounded Warrior Care & Transition Policy. Originally designated the Office of Transition Policy and Care Coordination, the organization was re-designated as the Office of Wounded Warrior Care & Transition Policy (WWCTP) in August 2009, to reflect a more accurate description of the evolving mission and makes the role clearer to a broader audience. The name aligns the office with the community in which it operates such as Wounded Warrior Programs (WWPs), Military and Veteran Service Organizations, and the Department of Veterans Affairs, and with the community it serves: the Recovering Service Members (RSMs) and families.

The RCP was established to provide assistance to RSMs and their families throughout recovery, rehabilitation, and return to duty or community reintegration. After developing a uniform, standardized curriculum, the WWCTP office has trained, in FY 2009, 89 Recovery Care Coordinators (RCCs) from all four Military Departments and Special Operations Command. The RCCs are located in 31 locations across the US.



RECOVERY CARE COORDINATOR SITES

As of 10/29/2009

NOTE: There may be more than one RCC at any given location

Service	# of contract RCCs	Active Duty RCCs
ARMY	16	
NAVY	2	4
MARINES	40 (*2)	
AIR FORCE	17 (*1)	
USSOCOM	7	
TOTAL	85	4

* RCCs in Leadership Positions

In coordination with the Military WWPs, the WWCTP created a template for the Comprehensive Recovery Plan (CRP) that is prepared by the RCCs and Recovery Teams for each RSM. The CRP provides a roadmap for recovery, rehabilitation, and return to duty or community reintegration, along with milestones and goals set by the RSM.

Once trained and on-site, the WWCTP office supports the RCCs through the RCP DKO portal. The WWCTP office posts information, policy, legislation and updates to the RCP, and conducts an RCC Forum where RCCs can exchange information on best practices. Curriculum to conduct annual refresher training for RCCs is being developed.

The DoD established policies, procedures and guidance for the RCC Coordination program through a Directive -Type Memorandum and DoD Directive. A Directive -Type Memorandum, "Recovery Coordination Program: Improvements to the Care, Management and Transition of Recovering Services Members," was published in January 2009 to establish the initial policy on the RCP. DoD Instruction (DoDI) 1300.24, "Recovery Coordination Program," was published on

December 1, 2009 to establish policy, assign responsibilities, and prescribe uniform standards for improvements to the care, management, and transition of RSMs across the Military Departments. The DoDI was written in order to meet the NDAA FY 2008 requirement for a comprehensive policy.

The draft intensity tool project was not completed in FY 2009. However, selected tools were tested and time categories of RCC effort expanded to better reflect actual activities. This activity will carry over into FY 2010.

In order to ensure ongoing content management, the WWCTP office developed a one-year communications and outreach plan that enhanced the NRD, an on-line tool, for RSMs, Veterans, their families, and those who support them. The NRD educates stakeholders within DoD, the Departments of Veterans Affairs and Labor, other Federal agencies, RSMs and Veterans and their families. Information is provided on the services and support available to them from national, state and local governments and military and civilian organizations. The Tri-Agency NRD Governance Board was established in May 2009.

In another effort to improve outreach, the WWCTP developed a strategic communications plan which called for a bi-weekly e-newsletter to be created. The e-newsletter was developed and launched in 2009. Entitled "The Square Deal," the e-newsletter is forwarded to the senior leaders in the VA, DoD, Department of Labor (DOL), the Military Departments and the private sector to keep them abreast of key DoD initiatives that support RSMs and families.

In August 2009, the WWCTP office developed and submitted standard questions to the Military WWPs for inclusion in their RSM satisfaction surveys. The results of these surveys are expected to be available in August 2010, and will become a resource for the RCP Evaluation Team.

In 2009, the WWCTP office coordinated with and briefed the Military Wounded Warrior Program Directors on the RCP site assistance visits and evaluation of the program. The process will consist of two phases:

- Phase I – site assistance visits, will begin in March 2010, at pre-determined sites based upon input from the WWPs, focusing on 1) a review of RCC roles and responsibilities, 2) a workload review, and 3) a review of case records to include RSMs' recovery plans. Baseline evaluations of those sites will be concluded by May 31, 2010.
- Phase II – site assistance visits, will begin in June 2010, at pre-determined sites based upon input from the WWPs with the same focus as Phase I. Visits and baseline evaluations will be completed by October 2010.
- A program evaluation report will be prepared by November 30, 2010, and baseline metrics, a continuous process improvement plan and outcome measures will be completed by December 2010.

GOAL 4
Integrated Information Sharing

OBJECTIVE 4.1
VA and DoD will utilize their enterprise architectures to foster an environment that ensures appropriate Departments, Agencies, Service members, Veterans, and family members have immediate and secure access to reliable and accurate personnel and beneficiary data that supports their needs.

BEC Personnel and Benefits Information Sharing/Information Technology Working Group

The objective of the VA/DoD Personnel and Benefits Information Sharing/Information Technology Working Group (IS/IT WG) is to utilize VA and DoD enterprise architectures to foster an environment that ensures appropriate Departments, Agencies, Service members, Veterans, and family members have immediate and secure access to reliable and accurate personnel and beneficiary data that supports their needs.

One of the main objectives of the IS/IT WG over the past several years was to reduce the legacy feeds between the two Departments to one feed between Defense's Defense Enrollment Eligibility Reporting System (DEERS) and VA's VA/DoD Identity Repository (VADIR). Originally, there were 31 feeds from DoD and 11 from VA. This fiscal year, the group successfully finished reducing those feeds down to one from each department (as depicted in the table below).

Number of Distinct Data Exchanges for FY 2006-2009

From DoD to VA	From VA to DoD
31	11
20	8
11	6
1	2
1	1

In addition to retiring the legacy feeds, the WG has been addressing *ad hoc* requirements for data exchanges; specifically, the Post-9/11 GI Bill and the Wounded, Ill, and Injured (WII) indicators.

The VA and DoD were able to put the capabilities in place for the VA to administer the Post-9/11 GI Bill by August 1, 2009. The Post-9/11 GI Bill provides financial support for education and housing to those individuals who qualify. The capability that allows Service members enrolled in the Post-9/11 GI Bill program to transfer unused educational benefits to their spouses or children was in place by August 1, 2009, as well.

The DMDC developed WII tables in DEERS in order to identify these Service members. Interfaces are currently being developed to populate the data fields that were added to DEERS to capture and store the WII data. The WII indicators being used are based upon the definitions developed and agreed upon in the DoD/VA WII Senior Oversight Committee's Line of Action Six, Clean Sheet Design. Both VA and DoD personnel and health communities will use the data

collected. The DMDC continues to update the tables to accommodate additional reporting requirements.

The IS/IT WG developed flexible and adaptable IT solutions to support non-clinical case management activities that allow for quick additions and adaptations of new and changing business requirements. One of these efforts is VA's Veterans Tracking Application (VTA) to track Service members through the Disability Evaluation System (DES) Pilot.

With the JEC's approval, the VTA tracking tool was adopted and modified as the single database to track Service members through the DES Pilot. This process included enhancing VTA to accommodate all aspects of the DES Pilot, providing access to the Veterans Information Portal for the users of the VTA tracking tool, developing a training guide, training users, establishing and manning a VTA help desk, initiating discussions for a VTA-DES Pilot help desk, populating VTA with the DES Pilot data, and testing the tool. Benefits of this tracking tool include; eliminating manual entry of data and the use of multiple databases for tracking; adopting a paperless process; providing recurring and *ad hoc* reports to leadership on DES Pilot statistics; accurately tracking a Service member's progress through the DES Pilot; and accessing the disposition of a Service member based upon the Medical Evaluation Board (MEB)/PEB determinations.

The IS/IT WG achieved full implementation of a common database to track severely disabled Service members through VTA by December 1, 2008. The IS/IT WG implemented additional enhancements to the VTA tracking tool to ensure this application meets user needs.

The IS/IT WG undertook specific initiatives to address the three data elements from the DD Form 214, *Certificate of Release or Discharge from Active Duty,* that are not electronically shared with the VA at this time: awards and decorations, dental indicator, and character of service for Reserve/Guard Personnel. DIMHRS was to have addressed these three data elements. Due to DoD's change in direction for DIMHRS, the IS/IT WG is developing alternatives to either share these three data elements with VA through an electronic exchange between the DEERS and VADIR, or determine how the information already shared between DEERS and VADIR can be used to provide VA with information to meet its business needs.

The Identity Management Common Military Population Strategy and Work Plan started out as an effort to implement the capability to assign a unique identifier to Service members and Veterans who are serviced by both VA and DoD, and the capability to establish a unique identifier and add Veterans to the DEERS database who entered and left military service prior to the creation of DEERS. This concept allows ease in sharing information on Service members and Veterans and ensures that systems are pointing to the same person. Through an analysis of various VA files (such as the files related to Education Payment, Veterans Group Life Insurance, Veterans Services Network, Veterans Assistance Discharge System, Gulf War Veterans Information System), VA and DoD have determined which Veterans should have the unique identifier shared by DEERS and VADIR. VA is now able to add Veterans, through the person-add capability developed this fiscal year who present for the first time to VA for services. These individuals can now be assigned a unique identifier. The IS/IT WG also developed a plan for matching individuals currently identified only by Service Number. At the end of FY 2009, there was an estimated joint population of 35 million.

The IS/IT WG has been developing a shared authentication service for Defense Self-Service log-on (DS log-on) and credentialing capabilities. These capabilities will allow users to securely manage benefits online. DS log-on has already been integrated with several DoD personnel and health applications. During FY 2009, VA began using DS log-on for eBenefits, My HealtheVet, and for Veterans Identification Card cardholders. These additional capabilities will expedite the delivery of benefits to Service members, Veterans, and their families as well as improve the management of patients in VA/DoD shared medical facilities.

The IS/IT WG began developing the eBenefits portal in FY 2009. The portal will provide a single information source for Service members and Veterans as directed by the President's Commission on the Care for America's Returning Wounded Warriors, July 2007. The eBenefits Web site was initially scheduled to be released in June 2009, however, the BEC delayed the release date in order to fully integrate Self-Servicing DS Log-on capabilities. These capabilities were crucial to the success of ensuring all potential eligible users would have the ability to obtain an account and perform self-servicing functions in a secured environment. The eBenefits Web site was successfully launched on the World Wide Web in 2009. The eBenefits portal is a secure Service member/Veteran-centric Web site focused on the health, benefits, and support needs of Service members, Veterans, and their family members or other delegates. The eBenefits portal consists of both a public Web site and a secure portal. The eBenefits portal allows for personalization by the user and will customize benefit information based upon user profile. It enables users to find tailored benefit information and services in one place, rather than scattered across Web sites and access channels. Most importantly, its design allows Wounded Warriors to find the information and services they need, whenever they need assistance.

OBJECTIVE 4.2
VA and DoD will structure their health enterprise architectures to support sharing of timely, consistent health data.

VA/DoD Health Architecture Interagency Group

The VA/DoD Health Architecture Interagency Group (HAIG) analyzed and reported current processes and opportunities to promote health care quality and efficiency through information sharing. Over the past fiscal year, the HAIG has expanded standards-based information sharing and refined shared health architecture components. They worked on the development of a Health Services Reference Model Framework. They also reported on ballot coordination for national standards and progress toward target VA/DoD Health Standards Profile updates.

The HAIG continued examining the activities of VA and DoD health architectures that further evolve the areas of provision of health care delivery. They reported on their progress on architecture reviews for Wounded Warrior projects including case management, disability determination, and continuity of care; identification of standards for the target VA/DoD Health Standards Profile; and incorporation of Information Exchange (IE) into national health process. They also provided updates to the VA/DoD IE matrix and leveraged Lines of Action architecture models to develop Wounded Warrior scenario use cases for the Federal Nationwide Health Information Network (NHIN)-Connect demonstrations.

Working toward a goal of a VA/DoD common services framework to facilitate the secure use of shared architectures, the HAIG developed the draft standard set of health care services names and definitions national standards. This includes provider identity management service, allergy/adverse reaction service, and orders management service, which the HAIG proposed as a framework for the Federal Health Architecture Service Reference Model. They also promoted Service Oriented Architecture (SOA) in Health Standards Development Organizations (SDOs).

To refine the Joint Common Services Framework, the HAIG added new components to the Health-SOA Reference Model based on the Electronic Health Record (EHR) Functional Model and Healthcare Information Technology Standards Panel (HITSP) interoperability specifications, including the Federal Health Information Model and Federal Health Data Model components. The IE Matrix Tool was developed and documents IE flows between the Departments. This provides several views (Management, Provider, IOM, and VA/DoD Architecture); documents and prioritizes future IEs; and identifies level of interoperability and standards for IEs.

OBJECTIVE 4.3
Facilitate the adoption of Health Information Technology (HIT) standards for greater interoperability between health systems.

DoD/VA Health Architecture Interagency Group

In FY 2009, the HAIG participated in the development of health standards and then jointly utilized health IT systems and products that meet recognized interoperability standards. They completed the review of HITSP standards specifications recommended by the HHS Secretary and incorporated the standards into the VA/DoD Health Standards Profile. They crafted national HIT standards from VA/DoD requirements (e.g., role-based access control) and Co-chaired the Federal HIT Standards Organization Participation WG, which leveraged Federal health agencies' participation and priorities to influence standards adoption. Through the HAIG, the Departments coordinated VA/DoD positions on SDO standards ballots.

To support the 2009 target VA/DoD Health Standards Profile and 2009 VHA/DoD Health Interoperability Standards Reference Model deliverables, the HAIG collaborated to identify joint information, data representation, security, and technical standards published annually; and defined a category of standards for VA/DoD information sharing.

OBJECTIVE 4.4
Enhance the effectiveness and efficiency of VA access to the electronic health data on separating and separated Military members, and VA and DoD access to electronic health information on shared patients, and support the health IT initiatives agreed to by the Wounded, Ill, and Injured Senior Oversight Committee.

The Information Management (IM)/IT WG monitored the following information sharing metrics.

- Historical data on over five million Service members has been transferred to VA;
- Over 44,400 patients have been flagged as "active dual consumers" (ADC) for VA/DoD computable data exchange purposes;

- Over 2.7 million Pre- and Post-Deployment Health Assessment (PPDHA) forms and PDHRA forms on over 1.1 million separated Service members and demobilized RC and National Guard members have been transferred to VA;
- Essentris is currently operational at 24 MTFs accounting for over 59 percent of total DoD inpatient beds and provides VA with access to DoD discharge summaries.

HEC IM/IT Working Group

In FY 2009, the IM/IT WG's focused on data sharing of electronic health information between VA and DoD.

In September 2008, DoD automated a process to identify patients being treated in both Departments and began setting the ADC "flag" on approximately 50 patients each day. In March 2009, the Departments developed a schedule for completing implementation of the automated activation of ADC patients and in April 2009, began a phased approach of this capability. In July 2009, DoD increased the automated ADC activation to approximately 100 patients each day.

The Departments established a joint VA/DoD requirements definition schedule (milestones and timelines) for the data elements submitted by the Interagency Clinical Informatics Board (ICIB), to achieve interoperability of electronic health systems or capabilities for the provision of clinical care.

In support of Section 1635 NDAA FY 2008, requiring the Departments to implement systems or capabilities that allow for full interoperability of personal health care information or capabilities by September 2009, the ICIB defined "full interoperability" as being able to share the necessary information to support the continuum of care between VA and DoD. The ICIB further defined this necessary information by recommending six high-level capabilities that, if implemented and added to the data already shared between the Departments, would achieve full interoperability. The recommendations were approved and the Departments achieved the successful completion of these capabilities. The following table depicts the ICIB's six high-level interoperability capabilities and their status as of September 30, 2009.

ICIB Capability	Status
DoD expansion of Essentris to at least one additional site in each Military Medical Department	CliniComp's Essentris™ product suite is the current Inpatient Documentation System (IDS) solution for DoD. DoD coordinated with the Military Departments to successfully deploy Essentris to one additional site per Military Department by September 2009. Four Army sites were added in FY 2009: Reynolds Army Community Hospital (ACH); Moncrief ACH; U.S. Army Hospital, Seoul, Korea; and Fort Leonard Wood ACH. Navy and Air Force sites included Naval Hospital Bremerton, David Grant Medical Center at Travis Air Force Base (AFB). Essentris is operational at 27 DoD sites. Inpatient discharge summaries are currently available to VA and DoD providers from 24 of the 27 DoD Essentris sites through BHIE, accounting for 59 percent of total DoD inpatient beds.
Demonstrate the operation of Partnership Gateways in support of joint VA/DoD health information sharing	Four new VA/DoD gateways to support expanded bandwidth requirements are operational in Dallas, Texas; Kansas City, Missouri; Santa Clara, California; and Reston, Virginia. Efforts are underway to migrate data traffic to the new gateways, with 30 percent complete as of September 2009.
Enhance sharing with VA of social history data currently captured in DoD EHR	Baseline functionality was completed in November 2008, for the one way sharing of social history data (DoD to VA). VA and DoD will address improved usability for enhancements beyond September 2009.
Demonstrate initial capability for scanning medical documents of Service members into DoD EHR and forwarding those documents electronically to VA Provide all Periodic Health Assessment data stored in DoD EHR to VA in such a fashion that questions are associated with responses	VA and DoD met the objective to demonstrate an initial capability for scanning medical documents and sharing these documents electronically with the VA utilizing a test environment. Going forward, when fully implemented, this capability will enable DoD users to scan/import documents and artifacts, associate those documents/artifacts with a patient's record, and make them globally accessible to authorized VA and DoD users. DoD will begin deployment to Limited User Test sites in the first quarter FY 2010. VA and DoD completed initial capability to enable display health assessment information using BHIE in November 2008, which established the capability for VA to view questions and answers from questionnaires collected at MTFs and stored in the DoD EHR. The Departments successfully completed the ability for VA to view information from DoD's health assessment reporting tool in September 2009.
Provide initial capability to share electronic access to separation physical exam information captured in DoD EHR with VA	Initial capability, which supports the separation physical exam processes, was met in May 2008. Health care information currently shared includes: Outpatient Treatment Record; Inpatient Discharge Summaries; Ancillaries (laboratory, radiology, and pharmacy); and Deployment Health Assessments.

In June 2009, the VA/DoD ICIB submitted a list of recommended EHR interoperability objectives (data elements and usability enhancements) for FY 2010 and beyond to the IM/IT WG. These interoperability objectives are high level statements of need. VA and DoD requirements teams have been engaged to evaluate the FY 2010 and beyond interoperability objectives.

DoD development of technical solutions to support the capture and display of automated neuropsychological assessment data from DoD's NeuroCognitive Assessment Tool (NCAT) are well underway. VA and DoD successfully demonstrated the ability to capture and share NCAT data with VA utilizing a test environment in September 2009.

Three Common Service pilot projects were proposed and approved: Unified Patient Registration/Patient Identification Management Service, Orders Management/Order Portability Service, and Single Sign On with Patient Context Management.

In FY 2009, a key focus of the IM/IT WG was the electronic sharing of images for shared VA/DoD patients.

The document titled *The Plan for Providing DoD Providers Access to Theater Images* describes DoD plans to implement a radiographic image repository whereby radiographic images captured in Theater will be made accessible to providers in continental U.S. facilities. This repository will contain emergent and non-emergent radiographs captured while Service members are undergoing care in the Theater of Operations. DoD will align its enterprise wide imaging initiative activities to make these Theater images accessible to all DoD providers. DoD will also align its enterprise wide imaging initiatives with corresponding VA projects in a continuing effort to improve VA/DoD data sharing. DoD is developing technical solutions to support the transfer of patient demographic data with radiographic orders to the Theater Picture Archiving and Communication Systems (PACS) and incorporating radiological reports into the Theater EHR.

The DoD imaging team reported on efforts to implement additional bandwidth in Theater to support image sharing. Army Central Command (CENTCOM) identified the need for enhanced telemedicine capability via a Joint Urgent Operational Needs Statement, identifying insufficient infrastructure within Theater of operations to support the timely transfer of radiographic images. They further identified that the communications infrastructure was not robust enough to support the continuum of care as Service members were evacuated from Theater to a sustaining base. Army CENTCOM is now managing this effort.

The Departments have expanded the William Beaumont Army Medical Center and El Paso VA Health Care System (HCS) Medical Image Sharing demonstration project to support clinicians' bidirectional exchange of digital images at key locations. DoD continues to monitor and evaluate the current capability as a transitional step toward broader enterprise image sharing capability.

In September 2009, VA and DoD demonstrated an initial capability for scanning medical documents into the DoD EHR and sharing these documents electronically with VA utilizing a test environment. Going forward, when fully implemented, this capability will enable DoD users to scan/import documents and artifacts, associate those documents/artifacts with a patient's record, and make them globally accessible to authorized VA and DoD users.

In FY 2009, the HEC IM/IT WG also worked toward the goal of increasing the amount of shared inpatient electronic health data between VA and DoD.

