VA/DoD Joint Executive Council
Annual Report
FISCAL YEAR 2010

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(as of September 30, 2010)

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Deputy Secretary
Department of Veterans Affairs

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

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SECTION 1 – INTRODUCTION

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Joint Executive Council (JEC) has completed its eighth year and is pleased to submit this *VA/DoD JEC Fiscal Year* (FY) *2010 Annual Report* (AR), for the period of October 1, 2009 to September 30, 2010, to Congress and the Secretaries of Defense and Veterans Affairs as required by law[1]. This report does not contain recommendations for legislation related to health care resource sharing.

The JEC provides senior leadership for collaboration and resource sharing between VA and DoD. By statute, the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness Co-Chair JEC meetings. JEC membership 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. These Sub-Councils ensure that the appropriate resources, expertise, and efficiencies are directed to the areas of health, benefits, and information technology. The Communications Working Group 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.

The *VA/DoD Joint Executive Council Joint Strategic Plan* (JSP) is the primary means to advance performance between VA and DoD, and it is continuously evaluated, updated, and improved. Historically, the JSP is attached as an appendix to the AR; however, on March 30, 2010 the JEC approved a new JSP way ahead timeline and management process that will result in the documents being published separately for FY 2010. This will be the first year the documents are published individually, allowing time to update the JSP strategic framework that will contain substantial revisions to the mission, vision, and goals found in the previous JSP FY 2010-2012.

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

SECTION 2 - ACCOMPLISHMENTS

Section 2 highlights the Fiscal Year (FY) 2010 accomplishments of the Working Groups (WGs). These accomplishments helped propel the Department of Veterans Affairs (VA) and the Department of Defense (DoD) forward in the mission to improve resource sharing. The structure of the *VA/DoD Joint Executive Council (JEC) FY 2010 Annual Report* (AR) links the year's accomplishments to the Sub-goals and performance measures established in the *VA/DoD Joint Executive Council Joint Strategic Plan* (JSP) FY 2010-2012. This approach clarifies the connection between strategic planning and outcomes achieved through VA and DoD's coordination and sharing efforts. The report also demonstrates achievements beyond planned activities.

GOAL 1
Leadership, Commitment, and Accountability

Sub-goal 1.1
Improve the efficiency and effectiveness of the JEC through an outcome-oriented joint strategic planning and monitoring process.

JEC Joint Strategic Planning Committee Working Group

The JEC expanded its role in providing strategic direction for VA/DoD collaboration in FY 2010. VA and DoD continued to dedicate permanent support staff from the *VA-DoD Collaboration Service* within the VA Office of the Assistant Secretary for Policy and Planning and the *Requirements & Strategic Integration* office within the Office of the Under Secretary of Defense (Personnel & Readiness) (USD(P&R)) to monitor coordination efforts. Working collaboratively, VA and DoD support staff helped establish JEC priorities, monitor performance, and improve accountability throughout the fiscal year.

In May 2010, the JEC began collecting quarterly performance status reports from its Sub-Councils and Independent Working Groups to track progress on every objective in the FY 2010-2012 JSP. The JSP Quarterly Status Report was provided to the JEC membership at each quarterly meeting to track progress on all strategic objectives, monitor potential risks, and identify additional actions required by the leadership. Efforts to improve the effectiveness of this tracking mechanism will continue in FY 2011.

The JEC remains committed to using quarterly meetings to make decisions and resolve issues. Meetings were held on December 4, 2009; March 30, 2010; June 11, 2010; and September 10, 2010. An example of this commitment evolved from the discussions at the March and June meetings, whereby both Departments agreed at the September 10, 2010 meeting to pursue a joint VA/DoD separation policy to address mandatory separation health assessments.

The JEC's priorities in FY 2010 included decisions regarding the evolution of the Virtual Lifetime Electronic Record (VLER), preparation for opening the James A. Lovell Federal Health Care Center (JALFHCC), continued development of the Transition Assistance Program (TAP), and improvement in availability and accessibility of VA benefits information through early communication with Service members.

In addition, on March 30, 2010, the JEC approved a new JSP Way Ahead timeline and management process, to include separately completing the FY 2011-2013 JSP and the FY 2010 AR. This change allowed additional time in FY 2010 to assess the existing strategic framework (mission, vision, goals) that had been in place since 2004, and enable new Department leadership to influence the strategic direction of the VA/DoD partnership from the top down.

The revised management process for the FY 2011-2013 JSP included an Environmental Scan to evaluate the atmosphere in which VA and DoD now operate. The Environmental Scan reviewed over 80 strategic documents and interviewed 17 senior officials from VA, DoD, and external agencies which share similar customers or functions. Eleven primary themes were identified which drove the innovative framework and strategic elements proposed for the next JSP. An off-site VA-DoD strategic planning meeting was held August 13, 2010 to determine the new mission, vision, and strategic goals. Final language for the strategic framework was ratified by the JEC on October 1, 2010. The Co-Chairs of the HEC, BEC, IPO, and Independent Working Groups were then able to begin developing new, more concise Sub-goals and Objectives based on the approved strategic framework.

The JEC continues to invite other Federal departments and agencies to meetings as appropriate. Representatives from the White House, Office of Management and Budget (OMB), and Department of Labor (DOL) attended in 2010 for awareness and information sharing.

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

VA/DoD JEC Communications Working Group
The Communications Working Group (CWG) is responsible for the coordination of legislative and public affairs activities between the Department of Defense and the Department of Veterans Affairs.

To achieve this, the CWG developed a Strategic Communications Working Group charter that was signed in October by both the Deputy Secretary of Veterans Affairs, W. Scott Gould, and the USD(P&R), Clifford L. Stanley. This charter provides clear and consistent guidance for communicating key JEC strategic messages through the VA and DoD's public affairs and congressional affairs offices, allowing the Departments to effectively communicate with stakeholders.

The CWG revisited the performance objective and determined that conducting a survey was not the best way to measure successful communications of strategic messages. Instead, the CWG believes that a more successful way to measure these communications is to track the frequency of coordination between the VA and DoD public and congressional affairs offices in planning strategy and response to shared issues. This coordination would include informed outreach and response to news media and issuance of coordinated press releases. Additionally, it would include joint briefings to members of Congress and their staff, joint congressional hearings on JEC strategic messages and coordinated congressional staff visits to joint sites/programs.

In support of this new measure, VA and DoD coordinated three press releases, conducted six briefings to congressional staff and members, participated in three joint hearings before congressional committees, and attended five congressional staff visits to joint Disability Evaluation System sites in the pilot program.

GOAL 2
HIGH QUALITY HEALTH CARE

Sub-goal 2.1
Increase patient safety resource sharing between VA and DoD.

Health Executive Council (HEC) Patient Safety Working Group

The VA/DoD HEC Patient Safety WG has continued to enhance the overall quality of care to Veterans and Service members through collaborative efforts in strengthening and coordinating safe patient care. In FY 2010, the WG focused on updating and developing a process to extend the life of previously developed Data Use Agreements (DUAs) versus initiating completely new DUAs on an annual basis. The DUAs allow the WG to share and analyze adverse event summary reports including patient falls, inpatient suicides, pressure ulcers, unintentionally retained surgical items and incorrect invasive procedures.

The WG expanded coordinated efforts to ensure alerts and advisories within the two Departments were shared in an organized and timely manner, thereby decreasing the risk factors that would potentially endanger Veterans and Service members. As a result, VA shared all Patient Safety and VA National Drug Safety alerts and advisories while DoD shared all Patient Safety alerts. This process has increased the opportunity to receive a more comprehensive list of alerts and advisories as they are published and released. Additionally, DoD has been provided the ability to review any VA alerts and advisories from previous years. Since the inception of this process, 100 percent of the alerts and advisories from each Department have been shared with the other Department. This process resulted in prompt awareness and resolution of several patient safety concerns to include bleeding during dialysis and high alert medication safety in the operating room which helps avoid selecting incorrect concentrations or an incorrect drug due to "look alike or sound alike" packaging.

In FY 2009, the coordinated efforts of sharing critical patient safety data were initiated. In FY 2010, these efforts transitioned from simply sharing to analyzing data for ensuring correct site surgery and retained surgical items through the use of established "codebooks" when evaluating presented cases with common themes. A close working relationship with VA/DoD Falls Collaborative teams that focus on fall prevention research, program development, and fall tool kits resulted in increased sharing of lessons learned between the WGs. Tool kits provide proactive strategies to reduce the frequency and severity of fall related incidents and provide a safe environment. These tool kits equip patient fall reduction champions with tactics to develop or refine their facility programs. The toolkits include customizable posters, brochures, video, assessment on CD, sample policies, case summaries, and tips/suggestions for success.

In January 2010, the Annual DoD/VA National Suicide Prevention Conference, "Building Strong and Resilient Communities," shared suicide prevention measures and data analysis between the two Departments. This information sharing included the use of VA root-cause analysis databases to identify common causes of suicide in Veterans and Active Duty Service members. The suicide prevention program provided emphasis on suicidal behaviors of Veterans in VA outpatient and inpatient care settings, whereas DoD typically reviews suicides that occur in the inpatient care setting only. In August 2010, VA and DoD patient safety groups convened at a

new Federal Health Care Facility (FHCC) demonstration project in North Chicago to evaluate the location and layout of the outpatient mental health (MH) department, which is located on the upper level of a rotunda type layout. This coordinated effort increased opportunities to intensify safety measures aimed in the prevention of potential suicide attempts.

The Veterans Health Administration (VHA) Medical Team Training and DoD TeamSTEPPS (team skills training) spoke with one voice at the VA National SimLEARN Leadership Conference. The shared breakout session demonstrated VHA and DoD commitment to improving patient outcomes, enhancing staff morale, and changing the culture of health care through teamwork and communication. During the two presentations, VHA and DoD shared best practices in team training. Both programs have incorporated simulation-based training into the curricula, and presented data demonstrating the effectiveness of simulation in teaching crew resource management teamwork and communication techniques.

Reviewing and sharing analytical tools utilized by the VA/DoD WGs continued to provide increased opportunities to evaluate and understand data usage within the two Departments. DoD WG members attended on-site visits to a local VA Medical Center (VAMC) to evaluate and review computer based programs used to report and analyze adverse events and near misses. Additionally, the process of sharing methods for using natural language processing for searching, discovering and analyzing reported events and data within the patient safety community opened opportunities to review events as they occur on a national level and develop action plans to decrease or eliminate the potential for recurrence. Increased collaboration within the WGs to actively include recent involvement of DoD at VA's Analytical Academy and VA Quality and Patient Safety Conferences increased opportunities for both Departments to share new information and technologies, thereby increasing methodologies VA and DoD utilize in data analysis.

Sub-goal 2.2
Lead the development of evidence-based clinical practice guidelines (CPGs).

HEC Evidence Based Practice Working Group

During FY 2010, the HEC Evidence Based Practice WG completed 100 percent of the annual target of four CPGs. Completed CPGs include asthma, bipolar disorder, chronic opioid management, and diabetes mellitus. Clinically diverse and collaborative expert groups representing VA and DoD executed each step of the CPG development process. CPGs were first disseminated to senior leaders for endorsement and then to health care team members who provide day-to-day care to our beneficiaries. CPGs are posted on the VA's Web site[2] and the Army's quality management Web site[3]. Dissemination of CPGs assist VA/DoD health care teams by providing evidence based recommendations which lead to improved quality of clinical decisions, improved consistency of care, and reduced variation in clinical practice.

Three of the four completed CPGs were submitted to the National Guideline Clearinghouse. Evidence based practice teams exhibited at 12 VA, DoD, and national medical conferences and

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[2] http://www.healthquality.va.gov
[3] https://www.QMO.amedd.army.mil/

provided formal podium presentations on a variety of CPGs at ten VA, DoD, and national educational conferences. These efforts educated thousands of VA and DoD health care team members about the availability of the 23 VA/DoD CPGs and the value of implementation. Marketing efforts also included providing information and education regarding ordering and shipping of tools directly to the medical facilities. The tools offer health teams valuable support materials which assist with CPG implementation and ultimately facilitate improved care delivery for patients and families across VA and DoD. Additional marketing efforts include the publication of articles regarding CPGs in professional journals. A recent article in the *Journal of the American Society of Nephrology*[4] partially attributes the VA/DoD chronic kidney disease CPG with the higher quality of care provided to end stage renal failure patients in VA and DoD as compared to the civilian sector.

The WG continued to collaborate with outside national professional organizations. Collaboration continued with the American Heart Association on the development of the stroke rehabilitation CPG and with the American Pain Society on the peri-operative pain CPG. This effort resulted in the ability to produce a greater number of CPGs while at the same time conserving valuable personnel and monetary resources.

During FY 2010, DoD received 118,024 CPG Internet requests. This 6.4 percent increase compared to FY 2009 shows a steady increase in CPG utilization across DoD. VA received 55,301 Internet requests during FY 2010, the first full year of production for the new VA Web site. The number of Internet requests is underestimated as individuals and organizations can access CPGs via other Web sites. Using the Google search engine, the VA/DoD CPGs are listed within the top five search results by clinical condition. Over 170 different CPG tools are available to medical facilities which provide health care teams with needed patient and provider support tools to assist with CPG implementation, thus providing optimal evidenced based care to VA and DoD beneficiaries. DoD had 949,565 CPG tools ordered from the Army's quality management Web site during FY 2010, an eight percent decrease from FY 2009. The decrease reflects Military Treatment Facilities (MTFs) increased utilization of print ready files available from the Quality Management Web site to print their own CPG tools as a cost avoidance measure, thus saving shipping costs.

Sub-goal 2.3
Actively engage in collaborative Health Professions Education (HPE).

HEC Health Professions Education Working Group

The HPE is committed to increasing shared training programs between the Departments by constantly improving collaborative efforts. The WG successfully established a new HPE trainee exchange program for Academic Year (AY) 2010-2011. The new program is based at the Hampton, Virginia VAMC and the Naval Medical Center (NMC) Portsmouth, Virginia. The WG also facilitated the establishment of a trainee exchange program between the South Texas Veterans Health Care System (STVHCS) and Wilford Hall Medical Center at Lackland Air Force

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[4] J Am Sco Nephrol 21: 1571-1577, 2010

Base (AFB) beginning in AY 2009-10 and continuing to the present. Trainee exchanges remain excellent vehicles for enhancing trainee experience.