CliniComp's Essentris™ suite, a Commercial-Off-The Shelf product, is the current IDS solution for the MHS supporting critical care, acute care, emergency department, labor and maternal child care, psychiatric care, pediatrics, and operative care. DoD established an Essentris deployment schedule. In support of the NDAA FY 2008 interoperability milestone, DoD coordinated with the Military Departments to successfully deploy Essentris to (at least) one additional site per Military Department by September 2009. Four Army sites were added in FY 2009: Reynolds ACH, Moncrief ACH, U.S. Army Hospital, Seoul, Korea, and Fort Leonard Wood ACH. Navy and Air Force sites included Naval Hospital Bremerton, David Grant Medical Center, and Travis AFB.

In July 2006, to increase the availability of clinical information on shared patients, VA and DoD collaborated to extend BHIE functionality to allow bidirectional access to inpatient discharge summaries from DoD's IDS. This capability is now operational at 24 of 27 DoD Essentris sites, which include some of DoD's largest inpatient facilities, representing more than 59 percent of DoD's total inpatient beds. In 2008, additional DoD inpatient note types became available to all DoD providers and VA providers in the Puget Sound area including operative notes; consultations, 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 June 2009, utilizing the existing VA production test environment in Puget Sound, VA and DoD began testing the exchange of inpatient clinical notes on shared patients. Additional DoD Essentris site deployments are planned in FY 2010, to increase coverage to more than 90 percent of DoD total inpatient beds by September 2010.

OBJECTIVE 4.5
VA/DoD will foster secure computing and communications infrastructure for electronic patient data sharing.

HEC IM/IT Working Group

In FY 2009, the HEC IM/IT WG continued to improve network security and communications partnership.

In 2008, a VA/DoD team defined functional, infrastructure, and policy interoperability requirements that resulted in a VA/DoD Multiple Gateway Concept of Operations (ConOps). The Departments have achieved the development and implementation of an enterprise architecture infrastructure solution and the establishment of a series of strategically planned network gateways between the Departments. The VA/DoD gateways provide secure, redundant connectivity between VA and DoD facilities, and facilitate the seamless transfer of health data. In 2008 and 2009, the Departments established four enterprise gateways, which are now receiving migrated network traffic for data exchange. As of September 2009, 30 percent of network data traffic has migrated to new enterprise gateways. The Departments anticipate completing the migration of data shared through VA/DoD enterprise systems (existing as of June 2009) in FY 2010. In March 2009, VA and DoD successfully developed and implemented a secure network gateway at the FHCC North Chicago.

Appendix A
Department of Veterans Affairs and Department of Defense Joint Executive Council Joint Strategic Plan for Fiscal Years 2010-2012

INTRODUCTION

The *Department of Veterans Affairs and the Department of Defense Joint Executive Council Joint Strategic Plan* (JSP) is the source document that conveys to the Secretaries of the Department of Veterans Affairs (VA) and the Department of Defense (DoD) the Joint Executive Council (JEC) recommendations for the strategic direction of joint coordination and sharing efforts between the two Departments. The JSP Fiscal Year (FY) 2010-2012 updates and improves upon the objectives from the JSP FY 2009-2011 to focus on performance outcomes. These enhancements are designed to help VA and DoD demonstrate and track progress toward goals, Sub-goals and objectives.

A Revised Approach

VA and DoD introduced a new methodology and standard template to create performance-based objectives and action plans for the JSP FY 2010-2012. The key to developing a performance-based objective is to make it "SMART": Specific, Measurable, Achievable, Realistic, and Time-bound. Through this performance-based approach, VA and DoD will be better able to:

- Articulate desired outcomes;
- Define strategic objectives, initiatives, and performance measures;
- Agree to a consistent method for measuring and reporting program performance;
- Create more accountability to compel organizations to concentrate time, resources, and energy on achieving objectives; and
- Demonstrate progress toward objectives and improve transparency to senior leaders in both Departments and Congress, as well as Veterans, Service members, and other stakeholders.

The SMART Objective template captures necessary details in a consistent, structured way. The JSP FY 2010-2012 concentrates on the following components:

- Goal
- Sub-goal
- SMART Objective
- Initiative
- Activities & Milestones
- Recommended Metric(s)
- Where is/should the Metric(s) be tracked

The components of the SMART Objective templates in Section 3 of the JSP FY 2010-2012 are organized and labeled using a simple three-part numbering system. The first number identifies the Strategic Goal, the second number identifies the Sub-goal, and the letter identifies the SMART Objective. This system is demonstrated using the following example:

EXAMPLE: JSP SMART OBJECTIVE 3.4.A

The first number **(3)** indicates that this component supports Strategic Goal 3.
There are a total of six Strategic Goals.

The second number in the above example **(4)** identifies the Sub-goal. The Sub-goal supports the accomplishment of the larger Strategic Goal. There may be multiple Sub-goals in support of each Strategic Goal.

The letter **(A)** identifies the SMART Objective. There may be one or more SMART Objectives in support of each Sub-goal. The first SMART Objective related to the Sub-goal is identified by the letter "A" (as in the example above), and any additional SMART Objectives are identified sequentially in alphabetical order.

SMART Objective Template

GOAL #: Title of Goal	**Working Group**	Identify Working Group
SUB-GOAL: Supports the accomplishment of the Goal		
SMART OBJECTIVE: Performance-based objectives should be written as statements that are: SMART **S**pecific: understand what needs to be accomplished **M**easurable: link to existing metrics where possible **A**chievable: attainable, can be completed as specified **R**ealistic: relevant and can be accomplished within time and resource limits **T**ime-bound: clear point in time for completion		
Initiatives	A specific strategy or activity that supports accomplishment of that SMART objective	
Activities & Milestones	Action plan for what needs to be accomplished by when	
Recommended Metric(s)	Quantitative measurements that can be monitored to demonstrate progress toward meeting the SMART objective	
Where is/should the Metric(s) be Tracked	How/where metrics should be documented and reported	

Description of Plan

Section 1displays the JEC vision, mission statement, guiding principles, and Strategic Goals. Section 2 describes major strategic outcomes and initiatives associated with each of the six Strategic Goals of the JSP FY 2010-2012. The detailed SMART Objective templates follow in Section 3. Section 4 outlines the way ahead.

SECTION 1

Mission - Vision Statement - Guiding Principles

Mission: To improve the quality, efficiency, and effectiveness of the delivery of benefits and services to Veterans, Service members, military retirees, and their families through an enhanced Department of Veterans Affairs (VA) and Department of Defense (DoD) partnership.

Vision Statement: A world-class partnership that delivers seamless, cost-effective, quality services to beneficiaries and value to our Nation.

Guiding Principles:

- **Collaboration** – to achieve shared goals through mutual support of both our common and unique mission requirements.
- **Stewardship** – to provide the best value for our beneficiaries and the taxpayer.
- **Leadership** – to establish clear policies and guidelines for VA/DoD partnership, promote active decision-making, and ensure accountability for results.

Strategic Goals

Goal 1 - Leadership, Commitment, and Accountability

Promote accountability, commitment, performance measurement, and enhanced internal and external communication through a joint leadership framework.

Goal 2 - High Quality Health Care

Improve the access, quality, effectiveness, and efficiency of health care for beneficiaries through collaborative activities.

Goal 3 - Seamless Coordination of Benefits

Improve the understanding of, and access to, services and benefits for eligible uniformed Service members and Veterans through each stage of their life, with a special focus on ensuring a smooth transition from Active Duty to Veteran status.

Goal 4 - Integrated Information Sharing

Ensure that appropriate beneficiary and medical data is visible, accessible, and understandable through secure and interoperable information management systems.

Goal 5 - Efficiency of Operations

Improve management of capital assets, procurement, logistics, financial transactions, and human resources.

Goal 6 - Joint Medical Contingency/Readiness Capabilities

Ensure the active participation of both agencies in Federal and local incident and consequence response through joint contingency planning, training, and conducting related exercises.

SECTION 2

Major Strategic Outcomes and Initiatives
VA and DoD modified the structure of the JSP FY 2010-2012 to include a new Section 2 which describes the major outcomes and initiatives associated with each of the six Strategic Goals. This section provides a high level overview of the strategic direction for the JEC. Section 3 of the document contains all the specific details captured in the SMART Objective templates for each goal.

These initial efforts to improve the joint strategic planning process will enable both Departments to develop a performance-based system for tracking progress on JEC initiatives. A formal tracking and reporting system will be refined in FY 2010 to help the JEC oversee the performance of its Sub-councils.

Goal 1 – Leadership, Commitment, and Accountability
Promote accountability, commitment, performance measurement and enhanced internal and external communication through a joint leadership framework

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) maintain a leadership framework to oversee and promote successful partnerships, institutionalize needed change, and foster collaboration to support Service members and Veterans. This framework includes the Wounded, Ill, and Injured Senior Oversight Committee (SOC) and the VA/DoD Joint Executive Council (JEC). The SOC will focus specifically on high priority needs of wounded, ill, and injured Service members and Veterans. The JEC institutionalizes VA and DoD sharing and collaboration to ensure the efficient use of services and resources for the delivery of health care and other authorized benefits to Service members and Veterans. The JEC recommends to the respective Secretaries the strategic direction for joint coordination and resource sharing efforts. The JEC will oversee the implementation of the JSP. JEC and SOC issues are often linked.

This leadership framework received new emphasis in FY 2009. VA and DoD expanded their permanent support staffs who coordinate efforts of the SOC and JEC. VA established the VA/DoD Collaboration Service in October 2008 within the Office of the Assistant Secretary for Policy and Planning and DoD established the Executive Secretariat under the Deputy Under Secretary of Defense (Plans) in December 2008.

As explained in the *VA/DoD JEC FY 2009 Annual Report* (AR), the VA/DoD Collaboration Service and the Executive Secretariat (SOC, JEC)/Office of Strategic Planning and Performance Management worked together to introduce a performance based approach to the JSP FY 2010-2012. The work has only begun. The staffs will continue to propose modifications to the JSP, the AR and the JEC processes to make them more outcome oriented. The staff will steer the JEC Working Groups (WGs) through this improvement process.

The Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness co-chair the quarterly JEC meetings. However, for purposes of high priority initiatives or issues, the Deputy Secretary of Defense will serve as the Department of Defense Co-Chair of the JEC. The Virtual Lifetime Electronic Record (VLER) will remain a high priority item.

To ensure that appropriate resources and expertise are directed toward priorities, the JEC established health and benefit councils. The Health Executive Council (HEC) is co-chaired by the VA's Under Secretary for Health and DoD's Assistant Secretary for Health Affairs. The Benefits Executive Council (BEC) is co-chaired by VA's Under Secretary for Benefits and DoD's Deputy Under Secretary for the newly established Wounded Warrior Care and Transition Programs. The Interagency Program Office (IPO) will be led by a permanent Director and Deputy Director, both selected through a joint vetting process between VA and DoD. The HEC and the BEC Co-Chairs, and the IPO Director will oversee accomplishment of the objectives, initiatives, activities, milestones, and metrics of the WGs that fall under their respective purviews. These leaders will monitor progress and report status to the JEC.

The collaborative work between VA and DoD to ensure leadership, commitment, and accountability in fiscal years (FY) 2010-2012 will result in the following strategic outcomes:

- Improve accountability that will accomplish JEC goals and priorities through a performance-based management system.
- Improved strategic communication of JEC priorities.

The JEC will pursue the following major initiatives toward the goal of leadership, commitment, and accountability:

- Develop a JSP that reflects the strategic priorities of the new administration and both departments.
- Develop a joint survey instrument to assess awareness of VA/DoD programs amongst wounded, ill, and injured Service members, Veterans, and family members.

This work is ongoing in the JEC's Joint Strategic Planning Committee (JSPC) and the Communications Working Group. These working groups will focus specifically on the following Sub-goals:

- 1.1: Improve the efficiency and effectiveness of the JEC through an outcome-oriented joint strategic planning and monitoring process (JEC JSPC Working Group).
- 1.2: Identify and communicate strategic messages and priorities of the JEC (JEC Communications Working Group).

Goal 2 – High Quality Health Care

Improve the access, quality, effectiveness, and efficiency of health care for beneficiaries through collaborative activities

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) are committed to working together to improve the access, quality, effectiveness, and efficiency of health care for Service members, Veterans, and their families. Subject matter experts from both departments engage in this collaborative work on a regular basis through the Health Executive Council (HEC) and its working groups. The HEC oversees the cooperative efforts of each department's health care organizations and supports mutually beneficial opportunities to improve business practices;

ensures high quality, cost effective health care services for both VA and DoD beneficiaries; and facilitates opportunities to improve resource utilization.

The collaborative work between VA and DoD to provide high quality health care in fiscal years (FY) 2010-2012 will result in the following strategic outcomes:

- Increased effectiveness of health care providers;
- Increased flow of information between VA, DoD, and other medical providers; and
- Improved experience for patients transitioning between health care providers.

The HEC will pursue the following major initiatives toward achieving the goal of high quality health care:

- Increase knowledge of suicide risk and prevention practices among health care providers, as demonstrated by enhanced diagnostic, treatment, and recovery outcomes.
- Improve Psychological Health (PH) and/or Traumatic Brain Injury (TBI) screening and identification of Service members and Veterans, by increasing the percentage of individuals who seek treatment after being referred.
- Reduce stigma of TBI and/or PH conditions in Service member and Veteran populations, by developing and implementing population focused anti-stigma public education campaigns.
- Increase health surveillance information sharing, track research initiatives on deployment health issues, and improve joint health risk communication, by improving the coordination and sharing of Service member and Veteran health information between VA and DoD.
- Establish and develop Centers of Excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of the following: military eye injuries, hearing loss and auditory system injuries, and traumatic extremity injuries and amputations.
- Complete an integrated Mental Health Strategy to address the issues of quality, access, and continuity of mental health care.

The following working groups under the HEC are leading this work: Patient Safety; Evidence Based Clinical Practice Guidelines; Continuing Education and Training; Health Professions Education; Deployment Health; and TBI, Psychological, and Mental Health. These working groups will focus specifically on the following Sub-goals:

- 2.1: Increase patient safety resource sharing between VA and DoD. (HEC Patient Safety Working Group)
- 2.2: Lead the development of evidence-based clinical practice guidelines (CPGs). (HEC Evidence Based Practice Working Group)
- 2.3: Actively engage in collaborative Health Professions Education (HPE). (HEC Health Professions Education Working Group)
- 2.4: Expand the number of continuing education and in-service training programs shared between VA's Veterans Health Administration (VHA) and DoD. (HEC Continuing Education and Training Working Group)
- 2.5: Design, develop and deploy a continuing education training program. (HEC Continuing Education and Training Working Group)

- 2.6: Coordinate efforts to increase health surveillance information sharing, track research initiatives on deployment health issues, and create joint health risk communication products annually. (HEC Deployment Health Working Group)
- 2.7: Leverage VA/DoD multi-disciplinary subject matter experts to address conditions related to PH/TBI. (HEC PH/TBI Working Group)
- 2.8: Improve and utilize VA/DoD population specific knowledge of suicide risk and prevention practices. (HEC PH/TBI Working Group)
- 2.9: Develop VA and DoD training goals to increase TBI/MH knowledge for providers in coordination with the Military Departments, VA, and DoD. (HEC PH/TBI Working Group)
- 2.10: Improve transition of care for Service members and Veterans affected by TBI and/or PH conditions. (HEC PH/TBI Working Group)
- 2.11: Improve TBI and/or PH screening and identification of Service members and Veterans. (HEC PH/TBI Working Group)
- 2.12: Reduce stigma of seeking care for TBI and/or PH conditions in Service member and Veteran populations. (HEC PH/TBI Working Group)
- 2.13: Improve the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries for members of the Armed Forces and Veterans. (HEC Centers of Excellence)
- 2.14: Improve the prevention, diagnosis, mitigation, treatment, and rehabilitation of hearing loss and auditory system injuries for members of the Armed Forces and Veterans. (HEC Centers of Excellence)
- 2.15: Improve the mitigation, treatment, and rehabilitation of traumatic extremity injuries and amputations for members of the Armed Forces and Veterans. (HEC Centers of Excellence)

Goal 3 – Seamless Coordination of Benefits

Improve the understanding of and access to services and benefits for eligible uniformed Service members and Veterans at each stage of their life, with a special focus on ensuring a smooth transition from active duty to Veteran status

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) will streamline benefits application processes, eliminate duplicative requirements, and correct business practices that complicate the transition from active duty to Veteran status via enhanced collaborative efforts. These efforts will be accomplished through joint initiatives that ensure dissemination of information on the array of benefits and services available to both VA and DoD beneficiaries to include health care, educational assistance, home loans, vocational rehabilitation and employment, disability compensation, pension, insurance, burial, and memorial benefits. The seamless coordination of benefits will be accomplished through the efforts of the Benefits Executive Council (BEC), the Federal Recovery Coordination Program (FRCP), and the Recovery Coordination Program (RCP).

The collaborative work between VA and DoD to ensure seamless coordination of benefits in fiscal years (FY) 2010-2012 will result in the following strategic outcomes:

- Increased efficiency and effectiveness of benefits programs.
- Improved Disability Evaluation System (DES).
- Improved awareness of VA and DoD benefits and services.

The BEC, FRCP, and RCP will pursue the following major initiatives toward the goal of seamless coordination of benefits:

- Implement an integrated DES that is faster, seamless, transparent, coordinated and aligned by VA and DoD.
- Decrease the volume of loose and late flowing medical documentation.
- Expand communication of benefits and services by leveraging military and VA Web sites, new media outlets, the eBenefits portal, and placing targeted comments on leave and earnings statements to increase the awareness of VA benefits.
- Develop and execute aggressive marketing campaigns to fully inform all Service members about Pre-discharge programs at all military installations and VA intake sites, in order to increase participation for all separating/retiring Service members including National Guard and Reserve members who are demobilizing.
- Improve the use of federal and private sector resource information regarding coordination of care and benefits for recovering Service members, Veterans, and their families.

The following working groups are leading these efforts: Pre-discharge (formerly known as Benefits Delivery at Discharge (BDD) Working Group), DES, BEC Communications, Medical Records, FRCP, and RCP. These working groups will focus specifically on the following Sub-goals:

- 3.1: VA and DoD will coordinate efforts to improve participation in the Pre-discharge Program (BDD and Quick Start). (BEC Pre-Discharge Working Group)
- 3.2: Jointly refine and expand an improved DES process to new locations, as directed. (BEC DES Working Group, Disability Advisory Council)
- 3.3: Increase knowledge of VA and DoD benefits and services. (BEC Communications Working Group)
- 3.4: Oversee the entire life-cycle of the paper military Service Treatment Record (STR). (BEC Medical Records Working Group)
- 3.5: Improve FRCP performance in providing coordination of care and benefits for recovering Service members, Veterans, and their families. (Federal Recovery Coordination Program)
- 3.6: Improve FRCP outreach efforts. (Federal Recovery Coordination Program)
- 3.7 Improve the use of Federal and private sector resource information regarding coordination of care and benefits for recovering Service members, Veterans, and their families. (Federal Recovery Coordination Program/Recovery Coordination Program)
- 3.8 - 3.12: Coordinate Federal and private sector resources and services needed by Recovering Service Members (RSM) and their families through the RCP. (Recovery Coordination Program)

Goal 4 – Integrated Information Sharing

Ensure that appropriate beneficiary and medical data is visible, accessible, and understandable through secure and interoperable information management systems

The Department of Veterans Affairs (VA) and Department of Defense (DoD), in collaboration with the VA/DoD Interagency Program Office (IPO) will work together to integrate and share appropriate information electronically via the use of enterprise architectures and data management strategies to support timely, secure, and accurate delivery of health care and

benefits. VA and DoD retain the responsibility for requirements development, life cycle program management, financial management, information technology development, and implementation.

On April 9, 2009, President Obama directed VA and DoD to create a Virtual Lifetime Electronic Record (VLER) that "will ultimately contain administrative and medical information from the day an individual enters military service throughout their military career and after they leave the military." Subsequently, the Joint Executive Council (JEC) approved the VLER initiative which is a primary focus for VA/DoD integrated information sharing efforts going forward. When fully implemented, VLER will enable VA, DoD, and other public and private sector service providers to securely exchange electronic health and benefits information. Electronic exchange of health information among Federal, state, local, and private sectors will facilitate continuity of care for Service members, Veterans, and family members. VLER will provide a comprehensive sharing capability that will allow for a streamlined transition of health care information between VA and DoD and ultimately include access to personnel and benefits information in the future.

The development of VLER will leverage VA and DoD enterprise architectures that currently exchange large quantities of administrative, benefits, and health information between the two Departments. This initiative will also demonstrate the capabilities of the Nationwide Health Information Exchange (NHIN) as VLER will be implemented using the NHIN framework. The Departments are working with the Department of Health and Human Services (HHS) and other Federal partners to create this open-architecture, standards-based capability to bring health and benefits delivery into the 21st century. The IPO will serve as the single point of accountability for the oversight and coordination of JEC approved IT projects, data, and information activities, including the VLER.

VA and DoD will continue to maintain and, when needed, enhance their current data sharing initiatives as the Departments move toward the full VLER capability.

The collaborative work between VA, DoD, and the IPO to ensure integrated information sharing in fiscal years (FY) 2010-2012 will result in the following strategic outcomes:

- Enhanced exchange of electronic viewable and computable health data types for shared patients.
- Improved immediate and secure access to reliable and accurate personnel and beneficiary data.
- Streamlined secure sharing of health, personnel, and benefits information between VA and DoD.

The IPO, the VA/DoD Health Executive Council (HEC) Information Management/Information Technology (IM/IT) Working Group, and the VA/DoD Benefits Executive Council (BEC) Information Sharing/Information Technology (IS/IT) Working Group will pursue the following major initiatives toward the goal of integrated information sharing:

- Implement solutions to share neuropsychological assessment data.
- Enhance the bidirectional sharing of electronic health information by increasing the exchange of inpatient data and scanned document images.

- Share more computable electronic health information, such as computable laboratory results.
- Identify future health information sharing needs as defined by the Interagency Clinical Informatics Board.
- Expand the eBenefits portal in support of VLER.
- Develop a joint Departmental, long-term IT solution to support seamless document management, case tracking, metrics, and reporting functions in support of the Disability Evaluation System (DES) Pilot.
- Interoperability – Coordinate, oversee, and validate the interagency execution of VA/DoD programs and projects applicable to electronic information and data sharing of health, personnel, and benefits systems.
- VLER – Begin the incremental development of VLER to include identifying and implementing national standards, protocols, and service-oriented design methodologies.
- VLER – Phase 1a: Validate the basic functional and technical capabilities for the exchange of patient care data, using the NHIN framework.
- VLER – Phase 1b: Expand data exchange through a follow-on pilot effort that incorporates additional communities and additional Health Information Technology Standards Panel (HITSP) standard data domains.
- VLER - Beginning with Phase 1b, in collaboration with the Departments, incrementally develop phased program plans, including joint Integrated Master Schedules with milestones using information derived from project schedules developed and maintained by the implementation organizations in both Departments.
- VLER - Develop the first increment of VLER requirements.

The IPO, the HEC IM/IT Working Group, and the BEC IS/IT Working Group are performing this work. These working groups will focus on the following Sub-goals:

- 4.1: 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).
- 4.2-4.3: Support continuity of patient care between VA and DoD by sharing electronic health information. (HEC Information Management/Information Technology Working Group)
- 4.4: Foster secure computing and communications infrastructures between VA and DoD. (HEC Information Management/Information Technology Working Group)
- 4.5: Support VA/DoD and national electronic health data sharing initiatives. (HEC Information Management/Information Technology Working Group)
- 4.6: Maintain and enhance legacy information, interoperability systems, and capabilities to improve the care of, and service to, Service members and Veterans (Interagency Program Office, VA and DoD).
- 4.7: Establish a capability that will allow electronic access/exchange of health care information between VA and DoD and ultimately include access to personnel, benefits, and administrative information from the day an individual enters military service throughout their military career, and after they leave the military (Interagency Program Office, VA and DoD).

Goal 5 – Efficiency of Operations

Improve management of capital assets, procurement, logistics, financial transactions, and human resources

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) will enhance the coordination of business processes and practices by improving the management of capital assets, leveraging the Departments' purchasing power, maximizing the recovery of funds directed for the provision of health care services, developing complementary workforce plans, and designing methods to enhance other key business functions.

The collaborative work between VA and DoD to ensure efficiency of operations in fiscal years (FY) 2010-2012 is focused toward achieving the following strategic outcomes:

- Improved purchasing methods for high quality medical products through joint contracting.
- Increased beneficiaries' access to care through VA/DoD Joint Venture Sites.

The Joint Executive Council (JEC) and Health Executive Council (HEC) will pursue the following major initiatives toward the goal of efficiency of operations:

- Identify, propose, and increase collaborative opportunities for Joint Capital Asset Planning.
- Develop the James A. Lovell Federal Healthcare Center (North Chicago) VA-DoD Medical Facility Demonstration Project.
- Expand the use of uniform identification codes with industry partners for medical surgical projects; demonstrate a growth in numbers of VA and DoD suppliers using global and identification standards by FY 2010 and FY 2012; and increase the dollar amount of product price reductions achieved per quarter.
- Oversee and approve new proposals receiving Joint Incentive Funds (JIF), using established criteria, and start the JIF process at the beginning of the fiscal year.
- Identify and expand geographical areas where joint VA/DoD sharing initiatives can improve support to their patients, by identifying a minimum of two sites per year.

This work is ongoing in the following working groups under the JEC and HEC: Construction Planning Committee, Acquisitions and Medical Materiel Management (A&MMM), Financial Management, and Joint Facility Utilization and Resource Sharing. These working groups will focus specifically on the following Sub-goals:

- 5.1: Identify, propose, and increase collaborative opportunities for Joint Capital Asset Planning. (JEC Construction Planning Committee Working Group)
- 5.2: Identify and leverage joint VA/DoD medical contracting venues and business practices to mutually benefit both agencies and medical facilities. (HEC A&MMM Working Group)
- 5.3: Enhance the joint VA/DoD medical surgical electronic catalog. (HEC A&MMM Working Group)
- 5.4: Develop a financial integration methodology. (HEC Financial Management Working Group)
- 5.5: Successfully manage the VA/DoD JIF for health care sharing. (HEC Financial Management Working Group)

- 5.6: Identify, document, and increase joint facility utilization and resource sharing. (HEC Joint Facility Utilization and Resource Sharing Working Group)
- 5.7: Develop quantitative measures (when applicable) for sharing initiatives, and work with selected sites to establish valid and reliable metrics. (HEC Joint Facility Utilization and Resource Sharing Working Group)

Goal 6 – Joint Medical Contingency/Readiness Capabilities

Ensure the active participation of both Departments in Federal and local incident and consequence response through joint contingency planning, training, and conducting related exercises

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) will collaborate to ensure that plans and readiness capabilities adequately support DoD combatant command contingency requirements and national emergency situations.

VA and DoD have fully implemented the Memorandum of Agreement (MOA) signed in 2006 regarding VA furnishing health care services to members of the Armed Forces during a war or national emergency. As a result there is a primary VA or DoD medical treatment facility that oversees all contingency patient movement activities in a given metropolitan area. At the same time these facilities are equally prepared to receive and distribute patients to local National Disaster Medical System (NDMS) hospitals during major national disasters.

The collaborative work between VA and DoD to ensure joint medical contingency/readiness capabilities in fiscal years (FY) 2010-2012 is focused toward achieving the following strategic outcome:

- Improved contingency capability.

The VA/DoD Health Executive Council (HEC) will pursue the following major initiative toward the goal of joint medical contingency/readiness capabilities:

- Incorporate Veterans Health Administration (VHA) capabilities into applicable U.S. Northern and Transportation Command functional, concept, and operations plans by September 30, 2011 to maintain an appropriate contingency capability to support DoD, in accordance with 38 U.S.C. Section 8110.

This work is ongoing in the Contingency Planning Working Group under the HEC. This working group will focus specifically on the following Sub-goal:

- 6.1: Ensure that VA maintains an appropriate contingency capability to support DoD in accordance with 38 U.S.C. Section 8110. (HEC Contingency Planning Working Group)

SECTION 3

Joint Strategic Plan Smart Performance Objectives

VA and DOD are committed to the new outcome performance objective process. The following reflects the templates created by the respective working groups to help steer and reach success. The templates will also demonstrate the magnitude of the day-to-day work being performed by both Departments.

GOAL 1

2010-2012 JSP OBJECTIVE 1.1.A

Goal 1: Leadership, Commitment, and Accountability	**Working Group**	**JEC Joint Strategic Planning Committee (JSPC) Working Group**
Sub-goal 1.1: Improve the efficiency and effectiveness of the JEC through an outcome-oriented joint strategic planning and monitoring process.		
SMART Objective 1.1.A: Improve progress toward joint VA/DoD priorities by increasing the number of outcome measures in the Joint Strategic Plan (JSP) by 30 percent by the date of publication of the JSP FY 2010-2012, with an increase of 10 percent by the next publication.		
Initiative	1.1.A Drive an outcome-oriented focus in the activities of the JEC and provide leadership to JEC Sub-councils and working groups; Investigate alternative options for publishing the VA/DoD JEC FY 2009 Annual Report (AR) to reduce paper usage, production time, and printing costs.	
Activities & Milestones	1.1.A 1. Provide strategic direction and tactical guidance to all JEC, HEC, BEC, and IPO working groups as needed. 2. Liaison with the Construction Planning Committee (CPC), Communications Working Group (CWG), and the Federal Recovery Coordination Program (FRCP) to provide direction and act as their primary point of contact for JEC related activities. 3. Establish and maintain best business practices in planning, preparing, and executing JEC meetings. 4. Coordinate VA/DoD JEC FY 2009 AR to Congress by January 31, 2010. Submit to Congress within one week after the President submits his new fiscal year budget to Congress. 5. Analyze current VA and DoD strategic plans by March 31, 2010 to determine links between the JSP objectives and the joint priorities of VA and DoD. Incorporate the results of the analysis in updating the FY 2011-2012 cycle of the JSP. 6. Develop a methodology for tracking JSP milestones by January 31, 2010, and begin tracking milestones by March 31, 2010. 7. Report progress toward and barriers to reaching agreed-upon end states to the JEC on a quarterly basis or as needed. 8. Research and evaluate publishing options for the JSP.	
Recommended Metric(s)	• Total number of performance measures in the JSP FY 2010-2012 compared to baseline in the VA/DoD JEC Strategic Plan FY 2009-2011 that are specific, measurable, achievable, realistic, time-bound, and outcome-oriented • Demonstrate reduced production and printing costs for the JSP FY 2010-2012 compared to publications of previous JSP cycles	
Where is/should the Metric(s) be Tracked	• Metrics tracked by VA/DoD collaborative offices and monitored by JEC	

2010-2012 JSP OBJECTIVE 1.2.A

Goal 1: Leadership, Commitment and Accountability	Working Group	JEC Communications Working Group (CWG)

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

SMART Objective 1.2.A: Increase awareness and transparency of JEC strategic messages among Service members, Veterans, families, Congress, and other stakeholders, as evidenced by: a) level of awareness as surveyed during baseline year FY 2011, and b) increased level of awareness as surveyed each year after baseline.

Initiative	**1.2.A** Identify and communicate key strategic messages – The CWG will actively communicate strategic messages and priorities of the JEC to internal/external stakeholders through agreed upon work products, and the CWG will liaison with working groups from the HEC, BEC, IPO, and JEC to identify strategic messages and priorities of the JEC.
Activities & Milestones	**1.2.A** 1. Conduct quarterly communications activities targeting both internal and external stakeholders, including: - Quarterly media events (multi-media) - Quarterly joint press releases 2. Three times quarterly, each department Web site links to communications products on the other Department's Web site to cross-promote communications products and improve access to helpful information. 3. Develop a joint survey instrument to assess awareness of VA/DoD programs in the population of wounded, ill, and injured Service members and Veterans and their families to establish a baseline and provide a mechanism for continued measurement of awareness. 4. Review the JSP FY 2009-2011 and identify opportunities for collaboration with HEC, BEC, IPO, and JEC working groups by October 31, 2009. 5. Establish points of contact within the HEC, BEC, IPO, and JEC working groups by December 31, 2009. 6. Review the final JSP FY 2010-2012 and identify opportunities for collaboration with HEC, BEC, IPO, and JEC working groups by January 31, 2010. 7. In collaboration with working group points of contact, develop a process for sharing information, including a contact list for all involved parties, by February 28, 2010. 8. The CWG will meet monthly by conference call and in-person once each quarter, to ensure progress and continuity. All communications efforts in support of the JSP will reflect the values, mission, and goals of both the Military Health System (MHS) Strategic Plan and the VA Strategic Plan.
Recommended Metric(s)	• Development of a survey instrument to assess awareness by the end of FY 2010 and conduct baseline assessment by the end of FY 2011 • Production of at least four joint press releases per year, to be scheduled in advance at monthly CWG meetings • Production of at least four joint media events per year, to be scheduled at quarterly CWG meetings. • Resume monthly meetings • At quarterly meetings, development of a long-term message calendar for upcoming actions, announcements, and releases
Where is/should the Metric(s) be Tracked	• The leadership of the CWG will identify two individuals (one VA and one DoD) to track this information and report back to CWG leadership and the JEC

GOAL 2

2010-2012 JSP OBJECTIVE 2.1.A

GOAL 2: High Quality Health Care	Working Group	HEC Patient Safety Working Group
Sub-goal 2.1: Increase patient safety resource sharing between VA and DoD.		
SMART Objective 2.1.A: Increase patient safety resource sharing between VA and DoD to enhance knowledge regarding the prevention of adverse events by: a) streamlining and coordinating the alert and advisory process, b) sharing patient safety data, and c) reviewing and sharing analytical tools used by the two agencies.		
Initiative	2.1.A Share selected resources (expertise, lessons learned, data, tools and products) developed or endorsed by the VA National Center for Patient Safety (NCPS) and/or DoD Patient Safety Center (PSC) (subject to data use agreements for sharing patient safety data).	
Activities & Milestones	2.1.A 1. Include VA and DoD counterparts, as appropriate, in the distribution of VA Alerts and Advisories and DoD Patient Safety Alerts, Advisories, and Medication Safety Notices. Automate distribution to the maximum extent possible. Target: October 2009 for automation, with review of status and for opportunities for technical improvements at outset of FY 2011 and FY 2012. 2. Establish the type of patient safety data to be shared (adverse events and close calls/near misses) and lessons learned on a variety of topics (e.g., patient falls, wrong surgery, retained foreign objects, pressure ulcers, etc.) and produced into materials that will enhance our knowledge regarding the prevention of adverse events. Target: January 2010, with review of status and for new priorities in January 2011 and January 2012. 3. Review causal factor analysis tool(s) to facilitate the improvement of VA and DoD root cause analyses of adverse events and draft study on the development of new tools for VA and DoD use. Targets: Review: September 2010; Draft Study: January 2011. 4. Share analytic tools and lessons learned in working with patient safety databases to improve insight into patient safety problems. Target: Inventory analytic tools in use: March 2010; Develop sharing plan: September 2010.	
Recommended Metric(s)	Metrics will include, reported semi-annually to HEC (January and July): • Total number of Alerts, Advisories, and Medication Notices shared year-to-date and each FY • Total number of shared data types between VA and DoD, including information on any new materials developed and utilized to enhance the prevention of adverse events at both Departments • Completion of study of causal factor analysis tools by January 2011 • Sharing plan on the use of analytics tools used with patient safety databases completed by September 2010	
Where is/should the Metric(s) be Tracked	• Metrics tracked jointly by Patient Safety Working Group (NCPS and PSC reconcile metrics quarterly) and reported to the HEC; the HEC reports progress of metrics to JEC, as requested	

2010-2012 JSP OBJECTIVE 2.1.B

GOAL 2: High Quality Health Care	Working Group	HEC Patient Safety Working Group
Sub-goal 2.1: Increase patient safety resource sharing between VA and DoD.		
SMART Objective 2.1.B: Increase knowledge regarding the prevention of adverse events by: a) exploring potential forums for VA and DoD representatives to share subject matter expertise and, b) evaluating methods to ensure an increase in participation from VA and DoD at information sharing venues.		
Initiative	2.1.B Expand existing and develop new communication lines (expertise, conferences) between VA and DoD.	
Activities & Milestones	2.1.B 1. Draft feasibility study for sharing in-progress development of alerts or advisories (where time permits and the topic is appropriate) with objective of issuing joint or simultaneous notices. Target:	

	Feasibility Study: March 2010; Implementation of feasible activities: June 2010. 2. VA and DoD representatives share subject matter expertise in appropriate settings such as conferences, conference calls, and panels on specific patient safety issues/initiatives. Target: Identify potential forums and expertise required: March 2010. 3. Draft feasibility plan for expanding VA National Center for Patient Safety (NCPS) biannual conference (next scheduled for FY 2011) to include DoD participants, and holding joint patient safety conference every two years thereafter. Target: Feasibility Plan: May 2010; Hold Conference (if approved): May 2011, May 2013 and every other year thereafter.
Recommended Metric(s)	Metrics will include, reported semi-annually to HEC (January and July): • Feasibility study results and regular updates on VA and DoD collaboration on the development of alerts and advisories • Itemized list of forums at which VA and DoD representatives are sharing subject matter expertise • Completion of feasibility plan on the expansion of VA NCPS biannual conference to include DoD patient safety participants; regular updates on status and DoD participation if joint conference proves feasible
Where is/should the Metric(s) be Tracked	• Metrics tracked jointly by Patient Safety Working Group (NCPS and PSC reconcile metrics quarterly) and reported to the HEC; the HEC reports progress of metrics to JEC, as requested

2010-2012 JSP OBJECTIVE 2.2.A

Goal 2: High Quality Health Care	**Working Group**	**HEC Evidence Based Practice Working Group**
Sub-goal 2.2: Lead the development of evidence-based clinical practice guidelines (CPGs).		
SMART Objective 2.2.A: Increase information sharing on military and Veterans health issues to providers as a clinical tool, as evidenced by: a) 100 percent of joint VA/DoD CPGs completed against the annual target of four guidelines, b) 75 percent of VA/DoD CPGs completed annually that are posted on the National Guidelines Clearinghouse Web site, c) Increase in VA/DoD internet requests from base FY 2009, reported quarterly; goal is 10 percent increase per year, d) Increase in DoD CPG tool kit orders from baseline FY 2006, reported quarterly; goal is 10 percent increase per year.		
Initiative	**2.2.A** Employ clinically diverse and collaborative groups to develop, update, adapt, adopt, and/or revise evidence-based clinical practice guidelines (EBCPGs).	
Activities & Milestones	**2.2.A** For each Evidence-Based Clinical Practice Group (EBCPG): 1. Clinical Champions and key leaders representing the VA and DoD assembled to develop the scope of the EBCPG and develop questions for literature search. 2. Systematic review of the literature conducted by national evidence center. Weekly teleconferences conducted by CPG Working Group (WG) to discuss literature pertaining to EBCPG topic. 3. Clinical expert group convened to grade evidence, follow-up calls as needed to discuss unresolved issues develop 1st draft of the CPG. Presentation to the VA/DoD Evidence Based Practice Working Group (EBP WG). 1st Draft posted for public comment and field review. 4. Final edit meeting to review field recommendations and public comments. 5. Submit final draft for independent review and presentation for approval by the VA/DoD EBP WG. 6. The guideline is posted www.healthquality.va.gov. The Evidence Based Practice WG will: 1. Formally introduce via podium presentations, abstracts, or exhibits, two EBCPGs at professional conferences, within six months of their completion date. 2. Collaborate with national professional health organizations when judged to be beneficial to VA and DoD to develop clinical practice guidelines. 3. Achieve National Guidelines Clearinghouse approval and recognition on all issued EBCPGs within one year after submission.	
Recommended Metric(s)	• Percentage based on the number of individual CPG work completed against the annual target of four guidelines • Number of VA/DoD evidence-based clinical practice guidelines completed annually that are posted on the National Guidelines Clearinghouse Web site	

	• Total number of VA/DoD Internet requests reported quarterly compared to number reported in base year, FY 2009 • Total number of DoD CPG tool kit orders ordered each year compared to the number ordered in the base year, FY 2006
Where is/should the Metric(s) be Tracked	• The VA/DoD Evidence based Practice Working Group will monitor progress monthly and report progress to HEC quarterly; the HEC reports metrics to the JEC, as requested

2010-2012 JSP OBJECTIVE 2.3.A

Goal 2: High Quality Health Care	**Working Group**	**HEC Health Professions Education (HPE) Working Group**
Sub-goal 2.3: Actively engage in collaborative HPE.		
SMART Objective 2.3.A: Increase staff ability to provide quality health care, as demonstrated by maintaining training capacity in Graduate Medical Education in Base Realignment and Closure (BRAC) affected areas.		
Initiative	**2.3.A** BRAC Assessment – Evaluate Graduate Medical Education (GME) programs adversely impacted by the Base Realignment and Closure (BRAC) Commission and present preliminary and final assessments with recommended VA/DoD actions.	
Activities & Milestones	**2.3.A** 1. Complete a preliminary assessment of GME programs by October 2010, to *include:* a list of residency programs likely to be impacted in the National Capital Region and other geographic areas as appropriate. The preliminary assessment will also include potential redundancy or duplication in programs that overlap, and a rank listing of programs that will likely be adversely impacted by BRAC. 2. Complete final assessment, with recommendations, six months following final BRAC report: Anticipated final assessment to be done in FY 2011-2012 timeframe.	
Recommended Metric(s)	• Completed preliminary assessment of GME programs in National Capital Region and any additional BRAC areas by October 2010	
Where is/should the Metric(s) be Tracked	• Health Professions Education Working Group	

2010-2012 JSP OBJECTIVE 2.3.B

Goal 2: High Quality Health Care	**Working Group**	**HEC Health Professions Education (HPE) Working Group**
Sub-goal 2.3: Actively engage in collaborative HPE.		
SMART Objective 2.3.B: Increase staff ability to provide quality health care, as evaluated through a demonstration project for trainee movement between sites.		
Initiative	**2.3.B** Seamless Transition for Trainees Pilot – Evaluate the Seamless Transition for Trainees pilot at San Diego, CA.	
Activities & Milestones	**2.3.B** 1. Report Seamless Transition for Trainees Pilot results and recommendations to HEC by October 31, 2009.	
Recommended Metric(s)	• Report submitted to HEC following October 31, 2009	
Where is/should the Metric(s) be Tracked	• HPE Working Group	