Some of the major strengths of trainee exchanges include the following:

- Provides trainees' exposure to a variety of patient populations and clinical material not possible in a single institution. For example, civilian trainees see a younger patient population in DoD, while military trainees see an older population with a heavier chronic disease burden in VA facilities.
- Allows trainees to see the continuity of care from Active Duty service to Veteran status.
- Promotes trainee understanding of the capabilities of both health care systems.
- Promotes trainee understanding of the differing cultural aspects of VA and DoD.

The HPE WG also assessed challenges and barriers to successful cooperation. The WG is pleased to report that the Graduate Medical Education programs of the National Capital Consortium have not been impacted by the Base Realignment and Closure Act. In addition, a sub-working group met to begin work on a standard template for VA/DoD Training Affiliation Agreements. Once complete, this agreement will facilitate trainee exchanges in future FYs.

Sub-goal 2.4
Expand the number of continuing education and in-service training programs shared between VHA and DoD.

HEC Continuing Education and Training Working Group

In FY 2010, the Continuing Education and Training WG achieved a cost avoidance for VHA and DoD of $16,175,666, which exceeded the FY 2010 performance target of $11,076,753 by 46 percent. This cost avoidance was generated through the sharing of 513 continuing education or in-service training programs between VHA and DoD. This success resulted in more training opportunities which would not have been available without the sharing effort.

The pilot project to validate the existence of overlapping training, establish a process for identifying and verifying specific overlapping courses, and develop a strategy for reducing the overlap in mandatory training between VHA and DoD, was completed in FY 2010 and generated excellent results. This pilot project is a necessary precursor to reducing overlapping training between VHA and DoD. The pilot project showed that a significant reduction in overlapping training can be achieved by granting reciprocity for courses identified by subject matter experts (SMEs) credible to the Military Departments and VHA.

In FY 2010, the WG's significant achievements included the sharing of: 91 Web-based leadership and management modules of instruction from DoD to VHA; 27 Web-based fire fighter training courses from the Air Force Institute for Advanced Distributed Learning to VHA; 21 case management training programs between VHA and DoD; 19 hours of compensation and pension training from VHA to DoD; 40 hours of Web-based compliance training in VHA and DoD; and the sharing of the VHA suicide prevention training for clinicians program with DoD. VHA, as the managing partner of the Federal Clinical Shared Training Consortia, also arranged to have access to 206 open source training programs made available to DoD by the Federal agencies which are a

part of the consortia. This sharing effort gave VHA staff access to 118 additional programs of instruction, valued at $4,130,000, and gave DoD staff access to an additional 287 training programs, valued at $10,045,000, that would not have otherwise been available to meet organizational training needs.

In addition, the WG implemented a robust virtual Grand Rounds training program focused on the health issues of returning Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) forces. The training program generated two to four episodes each month of training focused on high priority clinical topics (e.g., suicide prevention, post traumatic stress disorder (PTSD), integrated care of pain, traumatic brain injury (TBI), cognitive rehabilitation, and mild TBI (mTBI) and its related syndromes such as severe cognitive impairment, sleep disorders, etc. This program provided state of the art training to VHA and DoD clinicians caring for returning military personnel on the signature injuries and wounds incurred by returning OEF/OIF/OND forces. Qualitative data from the field indicates that these programs are highly valued by VHA and DoD clinical staff.

The WG continued facilitation and enhancement of the VA/DoD Facility Based Educators community of practice to increase shared training initiatives between VA health care facilities and DoD MTFs. Finally, the WG facilitated the implementation of a DoD Content on Demand capability in Military Health System (MHS) Learn Portal by providing training programs to DoD that can be deployed in this modality.

Sub-goal 2.5
Design, develop and deploy a continuing education training program.

HEC Continuing Education and Training Working Group

The curriculum development and deployment project executed to support the operations of the North Chicago FHCC demonstration project was successful, with 100 percent of the continuing education and in-service training curriculum developed and deployed. All staff of the FHCC available to participate in training was provided access to this training in FY 2010 and will continue to be provided with training in FY 2011 and beyond. The review of the refined and newly developed modules of instruction were found by VHA and DoD leadership to be appropriate and well designed in content and modality to meet the training needs of the integrated staff at the FHCC. The training program allowed the staff to learn how to effectively operate in the unique VA/DoD integrated facility setting. Efforts are on track to deploy these training modules to 60 percent of VA/DoD joint venture sites in FY 2011 as proposed, modifying the modules to meet each joint venture's specific need.

Other accomplishments in support of this Sub-goal resulted in the development of a refined and validated curriculum for meeting the training needs of staff at integrated or joint venture sites and the validation of a process for curriculum design, development and deployment of training to staff at integrated or joint venture sites. The curriculum utilizes existing VA and DoD Learning Management System (LMS) architecture. The WG also developed and refined a methodological model for collecting and transmitting training participant data between VA and the Military Departments. The WG also implemented special training initiatives for selected high priority clients, including: the Walter Reed Virtual Grand Rounds Program in the area of TBI; deployment

of the VHA weight management program (MOVE!) to Army; case management training for VHA and Military Department personnel; and management of the collaborative development and deployment of pharmacy technician training in VHA and DoD.

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.

HEC Continuing Education and Training Working Group and HEC Deployment Health Working Group

The VA/DoD Deployment Health WG (DHWG) was established to ensure coordination and collaboration between the Departments to maintain, protect, and preserve the health of Armed Forces personnel. The DHWG focuses on the health of Active Duty and Reserve members and Veterans, during and after combat operations and other deployments. The primary emphasis is on Service members returning from OEF/OIF/OND. In addition, the DHWG coordinates initiatives related to Veterans of all eras, going back to the 1940s. The DHWG shares health surveillance information, tracks research initiatives related to deployment health, and collaborates on health risk communication.

Health Surveillance and Follow-up Care of Military and Veteran Populations In FY 2010, the DHWG coordinated extensive sharing of information between VA and DoD on health surveillance, assessment, and follow-up care of military and Veteran populations. The DHWG reviewed efforts on the DoD identification of Veterans 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 Veterans; and VA's outreach efforts to these Veterans via notification letters. DoD continued to investigate and compile databases on three cohorts: Mustard/Lewisite, Project 112/Shipboard Hazard and Defense, and the Chemical/Biological Follow-on Database. As of September 2010, there were 4,618 Veterans named in the Mustard/Lewisite database, 6,440 Veterans in the Project 112 database, and 16,645 Veterans in the Chemical/Biological database. In FY 2010, DoD identified and added 3,610 new names to the databases and provided them to the VA. VA performed targeted outreach to the three cohorts, sending notification letters to Veterans regarding participation in the tests and about the availability of VA medical care and benefits. As of September 2010, the Veterans Benefits Administration (VBA) had mailed more than 8,200 letters to the Veterans named in the three cohorts.

In FY 2010, the DHWG coordinated 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 activities. The DHWG coordinated VA and DoD responses to environmental and occupational exposure incidents during nearly every monthly meeting. The DHWG initiated sharing of DoD information with VA on 24 documented environmental exposure incidents in OEF and OIF. The DHWG invited scientists from the U.S. Army Center for Health Promotion and Preventive Medicine 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 facilitated closer collaboration between VA and DoD scientists by organizing a full-day workshop in November 2009 on the VA and DoD responses to the four largest environmental exposure incidents in Iraq. This workshop also considered the potential health effects of exposure to incinerator emissions at the Naval Air Facility in Atsugi, Japan, which could impact the health of 5,600 U.S. Service members and 11,000 family members who lived there.

The DHWG also organized several other meetings in FY 2010 to coordinate VA and DoD responses to four specific environmental exposures in Iraq, Afghanistan, and the U.S.:

- Potential health effects of exposure to burn pit smoke in OEF/OIF/OND;
- Potential health effects of high concentrations of particulate matter in OEF/OIF/OND;
- Potential health effects of chromate exposure at Qarmat Ali, Iraq in 2003; and
- Potential health effects of contaminated drinking water at Camp Lejeune, North Carolina.

Exposure to smoke from the burn pits in OEF/OIF/OND could potentially impact tens of thousands of deployed Service members. In early 2010, VA funded an Institute of Medicine (IOM) study, entitled "IOM Committee on Long Term Consequences of Exposures to Burn Pits in Iraq and Afghanistan." DoD had already provided considerable health and environmental data to IOM for this study. In 2010, DoD completed a major research study, entitled "Epidemiological Studies of Health Outcomes Among Troops Deployed to Burn Pit Sites," on the potential long-term health effects of exposure to burn pit smoke. Overall, this report offers reassurance that the health of personnel deployed in a location with a burn pit appears to be better or about the same as the health of personnel who had deployed to an area without a burn pit or personnel who had never deployed, for the health conditions and deployment locations studied.

In FY 2010, the DHWG continued to monitor the progress of the Millennium Cohort Study (MCS), including newly-published deployment health studies. VA and DoD have collaborated on the MCS since its inception. 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 have 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. About 30 percent of the cohort has already separated from the military. In 2010, the Project Director of the MCS provided a detailed progress report to the DHWG. MCS researchers recently published articles on the following topics: planning for the long-term follow-up of the cohort; mortality in the cohort in 2001-2006; new-onset depression after combat deployment; new-onset diabetes after combat deployment; and new-onset respiratory conditions after combat deployment.

VA and DoD Collaborations on Medical Research VA and DoD collaborated on many diverse research initiatives in FY 2010. VA and DoD identified several high priority medical research areas that are shared. These high priority areas include: PTSD and other psychological conditions, TBI, multidisciplinary treatment of polytrauma, pain management, rehabilitation, prosthetics, and the health effects of deployments. VA and DoD have been responsible for

major breakthroughs in many areas, such as improved prosthetics for amputations, improved treatments for psychological disorders, and joint VA/DoD education programs to improve the treatment options of VA and DoD behavioral health providers.

DoD currently provides a substantial portion of the collaborative research funding, from all sources, that supports VA scientists. In the past year, DoD provided more than $30.5 million to VA researchers for 351 projects. DoD currently funds VA scientists to investigate several high-priority topics, including: PTSD, alcohol abuse, resilience to mitigate combat stress and post-deployment reintegration problems, MH of female Veterans including military sexual assault, treatment of TBI and spinal cord injuries, treatment for amputations and improved prosthetics, visual and hearing impairments, rehabilitation, telemedicine, and illnesses in Veterans of the 1990-91 Gulf War and Veterans of OEF/OIF/OND.

Individual VA and DoD scientists worked together on diverse research projects, including:

- Innovative service delivery for secondary prevention of PTSD in at-risk Service members from OEF/OIF/OND;
- The use of Propranolol to block memory reconsolidation in PTSD;
- Prospective study of the psychological, social and biological markers of risk and resilience for operation stress in Marines;
- mTBI following exposure to explosive devices: device characteristics; neuropsychological functioning, and symptoms of PTSD; and
- Effects of deployment to Iraq on psychological health of Veterans after returning home.

VA and DoD collaborated on the planning and evaluation of major research programs. For example, in July 2010, DoD invited senior VA research managers to participate in a day-long program evaluation of the progress on hundreds of DoD-funded projects on PTSD, suicide, and other psychological conditions. More than 90 percent of these projects were performed by scientists who worked for VA or universities.

VA and DoD Research Related to Deployment Health In FY 2010, the DHWG tracked research initiatives related to deployment health to improve sharing of health information, and to inform VA and DoD decision makers about the military and Veteran relevance of the research. The DHWG conducted an annual inventory of current research projects on deployment health that were funded by DoD, VA, and the Department of Health and Human Services (HHS). Additionally, the DHWG developed an analysis of the ongoing research. DHWG members worked with the centralized research offices in VA and HHS and with 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. In 2010, the DHWG developed an inventory of 1,145 VA and DoD research projects related to the health of deployed Service members and Veterans. DHWG members completed a comprehensive inventory for FY 2008 (the last year for which complete project data were available in 2010). The majority of projects focused on injuries or MH. Injury research included traumatic brain and spinal cord, musculoskeletal, and other types of injuries. Other research areas included infectious diseases, environmental and occupational exposures, vision and hearing injury (or loss), and pain management. Data collection has started on research projects funded in FY 2009. Descriptions

of the projects are published in a user-friendly format on the DoD Force Health Protection and Readiness Web site.[5]

VA and DoD Health Risk Communication Related to Deployment Health In FY 2010, the DHWG identified several emerging health concerns related to deployment health, and planned VA and DoD responses to these concerns during monthly meetings. For example, the DHWG facilitated DoD coordination and revisions of a 25-page VBA training letter, entitled "Environmental Hazards in Iraq, Afghanistan, and Other Military Installations." The purpose of the letter was to educate VBA staff nationwide, who process disability claims related to the health effects of environmental exposures. The letter included descriptions of four environmental exposures in Iraq and Afghanistan, potential exposure to incinerator emissions in Atsugi, Japan, and drinking water contamination at Camp Lejeune, North Carolina. The DHWG coordinated DoD/VA communication on each of these six emerging health concerns.

In FY 2010, the DHWG coordinated risk communication products to improve the sharing of information on the health of Service members and Veterans and to ensure consistency between VA and DoD. The DHWG coordinated outreach efforts to Active Duty personnel and Veterans on several environmental exposures. For example, DHWG members provided DoD coordination and revisions of a 95-page VA report, entitled "Draft Report of the Department of Veterans Affairs Gulf War Veterans' Illnesses Task Force to the Secretary of Veterans Affairs." This report included many recommendations to VA and DoD related to Veterans of the 1990-91 Gulf War and OIF, including efforts on environmental exposures, health surveillance, medical research, and improved outreach to Veterans. In 2010, VA started working with the Marine Corps to develop data that VA could use to contact former Marines who were stationed at Camp Lejeune and could have been exposed to contaminated drinking water in the 1950s to 1980s. The DHWG facilitated VA efforts related to Camp Lejeune, including discussing the VA and HHS plans to respond to recommendations in a 2009 National Academy of Sciences report entitled "Contaminated Water Supplies at Camp Lejeune: Assessing Potential Health Effects." The DHWG also facilitated VA and DoD coordination of a joint medical surveillance program and a joint VA/DoD letter and fact sheet to members of the National Guard and Army Corps of Engineers, who were at Qarmat Ali, Iraq in 2003, and who had potential exposure to sodium dichromate.