2010-2012 JSP OBJECTIVE 2.3.C

Goal 2: High Quality Health Care	Working Group	HEC Health Professions Education (HPE) Working Group
Sub-goal 2.3: Actively engage in collaborative HPE.		
SMART Objective 2.3.C: Increase staff ability to provide quality health care by implementing a new health professions trainee exchange program in Academic Year (AY) 2010-2011 to promote awareness of the capabilities standards of care, and services provided in their counterpart agencies.		
Initiative	**2.3.C** Cross Cultural Education of Health Professions Trainees – VA and DoD will explore the feasibility of implementing health professions trainee exchange programs; exchanges will assist in promoting awareness of the capabilities, standards of care, and services provided in their counterpart agencies.	
Activities & Milestones	**2.3.C** 1. Implement one new health professions trainee exchange program in AY 2010-2011. 2. Identify challenges and potential solutions in the implementation of health care trainee exchange programs between VA and DoD and report results to HEC on an annual basis. 3. Provide Annual Report to the HEC on the challenges and potential solutions for implementing health professions trainee exchanges.	
Recommended Metric(s)	• Implementation of new training exchange program in AY 2010-2011 • Total number of trainees affected • Qualitative evaluation of success of program	
Where is/should the Metric(s) be Tracked	• HPE Working Group	

2010-2012 JSP OBJECTIVE 2.4.A

Goal 2: High Quality Health Care	Working Group	HEC Continuing Education and Training Working Group
Sub-goal 2.4: Expand the number of continuing education and in-service training programs shared between VA's Veterans Health Administration (VHA) and DoD.		
SMART Objective 2.4.A: Expand the number of continuing education and in-service training programs shared between VHA and DoD in order to consolidate resources for both Departments, as evidenced by a direct cost avoidance of $11,700,000 in FY 2010.		
Initiative	**2.4.A** Optimize the sharing of training between VHA and DoD to assure that all sharable programs of value to either partner are made available to that partner.	
Activities & Milestones	**2.4.A** 1. Take advantage of enhanced Learning Management Systems (LMS) capabilities in VHA and DoD as they become available in FY 2010 (commencing on October 1, 2009). 2. Conduct a cost sharing pilot project of the purchase of private sector programming (to be completed by September 30, 2010). 3. Increase the volume of shared training deployed at the facility level (to be completed by September 30, 2010).	
Recommended Metric(s)	• Direct cost avoidance generated as a result of shared training for VHA and DoD each quarter and in aggregate for the year (target is $11,700,000 in FY 2010) • Number of programs shared each quarter and aggregate number of programs shared annually (target is 318 programs in FY 2010) for the following: – VHA shares 174 continuing education and in-service training programs with DoD – DoD shares 144 continuing education and in-service training programs with VHA	
Where is/should the Metric(s) be Tracked	• VHA Metrics tracked by the Employee Education System (EES) Interagency Shared Training Group • VHA and DoD Metrics tracked by the HEC Continuing Education and In-service Training Working Group	

2010-2012 JSP OBJECTIVE 2.4.B

Goal 2: High Quality Health Care	Working Group	HEC Continuing Education and Training Working Group
Sub-goal 2.4: Expand the number of continuing education and in-service training programs shared between VA's Veterans Health Administration (VHA) and DoD.		
SMART Objective 2.4.B: Identify, assess and decrease redundancies of continuing education and in-service training programs shared between VHA and DoD with a target to reduce redundancy by five percent in FY 2010.		
Initiative	2.4.B Reduce the overlap in mandatory training for VHA and DoD personnel who serve in both Departments.	
Activities & Milestones	2.4.B 1. Identify the required training courses that are mandated by VHA and one or more of the DoD uniformed Military Departments (to be completed by October 30, 2009). 2. Design and conduct a pilot project to assess the proposed strategy for reducing the overlap in required training for VHA and DoD personnel who serve in both agencies, and produce a report to assess data gathered from the pilot project (to be completed by June 30, 2009). 3. Assess the data gathered from the demonstration project and present findings to the HEC (to be completed by June 30, 2010). 4. If findings are positive and if HEC approval is forthcoming proceed to implement the strategy for reducing the overlap in required training for VHA and DoD personnel who serve in both agencies. (target is to reduce redundancy by five percent in FY 2010 (to be completed by September 30, 2010.) 5. VHA and DoD leadership approval for conducting a pilot project to assess the proposed strategy for reducing the overlap in required training for VHA and DoD personnel who serve in both agencies.	
Recommended Metric(s)	• The five percent reduction in overlapping required training in FY 2010 (measured by total number of required programs which overlap between VHA and one or more Military Department/the number of overlapping programs for which the overlap is terminated)	
Where is/should the Metric(s) be Tracked	• HEC Continuing Education and In-service Training Working Group • VA/DoD Sharing Office	

2010-2012 JSP OBJECTIVE 2.5.A

Goal 2: High Quality Health Care	Working Group	HEC Continuing Education and Training Working Group
Sub-goal 2.5: Design, develop and deploy a continuing education training program.		
SMART Objective 2.5.A: Improve training effectiveness in a joint sharing environment, as measured by: a) 100 percent of targeted staff of the North Chicago VA-DoD Medical Facility Demonstration Project have successfully completed the joint curriculum modules in FY 2010-2011, b) analysis of completed modules, and c) adjust and deploy modules to 60 percent of the current nine joint venture sites requesting such training support by the end of FY 2011.		
Initiative	2.5.A The design, development and deployment of a three part in-service and continuing education training curriculum initially for VHA DoD staff at the North Chicago VA-DoD Medical Facility Demonstration Project and potential expansion to nine current joint venture sites.	
Activities & Milestones	2.5.A 1. Working with subject matter experts (SMEs) design and develop instructional modules 1 and 2 (to be completed by March 31, 2010). 2. Curriculum Parts 1 and 2 are deployed (commencing on June 1, 2010). 3. Working with SMEs design and develop part 3 instructional modules (to be completed by July 31, 2010). 4. Curriculum Part 3 is deployed (commencing on October 31, 2010). 5. In collaboration with the leadership and designated Joint venture site facility SMEs, modify the VHA and Navy instructional components of each of the three major curricular elements of the curriculum to be site specific for the Joint Venture Sites (to be completed by December 31, 2010). 6. Working with Joint Venture site SMEs modify instructional modules 1 and 2 (to be completed by	

	June 30, 2011). 7. Curriculum modules 1 and 2 are deployed to Joint Venture sites (to be completed by September 30, 2011). 8. Working with Joint Venture site SMEs modify part 3 instructional modules (to be completed by September 30, 2011). 9. Curriculum Part 3 is deployed to Joint Venture sites (to be completed by December 31, 2011).
Recommended Metric(s)	• Total percentage of eligible staff who have completed each module of instruction (percentage of staff eligible to participate in training/percentage of eligible staff who took the training) by the end of Q1 FY 2011 • Analysis of completed modules by the end of Q1 FY 2011 • Percentage of the nine current Joint Venture sites which have been provided training of those requesting training by the end of FY 2011
Where is/should the Metric(s) be Tracked	• HEC Continuing Education and In-service Training Working Group • VHA Employee Education System (EES) • North Chicago VA-DoD Medical Facility Demonstration Project • VA/DoD Sharing Office • Joint Venture sites

2010-2012 JSP OBJECTIVE 2.6.A

Goal 2: High Quality Health Care	**Working Group**	**HEC Deployment Health Working Group (DHWG)**
Sub-goal 2.6: Coordinate efforts to increase health surveillance information sharing, track research initiatives on deployment health issues, and create joint health risk communication products annually.		
SMART Objective 2.6.A: Improve coordination and sharing of Service member and Veteran health information between VA and DoD, as demonstrated by: a) the proportion of Veterans, who were identified as participants in testing of chemical and biological agents, who were sent VA notification letters; b) the number of Veterans who potentially had embedded fragments, who had confirmatory medical testing; c) the number of environmental and occupational exposure incidents, which warranted VA follow-up; and d) the number of published medical articles from the Millennium Cohort Study.		
Initiative	**2.6.A** The HEC DHWG will identify opportunities to share information between VA and DoD on health surveillance, assessment, and follow-up care of military populations, including identification of cohorts with specific exposures or diseases.	
Activities & Milestones	**2.6.A** 1. Review DoD's identification of cohorts who participated in the testing of chemical and biological warfare agents from 1942 to 1975, DoD's ongoing provision of data to VA on these cohorts, and VA's outreach efforts to these cohorts, while providing an assessment to the HEC by September 30th, annually. 2. Review DoD's identification of Service members who were injured in combat incidents and who have embedded fragments, DoD's provision of data to VA on these individuals, and VA's medical follow-up activities, while providing an assessment to the HEC by September 30th, annually. 3. Review DoD's identification of major environmental and occupational exposure incidents during the current conflicts in Iraq and Afghanistan, DoD's identification of cohorts who were exposed in these incidents, DoD's provision of data to VA, and development of appropriate follow-up, while providing an assessment to the HEC by September 30th, annually. 4. Review the deployment health-related data from the Millennium Cohort Study, while providing an assessment to the HEC by September 30th, annually.	
Recommended Metric(s)	• Proportion of Veterans who were identified and were included in the database, who were successfully sent Veterans Benefits Administration (VBA) notification letters (annually) • Number of Veterans who potentially had embedded fragments, who had confirmatory testing through radiology, fragment analysis, or bioassay (annually); VA will report data to DoD annually • Number of major environmental and occupational exposure incidents, which warranted VA medical surveillance or other follow-up (annually); VA will report data to DoD annually • Number of published medical articles related to deployment health from the Millennium Cohort Study	

	(annually)
Where is/should the Metric(s) be Tracked	• VBA will report back to DoD Health Affairs (HA) on number of notification letters that were successfully delivered (annually) • Baltimore VA Medical Center (VAMC) will report back to VHA and DoD HA on number of Veterans who had confirmatory testing (annually) • VHA will report back to DoD HA and Center for Health Promotion and Preventive Medicine on number of major exposure incidents that warranted VA follow-up (annually) • Naval Health Research Center will report to DoD HA (annually)

2010-2012 JSP OBJECTIVE 2.6.B

Goal 2: High Quality Health Care	**Working Group**	**HEC Deployment Health Working Group (DHWG)**
Sub-goal 2.6: Coordinate efforts to increase health surveillance information sharing, track research initiatives on deployment health issues, and create joint health risk communication products annually.		
SMART Objective 2.6.B: Track research initiatives on deployment health issues to support improved coordination and sharing of Service member and Veteran health information between VA and DoD, with a goal of tracking and analyzing the number of deployment health research projects funded by VA, DoD, and Department of HHS in FY 2010, in order to inform decision makers of the military and Veteran relevance of the research and to identify potential research gaps.		
Initiative	**2.6.B** The HEC DHWG will foster research initiatives on military and Veteran-related health research funded by DoD, VA, and Department of Health and Human Services (HHS) to include deployment health issues in FY 2010.	
Activities & Milestones	**2.6.B** 1. Conduct an annual inventory and catalog current research on deployment health issues in each Department annually by September 30th. 2. Develop an analysis of the ongoing deployment health-related research annually by September 30th and report to the HEC.	
Recommended Metric(s)	• Number of deployment health research projects that were funded by VA, DoD, and HHS, and that were posted on a publicly accessible DoD Web site (annually)	
Where is/should the Metric(s) be Tracked	• DoD Health Affairs	

2010-2012 JSP OBJECTIVE 2.6.C

Goal 2: High Quality Health Care	**Working Group**	**HEC Deployment Health Working Group (DHWG)**
Sub-goal 2.6: Coordinate efforts to increase health surveillance information sharing, track research initiatives on deployment health issues, and create joint health risk communication products annually.		
SMART Objective 2.6.C: Create joint health risk communication products annually to improve coordination and sharing of Service member and Veteran health information between VA and DoD, as evidenced by the number of emerging health concerns that were identified as significant, for which risk communication products were developed by VA and DoD in FY 2010.		
Initiative	**2.6.C** The HEC DHWG, through its Health Risk Subcommittee, will develop joint health risk communication products related to deployment health in FY 2010.	
Activities & Milestones	**2.6.C** 1. Identify emerging health concerns, related to deployment and other aspects of military service, and report to HEC by September 30th annually on health concerns that were identified. 2. Develop joint, deployment health-related risk communication products and coordinate these products to ensure consistency among VA, DoD, and HHS, as appropriate, and report to HEC by September 30th annually on products that were developed.	

Recommended Metric(s)	• Number of emerging health concerns that were identified, for which risk communication products were developed, such as, printed fact sheets, pocket cards, and reports on VA and DoD Web sites (annually)
Where is/should the Metric(s) be Tracked	• DoD Health Affairs and Veterans Health Administration

2010-2012 JSP OBJECTIVE 2.7.A

Goal 2: High Quality Health Care	**Working Group**	**HEC Psychological Health/Traumatic Brain Injury (PH/TBI) Working Group**
Sub-goal 2.7: Leverage VA/DoD multi-disciplinary subject matter experts to address conditions related to PH and TBI.		
SMART Objective 2.7.A: Leverage VA/DoD multi-disciplinary subject matter experts to address conditions related to psychological health and TBI, as demonstrated by the re-chartering of the HEC Mental Health Working Group as the PH/TBI WG.		
Initiative	**2.7.A** The HEC Mental Health Working Group (MHWG) will continue coordination to re-charter as the HEC PH/TBI WG.	
Activities & Milestones	**2.7.A** 1. Acquire VA and DoD approval signatures on proposed PH/TBI WG charter by December 31, 2009. 2. Identify qualified subject matter experts (SMEs) to serve in designated membership positions from each Department by 30 days after the charter is signed by all parties, aligning the membership of the PH/TBI Working Group with that of Lines of Action 2 (LOA-2) as much as possible, consistent with the requirements for each group. 3. Establish PH/TBI WG regular meeting schedule. 4. PH/TBI WG will expand SMART objectives to include issues inter-related to PH and TBI while retaining applicable mental health objectives previously identified by the MHWG. 5. Incorporate relevant outcomes from the VA-DoD Mental Health Summit held during October 2009 for inclusion in a modified statement of Activities and Milestones for the coming year within 60 days after they have been approved by the Departments, or within 60 days after the first meeting of the PH/TBI Working Group, whichever is later.	
Recommended Metric(s)	• Assistant Secretary of Defense (ASD) (HA) and Undersecretary for Health (USH) VA adoption of the PH/TBI WG charter by December 31, 2009 • Departments designate members from each Department, 30 days after charter is signed. • New PH/TBI WG first meets, 60 days after charter is signed • Modified statement of Activities and Milestones incorporates outcomes from the VA-DoD Mental Health Summit 60 days after outcomes have been approved by the Departments, or 60 days after the first meeting of the Working Group, whichever is later	
Where is/should the Metric(s) be Tracked	• PH/TBI WG will monitor progress and report to HEC quarterly; the HEC reports status of metrics to the JEC, as requested	

2010-2012 JSP OBJECTIVE 2.8.A

Goal 2: High Quality Health Care	**Working Group**	**HEC Psychological Health/Traumatic Brain Injury (PH/TBI) Working Group**
Sub-goal 2.8: Improve and utilize VA/DoD population specific knowledge of suicide risk and prevention practices.		
SMART Objective 2.8.A: Increase and disseminate knowledge of suicide risk and prevention practices through the analysis of selected data, through a review of similarly focused VA and DoD prevention programs, and through coordinated training and collaboration with entities outside VA/DoD.		
Initiative	**2.8.A** Increase knowledge of suicide risk and advance collaboration on suicide prevention efforts.	

Activities & Milestones	**2.8.A** 1. Establish a joint VA/DoD Suicide Nomenclature and Data Working Group to analyze disparities between Service member and Veteran suicide rates. 2. Assess VA/DoD joint training modalities to educate and train community members, suicide prevention coordinators, and medical staff to apply community-based and clinical strategies to reduce suicide. 3. Network with 10 other Federal agencies, non-profit organizations and professional organizations with substantive activities in suicide prevention to exchange information ensure awareness of best practices, avoid duplication of effort and provide opportunities for mutually beneficial collaborative efforts. 4. VA and DoD will explore the advantages/disadvantages of enhanced and/or consolidated suicide hotline programs. 5. Suicide Nomenclature and Data Working Group will analyze disparities between Service member and Veteran suicide rates or identify prohibitive obstacles to complete task.
Recommended Metric(s)	• Establishment of a joint VA/DoD Suicide Nomenclature and Data Working Group by 30 days after the first meeting of the PH/TBI WG • Report recommendations to VA/DoD leadership on joint and coordinated training activities and the need for future joint activities to educate and train community members, suicide prevention coordinators and medical staff to apply community-based and clinical strategies to reduce suicide, within 120 days after the first meeting of the PH/TBI WG or the release of standardized nomenclature by the Centers for Disease Prevention, whichever is later. • Report recommendations to VA/DoD leadership on the advantages/disadvantages of enhanced and/or consolidated suicide hotline programs. Completed plan detailing VA/DoD hotline consolidation or alternative way ahead 120 days after the first meeting of the PH/TBI WG • Report recommendations to VA/DoD leadership related to analysis of disparities between Service member and Veteran suicide rates or report on prohibitive obstacles to complete task by six months after formation of Suicide Nomenclature and Data Working Group
Where is/should the Metric(s) be Tracked	• PH/TBI WG and Defense Centers of Excellence (DCoE)/Suicide Prevention and Risk Reduction Committee (SPARRC) and the Office of the VA National Suicide Prevention Coordinator • PH/TBI WG will monitor progress and report to HEC quarterly. The HEC reports status of metrics to the JEC, as requested

2010-2012 JSP OBJECTIVE 2.9.A

Goal 2: High Quality Health Care	**Working Group**	**HEC Psychological Health/Traumatic Brain Injury (PH/TBI) Working Group**
Sub-goal 2.9: Develop VA and DoD training goals to increase TBI/MH knowledge for providers in coordination with the Military Departments, VA and DoD.		
SMART Objective 2.9.A: To the extent supported by the needs of the Departments, coordinate VA and DoD training requirements (who gets trained, what is trained (content), when should training occur and how often, and how is training delivered) to provide consistency of expertise in identified clinical issues.		
Initiative	**2.9.A** Identify and analyze training requirements for TBI and MH to promote consistency of provider competence in and knowledge of best practices and clinical practices in identified clinical issues.	
Activities & Milestones	**2.9.A** 1. Identify policies and guidance affecting the training of mental health and TBI providers across the Departments and their components by 60 days after the first meeting of the Working Group. 2. Analyze identified policies and guidance for inconsistencies potentially affecting Service member and Veteran MH/TBI care. Make recommendations on measures to modify policies and guidance to improve consistency of provider competence in and knowledge of best practices and clinical practices in identified clinical issues across Departments.	
Recommended Metric(s)	• Completion of report on training policy recommendations to the Departments by 150 days after the first meeting of the Working Group	

Where is/should the Metric(s) be Tracked	• VA, DoD track progress and report to the HEC quarterly • The HEC reports progress to JEC, as requested

2010-2012 JSP OBJECTIVE 2.10.A

Goal 2: High Quality Health Care	**Working Group**	**HEC Psychological Health/Traumatic Brain Injury (PH/TBI) Working Group**
Sub-goal 2.10: Improve transition of care for Service members and Veterans affected by TBI and/or PH conditions.		
SMART Objective 2.10.A: Improve transition of care, as measured by: a) the number and duration of Service members enrolled in the In-Transition program, b) 90 percent of surveyed Service members with favorable satisfaction ratings for the In-Transition program reported annually, and c) 75 percent of those enrolled in the program who remain until hand-off to gaining site/provider in FY 2010.		
Initiative	**2.10.A** Provide support to Service members and Veterans affected by PH/TBI problems undergoing transition of duty location to ensure continuity of care.	
Activities & Milestones	**2.10.A** 1. (DoD) Establish the "In Transition" program policies and procedures by December 2009 to be implemented by phased approach.	
Recommended Metric(s)	• (DoD) Number of Service members referred to the In-Transition program (FY 2010 and reported annually thereafter) • Number of Service members enrolled in the In-Transition program during baseline year (FY 2010 and reported annually thereafter) • Average length of engagement per member (taken from yearly totals) • Total number of enrolled Service members with favorable satisfaction ratings relative to the total number surveyed (every six months beginning with program initiation) • The total number of enrollees who remain in the program from initial enrollment to hand-off to gaining site/provider compared to the total number of enrollees in the program in FY 2010 and reported annually thereafter	
Where is/should the Metric(s) be Tracked	• Force Health Protection & Readiness (FHP&R) and VA	

2010-2012 JSP OBJECTIVE 2.10.B

Goal 2: High Quality Health Care	**Working Group**	**HEC Psychological Health/Traumatic Brain Injury (PH/TBI) Working Group**
Sub-goal 2.10: Improve transition of care for Service members and Veterans affected by TBI and/or PH conditions.		
SMART Objective 2.10.B: Improve transition of care, as demonstrated by: a) the establishment of an assisted living pilot program by December 2009, b) the number of patients accepted into the program, c) Percent of surveyed patients reporting satisfaction with the assisted living facilities based on all patients surveyed, which will be fully documented by April 2013, d) Recommendations for extension or expansion of pilot program by FY 2013.		
Initiative	**2.10.B** Establish a program for assisted living care and long term rehabilitation and recovery programs.	
Activities & Milestones	**2.10.B** 1. (VA) Accept, at a minimum, the first five patients into the assisted living pilot program by December 2009. – Produce a final report on the program in April 2013, as required by National Defense Authorization Act 2008. – Assess the effectiveness of the assisted living program for Veterans with TBI.	
Recommended Metric(s)	• (VA) Number of patients accepted to the assisted living facilities • Total number of surveyed patients responding favorably in satisfaction surveys compared to the total number of surveyed patients	

	• Recommendations for extension or expansion of pilot program by FY 2013 • Total number of patients enrolled each year compared to baseline by FY 2013
Where is/should the Metric(s) be Tracked	• Force Health Protection and Readiness and VA

2010-2012 JSP OBJECTIVE 2.11.A

Goal 2: High Quality Health Care	**Working Group**	**HEC Psychological Health/Traumatic Brain Injury (PH/TBI) Working Group**
Sub-goal 2.11: Improve TBI and/or PH screening and identification of Service members and Veterans.		
SMART Objective 2.11.A: Improve the ability of VA/DoD to successfully document and implement TBI and PH screening and referral of Service members and Veterans by updating electronic health records systems with revised ICD-9-CM codes and reviewing and making recommendations on Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA) content.		
Initiative	**2.11.A** TBI and PH assessment requirements are monitored and reviewed annually.	
Activities & Milestones	**2.11.A** 1. DoD will update AHLTA following the publication of the International Classification of Diseases, Ninth revision, Clinical Modification (ICD-9-CM) codes. Requirements for implementing the update will be established and documented. 2. VA will update VISTA following the publication of the ICD-9-CM codes and associate them with the VA Schedule for Rating Disabilities (VASRD). Requirements for implementing the update will be established and documented. 3. Monitor and review TBI and PH assessment measurements, policies, and procedures by the end of calendar year 2010. 4. Review Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Re-Assessment (PDHRA) questions used to assess TBI and PH conditions for continued usefulness and relevance by 120 days after the first meeting of the Working Group in 2009.	
Recommended Metric(s)	• DoD will document requirements for updating AHLTA with ICD-9-CM codes and VA will document requirements for updating VISTA by 60 days after the first meeting of the Working Group • DoD will update AHLTA following the publication of the International Classification of Diseases, Ninth revision, Clinical Modification (ICD-9-CM) codes by October 2010 • VA will update VISTA and the VASRD following the publication of the ICD-9-CM codes by October 2010 • Report and recommend to VA/DoD leadership on TBI and PH assessment measurements, policies and procedures by December 31, 2010 • Report and recommend to VA/DoD leadership on PDHA and PDHRA questions used to assess TBI and PH conditions for continued usefulness and relevance by 120 days after the first meeting of the Working Group in 2009	
Where is/should the Metric(s) be Tracked	• Clinical & Program Policy (C&PP), Force Health Protection & Readiness (FHP&R), Defense Center of Excellence (DCoE), and the Veterans Health Administration (VHA)	

2010-2012 JSP OBJECTIVE 2.12.A

Goal 2: High Quality Health Care	**Working Group**	**HEC Psychological Health/Traumatic Brain Injury (PH/TBI) Working Group**
Sub-goal 2.12: Reduce stigma of seeking care for TBI and/or PH conditions in Military and Veteran populations.		
SMART Objective 2.12.A: Improve, expand and/or implement population focused anti-stigma public education campaigns to reduce the stigma of seeking care for TBI and/or PH conditions, as measured by the exposure of Service members, Veterans and their families to the campaign as well as other available output and outcome indicators.		

Initiative	**2.12.A** Continue to develop and implement anti-stigma public education campaigns.
Activities & Milestones	**2.12.A** 1. (DoD) Report the reach of the anti-stigma education campaigns, Real Warriors, Mental Health Self Assessment, and Afterdeployment.org on a quarterly basis. - Number of public service announcements released. - Number of visits to realwarriors.net, militarymentalhealth.org, and afterdeployment.org. - Number of positive or negative media stories on campaigns reported. 2. Incorporate applicable activities as recommended in the pending report from the October 2009 VA-DoD Mental Health Summit.
Recommended Metric(s)	• Number of visits to the identified mental health destigmatization Web sites designed to provide anonymous resources to Service members, Veterans, and their family members
Where is/should the Metric(s) be Tracked	• Defense Center of Excellence • Force Health Protection and Readiness

2010-2012 JSP OBJECTIVE 2.13.A

Goal 2: High Quality Health Care	**Working Group**	**HEC Centers of Excellence Working Group**
Sub-goal 2.13: Improve the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries for members of the Armed Forces and Veterans.		
SMART Objective 2.13.A: Improve the care of military eye injuries for members of the Armed Forces and Veterans, as evidenced by the establishment of the Center of Excellence in prevention diagnosis, mitigation, treatment, and rehabilitation of military eye injuries.		
Initiative	**2.13.A** Establish Center of Excellence in prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries.	
Activities & Milestones	**2.13.A** 1. Develop Concept of Operations (ConOps) by November 2009. 2. Develop implementation plan including definition of mission, functions and activities by March 2010. - Identify additional resource requirements to include staffing, funding, contract support, space to meet mission and functional requirements by March 2010. - Develop implementation plan for a VA-DoD eye injuries registry by January 2010 (ConOps approved September 2009). - Approval of implementation plan for registry by February 2010. - Pilot study for registry June 2010. - Obtain Assistant Secretary of Defense (Health Affairs) and Under Secretary for Health (VHA) approval of ConOps, implementation plan, resource requirements, and registry strategy.	
Recommended Metric(s)	• Obtain Assistant Secretary of Defense (Health Affairs) and Under Secretary for Health (VHA) approval of ConOps, implementation plan, resource requirements, and registry strategy	
Where is/should the Metric(s) be Tracked	• Health Executive Council	

2010-2012 JSP OBJECTIVE 2.14.A

Goal 2: High Quality Health Care	**Working Group**	**HEC Centers of Excellence Working Group**
Sub-goal 2.14: Improve the prevention, diagnosis, mitigation, treatment, and rehabilitation of hearing loss and auditory system injuries for members of the Armed Forces and Veterans.		
SMART Objective 2.14.A: Improve the care of hearing loss and auditory system injuries for members of the Armed Forces and Veterans, as evidenced by the establishment of the Center of Excellence in prevention diagnosis, mitigation, treatment, and rehabilitation of hearing loss and auditory system injuries.		
Initiative	**2.14.A** Establish Center of Excellence in prevention, diagnosis, mitigation, treatment, and rehabilitation of	

	hearing loss and auditory system injuries.
Activities & Milestones	**2.14.A** 1. Select Director and Deputy Director for center by January 2010. 2. Develop Concept of Operations by February 2010. 3. Develop implementation plan including definition of mission, functions and activities by March 2010. - Identify resource requirements to include staffing, funding, contract support, space to meet mission, and functional requirements by April 2010. - Develop a comprehensive plan and strategy for a hearing loss and auditory system injury registry by July 2010. - Obtain Assistant Secretary of Defense (Health Affairs) and Under Secretary for Health (VHA) approval of Concept of Operations, implementation plan, resource requirements, and registry strategy.
Recommended Metric(s)	• Obtain Assistant Secretary of Defense (Health Affairs) and Under Secretary for Health (VHA) approval of Concept of Operations, implementation plan, resource requirements, and registry strategy
Where is/should the Metric(s) be Tracked	• Health Executive Council

2010-2012 JSP OBJECTIVE 2.15.A

Goal 2: High Quality Health Care	**Working Group**	**HEC Centers of Excellence Working Group**
Sub-goal 2.15: Improve the mitigation, treatment, and rehabilitation of traumatic extremity injuries and amputations for members of the Armed Forces and Veterans.		
SMART Objective 2.15.A: Improve the care of traumatic extremity injuries and amputations for members of the Armed Forces and Veterans, as evidenced by the establishment of the Center of Excellence in mitigation, treatment, and rehabilitation of traumatic extremity injuries and amputations for members of the Armed Forces and Veterans.		
Initiative	**2.15.A** Establish Center of Excellence in mitigation, treatment, and rehabilitation of traumatic extremity injuries and amputations for members of the Armed Forces and Veterans.	
Activities & Milestones	**2.15.A** 1. Select Director and Deputy Director for center by January 2010. 2. Develop Concept of Operations by February 2010. 3. Develop implementation plan including definition of mission, functions and activities by March 2010. - Identify resource requirements to include staffing, funding, contract support, space to meet mission and functional requirements by April 2010. - Develop a comprehensive plan and strategy for traumatic extremity injuries and amputations registry and research agenda by July 2010. - Obtain Assistant Secretary of Defense (Health Affairs) and Under Secretary for Health (VHA) approval of Concept of Operations, implementation plan, resource requirements, research strategy.	
Recommended Metric(s)	• Obtain Assistant Secretary of Defense (Health Affairs) and Under Secretary for Health (VHA) approval of Concept of Operations, implementation plan, resource requirements, research strategy	
Where is/should the Metric(s) be Tracked	• Health Executive Council	

GOAL 3

2010-2012 JSP OBJECTIVE 3.1.A

Goal 3: Seamless Coordination of Benefits	Working Group	BEC Pre-discharge Working Group (formerly the Benefits Delivery at Discharge (BDD) Working Group)
Sub-goal 3.1: VA and DoD will coordinate efforts to improve participation in the Pre-discharge Program (BDD and Quick Start).		
SMART Objective 3.1.A: VA and DoD will achieve a goal of 65 percent participation (goal is the summation of two program percentages), and adjust marketing and awareness strategies based on participation rates calculated on a quarterly basis.		
Initiative	3.1.A The BEC will continue to develop and execute aggressive marketing campaigns to fully inform all Service members about the BDD pre-discharge program at all military installations and VA intake sites.	
Activities & Milestones	3.1.A 1. The BEC will continue to calculate and analyze the BDD participation rate at memorandum of understanding (MOU) sites that provide the single cooperative examination, on a quarterly basis. Adjust the marketing strategies as necessary to raise awareness and improve program participation. 2. The BEC will engage the Military Departments to instill ownership in the BDD pre-discharge program, with operational commanders to ensure separating/retiring Service members are provided BDD pre-discharge program information through attending VA Benefits and Disabled Transition Assistance Program (DTAP) briefings and Pre-separation Counseling Briefings that encourage participation in the BDD pre-discharge program. DoD will issue a Memorandum to Military Departments senior leadership to engage military commanders and instill ownership in the Pre-discharge Programs to include BDD and Quick Start by October 30, 2009.	
Recommended Metric(s)	• Continue to monitor BDD and Quick Start to ensure timely benefit completion • Total number of BDD and Quick Start claims filed for each FY • Total number of original claims filed within one year of discharge of FY • Total number of BDD claims that are filed by the National Guard and Reserve Component **Comment:** Participation rate for pre-discharge claims (BDD + Quick Start) will be determined according to approved methodology. For this performance measure, BDD claims are limited to MOU sites. The goal for the minimum level of participation in these Pre-discharge programs (BDD + Quick Start) is 65 percent of eligible Service members.	
Where is/should the Metric(s) be Tracked	• Veterans Benefits Administration (VBA) - Office of Performance Analysis & Integrity (PA&I) - VA/DoD Identity Repository (VADIR) • DoD - Defense Manpower Data Center (DMDC) **Comment:** DMDC provides data to VBA	

2010-2012 JSP OBJECTIVE 3.1.B

Goal 3: Seamless Coordination of Benefits	Working Group	BEC Pre-discharge Working Group (formerly the Benefits Delivery at Discharge (BDD) Working Group)
Sub-goal 3.1: VA and DoD will coordinate efforts to improve participation in the Pre-discharge Program (BDD and Quick Start).		
SMART Objective 3.1.B: VA and DoD will achieve a goal of 65 percent participation (goal is the summation of two program percentages), focusing on National Guard and Reserve members who are demobilizing.		
Initiative	3.1.B VA and DoD will coordinate respectively to market the Quick Start Pre-discharge Program to increase participation for all separating/retiring Service members who do not meet the BDD criteria, with a focus on National Guard and Reserve members who are demobilizing.	
Activities &	3.1.B	

Milestones	1. The BEC will monitor the Quick Start participation. To begin FY 2010. 2. The BEC will analyze the Quick Start participation rate on a quarterly basis, paying particular attention to National Guard and Reserve participation. Analysis to begin January 2010. 3. Based upon demobilization participation, the BEC will adjust the Quick Start marketing plan and information delivery methods as needed to raise awareness and improve program participation. 4. The BEC will engage the Military Departments to instill ownership in the Quick Start pre-discharge programs with operational commanders to ensure separating, retiring, and demobilizing Service members are provided pre-discharge program information through attending VA Benefits and DTAP briefings and Pre-separation Counseling Briefings to encourage participation in the Quick Start pre-discharge program where BDD is not feasible. DoD will issue a Memorandum to Reserve Components Military Departments senior leadership to engage military commanders to instill ownership in the Pre-discharge Programs to include BDD and Quick Start by October 30, 2009. 5. The BEC will explore ways to collect feedback to determine if Quick Start is meeting the needs of Service members with a focus on National Guard and Reserves. By the end of 2nd Quarter, FY 2010, the BEC will review and identify a methodology to collect feedback to determine if Quick Start is meeting the needs of those Service members.
Recommended Metric(s)	• Continue to monitor BDD and Quick claims to ensure timely benefit completion • Total number of BDD and Quick Start claims filed for each FY • Total number of original claims filed within one year of discharge of FY • Total number of BDD claims that are filed by the National Guard and Reserve Component **Comment:** Participation rate for pre-discharge claims (BDD + Quick Start) will be determined according to approved methodology. For this performance measure, BDD claims are limited to MOU sites. The goal for the minimum level of participation in these pre-discharge programs (BDD + Quick Start) is 65 percent of eligible Service members.
Where is/should the Metric(s) be Tracked	• Veterans Benefits Administration (VBA) - Office of Performance Analysis & Integrity (PA&I) - VA/DoD Identity Repository (VADIR) • DoD - Defense Manpower Data Center (DMDC) **Comment:** DMDC provides data to VBA.

2010-2012 JSP OBJECTIVE 3.2.A

Goal 3: Seamless Coordination of Benefits	**Working Group**	**BEC Disability Evaluation System (DES) Working Group, Disability Advisory Council (DAC)**
Sub-goal 3.2: Jointly refine and expand an improved DES process to new locations, as directed.		
SMART Objective 3.2.A: Create a DES process that is: a) 40 percent faster than the legacy DES, b) seamless and transparent, as measured by Service member and Veteran satisfaction scores, and c) integrates the Departments' disability system to the degree followed by current law by the end of FY 2010.		
Initiative	**3.2.A** Implement an integrated DES that is faster, seamless and transparent, is appropriately coordinated or aligned by VA and DoD, and that incorporates the features highlighted by Commission, Task Force, Study Groups, and Audit findings and recommendations to the degree allowed by public law.	
Activities & Milestones	**3.2.A** 1. The SOC/JEC shall make a determination on DES Pilot expansion on DES Pilot expansion by May 31, 2010. 2. The DES Pilot shall process 80 percent of Active Duty Service members through the program in 295 days or less; and, all Reserve Component Service members through the program in 305 days or less. 3. Service members separated as a result of the DES Pilot shall receive their VA benefits notification letter within 30 days of date of separation. 4. Execute a continuous process improvement strategy to further standardize and streamline DES procedures through quarterly quality control reports to VA and DoD. 5. The DES Pilot shall continue to demonstrate greater Service member customer satisfaction levels than legacy DES Service member customer satisfactions levels.	

	6. In accordance with the VA/DoD Memorandum of Agreement (MoA) "Expansion of the DoD/Integrated Pilot Disability Evaluation System (IPDES)" (January 16, 2009) the Financial Working Group will establish funding for single physical examinations for the DES Pilot, outside the National Capital Region, by October 1, 2009. 7. Develop a joint ability-based comprehensive, multidisciplinary medical, psychological, and vocational evaluation for members applying for compensation through the DES by FY 2012. 8. Continue to utilize a process in which the DoD determines fitness for duty and the VA provides disability ratings that may be used by both Departments. 9. Develop requirements for a joint Departmental, long-term IT solution to support seamless document management, case tracking, metrics, and reporting functions in support of the DES Pilot and BEC Information Sharing Information Technology (IS/IT) groups, by March 31, 2010.
Recommended Metric(s)	• Time Service members spend enrolled in the DES Pilot from the time of DES referral to issuance of the VA benefits letter • Service member and stakeholder satisfaction with the DES Pilot • Number of appeals of Physical Evaluation Board decisions
Where is/should the Metric(s) be Tracked	• After June 1, 2009, data is tracked using Veterans Tracking Application (VTA) • Defense Manpower Data Center (DMDC) Service member and stakeholder satisfaction surveys • A long-term, joint IT solution to metrics tracking and reporting needs to be developed

2010-2012 JSP OBJECTIVE 3.3.A

Goal 3: Seamless Coordination of Benefits	**Working Group**	**BEC Communications Working Group**
Sub-goal 3.3: Increase knowledge of VA and DoD benefits and services.		
SMART Objective 3.3.A: Leverage military and VA communication outlets to share benefits information, as evidenced by a 25 percent increase in information sites available to Service members and Veterans on benefits and services provided by VA and DoD.		
Initiative	Expand communication of benefits and services by: **3.3.A.1** Leveraging various military and VA web sites and new media outlets. **3.3.A.2** Using the eBenefits portal as a connecting hub for the seamless flow of benefits-related information between VA, OSD, and the Military Departments. **3.3.A.3** Placing targeted comments on Leave and Earnings Statement (LES). **3.3.A.4** Assessing increased knowledge of VA benefits. **3.3.A.5** Developing an automated system to alert Service members one year prior to separation of VA/DoD benefits.	
Activities & Milestones	**3.3.A.1/3.3.A.2/3.3.A.3/3.3.A.4/3.3.A.5** 1. Establish and formalize a dedicated, working relationship with the OSD and VA Public Affairs Offices to ensure that various VA and DoD Web sites contain the most current and pertinent information regarding benefits-related information and services for Service members, Veterans, and their families by December 1, 2009. 2. Jointly create benefits-related products to cross-promote VA/DoD benefits and services to include topics such as the Post 9/11 GI Bill and Disability Evaluation System by May 1, 2010. 3. Establish and formalize cross-promoting similar VA/DoD benefits and services through defined military and VA Web portals by September 30, 2010. 4. Review and revise eBenefits content material to ensure VA/DoD benefits, when feasible, provide the user with cross-promotion of similar benefits by September 30, 2011. 5. Identify a minimum of two topics (one by VA and one by DoD) to be targeted for the inclusion of comments on LES's during FY 2010 by September 30, 2010. Additional LES comments may be required if urgent posting notices are required by either Department. 6. Assess number of key benefits and services presented on LES and explore corresponding web analytics by August 1, 2010. 7. Analyze the effectiveness of LES comments through reviewing web traffic on this defined site for one	

	month prior to placement and after LES release by August 1, 2010. 8. Review National Survey of Veterans 2009 report which is released no later than September 30, 2010. 9. Identify subject matter experts to review defined VA/DoD benefit information maintained within the eBenefits portal with anticipated first review of content materials completed September 30, 2009, and updated periodic reviews throughout 2010. 10. Conduct a pilot to send VA benefits information electronically through eBenefits for Service members with ETS dates in FY 2012 by September 30, 2011. 11. Contact at least 85 percent of registered eBenefits users who have scheduled separations 180 days prior to discharge by September 30, 2012. 12. Cross-promote 85 percent of similar VA/DoD benefits and services over the lifecycle of Service members in FY 2010.
Recommended Metric(s)	• Analyze the results of the National Survey of Veterans to determine the exact number of surveyed Veterans who favorably respond that they are satisfactorily aware of the benefits and services provided by the VA • Ensure a minimum of 30 percent current content of VA/OSD/Service benefits-related information on the various VA and DoD Web sites are reviewed for content accuracy and that 100 percent of any new benefits mandated by law are disseminated to Service members, Veterans, and their families • Increase knowledge of similar VA/DoD benefits and services through promoting these topics through print or broadcast media. Work with the appropriate VA/DoD subject matter experts (SMEs) to ensure that at least two media-related products, one broadcast and one print, are produced in FY 2010
Where is/should the Metric(s) be Tracked	• Metrics will be tracked by VA/DoD communication working group collaborative offices and monitored by BEC