Sub-goal 2.7
Leverage VA/DoD multi-disciplinary subject matter experts to address conditions related to PH/TBI.

HEC Psychological Health/Traumatic Brain Injury Working Group

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

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[5] http://fhp.osd.mil/

Sub-goal 2.8
Improve and utilize VA/DoD population specific knowledge of suicide risk and prevention practices.

HEC Psychological Health/Traumatic Brain Injury Working Group

VA and DoD continued to participate in ongoing meetings of the Suicide Prevention and Risk Reduction Committee (SPARRC) to discuss effective mechanisms to share resources, develop programs, and monitor outcomes related to suicide prevention across the two Departments. The SPARRC is chaired by a staff member from the Defense Centers of Excellence and includes participation from each of the Military Departments, VA, and other entities including HHS.

In FY 2010, the Suicide Nomenclature and Data (SND) WG of the PH/TBI WG was established and will hold its first meeting at the beginning of FY 2011. The SND WG recommended adoption of the Center for Disease Control and Prevention's self-injury nomenclature system. VA and DoD approved the recommendation. VA began implementation of the system. DoD will incorporate the recommendation into the forthcoming DoD Instruction (DoDI), "Suicide Prevention, Data Collection, and Reporting."

In January 2010, the VA/DoD suicide prevention conference was attended by over 950 participants. Individual evaluations from the 2010 conference were overwhelmingly positive and indicated that participants gained new clinical and research knowledge and were satisfied with the conference offerings. The planning committee for the March 2011 conference has been formed and is in the process of developing the conference agenda. Ongoing "live meetings" have been held with National Guard suicide prevention staff, Substance Abuse and Mental Health Services Administration (SAMHSA), and VA suicide prevention coordinators to develop multifaceted strategies to reduce suicide.

The Federal Partners Work Group on Suicide Prevention held four networking meetings to discuss work that is being done in the areas of identification and response to suicide clusters and the issue of contagion. VA will develop a strategy in FY 2011 concerning these issues. Public messaging continued to be a topic of interest and concern and will be a major focus of VA/DoD conferences in FY 2011.

Suicide risk training initiatives were put into place at the national level. VA and SAMHSA developed a Treatment Improvement Protocol (TIP50), a suicide risk training program for clinicians who work with patients with substance use disorders; VA's program began in July 2010. Both VA and DoD are prime supporters of the SAMHSA sponsored Action Alliance. This is a public-private collaboration developed to implement the National Strategy for Suicide Prevention.

The DoD/VA Suicide Outreach Web site[6] was developed and launched in FY 2010. It is a SPARCC site that provides resources for suicide prevention across the Military Departments and VA. Also, suicide prevention Web-based training for clinicians caring for women is in the accreditation stage and will be available online within VA in early FY 2011.

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[6] http://www.suicideoutreach.org/

The VA Suicide Hotline expanded its initial message heard by callers to include Active Duty Service members. The Military Departments marketed the VA hotline on communication materials, and call transfers are taking place on a regular basis. Ongoing discussions are being held among VA, the Defense Center of Excellence (DCoE) Call Center, and Military OneSource to develop protocols for transferring calls as appropriate to and from the VA Hotline. There is a Memorandum of Understanding (MOU) in process with VA and the DCoE Call Center to formalize the existing collaboration between the Veterans Suicide Hotline and the DCoE Call Center for warm transfer of crisis calls.

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.

HEC Psychological Health/Traumatic Brain Injury Working Group

Ongoing work to develop consistent standards across VA and DoD for training in Evidence Based Psychotherapy (EBP) for PH conditions is in progress. In response to an Integrated Mental Health Strategy (IMHS) strategic action, VA and DoD will increase the availability of effective psychological treatments for PTSD, major depression, and other psychological health conditions.

In FY 2010, VA trained 1,273 MH clinicians to provide EBP, using such approaches as cognitive processing therapy, prolonged exposure therapy, acceptance and commitment therapy, and integrative behavioral couple's therapy. In addition, the EBP training programs trained 36 VHA Vet Center clinicians and another 307 non-VA (mainly DoD, as well as community MH) clinicians.

In FY 2010, DoD trained 1,217 MH clinicians to provide EBP, using such approaches as cognitive processing therapy and prolonged exposure therapy. In addition, EBP training programs were facilitated by the Army Medical Department (AMEDD) Center and School and the Military Departments to provide training to additional personnel.

Joint VA/DoD training in TBI care is primarily coordinated through the Defense and Veterans Brain Injury Center national network. The fourth Annual Military TBI Training Conference was held in August 2010, and approximately 933 providers from VA and DoD received training in the care of patients with TBI. Furthermore, providers from VA and DoD received training on policy guidance for management of concussion or mTBI in the deployed setting.

Staff from VA and DoD developed a joint, year-long training initiative to educate providers on the VA/DoD CPG: "Management of Concussion-mTBI in the Deployed Setting". Training consists of a review of management algorithms in the context of a clinical case example. As a result of the shared training, Service members and Veterans will receive a more standardized approach to health care delivery that facilitates accurate reporting and documentation of the exposure event and possible resultant injury. The expected outcome is early identification and timely treatment of concussion within the deployed setting and monitoring of these Service members to prevent

the potential physical sequelae of recurrent concussion. The training is available for continuing education credit on the DoD MHS Learn system and VA's LMS.

Sub-goal 2.10
Improve transition of care for Service members and Veterans affected by TBI and/or PH conditions.

HEC Psychological Health/Traumatic Brain Injury Working Group

The *inTransition* program, launched on February 1, 2010, offers a program to assist Service members requiring behavioral health treatment and experiencing a transition in health care systems, status or location. *inTransition*'s mission is to support continuity of care for the Service member during transition. A transition support coach provides support and guidance on healthy living, while motivating the Service member to connect with a treatment provider post-transition. The coach also assists the Service member with connecting to their gaining provider.

In FY 2010, DoD trained 22 registered OEF and OIF case managers on the requirements of the program. The number of trained individuals is increased via training that was offered to non-registered users through webinars, online tools and briefings. Meetings were also held with VA and DoD MH representatives to discuss the requirements necessary to implement the program across VA.

The *inTransition* program was initiated and developed within the Office of the Assistant Secretary of Defense, Health Affairs, Force Health Protection & Readiness. On April 28, 2010, the leadership and execution of the *inTransition* program was transferred to DCoE, Clearinghouse, Outreach and Advocacy Directorate. The *inTransition* program information was provided to VA staff members during the second half of FY 2010. Veterans Integrated Service Network (VISN) Directors, Chief Medical Officers, Chiefs of Staff, OEF/OIF case managers at the VISN and VAMC levels, and VA's Readjustment Counseling Service were informed of the program and trained via interactive conference calls and webinars.

Between the launch of the *inTransition* program on February 1, 2010 and September 30, 2010, 221 Service members out of 236 who qualified for the program accepted services. Of those Service members who accepted services, there have been 185 open coaching cases, 111 of which have been closed. Coaching cases are those that have been assigned a coach and are receiving coaching services. A coaching case is considered closed when the Service member has transferred successfully and has met or made an appointment with the new (gaining) provider, or when a coach attempts to contact a gaining provider three times without success. Thirty-one Service members with closed cases kept an appointment with the gaining provider; two did not keep appointments, and the status of follow-up for the other Service members with closed cases remains under review.

The DoD transition of care policy, "Continuity of Mental Health Care and Transfer of Records for those Transitioning from one Location to Another," was revised based on feedback received from the Military Departments. The transition of care policy is currently being converted to a DoDI. Once finalized, it will be rolled out throughout DoD.

The Assisted Living TBI (ALTBI) Pilot Program is designed to assess the effectiveness of providing assisted living services to Veterans with TBI. In February 2010, the program was approved for continuation in FY 2010. As of September 2010, VA enrolled 18 patients in the ALTBI program. In November 2009, VA established program metrics to rate the level of patient satisfaction throughout the duration of a patient's enrollment in the program. Satisfaction with the program and program effectiveness are being monitored for each patient on an ongoing basis. VA will produce a final report at the end of the program, scheduled for 2014. In FY 2010, a data management team was created for the ALTBI Pilot Program to collate and analyze collected data, which will be included in the final report.

Sub-goal 2.11
Improve TBI and/or PH screening and identification of Service members and Veterans.

HEC Psychological Health/Traumatic Brain Injury Working Group

In FY 2010, DoD developed supplemental questions used to screen for PH problems in the Pre-Deployment Health Assessment (PDHA) and Post Deployment Health Reassessment (PDHRA) screening instruments. Service members will receive a mental health assessment within two months before the estimated date of the deployment, between 3-6 months after return from deployment, and between 7-12 and 16-24 months after return from deployment. The Military Departments received policy guidance to implement revised deployment MH assessment questions and procedures. The intended outcome of the prospective mental health assessments is to improve identification of mental health conditions including PTSD, suicidal ideology and behaviors, other behavioral health conditions, and to ensure that Service members who screen positive will be referred for mental health treatment. This guidance complies with the FY 2010 National Defense Authorization Act (NDAA), Section 708.

In previous years, VA and DoD collaborated on efforts to improve TBI screening by developing four TBI screening questions for both the PDHA and PDHRA screening instruments. As part of an annual program review, DoD is reviewing the current TBI questions and updating TBI metrics.

VA and DoD developed and proposed the TBI code revision proposal with the National Center for Health Statistics, which resulted in approval of the revised International Classification of Diseases, 9th Edition (ICD-9) codes. ICD-9-Clincal Modification code revisions, which include two new TBI-specific screening codes, were released in October 2009, and were integrated into Armed Forces Health Longitudinal Technology Application (AHLTA), DoD's Electronic Health Record (EHR), and the Veterans Health Information Systems and Technology Architecture (VistA), in February 2010.

Sub-goal 2.12
Reduce stigma of seeking care for TBI and/or PH conditions in Service member and Veteran populations.

HEC Psychological Health/Traumatic Brain Injury Working Group

DoD continued to implement and expand DCoE's Real Warriors Campaign, which is a multimedia stigma reduction resource for Service members, Veterans, and their families. As

part of the campaign, DCoE continued to distribute Public Service Announcements, host message boards, and post new Web articles on its award-winning Web site[7]. Since its launch, the campaign has received over 20 awards of various types, distributed 140,000 marketing and educational items to more than 220 military installations, and partnered with more than 100 external organizations. The Real Warriors Campaign saw a significant increase in Web site traffic in January 2010, when a Staff Sergeant appeared on a major news network to promote the campaign. Future IMHS efforts will address specific mechanisms to develop and implement coordination of anti-stigma efforts across the two Departments.

VA and DoD continued to provide Web-based public information designed to promote positive cultural associations with MH treatment and care as well as disseminate information about anonymous MH resources to Service members, Veterans, and their family members. In FY 2010, there were 71,913 visitors to the Real Warriors Web site, 53,410 visitors to the After Deployment[8] Web site, and 178,635 visitors to the Military Pathways[9] Web site.

Integrated Mental Health Strategy Early in 2010, the Wounded Ill and Injured Senior Oversight Committee (SOC), chaired by the VA and DoD Deputy Secretaries, directed the development of a joint VA/DoD strategy to address the range of MH needs in Service members, Veterans and their families that have emerged in the wake of long running contingency operations in Afghanistan and Iraq. The resulting VA/DoD IMHS, defined by four strategic goals under which fall 28 actions, derives from joint activities of VA and DoD SMEs in recent years and the 2009 VA/DoD Mental Health summit. Once the IMHS was approved by the SOC in May 2010, the PH/TBI WG assumed responsibility for elaboration of implementation plans associated with each of the 28 strategic actions and will have oversight of the execution of the IMHS once it is approved for implementation by the HEC. The strategic goals of the IMHS are:

1. Expanding access to behavioral health care in VA and DoD
2. Ensuring quality and continuity of care across the Departments for Service members, Veterans, and their families
3. Advancing care through community partnership, education, and successful public communication
4. Promoting resilience and building better behavioral health care systems for tomorrow

Implementation plans and cost estimates for the 28 strategic actions were developed and approved by the IMHS Co-Chairs.

Sub-goal 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

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[7] http://www.realwarriors.net
[8] http://www.afterdeployment.org
[9] http://www.militarypathways.org

The Vision Center of Excellence (VCE) was established for the prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries. The VCE receives operational support from the Navy within DoD, and from the Office of Patient Care Services within VA. A VA and DoD MOU was signed in September 2009 to establish the collaborative support between VA and DoD. The VCE is jointly staffed, and the leadership team includes the Executive Director (DoD), Deputy Director (VA), Chief of Staff (VA), and Executive Officer (DoD).

The VCE is established as a virtual and distributed organization for VA and DoD, with the headquarters located in the National Capital Region. A 2009 Congressional military construction project was provided to establish the headquarters in Bethesda, which is on target for completion by fourth quarter FY 2011.

During FY 2010, the VCE directed its efforts toward a number of significant activities to enhance the quality of health care to patients, to include:

- The VCE developed the Defense and Veterans Eye Injury and Vision Registry (DVEIVR) functional requirements to track eye injuries and to facilitate the work of the VCE in its focus areas of readiness, health care delivery, and research. The DVEIVR will be the first to combine VA and DoD clinical information into a single data repository for tracking patients and assessing longitudinal outcomes. The Vision Registry Pilot will begin development in FY 2011 with a March 2012 target for pilot completion.
- Concurrently, the VCE implemented the Ocular Trauma Module (OTM) in coordination with the Joint Theater Trauma Registry (JTTR) to provide information on Service members with ocular injuries. The OTM is undergoing developmental testing and will be deployed in FY 2011. The OTM will assist in establishing continuity of care for Service members at point of injury on the battlefield, a capability that does not currently exist, and one that will greatly improve standard of care through data driven performance improvement.
- The VCE is leading a joint team of SMEs from VA and DoD to develop standardized eye care assessment templates and clinical guidance for the management and rehabilitation of vision dysfunction. These standardized assessment templates can assist in developing a common standard of care across the DoD and VA continuum of care.
- The VCE supported the National Intrepid Center of Excellence (NICoE), providing information and guidance for the NICoE to develop a comprehensive visual system assessment protocol for the program.
- The VCE supported a number of education and training initiatives for VA and DoD health care providers to enhance clinical competency and promote synergy with the private, public and academic sectors. The VCE co-hosted a conference on the sensory consequences of TBI for over 700 clinical personnel from VA and DoD.
- The VCE Executive Director coordinated with the DoD Telemedicine and Advanced Technology Research Center (TATRC) to announce $10 million in grant awards from its vision research program to support vision research in the military medical community.