2010-2012 JSP OBJECTIVE 3.4.A

Goal 3: Seamless Coordination of Benefits	**Working Group**	**BEC Medical Records Working Group (MRWG)**
Sub-goal 3.4: Oversee the entire life-cycle of the paper military Service Treatment Record (STR).		
SMART Objective 3.4.A: Implement policy and procedures resulting in the decrease in the volume of loose and late flowing medical documentation by 95 percent by FY 2010, and increase the availability of STR information to the VA and DoD designated benefits determination decision makers to 95 percent within 45 days of separation.		
Initiative	**3.4.A** Enhance collaborative efforts to improve all phases of the military paper Service Treatment Record (STR) Life-Cycle Management Process, to include facilitating the seamless transfer of STR-related information from DoD to VA to support timely benefits determination for all Service members and Veterans.	
Activities & Milestones	**3.4.A** 1. VA and DoD will finalize coordination of a records disposition schedule with the National Archives and Records Administration (NARA) to ensure paper-based STR issues and recommended solutions are consistent with Federal records keeping requirements. Obtain NARA approval and signatures by August 31, 2010. 2. Develop Department specific and individual component/organization guidance *and procedures* with internal controls and accountability to ensure consistency. Finalize updates of the Department of Defense Instruction and interagency Memorandum of Agreement (MOA) between VA and DoD relating to transfer and maintenance of military STR for benefits processing and obtain approval and signatures by June 30, 2010.	
Recommended Metric(s)	• Military Departments (MILDEPS) will reduce the volume of late flowing documents being transferred to VA by 95 percent of their October 1, 2009 baseline by March 31, 2010. • MILDEPS and VA Records Management Center (RMC) will reduce their known backlogs of loose medical documentation by 95 percent of their October 1, 2009 baseline by March 31, 2010. • VA access to accurate and complete STR information on all Service members and Veterans within 10 days of request 95 percent of the time.	
Where is/should the Metric(s) be Tracked	• MRWG	

2010-2012 JSP OBJECTIVE 3.5.A

Goal 3: Seamless Coordination of Benefits	Working Group	Federal Recovery Coordination Program (FRCP)
Sub-goal 3.5: Improve FRCP program performance in providing coordination of care and benefits for recovering Service members, Veterans, and their families.		
SMART Objective 3.5.A: Provide sufficient program capacity and support to evaluate 100 percent of new referrals; establish FRCP satisfaction baseline level in FY 2010 and demonstrate an increase in satisfaction levels by FY 2012; improve program staff knowledge through 100 percent FRCP staff participation in targeted educational activities.		
Initiative	**3.5.A.1** Determine client factors that correlate with care coordination activities and FRC time to balance workload with client needs. **3.5.A.2** Implement educational plans for FY 2010 and develop plans for FY 2011 to meet program personnel training requirements. **3.5.A.3** Complete a satisfaction survey and implement an improvement strategy.	
Activities & Milestones	**3.5.A.1** 1. Develop revised workload assessment tool. 2. Train FRCs to the new tool and conduct inter-rater reliability testing. 3. Prospectively collect client information and FRC activity times over a period of three months. 4. Analyze data to refine tool. 5. Train FRCs to new tool and conduct inter-rater reliability testing. 6. Integrate tool within Data Management System. 7. Develop reporting requirements within Data Management System. 8. Submit new requirements for Data Management System as needed following tool refinement (September 30, 2010). **3.5.A.2** 1. Develop FY 2011 education and training plans (July 30, 2010). 2. Assist General Accounting Office (GAO) with program evaluation and site visits (ongoing for duration of study). **3.5.A.3** 1. Identify strategic plan for improving satisfaction. 2. Revise current satisfaction survey based on initial results. 3. Submit revised satisfaction survey for Office of Management and Budget (OMB) and DoD approval. 4. Develop contract for survey administration. 5. Conduct Survey (September 30, 2012).	
Recommended Metric(s)	• Evaluate 100 percent of all FRCP referrals • Increase FRCP satisfaction over baseline by FY 2012 • Ensure 100 percent staff participation in FRCP educational activities	
Where is/should the Metric(s) be Tracked	• FRCP • Overarching Integrated Product Team • Senior Oversight Committee	

2010-2012 JSP OBJECTIVE 3.6.A

Goal 3: Seamless Coordination of Benefits	Working Group	Federal Recovery Coordination Program (FRCP)
Sub-goal 3.6: Improve FRCP outreach efforts.		
SMART Objective 3.6.A: Improve FRCP program outreach efforts as evidenced by increasing FRCP outreach by 25 percent in FY 2010 over baseline.		
Initiative	**3.6.A** Develop a two-year plan for FRC outreach and information dissemination.	
Activities & Milestones	**3.6.A** 1. Identify gaps in current FRCP outreach and information dissemination activities (October 31, 2009).	

	2. Develop strategy to close gaps (December 31, 2009). 3. Develop additional outreach materials (January 31, 2010). 4. Implement plan for effective outreach and communication (ongoing following activities).
Recommended Metric(s)	• Increase FRCP outreach by 25 percent in FY 2010
Where is/should the Metric(s) be Tracked	• FRCP • Overarching Integrated Product Team • Senior Oversight Committee

2010-2012 JSP OBJECTIVE 3.7.A

Goal 3: Seamless Coordination of Benefits	**Working Group**	**Federal Recovery Coordination Program/Recovery Coordination Program (FRCP/RCP)**
Sub-goal 3.7: Improve the use of Federal and private sector resource information regarding coordination of care and benefits for recovering Service members, Veterans, and their families.		
SMART Objective 3.6.A: Increase the accessibility of the National Resource Directory (NRD) Web site for recovering Service members, Veterans, and their families, and those who support them, by a) developing business requirements to optimize technology that will support additional usage and content; and b) increasing NDR usage by 35 percent in FY 2010 compared to FY 2009.		

Initiative	**3.7.A** Optimize technology to increase accessibility of the NRD resulting in increased usage and targeted information content, and supplement outreach efforts.
Activities & Milestones	**3.7.A** 1. Provide a questionnaire to Federal Recovery Coordinators (FRC) and RCCs regarding the quality of the NRD site content by December 31, 2009. 2. Develop technical requirements and wireframes by January 15, 2010. 3. Finalize Business Plan by February 15, 2010. 4. Launch second iteration of the NRD Web site with phase II Web 2.0 technology requirements by June 30, 2010. 5. Continuously monitor the quality of the NRD content by seeking input from Military Wounded Warrior programs, FRCs, RCCs and Wounded Warrior Care Transition Policy staff.
Recommended Metric(s)	• Increase in NRD usage during FY 2010 compared to same period for FY 2009 by 35 percent
Where is/should the Metric(s) be Tracked	• NRD Governance Board • OIPT • SOC

2010-2012 JSP OBJECTIVE 3.8.A

Goal 3: Seamless Coordination of Benefits	**Working Group**	**Recovery Coordination Program (RCP)**
Sub-goal 3.8: Coordinate Federal and private sector resources and services needed by Recovering Service Members (RSM) and their families through the RCP.		
SMART Objective 3.8.A: Ensure the RCP effectively supports RSMs and their families, by a) providing a trained non-medical care coordinator/Recovery Care Coordinator (RCC) to 100 percent of eligible wounded, ill and injured Service members by FY 2011, and b) evaluating the program using additional metrics as established during baseline year FY 2010 and implementing improvements at levels to be determined in FY 2011.		

Initiative	**3.8.A** Through site assistance visits in FY 2010 and requirements from NDAA 08 Section 1611(e)(1), establish

	baseline criteria for program evaluation in FY 2011.
Activities & Milestones	**3.8.A** 1. Developed standard questions for inclusion in the Military Departments customer satisfaction surveys by August 31, 2009. 2. Execute Phase I quality assurance (QA) site assistance visits at pre-determined sites based upon input from the Military Wounded Warrior programs, focusing on (1) a review of Recovery Care Coordinator (RCC) roles and responsibilities, 2) a workload measure review and (3) a review of case records to include RSMs' recovery plans by February 15, 2010. 3. Complete Phase I baseline evaluations by May 31, 2010. 4. Execute Phase II QA site assistance visits at pre-determined sites based upon input from the Military Wounded Warrior programs by June 15, 2010. 5. Evaluate Military Department Wounded Warrior Program customer satisfaction surveys by August 2010. 6. Complete Phase I and II program evaluation by November 30, 2010. 7. Complete baseline metrics, develop a process improvement plan, and establish outcome measures by December 31, 2010. 8. Deploy an RCP IT solution system to automate Comprehensive Recovery Plans by December 31, 2010. 9. Publish a revision to DoDI 1300.ii, "Recovery Coordination Program," that reflects modifications to RCP care, management, and transition processes or procedures by March 31, 2011. 10. Develop Comprehensive Recovery Plan (CRP) for every recovering Service member assigned a non-medical care manager/RCC by FY2011.
Recommended Metric(s)	• Percentage of eligible wounded, ill and injured Service members satisfied with non-medical care coordinator/Recovery Care Coordinator by FY 2011 • Number of wounded, ill and injured Service members administered by a RCC for which a Comprehensive Recovery Plan (CRP) has been established and applied • Number of wounded, ill, and injured Service members assigned to each RCC by FY 2011, not exceeding 1:40 ratio of Service members to RCCs • Develop measures to evaluate workload for pre-determined sites by February 2010 • Number of customers reporting favorably on RCP based on satisfaction surveys administered by the Military Departments Wounded Warrior Program by August 2010 • Establish baseline outcome measures by December 31, 2010 • Complete program evaluations at 100 percent of sites by December 31, 2011
Where is/should the Metric(s) be Tracked	• Wounded Warrior Care Transition Policy office • RCP IT Solution

2010-2012 JSP OBJECTIVE 3.9.A

Goal 3: Seamless Coordination of Benefits	**Working Group**	**Recovery Coordination Program (RCP)**
Sub-goal 3.9: Coordinate Federal and private sector resources and services needed by Recovering Service Members (RSM) and their families through the Recovery Coordination Program.		
SMART Objective 3.9.A: Provide outreach to increase awareness of the Recovery Coordination Program (RCP) to RSMs and their families, as evidenced by: a) the number of communications products and functions marketing the RCP, b) tracking outreach of these efforts by January 31, 2010, and c) establishing targets for stakeholder outreach annually thereafter.		
Initiative	**3.9.A** Establish communications plan to increase outreach through the use of media and attendance at events, conferences and other activities, to raise the level of RSMs and their families' program awareness	

Activities & Milestones	**3.9.A** 1. Launch a bi-weekly e-newsletter that highlights RCP activities by November 30, 2009. Identify gaps in current outreach and information dissemination activities, revise strategy to close gaps, and implement plans for greater outreach and communication by December 2010. 2. Develop RCP key messages and supporting facts/stories by November 30, 2009. 3. Develop RCP marketing materials, including content for RCP section of Wounded Warrior Care Transition Policy office Web site, brochure, fact sheet and revised power point presentation by December 31, 2009. 4. Maintain list of key stakeholders and track outreach by January 31, 2010. 5. Present information about the RCP at event/conferences and track outreach efforts (ongoing) by February 28, 2010. 6. Identify partnership opportunities with government and civilian agencies and organizations by March 31, 2010.
Recommended Metric(s)	• Number of communications products distributed through various channels annually (e.g., e-newsletters, Web site, brochures, fact sheets, presentations, conferences) • Number of stakeholders aware of RCP, as tracked by January 31, 2010, and the target number of stakeholders reached annually thereafter
Where is/should the Metric(s) be Tracked	• Wounded Warrior Care Transition Policy office

2010-2012 JSP OBJECTIVE 3.10.A

Goal 3: Seamless Coordination of Benefits	**Working Group**	**Recovery Coordination Program (RCP)**
Sub-goal 3.10: Coordinate Federal and private sector resources and services needed by Recovering Service Members (RSM) and their families through the Recovery Coordination Program.		
SMART Objective 3.10.A: Ensure highly trained Recovery Care Coordinators (RCC) support RSMs and their families by providing standardized, quality training that is reflected in the satisfaction level of the RCCs, and ensure that all RCCs requiring annual training and/or re-certification will have completed the necessary training/re-certification programs by FY 2012.		
Initiative	**3.10.A** Provide standard certification training and develop on-line refresher training.	
Activities & Milestones	**3.10.A** 1. Disseminate DoD Instruction (DoDI) 1300.ii, "Recovery Coordination Program," via the RCC portal on Defense Knowledge On-line by December 1, 2009. 2. Review all RCC training evaluations, and prioritize needed changes for implementation by December 31, 2009. 3. Review RCC training modules and align them to clearly defined tasks, conditions and standards, and identify short falls, compile, and prioritize needed changes for implementation by December 31, 2009. 4. Incorporate needed changes into training curriculum by February 1, 2010. 5. Develop an on-line, self-administered, standard, uniform training program for annual re-certification of all RCCs to reinforce initial training by August 1, 2010. 6. Begin a 90-day trial period using the on-line, self-administered, standard, uniform training program by September 1, 2010.	
Recommended Metric(s)	• The number of RCC training course evaluations results that evidence a "highly satisfied" outcome for RCC satisfaction with the RCC training annually • The number of RCC on-line, self-administered, standard, uniform training program evaluation results that evidence a "highly satisfied" outcome with the re-certification training annually • The number of RCCs requiring annual training and/or re-certification that have completed the necessary programs by FY 2012	
Where is/should the Metric(s) be Tracked	• Wounded Warrior Care Transition Policy office	

2010-2012 JSP OBJECTIVE 3.11.A

Goal 3: Seamless Coordination of Benefits	Working Group	Recovery Coordination Program (RCP)
Sub-goal 3.11: Coordinate Federal and private sector resources and services needed by Recovering Service Members (RSM) and their families through the Recovery Coordination Program.		
SMART Objective 3.11.A: Ensure the RCP effectively supports RSMs and their families by providing an IT system solution that supports reporting and sharing of RCC metrics regarding the program's policy, processes, and tools by FY 2011.		
Initiative	3.11.A Develop an IT solution that is responsive to the RCP's need for data collection, process flow, and management oversight and reporting.	
Activities & Milestones	3.11.A 1. Finalize system design by February 28, 2010. 2. Accomplish system testing by April 30, 2010. 3. Deploy system for full implementation by June 30, 2010. 4. Establish interoperability between DoD Military Departments' IT solutions by December 31, 2010.	
Recommended Metric(s)	• Caseload data on RCP that can be reported to stakeholders in FY 2011, which result from implementation of the IT solution by December 31, 2010	
Where is/should the Metric(s) be Tracked	• Wounded Warrior Care Transition Policy office	

2010-2012 JSP OBJECTIVE 3.12.A

Goal 3: Seamless Coordination of Benefits	Working Group	Recovery Coordination Program (RCP)
Sub-goal 3.12: Coordinate Federal and private sector resources and services needed by Recovering Service Members (RSM) and their families through the Recovery Coordination Program.		
SMART Objective 3.12.A: Increase the accessibility of the National Resource Directory (NRD) for RSMs, Veterans and their families, and those who support them, by: a) developing business requirements to optimize technology that will support additional usage and content; and b) increasing NRD usage by 35 percent in FY 2010 compared to FY 2009.		
Initiative	3.12.A Optimize technology to increase accessibility of the NRD resulting in increased usage and targeted information content, and supplement outreach activities.	
Activities & Milestones	3.12.A 1. Provide a questionnaire to Federal Recovery Coordinators (FRC) and RCCs regarding the quality of the NRD site content by December 31, 2009. 2. Develop technical requirements and wireframes by January 15, 2010. 3. Finalize Business Plan by February 15, 2010. 4. Launch second iteration of the NRD web site with phase II Web 2.0 technology requirements by June 30, 2010. 5. Continuously monitor the quality of the NRD content by seeking input from Military Wounded Warrior programs, FRCs, RCCs and Wounded Warrior Care Transition Policy staff.	
Recommended Metric(s)	• Increase in NRD usage during FY 2010 compared to same period for FY 2009 by 35 percent • Increase participation in outreach activities	
Where is/should the Metric(s) be Tracked	• NRD Governance Board	

GOAL 4

2010-2012 JSP OBJECTIVE 4.1.A

Goal 4: Integrated Information Sharing	Working Group	BEC Information Sharing/Information Technology (IS/IT) Working Group
Sub-goal 4.1: Ensure appropriate Departments, Agencies, Service members, Veterans, and family members have immediate and secure access to reliable and accurate personnel and beneficiary data.		
SMART Objective 4.1.A: Support stakeholder data needs by: a) increasing the number of eBenefits user accounts by 10 percent quarterly, b) adding one strategic partner with sign-on capabilities per quarter, c) adding one self-service application per quarter, and d) completing 75 percent of activities in accordance with associated milestones and quantitative and qualitative measures.		
Initiative	4.1.A Build upon the framework established between VA and DoD for personnel/benefits data sharing to enhance level of data sharing and accommodate future requirements.	
Activities & Milestones	4.1.A 1. Support current and future task force recommendations to streamline information sharing across the VA and DoD for the delivery of benefits including health care data access. 2. Enhance the Veterans Tracking Application to maintain a common database of severely disabled Service members in support of the Disability Evaluation System (DES) pilot to *include* any additional requirements in support of other efforts. 3. Uniquely identify Active Duty Service members through accession Level 1 and Level 2 credentials, to enable seamless access to VA and DoD through eBenefits. - By December 31, 2009, eBenefits will support single sign-on capability. 4. Expand the eBenefits portal in support of the Virtual Lifetime Electronic Record (VLER) by providing additional applications and functionality. - By December 31, 2009, eBenefits will migrate from links and viewable information toward the final product. - By December 31, 2009, eBenefits will provide social media opportunities for users. - By December 31, 2010, eBenefits will provide benefits information from across both Department tailored to the user's needs based upon individual profiles. - By December 31, 2010, eBenefits will provide secure messaging for users with accounts.	
Recommended Metric(s)	• Increase the number of users with an account and accessing eBenefits 10 percent per quarter • Add one integrated strategic partner utilizing single sign-on capabilities per quarter (e.g. Army Knowledge Online, TRICARE Online, MyHealtheVet, Veterans Information Portal) • Add one self-service application per quarter (e.g. Certificate of Eligibility (COE), Specially Adapted Housing (SAH), Veterans On Line Application (VONAPP), Veteran's Online Application (VOA), Prescriptions) • Within one month of receiving a new requirement directed by the BEC resultant from any task force recommendation, the BEC IS/IT Working Group will establish a plan of action and milestones to incorporate the data exchanges required to meet the requirement	
Where is/should the Metric(s) be Tracked	• Metrics will be tracked by the BEC IS/IT Working Group and reported up to the BEC	

2010-2012 JSP OBJECTIVE 4.2.A

Goal 4: Integrated Information Sharing	Working Group	HEC IM/IT Working Group
Sub-Goal 4.2: Support continuity of patient care between VA and DoD by sharing electronic health information.		
SMART Objective 4.2.A: Share electronic health information at the time of a Service member's separation, while maintaining appropriate security, and supporting the electronic bidirectional sharing of health information in real-time for patients between the Departments by completing 80 percent of all proposed milestones in FY 2010 and FY 2011.		
Initiative	4.2.A Support continuity of care by enhancing viewable bidirectional electronic health data sharing (e.g., Bidirectional Health Information Exchange).	