Ongoing efforts being conducted by the VCE include:

- Assisting the Warrior Transition Units within DoD with identification of Service members with visual dysfunctions in order to support rehabilitation and reintegration of Service members and Veterans returning to duty or reentering the community.

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- Collaboration and integration with other DCoEs for clinical care and research to better leverage capabilities, and affect a more holistic approach to patient centered care.
- Establishing a communications network between DoD military treatment facilities and VA medical centers in the National Capital Region for vision and blind rehabilitation services, and developing strategies for better coordination of vision and blind rehabilitation and restoration services across the DoD and VA.
- Working with the Military Combat Eye Protection Program toward improving eye protection and mitigating traumatic eye and visual system injuries.

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.

HEC Centers of Excellence

The Hearing Center of Excellence (HCE) continued to work toward achieving initial operating capability (IOC). The HCE was established with the Air Force as the Lead Component. An interim director for the HCE was appointed, a working group of SMEs representing each Military Department and the VA was established, and a Concept of Operations (CONOPS) was developed and coordinated through the Air Force leadership. The HCE CONOPS, facility planning and staffing documents, implementation plan for the registry, and proposed budget are pending approval by DoD, before forwarding to VA for review and comment.

During FY 2010, the HCE accomplished the following actions:

- The HCE advised the NICoE in developing the audiovestibular diagnostic capability, patient flow, and resource sharing for that center to evaluate and plan for the care of patients with TBI.
- The HCE reviewed information technology (IT) systems and solutions within VA, DoD, and industry related to the management and flow of audiologic information and has taken preliminary steps to provide a functional network for bidirectional data flow between the agencies.
- The HCE reviewed and provided recommendations to the Joint Theater Trauma System (JTTS) with regard to the triage, initial care, and air evacuation management of OEF/OIF patients. The HCE also worked with the JTTS and Registry teams to develop a pilot module to collect auditory system injury data from OEF/OIF/OND.
- The HCE developed draft Joint Hearing Loss and Auditory System Injury Registry functional requirements to identify, capture and longitudinally manage auditory injury data.
- The HCE initiated a centralized Digital Information Assurance Certification and Accreditation process for software that the MHS will use to capture computable audiograms for the bidirectional exchange of clinical data with VA to ease the transition and provide continuity for patients between Departments.
- The HCE assessed DoD gaps and resources related to acoustic research in an effort to coordinate and link research efforts across the HCE network, and prioritize acoustic research efforts through the TATRC.

- The HCE identified functional VA and DoD models of centralized Institutional Review Boards (IRB) and initiated Centers of Excellence (CoE) group discussion and efforts to explore and establish an integrated central IRB for the congressionally mandated CoEs.
- The HCE identified means to study blast effect on the microscopic anatomic, cellular and molecular mechanisms and pathways of the human inner ear and has established a process with premier academic centers to accomplish this goal. The HCE has outreach relationships with a consortium of VA, DoD, academic and industry entities to encourage and facilitate the conduct of research and the development of best practices and clinical education on hearing loss and auditory system injury incurred by members of the Armed Forces.

The HCE continued to establish its operation, while concurrently pursuing solutions that will change the paradigm of uncoordinated research efforts and isolated delivery of care. Establishing the Registry and clinical electronic network and resourcing the spoke sites for the HCE will facilitate and encourage joint collaborations for prevention, health care, and research, to improve outcomes for Service members and Veterans with hearing loss and auditory disorders.

Sub-goal 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

VA and DoD completed a number of significant actions during FY 2010 toward establishing the Traumatic Extremity Injuries and Amputations Center of Excellence (EACE).

The EACE continues to work toward achieving IOC. The EACE was established with the Army as the Lead Component. An interim director for the EACE was appointed, and a CONOPS was developed and coordinated through the Army leadership. The EACE CONOPS, facility planning and staffing documents, and proposed budget are pending approval.

The MOU for the "Establishment of the Traumatic Extremity Injuries and Amputations Center of Excellence" was approved and completed the establishment of the EACE. During FY 2010, the DoD/VA Extremity Trauma and Amputation WG accomplished a number of significant efforts to enhance the quality of health care to patients, including:

- Funding for the EACE was approved for FY 2011 and the FY 2012-FY 2016 Program Objective Memorandum, which allowed for the establishment of the program.
- Released *Textbooks of Military Medicine: Care of the Combat Amputee*, co-edited by VA and DoD personnel. This was the culmination of over four years of work by VA and DoD leaders in extremity trauma and amputee patient care.
- Chartered the Hand Transplant Advisory Board by the U.S. Army Surgeon General, consisting of 21 members from both VA and DoD. This Board provides information and consultation to wounded warriors who are considering hand transplantation surgery.
- Established the Major Extremity Trauma Research Consortium (METRC). This long term clinical research consortium consists of four MTFs and more than 30 of the busiest trauma

centers in the U.S.. The METRC aims to address and solve the most critical clinical knowledge gaps, including: treatment and prevention of infections related to open lower extremity injuries; optimal stabilization of severely comminuted open fractures; monitoring and prevention of acute compartment syndrome in extremity injuries; and determination of bone graft versus bone morphogenetic protein in segmental loss of open tibia fractures.

- Completed and initiated an Internet-based consolidated trauma database, the Military Orthopedic Trauma Registry (MOTR).
- Distributed *The Next Step: The Rehabilitation Journey After Limb Amputation*, a jointly-written 101-page patient education book augmenting the previously published DoD/VA CPGs for Lower Extremity Amputation.
- Completed research on the development of the Comprehensive High-level Activity Mobility Predictor (CHAMP) test, which was instituted in September 2010 as a functional outcomes measure with DoD for amputation patients. This test was recently presented at a joint British, French, Dutch, Canadian, and U.S. meeting for treatment of extremity trauma and amputations. All nation representatives supported the use of the CHAMP as a common tool to measure progress and treatment outcomes. The results of once monthly testing will be utilized by the patient and multidisciplinary teams to focus rehabilitation and demonstrate progress. The results will also permit the above mentioned nations to compare outcomes to develop best practices.
- Continued close VA/DoD collaboration in meeting the responsibility to perform basic, translational and clinical research to develop scientific information within this population. Collaborative clinical assessment of upper extremity prosthetic components was provided in support of the Defense Advanced Research Projects Agency (DARPA) Revolutionizing Prosthetics Program, including efforts at one DoD and three VA sites aimed at optimization of the DEKA arm, a robotic arm intended to restore functionality for individuals with upper extremity amputations. Additionally, VA and DoD have jointly begun to provide patients with the Genium/X2 knee prosthetic device. This device is a culmination of five years of research and has advanced the capabilities of above knee amputees.

GOAL 3
Seamless Coordination of Benefits

Sub-goal 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

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

Both Departments began developing a strong communication plan to encourage participation in the program. VBA provided DoD with 350,000 BDD and Quick Start brochures (total of 700K) to be distributed to Service members (including National Guard and Reserves at demobilization/deactivating sites). Additionally, VBA produced a Pre-discharge video as part of the American Veteran Series. This video is currently on the VA Web site and will be shared with DoD for use in its media outlets. The DoD posted information on BDD and Quick Start on its Web sites, to include Turbo TAP and the TAP Facebook social media site. The USD(P&R) issued a Memorandum to the Secretaries of the Military Departments, Chairman of the Joint Chiefs of Staff, Under Secretaries, and Assistant Secretaries of Defense asking them to endorse the Memorandum down through all levels of the Secretariats, Commands and to the Chiefs of the Reserve Components to ensure that BDD and Quick Start programs acquire the visibility and support required. As part of the TAP, both BDD and Quick Start are briefed to separating/retiring Service members.

As a result of these efforts, for BDD intake sites with a MOU in place, in FY 2010 a total of 54,733 claims were received. Out of these claims, 30,057 were Pre-discharge claims (55 percent). For these Pre-discharge claims, 14,377 were BDD claims (26 percent) and 15,680 were Quick Start claims (29 percent). Additionally, there were 6,148 claims from National Guard and Reserve members, with 1,095 being BDD (18 percent) and 5,053 Quick Start (82 percent). Additional BDD intake sites will be added in FY 2011. To further increase participation in these programs, efforts are also underway to expand the intake sites to those facilities where the Integrated Disability Evaluation System (IDES) is available. This will enable the program to reach the goal of 65 percent participation by the end of FY 2012; however, this may depend on the BDD expansion and the Services' support to get Service members to file claims under the BDD guidelines.

Sub-goal 3.2
Jointly refine and expand an improved DES process to new locations, as directed.

BEC Disability Evaluation System Working Group (Disability Advisory Council)

The DES WG provides quarterly briefings to the BEC and the JEC. During FY 2009, the Pilot process expanded to an additional 18 MTFs. Prior to each location beginning DES Pilot operations, the Departments verified the site was prepared to meet Pilot staffing and system support requirements. A training team from VA and DoD traveled to each site to conduct Pilot training and identify any remaining issues or problems. On September 17, 2009, the SOC approved expansion to an additional six locations. This phase of expansion began January 4, 2010, and was completed March 31, 2010. Upon completion, approximately 47 percent of all Service members entering the DES were enrolled in the DES Pilot process.

The DES Pilot process is simpler and more transparent from the perspective of a Service member being evaluated for disability, as they receive their proposed VA and DoD disability ratings simultaneously, prior to separation, and are able to make better informed decisions about the future. The Pilot process is also more efficient because Service members now undergo a single set of disability examinations from VA instead of separate examinations by each Department. In November 2007, VA and DoD signed a Memorandum of Agreement (MOA) for the single DES examination in the National Capital Region, which was subsequently updated in January 2009. During FY 2010, the DES WG had continued success in achieving a single examination that meets the needs of both Departments. During this FY, VA and DoD reached an important milestone, when the Deputy Secretary of Veterans Affairs and Deputy Secretary of Defense signed a cost sharing agreement that is fair and equitable to both Departments. VA is implementing billing procedures to enact the DES examination agreement.

Building upon the success of the DES Pilot, the Departments set a goal to expand the DES Pilot process to all Service members by the end of FY 2011. During the first quarter of FY 2010, VA and DoD designed a joint expansion strategy that would offer the DES Pilot process to all remaining Service members. The Departments agreed that further expansion of the DES Pilot process into a program called the IDES, would be implemented by region because it provides opportunities to consolidate resources and minimize duplication of effort. In August 2010, the Departments agreed to offer the benefits of the Pilot process, now the IDES, to all Service members, including those serving at overseas locations. VA and DoD conducted two conferences on September 27-28, 2010 and September 29-30, 2010 in preparation for the next stage of IDES expansion. The Departments have a target date to achieve IDES coverage for 100 percent of Service members by the end of FY 2011.

CASELOAD - Since November 26, 2007, 14,207 Service members have enrolled in the DES from 27 MTFs. A total of 3,401 Service members completed the program by returning to duty, separation, or retirement and 527 were removed for other reasons (additional medical treatment needed, case terminated pending administrative discharge processing, etc.). A total of 10,279 Service members remain enrolled in the IDES[10].

Active Component Service members, who completed the IDES without pre-separation leave, averaged 299 days from IDES entry to VA Benefits Letter. Active Component Service members, who completed the IDES with pre-separation leave, averaged 314 days. This 314-day average exceeds the IDES goal of 295 days, established for Active Component Service members, but is

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[10] This data is accurate as of September 30, 2010.

42 percent faster than the Legacy DES and subsequent VA Claim process, which, together, take a total of 540 days to complete.

Reserve Component and National Guard Service members who completed the IDES averaged 300 days from entry to issuance of the VA Benefits Letter, which is two percent faster than the IDES goal of 305.

VALIDATION OF PROGRAM BY SERVICE MEMBERS – Surveys of nearly 4,400 Service members in the DES showed that IDES participants were more satisfied with their experience than participants in the Legacy DES process. IDES participants were also more satisfied with the fairness of the process compared to participants in the Legacy system. In FY 2010, 11 percent of Service members in the IDES appealed the results of the Physical Evaluation Board (PEB) adjudication (25 out of a total of 227). This rate of appeal is lower than the latest appeal rate available for the Legacy DES (25 percent in FY 2009) and suggests Service members in the IDES better understand and accept the IDES process and its outcomes.

On October 1, 2008, in the National Capital Region, VA initiated a "paperless" program for processing all DES claims electronically. 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 2010, 659 imaged documents were scanned into Virtual VA and 517 VA rating decisions were stored in Virtual VA. Currently, VA is developing the Veterans Benefits Management System for paperless claims processing.

On March 29, 2010, DoD implemented a policy entitled "Cross-Service Support and Service Organization Role at DES Pilot Locations." This policy ensures Service members who are being treated at another Military Department's MTF operating under the IDES process can participate in the IDES. This policy furthers the goal of creating a seamless DES process from the Service member's perspective.

DoD authorized the temporary implementation of a two-member Informal Physical Evaluation Board (IPEB) on July 21, 2010, in response to a request from the Department of the Air Force. This authorization will be in effect until June 15, 2011, and allows all Military Departments to use two-members IPEBs to speed their DES process.

Sub-goal 3.3
Increase knowledge of VA and DoD benefits and services.

BEC Communications Working Group

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

The CBSWG achieved many beneficial outcomes in FY 2010 through leveraging both VA and

DoD communication outlets to share benefits information. This was evidenced by a sharp rise in the number of registered eBenefits premium accounts from approximately 325 accounts to over 160,000. There were corresponding spikes in the following benefits requested:

- Requests for Official Military Personnel Files Information (DD-214);
- Requests for VA Home Loan Certificate of Eligibility;
- Compensation & Pension (C&P) Claims Status Inquiries; and
- VA Payment History Inquiries.