Activities & Milestones	**4.2.A** 1. DoD will increase access to inpatient documentation for shared patients from DoD's inpatient documentation system: - To 70 percent or more of DoD inpatient beds by January 30, 2011. - To 85 percent or more of DoD inpatient beds by July 31, 2011. - To 90 percent of DoD inpatient beds by September 30, 2011. 2. DoD will begin implementing technical solutions to support the capture and display of automated neuropsychological assessment data by December 31, 2010. 3. VA will begin implementing technical solutions to enable VA providers to view DoD neuropsychological assessment data by June 30, 2011. 4. VA and DoD will receive a list from the Interagency Clinical Informatics Board of clinical information sharing needs or usability enhancements, to be made available in FY 2011 or beyond, by June 30, 2010. 5. VA and DoD will initiate the development of a draft DoD/VA requirements management approach to support collaboration on health care data sharing efforts and provide the HEC IM/IT Working Group a status report by October 31, 2009. 6. VA and DoD will report progress toward electronic patient registry requirements and concept of operations to the HEC IM/IT Work Group by March 31, 2010. 7. DoD will begin implementing technical solutions to enhance provider usability of the Bidirectional Health Information Exchange data viewer for DoD providers by June 30, 2011. 8. By January 31, 2010, VA and DoD will establish an integrated IT master schedule to support the implementation of the following capabilities at the North Chicago DoD-VA Medical Facility Demonstration Project: - Single patient registration. - Single sign on for clinical systems with patient context management. - Interoperability Foundation: Enterprise Service Bus (ESB).
Recommended Metric(s)	• Completion of 80 percent of activities and milestones listed above • Monitor information sharing metrics and report monthly progress (comparing FY 2009 and FY 2010 statistics) to the HEC IM/IT Working Group, HEC, and JEC as requested. Metrics will include, but not be limited to: - The number of DoD Service members with historical data transferred to VA - The number of Pre- and Post-Deployment Health Assessment (PPDHA) forms and Post-Deployment Health Re-Assessments (PDHRA) forms transferred to VA - The number of individuals with PPDHA and PDHRA forms transferred to VA - The percentage of DoD inpatient beds providing VA provider access to inpatient documentation (e.g., discharge summaries) - The number of DoD personnel with data available real-time to VA and DoD providers - The number of data queries by VA and DoD providers
Where is/should the Metric(s) be Tracked	• HEC IM/IT Working Group will monitor progress and report to the HEC quarterly • The HEC will report status of metrics to the JEC as requested

2010-2012 JSP OBJECTIVE 4.2.B

Goal 4: Integrated Information Sharing	**Working Group**	**HEC IM/IT Working Group**
Sub-Goal 4.2: Support continuity of patient care between VA and DoD by sharing electronic health information.		
SMART Objective 4.2.B: Share more computable electronic health data, while maintaining appropriate security, and supporting the electronic bidirectional sharing of health information between the Departments by completing 80 percent of all proposed milestones in FY 2010 and FY 2011.		
Initiative	**4.2.B** Support continuity of care by enhancing computable electronic health data sharing between VA and DoD.	
Activities & Milestones	**4.2.B** 1. Contingent upon VA and DoD electronic health record stabilization efforts, VA and DoD will increase the number of Clinical Data Repository/Health Data Repository (CHDR) active dual consumers (ADCs) to over:	

	- 38,000 ADCs in the 1st Quarter FY 2010. - 41,000 ADCs in the 2nd Quarter FY 2010. - 44,000 ADCs in the 3rd Quarter FY 2010. - 47,000 ADCs in the 4th Quarter FY 2010. 2. Contingent upon VA electronic health record stabilization efforts, VA and DoD will begin sharing computable chemistry and hematology laboratory results in real-time and bidirectionally for shared patients by September 30, 2011.
Recommended Metric(s)	• Completion of 80 percent of activities and milestones listed above • Monitor information sharing metrics and report monthly progress (comparing FY 2009 and FY 2010 statistics) to the HEC IM/IT Working Group, HEC, and JEC as requested. Metrics will include, but not be limited to: - Increase in the number of patients flagged as "active dual consumers" for VA/DoD computable pharmacy and allergy data exchange
Where Is/should the Metric(s) be Tracked	• HEC IM/IT Working Group will monitor progress and report to the HEC quarterly • The HEC will report status of metrics to the JEC as requested

2010-2012 JSP OBJECTIVE 4.3.A

Goal 4: Integrated Information Sharing	**Working Group**	**HEC IM/IT Working Group**
Sub-goal 4.3: Support continuity of patient care between VA and DoD by sharing electronic health information.		
SMART Objective 4.3.A: To support continuity of patient care between the Departments, VA and DoD will continue to support the electronic sharing of images for shared patients by completing 75 percent of all proposed activities and milestones in FY 2010 and FY 2011.		
Initiative	4.3.A Increase the type and amount of electronic image data shared between DoD and VA.	
Activities & Milestones	4.3.A 1. VA and DoD will report on the status of testing technical solutions which support global access and global awareness of scanned patient records and related artifacts to the HEC IM/IT Working Group by November 30, 2009. 2. DoD will report on the status of the Authority to Operate (ATO) for technical solutions which support global access and global awareness of scanned patient records and related artifacts to the HEC IM/IT Working Group by November 30, 2009. 3. DoD will develop a schedule, by April 30, 2010, for limited user testing of technical solutions which support global access and global awareness of scanned patient records and related artifacts. 4. VA will develop a schedule, by November 30, 2010, for beginning user testing of technical solutions to enable VA providers to view DoD scanned patient records and related artifacts. 5. DoD will begin implementing technical solutions to ensure that radiological orders and patient demographics are sent to the Theater Picture Archiving and Communication Systems, and that the corresponding radiological reports are incorporated in the Theater electronic health record by September 30, 2011.	
Recommended Metric(s)	• Completion of 75 percent of activities and milestones listed above	
Where Is/should the Metric(s) be Tracked	• HEC IM/IT Working Group will monitor progress and report to the HEC quarterly • The HEC will report status of metrics to the JEC as requested	

2010-2012 JSP OBJECTIVE 4.4.A

Goal 4: Integrated Information Sharing	**Working Group**	**HEC IM/IT Working Group**
Sub-goal 4.4: Foster secure computing and communications infrastructures between VA and DoD.		
SMART Objective 4.4.A: Facilitate the development and implementation of a trusted network security and communications partnership in support of electronic health data sharing by: a) September 30, 2010, completing 100 percent of data traffic		

migration from the VA Austin Automation Center to the new multipurpose gateways for VA/DoD enterprise systems existing as of June 30, 2009, and b) monitoring and reporting bandwidth and network performance on a quarterly basis in FY 2010.	
Initiative	4.4.A Increase the percentage of data being shared between VA and DoD through the new multipurpose gateways.
Activities & Milestones	4.4.A 1. VA and DoD will complete the migration of the data (from the VA Austin Automation Center to the new multipurpose gateways), being shared through VA/DoD enterprise systems existing as of June 2009, by September 30, 2010. 2. VA and DoD will monitor, assess, and report bandwidth and network performance to the HEC IM/IT Working Group by February 28, 2010, June 30, 2010, and October 31, 2010.
Recommended Metric(s)	• Completion of 100 percent data traffic migration by September 30, 2010 • Quarterly monitoring and reporting of bandwidth utilization to ensure it does not exceed 90 percent • Quarterly monitoring and reporting of network performance to ensure network availability is maintained at 98.5 percent or better across the four multipurpose gateways
Where is/should the Metric(s) be Tracked	• HEC IM/IT Working Group will monitor progress and report to the HEC quarterly • The HEC will report status of metrics to the JEC as requested

2010-2012 JSP OBJECTIVE 4.5.A

Goal 4: Integrated Information Sharing	**Working Group**	**HEC IM/IT Working Group**
Sub-goal 4.5: Support VA/DoD and national electronic health data sharing initiatives.		
SMART Objective 4.5.A: Assess VA/DoD health data sharing initiatives and promote VA/DoD collaboration on architectural compliance and adoption of Health Information Technology (HIT) standards for identified projects by: a) meeting 80 percent of milestones in FY 2010, which include updating and completing the architectural compliance review for VA/DoD health data sharing initiatives, b) incorporating interoperability standards into the Target Health Standards Profile, and c) assessing the level of usage of the VA/DoD Information Exchange tool in FY 2010.		
Initiative	4.5.A Support VA/DoD electronic data sharing by promoting architectural compliance and adoption of HIT standards.	
Activities & Milestones	4.5.A 1. The Health Architecture Interagency Group (HAIG) will update the architectural compliance review checklist by February 28, 2010. 2. The HAIG will review National HIT standards recommended for implementation by June 30, 2010. 3. The HAIG will collect and assess observed uses of the newly developed VA/DoD Information Exchange (IE) Tool and report findings to the HEC IM/IT Working Group by June 30, 2010. 4. The HAIG will provide recommendations on the sustainment and/or enhancement of the VA/DoD Information Exchange (IE) Tool to the HEC IM/IT Working Group by September 30, 2010. 5. The HAIG will complete the architectural compliance review for VA/DoD health data sharing initiatives, identified by the HEC IM/IT Working Group, by September 30, 2010. 6. The HAIG will incorporate recognized interoperability standards into the target VA/DoD health standards profile by September 30, 2010.	
Recommended Metric(s)	• Meet 80 percent of milestones in FY 2010, which include updating and completing the architectural compliance review for VA/DoD health data sharing initiatives • Incorporation of interoperability standards into the target VA/DoD health standards profile • Assessing the level of usage and value of the VA/DoD Information Exchange tool in FY 2010	
Where is/should the Metric(s) be Tracked	• HEC IM/IT Working Group will monitor progress and report to the HEC quarterly • The HEC will report status of metrics to the JEC as requested	

2010-2012 JSP OBJECTIVE 4.6.A

Goal 4: Integrated Information Sharing	Working Group	Interagency Program Office (IPO), DoD, and VA
Sub-goal 4.6: Interoperability **Maintain and enhance legacy information, interoperability systems, and capabilities to improve the care of, and service to, Service members and Veterans.**		
SMART Objective 4.6.A: Ensure the achievement of information sharing of health, personnel and benefits data between the DoD and VA. Collaborate with the Departments, the HEC, the BEC and the Interagency Clinical Informatics Board (ICIB) to assist in the identification of additional functionality to meet the needs of health care providers and incrementally enhance interoperability. Confirm the completion of these interoperability objectives in FY 2010 and beyond.		
Initiative	**4.6.A** Coordinate, oversee and validate the interagency execution of VA/DoD programs and projects applicable to electronic information and data sharing of health, personnel and benefits systems.	
Activities & Milestones	**4.6.A** 1. In coordination with the Departments, by March 31, 2010, develop a framework for a Joint Evaluation Plan for Success that can be adapted for each JEC-approved IT initiative. 2. In coordination with the Departments and the HEC, develop and monitor metrics for successful IT implementations, including coordinating the development of a Joint Assessment Plan for Success for each approved interoperability initiative no later than 30 days after approval of the functional requirements document. 3. Confirm the user acceptance results using the measures outlined in the Joint Assessment Plan for Success for each approved interoperability initiative no later than 90 days after completion of user acceptance testing. 4. In coordination with the Departments and the HEC develop a Joint Interagency Master Schedule (using project schedules developed by the implementation activities of each Department) showing critical path Departmental project interdependencies and milestones for each approved interoperability initiative to provide oversight of project status and risk impacts to schedule and deliverables, and distribute it on a monthly basis. 5. Provide quarterly updates to the JEC on the progress of data sharing initiatives.	
Recommended Metric(s)	• Complete the framework for the Joint Assessment Plan for Success by March 31, 2010 • Ensure that for each interoperability objective, user acceptance testing is confirmed to include: a 100 percent of users participating in user acceptance testing are satisfied with critical key performance parameters (e.g., correct data retrieved), and b) 70 percent of the users are satisfied with processing functionality (e.g., screen layouts, ease of use) of the interoperability enhancement • 85 percent of interoperability capabilities are implemented in accordance with the schedule estimates of the Joint Interagency Master Schedule	
Where is/should the Metric(s) be Tracked	• IPO • DoD • VA	

2010-2012 JSP OBJECTIVE 4.7.A

Goal 4: Integrated Information Sharing	Working Group	Interagency Program Office (IPO), DoD, and VA
Sub-goal 4.7: Virtual Lifetime Electronic Record (VLER) **Establish a capability that will allow electronic access/exchange of health care information between DoD and the VA and ultimately include access to personnel, benefits and administrative information from the day an individual enters military service throughout their military career, and after they leave the military.**		
SMART Objective 4.7.A: Incrementally begin to establish the capability for a VLER through use of the Nationwide Health Information Network (NHIN) as the foundation that will facilitate transition from a customized point-to-point interoperability solution to a standards-based, net-centric, health information exchange between VA, DoD, and other public and private service providers following a time-phased approach beginning in FY 2010 through FY 2014 and beyond.		
Initiative	**4.7.A.1** VLER Phase 1a: Validate the basic functional and technical capabilities for the exchange of patient care	

	data, using the NHIN framework. **4.7.A.2** VLER Phase 1b: Expand data exchange through a follow-on pilot effort that incorporates additional communities and additional Health Information Technology Standards Panel (HITSP) standard data domains. **4.7.A.3** Beginning with Phase 1b, in collaboration with the Departments, incrementally develop phased program plans, including joint Interagency Master Schedules with milestones, using information derived from project schedules developed and maintained by the implementation organizations in both Departments. **4.7.A.4** Develop the first increments of VLER requirements as needed to implement each approved Phase.
Activities & Milestones	**4.7.A.1** 1. Install NHIN standards-based CONNECT capability to enable electronic record data exchange between VA, DoD, and private sector sites in support of Phase 1a. 2. Complete technical and user acceptance testing with the VA, DoD and the private sector service provider by January 31, 2010. **4.7.A.2** 1. Install NHIN standards-based CONNECT capability to enable electronic record data exchange between VA, DoD, and private sector sites in support of Phase 1b. 2. Define and prioritize additional data exchange requirements from the user community by February 28, 2010. 3. Map all defined data requirements to HITSP standards by February 28, 2010. 4. Define the additional data standards for Phase 1b capability. 5. Complete technical and user acceptance testing with the VA, DoD and the private sector service provider by July 31, 2010. **4.7.A.3** 1. Beginning with Phase 1b and continuing with phases as approved by the JEC, harmonize the Departments' project plans, including tasks, activities, dependencies, and schedules to serve as the baseline agreement and roadmap required to achieve successful implementation. 2. No less than quarterly, conduct milestone and program reviews to track program and project progress and report directly to the Departments' Deputy Secretaries on program status. **4.7.A.4** 1. Beginning with Phase 1a, and continuing with phases as approved by the JEC, in coordination with functional users, develop interagency synchronized requirements to support VLER.
Recommended Metric(s)	**4.7.A.1** *Technical:* • Demonstrate the successful exchange between VA, DoD, and the private sector service provider of at least one C-32 Summary of Care Record (as constrained for Phase 1a) using the HITSP standard NHIN CONNECT capability by February 28, 2010 or when the first qualifying patient presents himself or herself for services, if later *Functional* • Identify and baseline measures of effectiveness (e.g., completeness of information; accuracy of clinical information; medication management; impact on clinician workflow) by July 31, 2010 • Demonstrate the capability to measure the effectiveness of the data exchange by July 31, 2010 **4.7.A.2** *Technical:* • Demonstrate the successful exchange between VA, DoD, and the private sector service provider of the agreed upon additional Phase 1b data domains and/or additional HITSP standard C documents using the NHIN CONNECT capability by August 31, 2010 or when the first qualifying patient presents himself or herself for services, if later *Functional* • Validate the baseline measures of effectiveness developed for phase 1a and identify and baseline additional measures as needed for the additional data elements included in phase 1b by October 31, 2010 • Demonstrate the capability to measure the effectiveness of the data exchange by December 31, 2010 **4.7.A.3**

	• In conjunction with the Departments, complete the phased program plan no later than one month prior to the commencement of each JEC-approved phase **4.7.A.4** • In conjunction with the Departments, complete interagency synchronized requirements no later than one month prior to the commencement of each JEC-approved phase
Where is/should the Metric(s) be Tracked	• IPO • VA • DoD • HEC Information Management/Information Technology (IM/IT) Working Group • BEC Information Sharing/Information Technology (IS/IT) Working Group (as applicable) • For 4.7.A.3, progress toward development of phased program plan will be tracked by the IPO

GOAL 5

2010-2012 JSP OBJECTIVE 5.1.A

Goal 5: Efficiency of Operations	Working Group	Construction Planning Committee (CPC) Working Group
Sub-goal 5.1: Identify, propose, and increase collaborative opportunities for Joint Capital Asset Planning.		
SMART Objective 5.1.A: Identify, propose, and increase collaborative opportunities for Joint Capital Asset Planning, with a goal of developing and gaining JEC approval for a budget mechanism that authorizes and funds joint VA and DoD planning initiatives by May 2010.		
Initiative	5.1.A Develop a budget mechanism (line item in the budget request of both Departments) to provide authority and funding for joint planning and design initiatives to include VA and DoD; and determine and develop policy guidance necessary to improve collaborative construction and facility planning initiatives.	
Activities & Milestones	5.1.A 1. The CPC will develop the budget instrument requirements. 2. General Counsel will review and modify the proposed language. 3. Request Department approval for budget mechanism. 4. Request authority for budget mechanism in future budget submission. 5. Analyze required policy guidance to assist joint collaborative efforts at all levels and report back to CPC. 6. The CPC will develop policy guidance as required and seek appropriate document approval.	
Recommended Metric(s)	• Complete development of budget mechanism (for both Departments) by March 2010 • Seek budget mechanism approval from the JEC by May 2010 • Complete policy guidance for collaboration and facility planning by April 30, 2010 • Seek Policy Guidance approval from the JEC by May 2010	
Where is/should the Metric(s) be Tracked	• CPC Meeting Minutes	

2010-2012 JSP OBJECTIVE 5.2.A

Goal 5: Efficiency of Operations	Working Group	Acquisition and Medical Materiel Management (A&MMM) Working Group
Sub-goal 5.2: Identify and leverage joint VA/DoD medical contracting venues and business practices to mutually benefit both agencies and medical facilities.		
SMART Objective 5.2.A: Expand the number of VA and DoD joint contracts and increase usage by pursuing at least one new opportunity by December 31 annually to benefit both agencies and medical facilities. Based on the results of the Joint Incentive Fund (JIF) dollar savings analysis project, establish a baseline to assess cost avoidance by December 31, 2010.		
Initiative	5.2.A The HEC Acquisition and Medical Materiel Management (A&MMM) WG will assess VA and DoD processes related to the acquisition of goods and services and make recommendations to achieve best joint operational and business efficiencies.	
Activities & Milestones	5.2.A 1. Pursuing additional opportunities and pilots for joint purchasing consolidation during each calendar year (CY) and report the previous fiscal year progress of these medical contracting opportunities to the HEC by December 31st annually. 2. Using current JIF project entitled "Analysis of Dollar Savings Achieved from the Negotiation of Joint Diagnostic Imaging System Contracts" to pursue identification of dollar savings or cost avoidance opportunities achieved from the negotiation of joint contracts and increased access to both agencies' contracting venues by December 31, 2010. 3. Identifying opportunities to maximize the use of all VA and DoD contracting instruments and minimize duplication of contracting efforts annually by December 31.	

Recommended Metric(s)	• JIF analysis project to be completed by December 31, 2010, will provide baseline to establish a metric to capture cost avoidance opportunities
Where is/should the Metric(s) be Tracked	• A&MMM WG quarterly reports and meetings

2010-2012 JSP OBJECTIVE 5.2.B

Goal 5: Efficiency of Operations	**Working Group**	**Acquisition and Medical Materiel Management (A&MMM) Working Group**
Sub-goal 5.2: Identify and leverage joint VA/DoD medical contracting venues and business practices to mutually benefit both agencies and medical facilities.		
SMART Objective 5.2.B: Expand the number of joint contracts and increased usage, with a target of expanding joint contracts by $10 million annually.		
Initiative	**5.2.B** The HEC A&MMM WG will increase the value of joint contracts, targeting commonly used manufacturers for joint contract initiatives and continuing to seek new opportunities for joint contracts.	
Activities & Milestones	**5.2.B** 1. Increasing collaborative logistics and clinical participation in standardization programs across VA/DoD. Share standardization business processes and identify opportunities for VA/DoD standardization annually by December 31, 2010. 2. The A&MMM WG will track the number and dollar value of joint contracts and provide joint contract sales to the HEC quarterly. 3. The VA National Acquisition Center and the Defense Logistics Agency will report dollars expended within their programs on a quarterly basis to the HEC.	
Recommended Metric(s)	• Identify quarterly growth, both in number and dollar value of joint contracts as a percentage of total sales with a target of expanding the amount of contracts by $10 million annually	
Where is/should the Metric(s) be Tracked	• A&MMM WG quarterly reports and meetings	

2010-2012 JSP OBJECTIVE 5.3.A

Goal 5: Efficiency of Operations	**Working Group**	**Acquisition and Medical Materiel Management (A&MMM) Working Group**
Sub-goal 5.3: Enhance the joint VA/DoD medical surgical electronic catalog.		
SMART Objective 5.3.A: Enhance the joint VA and DoD medical surgical electronic catalog to achieve cost efficiencies, as evidenced by: a) showing the growth in numbers of VA and DoD suppliers using global location and identification standards by FY 2010 and FY 2012 b) increasing number and percentage of growth of VA and DoD users from end FY 2009, and c) dollar amount of product price reductions achieved per quarter.		
Initiative	**5.3.A.1** The HEC A&MMM WG will work with industry to adopt uniform identification codes for medical surgical products and strive for consensus between industry and Federal partners on use of commercial standard product data identifiers, formats and data sharing networks for both internal and external supply chain operations. **5.3.A.2** The HEC A&MMM WG will provide methods at the national, regional, and facility level to automatically identify the lowest contracted price on medical surgical items.	
Activities & Milestones	**5.3.A.1/5.3.A.2:** 1. Participating in at least two industry forums, venues and pilots annually to advance adoption of industry-wide use of medical surgical product data standards and data sharing networks. 2. Building on DoD Health Care Pilot Lessons Learned and 40 supply chain attributes (selected by U.S. and global health care standards groups) to develop adoption plan for selected standard product and	

	organizational identifiers within VA and DoD by October 2010. 3. The HEC A&MMM WG will provide methods at the national, regional, and facility level to automatically identify the lowest contracted price on medical surgical items by: - Developing an implementation plan to integrate the Common Catalog functionality into VA and DoD logistical systems by December 31, 2011. - Providing VA/DoD electronic catalog tools (pricing/sourcing) access to all VA and DoD sites by October 2010.
Recommended Metric(s)	• Number and percent of VA and DoD suppliers using Global Location Numbers (GLN) by December 2010; percent of VA and DoD suppliers using Global Trade Identification Numbers (GTIN) by October 2012 • Number of pilot participants in VA/DoD data synchronization pilots • Number of VA/DoD purchasing sites using Data Sync eZ SAVe and Common Catalog • Dollar amount of product price reductions achieved per quarter • Percent of sites accessing MEDPDB tools via DoD networks
Where is/should the Metric(s) be Tracked	• A&MMM WG quarterly reports and meetings • Joint Federal Working Group sessions • VA/DoD program manager Interim Progress Reports

2010-2012 JSP OBJECTIVE 5.4.A

Goal 5: Efficiency of Operations	**Working Group**	**Financial Management Working Group**
Sub-goal 5.4: Develop a financial integration methodology.		
SMART Objective 5.4.A: Establish financial responsibility at integrated VA/DoD facilities, as evidenced by: a) 100 percent completion of financial reconciliation methodology by December 31, 2009, and b) testing of 100 percent of agreed upon data elements through the encoder/grouper by October, 2010.		
Initiative	**5.4.A** The North Chicago VA-DoD Medical Facility Demonstration Project will have integrated health care operations and business processes, and will use the VA Financial Management System as the sole accounting system for the new appropriation. In order to determine funding responsibility in a combined operation, VA and DoD will use a standardized health care workload value in a quarterly data reconciliation process. VA and DoD will identify, develop and test the methodology and interfaces of the Navy, VA and DoD data to ensure full functionality of the agreed upon systems and processes to be used for financial reconciliation.	
Activities & Milestones	**5.4.A** 1. VA's Financial Management System (FMS) and Decision Support System (DSS) will be used to determine workload cost. The DoD's encoder grouper will be used to assign industry standard weights to clinical workload. Together, this data will be used to determine workload value and to reconcile funding responsibility to each Department for the combined operations. **Specific Activities:** - Complete the reconciliation methodology and test for accuracy (shadow reconciliation) by December 2009. - Assist the local Financial Task Group (TG) to develop executive decision memorandums documenting financial policies, processes and procedures to support integrated operations at the demonstration pilot in Chicago by October 1, 2010. - Assist the local Financial TG to identify and set up all data feeds for the reconciliation process by October 1, 2010.	
Recommended Metric(s)	• Develop 100 percent of methodology acceptable to the Chief Financial Officers by December 31, 2009 • Test the processing of 100 percent of agreed upon data elements through the encoder/grouper by October, 2010	
Where is/should the Metric(s) be Tracked	• Progress will be tracked by the Financial Task Group of the demonstration pilot Leadership Task Group	

2010-2012 JSP OBJECTIVE 5.5.A

Goal 5: Efficiency of Operations	Working Group	Financial Management Working Group (FMWG)
Sub-goal 5.5: Successfully manage the VA/DoD Joint Incentive Fund (JIF) for health care sharing.		
SMART Objective 5.5.A: Better serve VA and DoD beneficiaries by: a) allocating 80 percent of funds for approved projects within 60 days of approval, and b) increasing percentage of JIF funds allocated within 60 days by five percent each year.		
Initiative	5.5.A The HEC FMWG will continue to solicit and recommend JIF projects to the HEC, working under the guidance Memorandum of Agreement governing the JIF, and monitoring funded projects until completed.	
Activities & Milestones	5.5.A 1. The FMWG will monitor JIF allocations and obligations by project and assess the overall progress of the project through the use of financial reports and Interim Progress Reports on a quarterly basis. Reports are due from local sites to the FMWG on January 15th, April 15th, July 15th, and October 15th of each fiscal year. 2. Allocate 80 percent of funds for approved projects within 60 days of approval.	
Recommended Metric(s)	• Number of obligations achieved per quarter as compared to the number of planned obligations • Total allocations as a percentage of total funds available by year	
Where is/should the Metric(s) be Tracked	• Metrics will be tracked in the quarterly interim progress reports and financial system reports by the FMWG	

2010-2012 JSP OBJECTIVE 5.6.A

Goal 5: Efficiency of Operations	Working Group	Joint Facility Utilization and Resource Sharing (JFU&RS) Working Group
Sub-goal 5.6: Identify, document, and increase joint facility utilization and resource sharing.		
SMART Objective 5.6.A: Expand the footprint of joint market operations through the increase of VA and DoD joint sharing sites by a minimum of two new sites per year.		
Initiative	5.6. A The Joint Marketing Opportunities (JMO) team will select and encourage the development of new sites annually and assist with the development of a Concept of Operations (ConOps) for selected sites.	
Activities & Milestones	5.6.A 1. Identify sharing opportunities at selected new sites based on objective criteria. Encourage development of these opportunities by developing and enforcing metrics, providing oversight for sharing efforts and assisting with business plan development. 2. Conduct Interim Progress Reviews and report new initiatives to the HEC annually. - New sharing initiatives will be documented as appropriate in the VA/DoD Sharing Agreement database. 3. JMO team will assist with the development of a ConOps and business plans for selected sites to capture and formalize sharing initiatives by major functional area.	
Recommended Metric(s)	• Increase sharing at two new sites annually FY 2010-2012 • Increase number of sites with detailed business plans and ConOps for future sharing plans by at least two sites annually	
Where is/should the Metric(s) be Tracked	• Established sharing opportunities, business plans and CONOPS will be evaluated and coordinated by VA/DoD Program Coordination Office, Health Affairs and the DoD Coordination Office, VHA • Service Liaisons and VHA VA/DoD Liaison Office will report resolution of action items back to originating site; results will be documented in the VA/DoD HEC eRoom and reported to the HEC via briefing or JFU&RS WG status update to HEC briefing books	

2010-2012 JSP OBJECTIVE 5.7.A

Goal 5: Efficiency of Operations	Working Group	Joint Facility Utilization and Resource Sharing (JFU&RS) Working Group

Sub-goal 5.7: Develop quantitative measures (when applicable) for sharing initiatives, and work with selected sites to establish valid and reliable metrics.

SMART Objective 5.7.A Evaluate the Enhanced DR and determine its benefit in capturing quality, cost, and access data by April 2011. If determined successful, DoD and VHA will submit a national level Joint Incentive Fund (JIF) proposal by November 2011 for Enhanced Document Management and Referral Management (eDR) to be implemented at all Joint Venture sites to enhance the establishment of outcome-focused performance measures to evaluate sharing initiatives at the local level by September 30, 2012.

Initiative	5.7.A Establish an outcome focused process for Joint Marketing Opportunities (JMO) targeted sites using HA and VHA acceptable measures by evaluating the capabilities of the Enhanced DR. **Comment:** eDR will provide a first-time, automated, referral and resource tracking capability which is bi-directional between the VA and DoD health care facilities. eDR provides episode of care data (by Current Procedural Terminology , Diagnostic Related Group, and Relative Value Unit/Relative Weighted Product) that has the capability of tracking real time at the facility level and rolling up into national metrics/reports. eDR links data to metrics through timely, user-friendly reports that can be tailored to facility operations and supportive of national metrics.
Activities & Milestones	5.7.A 1. Enhanced DR scheduled for full activation at Tripler Army Medical Center and VA Pacific Islands Health Care System Interim Progress Report (IPR) in September 2010. 2. The JMO team will evaluate the capabilities of the eDR and determine its ability to provide data for Health Affairs and VHA acceptable measures to determine access, quality, and cost of shared health care by April 2011. 3. If the eDR is successful in providing data to measure the success of VA/DoD Sharing, the JMO team will recommend that a JIF proposal be submitted by November 2011 to expand the use of the eDR to all Joint Venture sites.
Recommended Metric(s)	Metrics that will be used to evaluate the capabilities of the eDR include: • Access to care timeliness (percentage) • Decrease in indirect (purchased) care costs (dollars) • Increased direct care (Recaptured care) (percentage) • Timeliness of Billing and Payment process (number of days) as an assessment of process improvement
Where is/should the Metric(s) be Tracked	• Results will be reported to the HEC via briefing or JFU&RS Working Group status update to HEC briefing books semi-annually

GOAL 6

2010-2012 JSP OBJECTIVE 6.1A

Goal 6: Joint Medical Contingency/Readiness Capabilities	**Working Group**	**HEC Contingency Planning Working Group**
Sub-goal 6.1: Ensure that VA maintains an appropriate contingency capability to support DoD in accordance with 38 U.S.C., Section 8110.		
SMART Objective 6.1.A: Determine DoD wartime bed requirements and develop a plan for VA to support this requirement in accordance with 38 U.S.C., Section 8110 by September 30, 2011. As practical, concurrently incorporate VHA capabilities into applicable functional, concept, and operations plans by September 30, 2011.		
Initiative	**6.1.A** VHA development of a plan to support DoD contingency bed requirements.	
Activities & Milestones	**6.1.A** 1. VA and OSD members of the HEC Contingency Planning Working Group will review the DoD Mobility Capabilities and Requirements Study upon its completion/approval in early 2010. Complete this review by September 30, 2010. 2. VA and OSD members of the HEC Contingency Planning Working Group review existing U.S. Northern and Transportation Command functional, concept and operations plans by September 30, 2010. 3. VA and OSD members of the HEC Contingency Planning Working Group ascertain other U.S. Northern Command (NORTHCOM) or U.S. Transportation Command (TRANSCOM) contingency requirements that could be supported by VHA by September 30, 2010. 4. Determine DoD bed and patient transport flow requirements by September 30, 2010. 5. Review/determine TRICARE and National Disaster Medical System (NDMS) transport and bed (or other) capabilities as of November 30, 2010. 6. Provide a classified estimate of DoD contingency medical capabilities to VHA by December 31, 2010. 7. Agreement between the two agencies on what VHA support can be provided by March 31, 2011. 8. VHA develops a plan to support an agreed-upon portion of DoD contingency medical requirements by December 31, 2011. 9. As practical, concurrently incorporate VHA capabilities into applicable U.S. Northern and Transportation Command functional, concept and operations plans by December 31, 2011.	
Recommended Metric(s)	The number of potential plans to review is unknown. Hence, the metrics to measure this task are limited to the major milestones: • Outline of DoD medical contingency requirements based upon available studies and plans evaluated by September 30, 2010 (25 percent task completion) • Comparison of medical contingency requirements to existing DoD capabilities by November 30, 2010 (50 percent task completion) • Agreement between DoD and VHA on the amount of support to be provided by March 31, 2011 (75 percent task completion) • Completed VA supporting plan by December 31, 2011 (100 percent task completion)	
Where is/should the Metric(s) be Tracked	• DoD Mobility Capabilities and Requirements Study • U.S. Transportation Command to review/determine DoD patient transport flow requirements • U.S. Northern Command to review/determine DoD patient bed (or other) requirements • VHA Office of Emergency Management Strategic Health Care Group to review/determine VHA transport and bed (or other) capabilities • HEC Contingency Planning Working Group to review applicable drafts of functional, concept and operations plans to assess progress toward incorporation of VHA capacities • HEC Contingency Planning Working Group to provide an annual progress report to the HEC	

SECTION 4

Conclusion - The Way Ahead

The Joint Strategic Plan's new performance-based methodology clearly defines the milestones and performance measures that will help improve accountability within each Department for joint VA/DoD efforts. The SMART Objective is a new approach that will help the JEC oversee the performance of its Sub-councils. A formal tracking and reporting system is being refined for the JEC to monitor the status and progress of its priorities.

The Department of Veterans Affairs and the Department of Defense remain committed to maintaining a leadership framework to oversee and promote successful partnerships, institutionalize change, and foster momentum and collaboration into the future. Both Departments strive for a world-class partnership that delivers seamless, cost-effective, quality services to beneficiaries. The care of Service members and Veterans will continue to be a challenge that the Departments and the nation must meet. They deserve all the thanks and support a grateful nation can offer.

Appendix B
Memorandum of Understanding: VA/DoD Health Care Resources Sharing Guidelines, July 1983

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

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

I. PURPOSE

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

II. AUTHORITY

The Secretary of Veterans Affairs and the Secretary of Defense establish these guidelines pursuant to the authorities in and requirements of Title 38, United States Code, section 81 11 (38 U.S.C. 5811 I), entitled "Sharing of Department of Veterans Affairs and Department of Defense Health Care Resources," and the authorities contained under Title 10, United States Code, section 1104 (10 U.S.C.5 1104), entitled "Sharing of Resources with the Department of Veteran's Affairs," which incorporates Title 31, United States Code, section 1535 (31 U.S.C. 51 535), entitled "Agency Agreements," also known as the "Economy Act." These guidelines assist in the implementation of these statutes.

III. JOINT EXECUTIVE COUNCIL (JEC)

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

B. Responsibilities: The JEC shall:

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

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

IV. SHARING AGREEMENTS

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

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

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

D. Scope of Agreements:

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

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

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

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

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

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

G. Modification, Termination, and Renewal: Except as noted in section D2 above, relating to joint ventures, sharing agreements may be written for a period of up to 5 years. Each sharing agreement and joint venture shall include a statement on how the agreement may be modified or terminated. Either party may terminate a sharing agreement with a minimum of 30 days written notice to the other party. For joint ventures, the agreement must set forth the terms and conditions for dissolution of the joint venture in the event of unforeseen exigencies that require

the agreement to be rescinded, with a minimum of 180 days written notice to the other party from the original approving authority. Examples would include Base Realignment and Closure (BRAC) or VA Capital Assets Realignment for Enhanced Services (VA CARES) decisions or significant demographic changes. Sharing agreements shall provide for modification or termination in the event of war or national emergency, as necessary. Annual reviews of sharing agreements are required by all involved agencies for VA/DoD health care sharing agreements. Military Departments, working with their VA counterpart, shall ensure that decisive action is taken to approve or disapprove requests for renewal of sharing agreements prior to the expiration of the sharing agreement. In the event the renewed or amended agreement is not completed prior to the expiration date, written requests for extension of the agreement must be forwarded to the Military Departments' approval authority. Renewals may be written for up to 5 years. Amendments that are required prior to the renewal of an agreement must last only as long as the agreement upon which it is based.

V. EFFECTIVE DATE AND MODIFICATION OF GUIDELINES

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

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

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

_____/s/_____
Gordon H. Mansfield
Deputy Secretary of Veterans Affairs
October 29, 2008

_____/s/_____
Gordon England
Deputy Secretary of Defense
October 31, 2008

Appendix C
Cost Estimate to Prepare Congressionally Mandated Report

Title of Report: VA/DoD 2008 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	$307,072
Contract(s) Cost	$103,000
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 2009 hourly rate structure for the metropolitan Washington, DC area. The calculated net labor costs were multiplied by the fiscal year 2009 fringe benefit amount of 36.25%. The reported information in the cost statement reflects the sum of direct labor hour costs and fringe benefits.

Glossary of Abbreviations and Terms

ACH – Army Community Hospital
ADC - Active Dual Consumers
AFB - Air Force Base
AFHSC - Armed Forces Health Surveillance Center
AHRQ - Agency for Healthcare Research and Quality
AMEDD - Army Medical Department
A&MMMWG - Acquisitions and Medical Material Management Working Group
AR - VA/DoD JEC Fiscal Year 2009 Annual Report
BEC – Benefits Executive Council
BDD - Benefits Delivery at Discharge
BHIE - Bidirectional Health Information Exchange
BUMED - Bureau of Medicine and Surgery
CDMRP - Congressionally Directed Medical Research Programs
CENTCOM - Central Command
CHDR - Clinical Health Data Repository
CHPPM - Center for Health Promotion and Preventive Medicine
CIO – Chief Information Officer
CM - Clinical Modification
CNVAMC - Charlie Norwood VAMC
COE - Certificate of Eligibility
ConOps - Concept of Operations
CPC - Construction Planning Committee
CPGs - Clinical Practice Guidelines
CPT - Cognitive Processing Therapy
CRP - Comprehensive Recovery Plan
CSoC - Clinical Standards of Care
CWG - Communications Working Group
DAC – Disability Advisory Council
DCoE - Defense Centers of Excellence
DDEAMC - Dwight D. Eisenhower AMC
DEERS - Defense's Defense Enrollment Eligibility Reporting System
DES - Disability Evaluation System
DHWG - Deployment Health Working Group
DIMHRS - Defense Integrated Military Human Resources System
DIN/PACS - Digital Imaging Network/Picture Archiving and Communications System
DKO – Defense Knowledge Online
DLA - Defense Logistics Agency
DMDC - Defense Manpower Data Center
DMS - Data Management System
DoD – Department of Defense
DoDI – Department of Defense Instruction
DOL – Department of Labor
DSCP - Defense Supply Center Philadelphia
DS log-on - Defense Self-Service log-on

DSS - Demonstration Site Subgroup
DTAP – Disable Transition Assistance Program
DUA - Data Use Agreements
DVBIC - Defense and Veterans Brain Injury Center
DVEIR - Defense and Veterans Eye Injury Registry
EDM – Executive Decision Memorandum
EES - Employee Education System
EHR - Electronic Health Record
ETS – Expiration Term of Service
eZSAVe - Data Synchronization Pricing and Site Data Enhancement Application
FCCs - Federal Coordinating Centers
FHCC – Federal Health Care Center
FMWG - Financial Management Working Group
FRC - Federal Recovery Coordinator
FRCP - Federal Recovery Coordination Program
FTEE – Full Time Equivalent Employee
FY – Fiscal Year
GAO – Government Accountability Office
GME - Graduate Medical Education
GS - Government Service
GWVIS - Gulf War Veterans Information System
HAIG - Health Architecture Interagency Group
HCS - Health Care System
HEC – Health Executive Council
HHS - Department of Health and Human Services
HIPAA - Health Insurance Portability and Accountability Act
HIT - Health Information Technology
HITSP – Health Information Technology Standards Panel
HPE - Health Professions Education
ICD-9 - International Classification of Diseases, 9th Edition
ICIB – VA/DoD Interagency Clinical Informatics Board
IDS - Inpatient Documentation System
IE - Information Exchange
IIP - Information Interoperability Plan
IM/IT - Information Management / Information Technology
IOM - Institute for Clinical System Improvements and the Institute of Medicine
IPDES – Integrated Pilot Disability Evaluation System
IPO – Interagency Program Office
IPR - Interim Progress Report
IRD - Integrated Requirement Design Directorate
IS/IT - Information Sharing / Information Technology
IT – Information Technology
JACC - Joint Ambulatory Care Center
JEC – Joint Executive Council
JIF- Joint Incentive Fund
JMO - Joint Market Opportunities

JSP – VA/DoD JEC Joint Strategic Plan
JSPC - Joint Strategic Planning Committee
LES - Leave and Earnings Statement
LMS - Learn Learning Management System
MCS - Millennium Cohort Study
MCSC - Managed Care Support Contractors
MEB - the Medical Evaluation Board
MEDPDB - Medical Surgical Product Data Bank
MH – Mental Health
MHS - Military Health System
MILDEPS – Military Departments
MOA - Memorandum of Agreement
M&RA – Manpower and Reserve Affairs
MRI - Magnetic Resonance Imaging
MRWG - Medical Records Working Group
mTBI - Mild Traumatic Brain Injury
MTFs - Military Treatment Facilities
NAC - National Acquisition Center
NARA - National Archives and Records Administration
NCAT - NeuroCognitive Assessment Tool
NCHS - National Center for Health Statistics
NDAA – National Defense Authorization Act
NDMS - National Disaster Medical System
NHIN - Nationwide Health Information Exchange
NIH - National Institutes of Health
NRD - National Resource Directory
OASD (HA) - Office of the Assistant Secretary of Defense (Health Affairs)
OEF - Operation Enduring Freedom
OIF - Operation Iraqi Freedom
OMB – Office of Management and Budget
OSD – Office of the Secretary of Defense
PACS - Picture Archiving and Communication Systems
PA&I – Performance Analysis and Integrity
PDB - Product Data Base
PDHRA - Post Deployment Health Reassessment
PE - Prolonged Exposure
PEB – Physical Evaluation Board
PH - Psychological Health
PMAS - Management Accountability System
PMBOK - Project Management Body of Knowledge
PPDHA - Pre- and Post-Deployment Health Assessment
PRCs - Primary Receiving Centers
PTSD - Post Traumatic Stress Disorder
QA – Quality Assurance
RC - Reserve Component
RCC – Recovery Care Coordinators

RCP - Recovery Coordination Program
RSMs - Recovering Service Members
SAH - Specially Adapted Housing
SCORM - Shareable Content Object Reference Model Conformant
SDO – Standard Development Organization
SMART - Specific, Measurable, Achievable, Realistic, and Time-bound
SME – Subject Matter Expert SOC – Senior Oversight Committee
SOA - Service Oriented Architecture
SOC - Senior Oversight Committee
STR - Service Treatment Record
STVHCS - South Texas Veterans Health Care System
TeamSTEPPS - Team Skills Training
TBI - Traumatic Brain Injury
TIMPO - Tri-Service Infrastructure Management Program Office
TJC - The Joint Commission for Hospital Accreditation
USC – United States Code
USD(P&R) – Under Secretary of Defense (Personnel and Readiness)
VA – Department of Veterans Affairs
VADIR – VA/DoD Identity Repository
VADS - Veterans Assistance Discharge System
VAMCs - VA Medical Centers
VA RMC – Veterans Affairs Record Management Center
VASRD - Veterans Affairs Schedule of Rating Disabilities
VBA – Veterans Benefits Administration
VCE - Vision Center of Excellence
VETSNET - Veterans Services Network
VGLI - Veterans Group Life Insurance
VHA - Veterans Health Administration
VLER - Virtual Lifetime Electronic Record
VOA - Veteran's Online Application
VTA - Veterans Tracking Application
WG – Working Group
WHMC - Wilford Hall Medical Center
WII - Wounded, Ill, and Injured
WWCTP – Wounded Warrior Care and Transition Program
WWP – Wounded Warrior Program