The CBSWG also successfully leveraged existing VA and DoD channels to promote shared benefit information through the production and release of videos in "The American Veteran" Series. The first two-part set of videos focused on the benefits and tools available to Service members, Veterans and their families through the eBenefits portal. The CBSWG again teamed up with "The American Veteran" Series to produce and release the pre-discharge video, which highlighted the BDD and Quick Start programs. The BDD and Quick Start Programs allow Service members the opportunity to submit an application for service-connected compensation while still on active duty.

In the third and fourth quarters of FY 2010, the CBSWG made a massive push to surpass its goal of 25 percent increase in information sites. Currently, eBenefits is featured on numerous .mil and va.gov Web sites. Below is a small sampling of the Federal .gov, State .gov, DoD .mil and VA .gov Web sites that feature eBenefits information and links:

Federal (.gov, .mil) and State (.gov)	Civilian (.com, and .org)
http://www.va.gov/	http://www.military.com
http://www.defense.gov/	http://www.veteransbenefitsinformation.com
http://www.vba.va.gov/	http://www.moaablogs.org
http://www.af.mil	http://www.govexec.com
http://www.tricare.mil/	http://www.federalnewsradio.com
http://militarypay.defense.gov/	http://rollingthunderoh6.org
http://prhome.defense.gov	http://www.veteransnewsletter.com
http://www.warriorcare.mil	http://www.aaptsdassn.org/
https://www.dmdc.osd.mil	http://www.nasdva.net
http://www.aw2.army.mil	http://www.midntgrv.com/veterannews.html
http://www.acap.army.mil/	www.mcchordrao.com
http://www.veterans.arkansas.gov/	www.rao-osan.com
http://www.maine.gov/dvem/bvs/benefits.htm	http://www.wpwoundedwarriormentorprogram.com
http://www.ong.ohio.gov/Alumni_News/	http://vets.yuku.com
http://worh.org/federal-news/ebenefits	http://www.penfed.org/usawoa/ret-vets-news.htm

Additionally, the eBenefits logo was added to numerous VA and VBA Web sites. Moving forward, eBenefits will continue to add features for Veterans and retirees. In addition, the CBSWG will look to increase the number of benefits available to the Service member population by incorporating existing DoD benefits sites and capabilities. These sites include the calculators for Basic Allowance for Housing (with or without dependents), Basic Allowance for Subsistence, Temporary

Duty Pay, promotion point calculators, and Special Pay/Hazardous Duty Pay. The CBSWG will also continue to develop, incorporate and market new applications such as a Deployment Pay Calculator, Time in Service and Time in Grade specific Special Pays calculators, and Permanent Change of Station/Relocation budget planner and calculators.

Lastly, in order to ensure 100 percent of any new benefits mandated by law were disseminated to Service members, Veterans, and their families, the CBSWG (in coordination with the Benefits Assistance Service), promoted awareness and use of the eBenefits site and supported over 25 outreach and advertising activities and events from April to September 2010. The promotion of the site encouraged users to register and use the features available in eBenefits that would traditionally be obtained by visiting a VA Regional Office or placing a call to a VA call center. As a result, the number of premium account registered users increased by over 25 percent.

Sub-goal 3.4
Oversee the entire life-cycle of the paper military Service Treatment Record (STR).

BEC Medical Records Working Group

The BEC Medical Records WG (MRWG) was established to oversee the entire life cycle of the paper military Service Treatment Record (STR). In FY 2010, the MRWG concentrated its energy on enhancing and improving collaborative efforts in managing paper records.

The BEC approved three milestones for the MRWG based on the findings and recommendations from an in-depth Lean-Six Sigma business process improvement study conducted last year and described in last year's AR. The first milestone for the MRWG was the development of a disposition schedule for the STR. At the close of this reporting year, a STR disposition schedule was submitted to the National Archives and Records Administration (NARA) for approval. The recommended disposition schedule was assigned a dedicated job number (N1-330-10-03) and is currently in NARA's review process.

The second milestone for the MRWG included the issuance of new DoD policy and procedures for the creation, maintenance, use, transfer, and disposition of the STR that were also largely derived from the recommendations from the Health Treatment Record Interagency Task Force and the Lean-Six Sigma study. As of the end of FY 2010, the DoDI was in the final coordination for approval and signature from the USD(P&R).[11]

The third milestone for the WG was to update the MOA between VA and DoD concerning the physical transfer of STRs for Veterans benefits processing. During the coordination process between the two Departments, new exigencies arose, mostly related to storage space issues at the VA Records Management Center (RMC), that were not originally accounted for in the draft MOA. As a result, the MRWG pulled the document out of formal coordination and will focus intently on getting it updated by the second quarter of FY 2011.

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[11] The DoDI 6040.45, STR and NSTR Life Cycle Management, received approval and signature from the USD(P&R) on October 28, 2010.

The BEC also established three performance metrics to measure progress in meeting the MRWG's mandated objectives.

The first metric measured the decrease in the volume of loose and late flowing medical documentation with a reduction target of 95 percent (or 162,600 total documents for the year). To track the performance for this metric, VA RMC provided a monthly count of the actual volume of loose and late flowing documentation received from all the Military Departments. Over the course of FY 2010, DoD collectively decreased the overall amount of loose and late flowing medical documentation sent to VA RMC by approximately 59 percent, from 3,252,000 to about 1,327,659. The monthly average demonstrates a similar trend coming in at almost 110,638 per month instead of the targeted 13,550 per month or a 72 percent reduction. However, there was a precipitous decrease in the volume being sent VA RMC, beginning in March and continuing for the remainder of FY 2010. During the last seven consecutive months of FY 2010, the monthly average was 39,638 documents or an 86 percent reduction with a range of 28,374 in May to 47,309 documents in June.

Sub-goal 3.5
Improve Federal Recovery Coordination Program (FRCP) program performance in providing coordination of care and benefits for recovering Service members, Veterans and their families.

Federal Recovery Coordination Program

The Federal Recovery Coordination Program (FRCP) is a joint VA/DoD program designed to coordinate access to Federal, state, and local programs, benefits, and services for severely wounded, ill, and injured Service members, Veterans, and their families through recovery, rehabilitation, and reintegration into the community. Federal Recovery Coordinators (FRCs) serve as the single point of contact for oversight/coordination of clinical and non clinical case management for Service members and Veterans (or Clients) and their families.

FRCs help Clients in accessing the services and benefits available to them and navigating through the DoD and VA health care systems. FRC's develop a customized Federal Individual Recovery Plan (FIRP) for each Client. The FIRP, based on input from the Client's family members and the interdisciplinary team, identifies the Client's goals as well as the needs, resources, services, and benefits to meet those goals.

In FY 2010, FRCP successfully ensured that all those who were referred to the program were evaluated and assigned appropriately. In cases where it was not appropriate for an individual to enroll in FRCP, the evaluation process identified what assistance a Service member or Veteran needed and a FRC facilitated access to that service or benefit. This ensured that any Service member or Veteran referred to the program was not without resources to resolve outstanding issues.

The FRCP program met its established goal of 100 percent participation in targeted educational activities. Education and training contribute to overall FRCP performance as well as client satisfaction. Well trained FRCs are better able to assist clients in achieving goals, identifying resources, and solving problems. A consistent knowledge base across FRCs means that a client

or caregiver receives the same high quality service regardless of where he/she is located or to whom he/she is assigned. Continuous learning enables FRCs to maintain comprehensive, up-to-date knowledge of programs and services which may benefit the client or caregiver. Equally, continued education and training ensure that FRCs can provide the best care coordination possible for clients and caregivers.

To assess program performance and establish a baseline measure of client satisfaction, FRCP conducted a satisfaction survey in FY 2010. The overall satisfaction score for clients was 80 percent, indicating that most respondents rated overall service as very good or excellent. Survey results also identified key areas for improvement. Improvement strategies based on survey results have been incorporated into program operations and performance plans. These actions are designed to generate the expected improvement in satisfaction levels for FY 2012.

The Government Accountability Office (GAO) conducted a program evaluation of the FRCP throughout FY 2010. FRCP staff assisted GAO analysts throughout the process by responding to information and data requests. FRCP anticipates the information from the GAO exit interview and subsequent GAO report will provide additional guidance for the program and facilitate further improvements including the development of process and outcome measures.

FRCP implemented further improvements to its data management system to improve reporting. This allowed the program to improve performance in several different areas, including the time between client contacts for each FRC. Additional enhancements to the data management system are planned for FY 2011 to support additional analysis. In FY 2011, FRCP plans to develop and test tools for the purpose of measuring and recording intensity of services required by clients to better balance the FRC workload.

The FRCP Directive and Handbook are in the final stages of coordination.

Sub-goal 3.6
Improve FRCP outreach programs efforts.

Federal Recovery Coordination Program

FRCP participation (active clients) has grown by 567 percent since FY 2008. This outcome is a result of increased awareness of the program combined with the high level of Client satisfaction. The FRCP participated in more than 80 outreach activities at the national and local level during FY 2010. FRCP is currently experiencing new referrals at a rate of 50 per month (a 100 percent increase over FY 2009). FRCP will continue to evaluate the need for and placement of additional FRCs throughout the year.

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.

Federal Recovery Coordination Program/Recovery Coordination Program (RCP)

Using Online Resources to Improve Education on Services The National Resource Directory (NRD) provides information on; and access to, services and resources for wounded, ill, and injured Service members, Veterans, their families, and those who support them. The NRD is a tri-agency effort with support provided by the Departments of Defense, Veterans Affairs, and Labor.

During FY 2010, improvements to the NRD resulted in a 254 percent increase in visitors in the fourth quarter of the year compared to first quarter. The NRD currently averages 32,800 unique users per month. These statistics exceed the projected goal of a 35 percent increase in users. Additionally, the NRD increased the number of resources by 2,000 in FY 2010.

Currently, the NRD provides a State widget which allows individuals and organizations to display resources tailored by state and subject matter to their own Web sites. A mobile application has been developed and will be released in early FY 2011.

The NRD team has also implemented a comprehensive outreach strategy. From FY 2009 through FY 2010, the NRD Governance Board and team members provided over 50 demonstrations and seven trainings to a variety of stakeholders.

Sub-goal 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

The RCP is under the purview of the Office of Wounded Warrior Care & Transition Policy (WWCTP) and supports recovering Service members and their families through recovery, rehabilitation, and reintegration back to duty or back to the communities. The RCP supports the RSMs and their families with trained Recovery Care Coordinators (RCCs) as well as supportive online case management tools, such as the Recovery Coordination Program Support Solution (RCP-SS). The RCP-SS

Figure 1 – Recovery Coordinator Sites

RECOVERY CARE COORDINATOR SITES — 65 Separate Locations (32 States, Territories, Overseas)   As of 10/28/2010

Color	Service	# of RCCs
	Army	15
	Navy	4
	Marines	50
	Air Force	32
	USSOCOM	16
	Army Reserves	19
		136
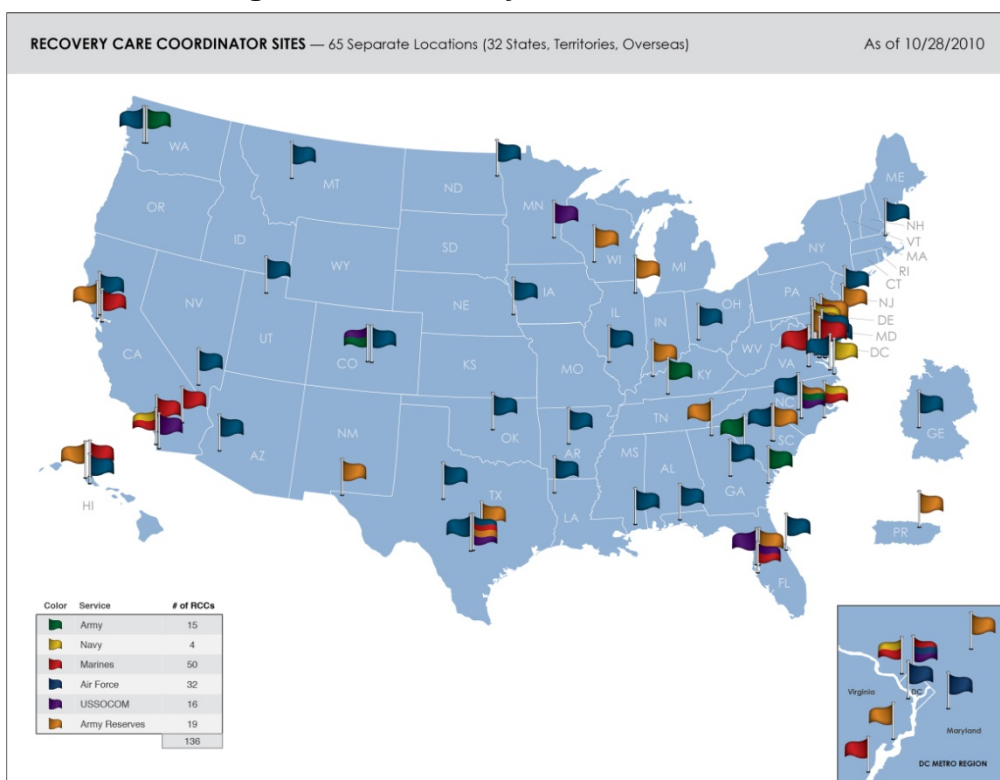
provides secure, Web-based access to the tools needed to successfully manage a Service member's non-medical care, and is now available to all branches of the military Services.

Deploying Trained and Coordinated Recovery Care Coordinators In FY 2010, WWCTP trained 57 RCCs from all four Military Departments, Special Operations Command, and the Army Reserve. Currently, there are 136 RCCs located in 65 locations to include Puerto Rico and Germany (see Figure 1). At the end of FY 2010, the RCP had met its goal to have 100 percent of the RCCs trained.

Recovery Care Coordinator Evaluations In an effort to continually improve the initial training conducted by WWCTP, training evaluations were adjusted to evaluate each training module throughout the one week course. This adjustment enabled WWCTP, in conjunction with the Military Departments, to prioritize needed changes to the training modules. Additionally, an evaluation was implemented for the first time in FY 2010 to measure how each training module aided the RCCs in performing their duties within the first 90 days of working with RSMs and their families. In FY 2010, the office began to incorporate Instructor's Guides for each training module to standardize the delivery of the training materials regardless of the trainer.

Paperless Comprehensive Recovery Plan Management Tool In August 2009, WWCTP began the development of the RCP-SS. The RCP-SS was developed as a secure, Web-based tool which would eliminate duplicative, hand-written paperwork and have the capability to interface with other systems already in use across the Military Departments. The system was also built to automate the Comprehensive Recovery Plan (CRP) that all recovering Service members use as they progress through the continuum of care. The RCP-SS is expected to achieve Full Operating Capability (FOC) in November, 2010 and will continue to be enhanced quarterly. RCCs, as well as RCP Program Managers and Wounded Warrior Program (WWP) leadership, will use the RCP-SS to streamline non-medical case management and CRP tracking. The Military Departments will play an integral part in the advancement of the system by maintaining representation on the Governance Board and Configuration Control Board which will be responsible for approving and prioritizing future enhancements.

Measuring Success and Developing Best Practices In FY 2010, WWCTP began the process of establishing a baseline for the development of performance metrics for the RCP. As part of the process, WWCTP developed the plan as a two-phased approach with specific goals and objectives.

Phase I began in February 2010 at predetermined sites and focused on:

- Reviewing the RCCs roles and responsibilities;
- Reviewing the workload; and
- Reviewing the case records to include recovering Service member's recovery plans.

Phase I was successfully completed in July 2010. At the completion of Phase I initial trends were identified and were used to tailor some questions for Phase II.

- Phase II began in September 2010 and is scheduled to be completed by November, 2010.

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- The results of Phase I and II will be compiled into a report to be completed by December 2010.

The report will include some baseline metrics as well as recommendations for the establishment of other performance metrics based on the understanding of how the RCP is being implemented. This should lead to enhanced management of the program as well as improved services to the RSMs.

Evolving Print Media and Leveraging New Media In FY 2010, WWCTP began publishing a bi-weekly e-newsletter to stakeholders in DoD, DOL, VA, other government agencies, and the private sector. These newsletters regularly featured articles that highlighted activities of the RCP. The newsletter distribution list was an estimated 700 stakeholders. The new forum for communication has been transformed to a daily news-briefing with an online forum for highlighting new policies. The RCP team is reworking an over-arching RCP communications strategy for review and implementation by mid FY 2011.

Additionally, RCP key messaging was developed to support several policy initiatives:

- The publication of DoDI 1300.24 which outlines the roles and responsibilities of RCCs, WWP staff, and other recovery team members;
- How RCP works with WWPs and the larger wounded warrior and Veteran community;
- The RCC as non-medical "go-to" person for RSMs and their families as they navigate recovery and rehabilitation; and
- The importance of the RCP and RCC in setting goals for the RSMs and family including access to G.I. Bill benefits, vocational training, transition assistance and relocation challenges.

RCP partners are identified and cultivated in a number of ways. For example, the RCC training brings together subject matter experts from across VA and DoD. These experts train RCCs in all aspects of non-medical care and needs of RSMs and their families. In addition, the RCP team meets regularly with partners across VA, DoD, and the Veteran Service Organization sector to educate leaders about the issues facing the RSMs. As the RCP team updates the FY 2011 communications strategy, emerging opportunities for briefings and cultivating partnerships will be identified.

GOAL 4
Integrated Information Sharing

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.

BEC Information Sharing/Information Technology Working Group

The objective of the VA/DoD Benefits Information Sharing/Information Technology (IS/IT) WG is to use 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 support their needs.

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

During FY 2010, eBenefits registered user accounts increased quarterly by ten percent or more. As of the fourth quarter of FY 2010, the number of registered eBenefits users was 163,541. From the first quarter (95,000) to the second quarter (112,496) the number of registered eBenefits user accounts increased by over 18 percent and a 29 percent increase from the third quarter to the fourth quarter of FY 2010. This year's increase in registered users suggests that VA/DoD outreach efforts were successful in spreading awareness of this powerful tool. The eBenefits communication plan developed this year will also aid in outreach efforts to ensure Service members and Veterans are aware of the benefits to which they are entitled.

The BEC IS/IT WG has effectively and proactively implemented many helpful self-service features available to eBenefits users. All of these self-service features require a level of authentication so the portal can provide personalized benefit information. This authentication is the DoD Self-Service (DS) Logon, which is a secure, self-service logon ID (user name and password) that allows beneficiaries affiliated with the VA or the DoD access to several Web sites using a single username and password. eBenefits has single sign on capability with several other sites that also accept the DS Logon for access. Users can log on once to eBenefits using their DS Logon, and navigate to several other sites from a link in eBenefits without having to log on at the other sites since the credentials are mutually authenticated.

The BEC IS/IT WG introduced a robust set of new self-service capabilities in each quarterly release since the first quarter of FY 2010. The quarterly releases provided users with new or improved access to information as follows:

- Winter 2009 (Release 2.2)

- o Enhanced User customization of My eBenefits dashboard
- o Service members Group Life Insurance
- o Defense Personnel Records Information Retrieval System Integration
  - Request/print DD 214 online
  - Access to employment history
- Spring 2010 (Release 2.3)
  - o VA Payment History
  - o VA Health Eligibility Check
  - o C&P Claims Status
  - o Loan Guaranty Certificate of Eligibility
  - o Most Active Duty and Reserve Component Personnel
  - o Civilian Employment Information
  - o TRICARE Health Insurance
  - o Catastrophic Cap and Deductible (CCD)
  - o CCD Fee
- Summer 2010 (Release 2.4)
  - o Messaging Center
  - o Specially Adapted Housing
  - o Additional VA Claims Status for Appeals
  - o Personal Information Update (VA/DoD)
  - o Opt-in to notify state directors of transitions
- Fall 2010 (Release 2.5)
  - o Transfer of Post 9/11 GI Bill Education Benefits
  - o Mobile Web (m.ebenefits.va.gov)
  - o Homepage Redesign
  - o Message Center Enhancements
  - o Military Compensation Links (DoD)

The BEC IS/IT WG enabled the availability of multiple types of benefits information through the eBenefits portal. This information is timely and tailored to a Service member's or Veteran's specific and current needs. In many cases, users of eBenefits are able to enter the portal at any time and find information about, apply for, and track status of benefits and services in one place - eBenefits.

The BEC IS/IT WG, in partnership with the OMB, successfully developed the key feature of the Mobile Accessibility capability allowing eBenefits users to access claims status and locate facilities using a mobile device. This self-service capability is currently available from mobile devices at (https://m.eBenefits.va.gov). The mobile claims status feature provides access to claims information consistent with status details available in the My eBenefits Dashboard. The service also locates VA and DoD facilities using the smart device's Global Positioning System and provides users with the option to map directions or call a facility. This feature gives Service members and Veterans easy, immediate, and mobile access to benefits information whenever and wherever needed.

Veterans Tracking Application (VTA) for the Integrated Disability Evaluation System (IDES) Module replaced the original DoD database hosted on Army Knowledge Online as the primary tracking and metrics reporting application in June 2009. The application is utilized by personnel from both Departments. VA users include: Military Service Coordinators, Rating Activity Sites, Regional

Office Management, and VA Central Office management. DoD users include: PEB Liaison Officers, PEB Staff, Personnel / Transition Centers, and DoD and Service Leadership.

VTA IDES has deployed five releases. The releases provide maintenance and enhancements to existing user groups FRC, VHA, VBA, and IDES. Enhancements improve the VTA architecture and ability to accommodate future expansion of the IDES. The enhancements continue to improve reporting functionality and capability.

VTA is a Web-enabled application that is used by VA and DoD. VTA is a tracking application that allows VA and DoD non-clinical case managers to monitor Service member and Veteran progress through the process. Data from VTA is used to identify bottlenecks in the process at each IDES site and to identify specific cases that exceed case processing guidelines for any tracked phase of the process. Identification of bottlenecks to senior leadership permits the application of additional resources to address the problem, leading to a more timely case processing for Service members and Veterans. Identification of specific members spending longer than anticipated time in any given stage assists the non-clinical case managers to ensure that members do not languish in the DES.

Sub-goal 4.2 and 4.3
Support continuity of patient care between VA and DoD by sharing electronic health information.

HEC Information Management - Information Technology Working Group

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

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

Between October 2009 and September 2010, the HEC IM/IT WG successfully completed 100 percent of FY 2010 quarterly metric milestones to enhance viewable bidirectional electronic health data sharing. The benefit of this progress is that more Service members and Veterans than ever have more data available for use in the provision of care and the adjudication of claims:

- The number of DoD Service members with historical data transferred to VA increased from over 5.0 million to over 5.3 million;
- The number of PPDHA and PDHRA forms transferred to VA increased from over 2.7 million to over 2.8 million;
- The number of individuals with PPDHA and PDHRA forms transferred to VA increased from over 1.1 million to over 1.2 million;
- The percentage of DoD inpatient beds covered by DoD's interim inpatient solution increased from 59 percent to 77 percent;
- The number of DoD beneficiaries with real-time data available to VA and DoD providers increased from over 3.5 million to over 3.8 million; and
- The number of data queries by VA and DoD providers increased from over 8.2 million to over 10 million.

DoD technical development of BHIE data viewer enhancements is complete, which will improve usability for DoD providers. VA and DoD are currently working to achieve connectivity with the demonstration, test, and evaluation laboratory to support end-to-end system integration testing.

DoD continued development of technical solutions to support the capture and display of automated neuropsychological assessment data from the NeuroCognitive Assessment Tool (NCAT). DoD is coordinating with the Military Departments on Service-level information assurance activities in preparation for testing and deployment. VA initiated technical development efforts related to the Clinical Display Module. This module will support the initial capability for VA and DoD clinicians to view NCAT data electronically. VA is scheduled to begin testing in February 2011.

The DoD/VA Interagency Clinical Informatics Board (ICIB) continuously evaluates the clinical information sharing capabilities between VA and DoD, and annually refines clinical information sharing needs to support functional requirements. The ICIB identified a number of capabilities needed to reach a more robust level of interoperability between the Departments and to enable the exchange of information with private sector and other Federal partners. The list below highlights the recommended clinical objectives provided by the ICIB for FY 2011 and beyond. Many of these objectives do not require IT action at this point, but instead require functional action. The ICIB objectives for FY 2011 and beyond are as follows:

- Enhance System Performance and Usability of the BHIE Solution;
- Enhance Clinical Note Retrieval Capability;
- Extend Sharing of Clinical Images and Scanned Health Encounter Documents;
- Increase Inpatient Documentation Exchanges;
- Begin Transfer of MHS Purchased Care Data to VA;
- Initiate Exchange of Computable Laboratory Data;
- Integrate Family Health Information Sharing Requirement;
- Complete Radiology Terminology Projects;
- Define Data Set Needed to Support Common Clinical and Quality of Care Performance Measures;
- Support the Definition of Health Information Sharing Requirements for the VLER Efforts of the IPO;

- Increase Adherence to Evolving National Standards for Health Information Exchange; and
- Promote the Definition of Common Strategy, Architecture, and Standards upon which Clinical Registries will be Designed.

The DoD/VA Interagency Requirements Process WG outlined the following steps that the members will take in developing the draft VA/DoD Requirements Management Approach to support collaboration on health data sharing efforts going forward. They are: identify governance structure; specify milestones; document VA and DoD requirements development processes and potential coordination touch points; perform gap analysis; identify approval processes; and conduct pilot. Future development of the VA/DoD Requirements Management Approach has been integrated into the Requirements Working Integrated Product Team of the IPO.

The HEC IM/IT WG achieved the following activities in support of electronic patient registry requirements development and CONOPS in FY 2010:

- Reviewed the NDAA FY 2008 registry requirements;
- Collaborated with the Interagency DVEIVR, Interagency Hearing and Auditory System Injuries Registry, and the EACE;
  - JTTR eye trauma module and MOTR demonstration and review;
  - Ongoing meetings with stakeholders focusing on registry data elements and data sources; and
  - Completion of the DVEIVR requirements, CONOPS, and eye registry data store.

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

An integrated VA/DoD IT master schedule for the North Chicago FHCC demonstration project was established for the implementation of: single patient registration, medical single sign on for clinical systems with patient context management, and an Integration Platform (Common Service Broker (Enterprise Service Bus) capability). IT development activities are underway for use at the FHCC.

Since 2006, VA and DoD have been sharing computable outpatient pharmacy and medication allergy data through the interface between AHLTA's Clinical Data Repository and VA's Health Data Repository (HDR). This initiative is called "CHDR." Exchanging more computable electronic health data on patients supports improved patient care and safety through the ability to conduct drug-drug and drug-allergy interaction checks using data from both VA and DoD systems.

The HEC IM/IT WG successfully completed 100 percent of FY 2010 quarterly milestones to enhance computable electronic health data sharing between VA and DoD. The number of CHDR active dual consumers increased from over 45,900 in October 2009 to over 251,000 in

September 2010. This represents an increase of almost 370 percent in FY 2010. VA and DoD technical and functional experts, including the VA/DoD ICIB, are working to further refine requirements and solutions to support the sharing of computable chemistry and hematology laboratory results in real-time and bidirectionally for shared patients.

The Healthcare Artifact and Image Management Solution (HAIMS) is an MHS strategic project that will enhance medical informatics through seamless integration of medical digital images into the EHR. The objective of HAIMS is to give health care providers global awareness and access to essential health care artifacts and images throughout the continuum of care from theater to the sustaining base to VA. HAIMS will provide a single enterprise-wide image sharing capability for artifacts and images, including radiographs, photographs, waveforms, audio files, video, and scanned documents. The following HAIMS testing activities were completed in FY 2010 to support global access and global awareness of scanned patient records and related artifacts:

- DoD HAIMS Release 1 System Integration Testing was completed in November 2009.
- DoD HAIMS Release 1 Limited User Testing (LUT) began in December 2009, demonstrating an initial capability for scanning medical documents and sharing those documents electronically with VA utilizing a test environment.
- DoD HAIMS Release 1 LUT schedule (completed in April 2010) identified deployment dates to nine LUT sites (three sites from each Military Department).
- DoD HAIMS Release 1 Authority to Operate was completed in April 2010.
- VA identified a testing schedule through FY 2011 for user testing of the VA's Advanced Web Image Viewer, a technical solution which will enable VA providers to view DoD scanned patient records and related artifacts.

DoD completed development of the technical solutions that send radiological orders and patient demographics from the Theater Medical Information Program Composite Health Care System Cache (TC2) system to the Deployed Tele-Radiology System (DTRS) and Theater Picture Archiving and Communication Systems. This capability was released to the Service Infrastructure Offices in September 2009 for deployment in theater. Additionally, DoD continued its development of the capability to push the corresponding radiological reports from DTRS into the Theater Medical Data Store. DoD anticipates completing this milestone on schedule in FY 2011. This capability improves continuity of care from battlefield to garrison to VA by ensuring that theater radiology information and images move with the wounded warrior during the provision of care. Further, by ensuring that theater radiology information is readily accessible, the risk of radiation exposure is reduced by negating the need for repetitive radiology services.

The HEC IM/IT WG successfully completed 100 percent of FY 2010 quarterly milestones to increase the type and amount of electronic image data shared between DoD and VA.

Sub-goal 4.4
Foster secure computing and communications infrastructures between VA and DoD.

HEC Information Management Information Technology Working Group

The HEC IM/IT WG successfully completed 100 percent of proposed FY 2010 milestones by migrating data traffic for 12 systems (182 sites) from the VA Austin Automation Center to the

DoD/VA multipurpose gateways located in the North, South, East, and West United States locations. As a result of the completion of this goal, VA and DoD are now utilizing network gateways that facilitate the seamless transfer of health data, as well as providing secure, redundant connectivity (e.g., more than one operating circuit) and failover capability (i.e., reduce the risk from a "single point of failure") between VA and DoD systems and facilities. The implementation of multipurpose gateways replaces the single point of failure legacy gateway, helping to ensure a continuous flow of data.

Additionally, DoD Tri-Service Infrastructure Management Program Office (TIMPO) provided a quarterly briefing regarding bandwidth and network performance to the HEC IM/IT WG. TIMPO developed traffic analysis reports to identify traffic levels, types, and patterns (including protocol type and distribution of imaging traffic) and overall bandwidth demand levels for inbound and outbound wide area network traffic. The current assessment is that the existing network infrastructure and available bandwidth is more than adequately supporting current VA/DoD data traffic based on established FY 2010 metrics:

- Network bandwidth utilization did not exceed 90 percent; and
- Network availability was maintained at 98.5 percent or better across the four multipurpose gateways.

Sub-goal 4.5
Support VA/DoD and national electronic health data sharing initiatives.

HEC Information Management / Information Technology Working Group

The VA/DoD Health Architecture Interagency Group (HAIG), an advisory working sub-group to HEC IM/IT WG, was established January 2005 to facilitate interagency cooperation and specifically to foster collaboration on enterprise architecture sharing initiatives between the Departments.

In February 2010, the HAIG approved the updated architectural compliance review checklist. This checklist is used in conducting VA/DoD electronic health data sharing architecture compliance reviews relating to various aspects of project architecture. The HAIG, guided by a joint VA/DoD revision team, restructured the 2009 checklist to include side-by-side VA and DoD input columns for ease of project comparison. The joint VA/DoD electronic health data sharing architecture compliance review submission received formal HAIG acceptance and approval.

The HAIG reviewed and provided comments on the 2010 HHS National Health Information Technology (HIT) Standards related to meaningful use of EHRs in June 2010. These standards were published in the Federal Register in July 2010. Additionally, the HAIG outlined the following activities in support of the 2010 Target DoD/VA Health Standards Profile and 2010 DoD/VHA Health Interoperability Standards Reference Model deliverables:

- Reviewed and incorporated HIT Standards Panel (HITSP) standards into the Target DoD/VA Health Standards Profile;
- Collaborated with VA and DoD to identify joint information, data representation, security, and technical standards;

- Defined a category of standards for VA/DoD health information sharing; and
- Identified gaps in existing interoperability standards and data exchange specifications.

The HAIG is a collaborative interagency board that oversees VA and DoD efforts to ensure that emerging technologies meet national interoperability standards. The HAIG's efforts will facilitate the exchange of meaningful health data between VA and DoD to support health care delivery and claims adjudication. The HAIG reviewed and accepted the FY 2010 VA/DoD health data sharing architectural compliance review, which included a combined VA and DoD annual review of FHIE, BHIE, and CHDR initiatives. This activity supports VA/DoD electronic health data sharing by promoting architectural compliance, adoption of HIT standards, and identification of new information exchanges. Additionally, the HAIG outlined the following activities in support of collecting and assessing observed uses of the enhanced VA/DoD Information Exchange (IE) tool:

- Assessed VA and DoD alignment to recognized HITSP interoperability specifications;
- Assessed VA and DoD alignment to the Secretary of HHS Standards and Certifications Interim Final Rule;
- Prioritized IEs and identified gaps in the information shared between VA and DoD;
- Assessed compliance of VA/DoD health data sharing initiatives against VA/DoD IE requirements; and
- Provided VA/DoD IE tool for hosting on the IPO collaboration Web site to prototype a common portal for the publication of VA/DoD shared architecture products.

The HAIG recommended continued sustainment of the IE tool. The HAIG's assessment of the FY 2010 usages and value of the IE tool accomplished the following:

- Documented five new IE data flows between VA and DoD;
- Validated IE flows with architectural compliance reviews;
- Documented and prioritized future health IEs; and
- Identified levels of interoperability and standards for IEs.

The VA/DoD IE tool enables agency stakeholders to prioritize and establish measurable data sharing objectives; determine IM/IT program compliance with interoperability standards; and approve the annual interoperability standards for the Departments in a more streamlined manner.

The HAIG successfully completed 100 percent of FY 2010 proposed milestones. Completion of these goals has resulted in identifying and documenting architectural compliance, maturity, and levels of interoperability standards in current VA/DoD health data sharing initiatives. In addition, HAIG products are serving to educate VA, DoD, and other stakeholders about current health data sharing strategies and statuses.

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.

Interagency Program Office, VA and DoD

While the ribbon cutting ceremony for the JALFHCC occurred in FY 2011, much of the groundwork that led to that took place in FY 2010. The JALFHCC combines the missions of the Naval Health Clinic (NHC) Great Lakes and the North Chicago VA Medical Center into a single organizational structure. The JALFHCC is a unique VA/DoD effort that will operate under a single line of authority, integrating management of the full spectrum of health care services and sharing of resources.

After several years of effort, the JALFHCC functional community agreed upon a defined set of requirements for the initial core Information Technology (IT) capabilities necessary for VA and DoD systems in July 2009. These capabilities include: single patient registration; medical single sign-on with patient context management; and orders portability for laboratory, pharmacy, and radiology. Funding for IT development was approved under the Joint Incentive Fund (JIF) in late August 2009, leaving little time for IT design, development, testing, information assurance, and deployment. In February 2010, with the project well underway, significant concerns regarding the ability to deliver IT capabilities in such a compressed time frame were elevated to the Deputy Secretaries of Defense and Veterans Affairs. In FY 2010, the IPO began overseeing the IT program with the goal of safely exchanging health care data between VA and DoD IT systems to support an integrated VA/DoD health care facility with multiple care locations.

JALFHCC IM/IT Governance The IPO led the effort to address the IM/IT governance structure for the project. IPO established an Executive Committee (EXCOM) with the purpose of guiding the initiatives, decision-making, arbitration, approval of strategy, and strategic communications. The EXCOM core members include the IPO Director and Deputy Director, the VA Special Assistant for Health Affairs, the Deputy Chief Management Officer, the Secretary of the Navy - Department of the Navy Chief Information Officer, the Deputy Surgeon General, the VA Chief Information Officer, the Navy and Federal Health Care Center Integration Officer, and the Director and Deputy Director of the JALFHCC.

Utilizing the new governance structure, the IPO was able to help the Departments manage risks and issues to help move the project forward. In early March, the IPO provided a Joint Interagency Master Schedule intended to more accurately and specifically define and organize the scope of the total project; help with assigning responsibilities, resource allocation, monitor control of the project; make the deliverables more precise and concrete so that all participants know exactly what has to be accomplished; allow for better estimating of cost, risk, and time and allow the opportunity to validate the deliverables' specifics with the stakeholders and ensure there is nothing missing or overlapping. The Master Schedule (as referenced in Figure 2) contains various measures for managing the project that includes a mechanism for IM/IT oversight and monitoring of the project.

One outcome was the identification of the need for the Departments to conduct a third-party, independent technical assessment of Orders Portability. This included an analysis of alternatives conducted by the Institute for Defense Analysis (IDA) and MITRE to address the way ahead. The IDA & the MITRE Corporation are Federally funded research and development centers.

Figure 2 – Joint High-Level Milestones

The IPO's FY 2010 oversight helped move the project forward throughout the year. The JALFHCC was dedicated on October 1, 2010 with a ribbon-cutting ceremony and the stand-up of its JALFHCC governance structure. The IPO continued to work closely with VA and DoD to achieve the necessary initial capabilities to support the JALFHCC integrated, single health care services structure. The collaborative integration of IM/IT capabilities will effectively transfer data for patient record systems between organizations, better informing medical decisions by creating access to patient data across systems.

EHR – Joint Health IT Strategy In March 2010 the VA/DoD JEC and HEC delivered a report to Congress concerning the Departments' health IT efforts. The report states that the Departments are committed to assessing all possible common capability development and/or acquisition for the next generation of EHR systems. The Departments view the lifecycle of health care as a single continuum with each Department providing health care services at various points in the process.

The JEC/HEC Medical IT Report to Congress identifies the following efforts underway and anticipated by VA and DoD to fulfill EHR integration:

- A disciplined process for reviewing and identifying potential opportunities for shared development or acquisition;
- Movement to a common services strategy;
- DoD EHR Way Ahead Analysis of Alternatives; and
- VA/DoD ICIB review and prioritization of common services for clinical care.

To strengthen the unified focus for EHR modernization efforts, VA and DoD have identified core functional capabilities required to provide services to customers throughout the health care lifecycle. Nine of thirteen capabilities are common to both Departments and represent opportunities for joint/shared planning and development. VA, DoD, and the IPO are facilitating an end-to-end functional business process review, from the perspective of a Service member or Veteran, of the nine core capabilities in order to assess and exploit opportunities for common or joint development. The review is scheduled to be completed in FY 2011.

Sub-goal 4.7
VLER – Establish a capability that will allow electronic access/exchange of health care information between VA and the 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.[12]

Interagency Program Office, VA and DoD

VLER will enable the secure and seamless access, sharing and exchange of data for comprehensive health, benefits and administrative information. Within this broad definition of VLER, the scope of relevant data exchange will take place between Service members, Veterans, beneficiaries and/or designees, VA, DoD, and other public and private health care and benefits providers (see Figure 3).

Figure 3 – VLER Concept

In FY 2010 VLER focused on exchange of nationally standardized data using the HHS Nationwide Health Information Network (NwHIN) technical solutions as the foundation for health data exchange between the Departments and participating private providers. The NwHIN provides the means by which health care entities are able to securely exchange interoperable health information across the nation. In order to serve in this capacity, HHS has specified a set of health data standards and developed software which will allow interoperability between

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[12] This Sub-goal was operationally expanded in FY 2010 to include benefits information.

different health care organization systems to securely communicate with each other over the Internet.

VLER Capability Areas (VCA's) In 2010 the IPO and the Departments established four VLER Capability Areas. As depicted in Figure 4, these VCAs will enable sharing of different data sets allowing for the exchange of information provided by VLER. Each VCA provides improved access to health and/or benefits information in direct support of specific users.

- VCA 1 will enable the exchange of minimum essential information needed by clinicians for a clinical encounter.
- VCA 2 will expand upon VCA 1 to include the complete set of available health information to facilitate the processing of disability claims.
- VCA 3 will enable benefits providers the ability to access the information needed to efficiently deliver benefits services such as home loans, insurance, education, and memorials.
- VCA 4 will provide a single access portal for Service members, Veterans, and their beneficiaries by providing a single access portal to health and benefits services.

The Departments are working together to achieve IOC for VCA 1 by July 2012, VCA 2 and 4 by December 2012 and FOC being achieved by December 2014.

Figure 4 – DoD/VA VCA/Joint Strategy for VLER
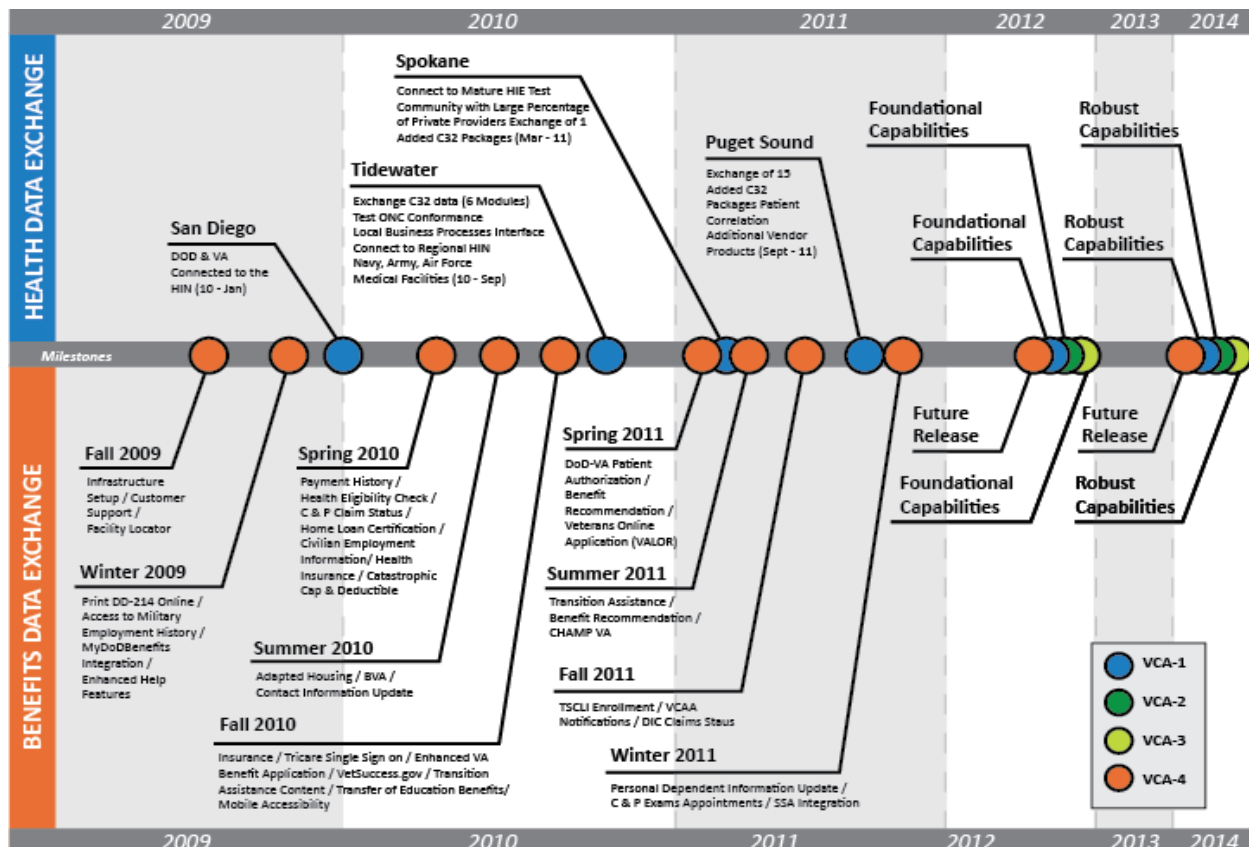
VLER Governance To successfully accomplish the goals and objectives of VLER, a collaborative approach to capability development and delivery is being overseen by a number of entities within the VLER governance structure (see Figure 5). At the center of this collaborative effort are the VA and DoD, which jointly staff the key governance bodies at the executive and management levels that are responsible for oversight of the VLER Initiative. In addition, the governing bodies work in collaboration with other Federal and private partners that include HHS, Homeland Security in support of the Coast Guard, the Social Security Administration, and other private health providers.

Figure 5 – VLER Governance Structure
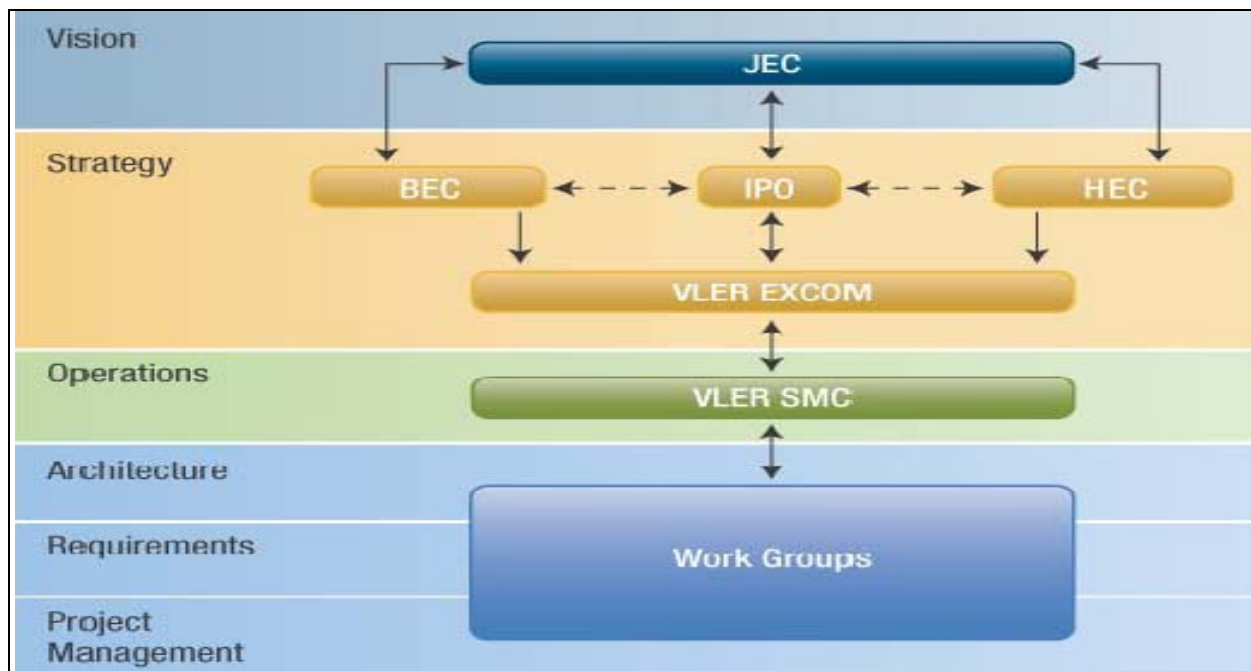
The Departments worked the VLER initiative in conjunction with the IPO, by researching and identifying roadblocks to the initiatives' success spanning from communication gaps in the planning and execution process from the highest levels of leadership on down through program execution. IPO worked with the Departments to establish a VLER governance structure to implement a more coordinated joint planning, program management, and communication approach.

The governance structure includes defining an Executive Committee and a Senior Management Committee (SMC) with the capacity and authority to keep the initiative on track. The VLER Executive Committee is chaired by the IPO Deputy Director. The Executive Committee provides Senior Executive decision-making, arbitration, guidance, approval of strategy, strategic communications, and direction to the VLER SMC. The SMC is co-chaired by the IPO Deputy Director, the VA Deputy Director for the VLER Enterprise Program Management Office, and the DoD VLER Manager. The SMC responsibilities include program management and execution-level decision-making, negotiation, and guidance. The SMC serves as an interagency resource

that provides direction, guidance and oversight of working groups for VLER development and implementation.

VLER Core Documentation for the Initiative The IPO and the Departments identified impediments to the initiative's success which included the lack of joint structural and coordinated program guidance and core systems and project documentation. To address this need the IPO, in coordination with the Departments, initiated the drafting of two core project documents to serve as the planning criterion to guide the Departments in achieving VLER goals; the VLER Strategic Plan and the VLER CONOPS.

The Interagency VLER Strategic Plan outlines the vision for the initiative while the VLER CONOPS outlines the "what, when, and how", specific goals, milestones and timelines of the program plan. The core project documents serve as "road maps" that move the Departments forward on agreed objectives and deliverables. There are other documents that support these core plans that contribute to the success of the program. These include: the Joint Test Plan that provides a high-level testing strategy and detailed approach; the Joint Evaluation Plans for Success which enables the Departments to monitor, and synchronize efforts; the Joint Interagency Master Schedule helps define agreed-on milestones and mitigate interagency critical path risks and any dependencies identified in the interagency space that may impact program plans and schedules; and the Joint Business and Technical Requirements document which describes business requirements and specifications needed for technical development and configuration control. The IPO will coordinate core project documentation and guidance and use them for oversight.

VLER Capability Area (VCA) 1 Pilots The Departments used a pilot strategy to incrementally develop and test capabilities for sharing critical electronic health data between each other and also with providers in the private sector. The key functional benefits of the VLER VCA 1 capabilities are to improve quality of care, reduce the cost for delivery of health care, increase efficiency of health care operations, and improve customer satisfaction.

The VLER VCA 1 San Diego pilot was the first project deployed in January 31, 2010. The key capability tested in the San Diego pilot allowed health care providers' access to Service member and Veteran health information in a secure and authorized way regardless of where care was provided. The objective of the pilot was to implement the ability to exchange health information using the NwHIN Standards between Naval Medical Center San Diego, VA Medical Center San Diego, and a private provider within a defined data set that includes Demographic, Emergency Contact, Allergies, Problem List, and Medications. The pilot demonstrated that health information can be exchanged using the NwHIN.

The pilots were designed to incrementally build additional health care capabilities and sites and to expand the capabilities of VLER to achieve IOC in FY 2012. The Tidewater Virginia area was the location of the second VLER VCA 1 pilot. This pilot was the implementation of the ability to exchange health information, using the NwHIN standards, between VA, DoD and the private sector, adding the exchange of additional data from the San Diego pilot. The Tidewater pilot was deployed on September 15, 2010 at the Naval Medical Center Portsmouth, the Hampton VAMC, and a local private sector Health Information Exchange.

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GOAL 5
Efficiency of Operations

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Sub-goal 5.1
Identify, propose, and increase collaborative opportunities for Joint Capital Asset Planning.

JEC Construction Planning Committee Working Group

In FY10, the Construction Planning Committee (CPC) coordinated both VA's and DoD's capital asset planning and priority processes to better identify which projects would have the highest possibility of joint departmental collaboration. This enhancement, coupled with criteria to evaluate and provide greater priority to those projects that have elements of VA/DoD collaboration, has resulted in a larger window of opportunity for collaboration efforts across the departments.

VA's Strategic Capital Investment Planning (SCIP) process was initiated in FY 2010 for the FY 2012 budget cycle. Implementation of SCIP will significantly reduce existing and projected gaps in safety, access, space, condition, utilization, security and other identified performance areas. DoD CPC members participated actively in VA's SCIP evaluation process and assisted in identifying possible construction locations that would support increased collaboration. Also, in FY 2010, the DoD's Capital Investment Decision Making process included key evaluation criteria rankings that denoted those projects that entail VA/DoD collaboration efforts. The outcome of adding greater insight to each department's capital asset planning has resulted in each department sharing capital construction priorities with the expressed goal of fostering a more effective use of Federal funds.

In FY10, the CPC worked to identify and propose a joint VA/DoD budget mechanism that would assist in streamlining the funding challenges once a collaborative project was identified. In concert with DoD staff, VA developed and submitted for consideration a proposed modification to funding language that would allow for joint planning of construction projects. In FY 2011, the CPC will coordinate refinements to this proposed funding mechanism and resubmit to both VA and DoD governance process for consideration in a future budget cycle.

The CPC Projects WG and CPC Budget WG partnered on a regular basis throughout FY10 to evaluate and refine opportunities for greater collaboration. The efforts of the CPC will continue in FY11 with the expressed goal of increasing the impact of joint capital asset efficiencies.

Sub-goal 5.2
Identify and leverage joint VA/DoD medical contracting venues and business practices to mutually benefit both agencies and medical facilities.

HEC Acquisition and Medical Materiel Management Working Group (A&MMMWG)

During this reporting period, VA and DoD awarded four new joint radiology contracts. These awards will increase the scope of products available to customers under these contracts. These contracts were: iCAD, Inc.; Aurora Advanced Breast Imaging; iCRco; and Neurologica. In addition to these awards, VA and DoD received four new offers during this year's open season from Bronchus Technology, Technical Communities, Ultrasonix and Insighttec. VA National Acquisition Center and Defense Logistics Agency Troop Support Medical worked on these potential joint

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contracts. For radiation therapy, VA and DoD awarded nine of ten follow-on contracts. These follow-on contracts replaced previous contracts which expired in August 2010 and allow VA and DoD to procure radiation therapy systems. A Contract Review Board is meeting to finalize these awards.

Both VA and DoD continued to track savings from their capital equipment joint ventures. A study to review cost avoidance for consolidated high-tech medical equipment contracts concluded that VA and DoD had a combined cost avoidance of over $500,000 in administering joint radiology contracts. This conclusion was based on a detailed analysis of four key vendors: General Electric, Philips Medical Systems, Toshiba Medical Imaging and Siemens.

Joint sales for the remainder of FY 2010 were less promising. Sales figures through the second quarter of FY 2010 indicated a declining trend in two of three categories (see Figure 6). While joint pharmaceutical sales showed solid growth, a reduction in equipment sales placed significant downward pressure on total sales. The reduction in joint equipment sales is not directly proportional to the number of joint contracts; joint contracts have increased over last FY. Equipment sales are more directly related to Department budgets and the need for high-tech medical equipment. Within VA, substantial sales growth prior to and including FY 2009 impacted FY 2010 requirements because this high-dollar equipment has a multi-year life expectancy and did not yet need replacement. Of the total sales depicted below, 27.4 percent are joint/shared sales.

The need for more initiatives within the medical/surgical commodity is evident. The A&MMMWG continued to meet regularly and discuss ways to increase joint contracts and sales. The WG continues to focus on initiatives and strategies to affect the expansion of the medical/surgical joint contracts.

Figure 6 – Joint Sales

*Amount is shown in $ millions

Commodity	FY10 (through 2nd Qtr)	FY09 (through 2nd Qtr)	Change (through 2nd Qtr)
Pharmaceuticals	$1,115.64	$1,108.73	$6.91
Medical/Surgical Supplies	$0.015	$0.016	($0.001)
Equipment	$223.5	$368.63	($145.13)
Total	$1,339.16	$1,477.38	($138.22)

Sub-goal 5.3
Enhance the joint VA/DoD medical surgical electronic catalog.

HEC A&MMMWG

Over the past four years, DoD Medical Surgical Product Data Bank (MEDPDB) has expanded to include VA medical surgical product files, contract data and site purchase data. The resultant VA/DoD authoritative database contributes to the objective of a common electronic Federal catalog for medical surgical items and constitutes a precursor to a joint Federal electronic catalog capability. Both Departments continued to further integrate MEDPDB capabilities into their internal logistical

systems, expand its capabilities based upon new data sources and improved data algorithms, and leverage the health care industry's move toward use of global data standards.

In FY 2010, VA and DoD processed more than 51 million individual records from 87 unique data sources to update the MEDPDB monthly. Sources include 39 manufacturers (an increase of four from FY 2009), two DoD and seven VA prime vendors and distributors, and 269 VA and DoD medical treatment facilities. MEDPDB's synchronized data and powerful analysis tools provide VA and DoD the unique ability to analyze spending, resource and standardize products, manage assemblages, and determine best pricing from a single system. This capability is unique because no one in the Health Care Supply Chain system has an application that contains the level of synchronized data and the large volume of both government and commercial data that is stored in MEDPDB.

In FY 2010, a pilot project expanded MEDPDB to include VA and DoD pharmaceutical and medical equipment data. Analysis of the initial data set identified significant opportunities for cost savings. The task to refine this capability for production was approved by both VA and DoD via a submission for future JIF funding. The HEC will evaluate the proposal for funding and DoD/VA anticipates a decision in FY 2011.

As VA and DoD expanded the capabilities and utility of the MEDPDB, its user base continued to grow. The number of active users increased from 684 in October 2009 to 869 in October 2010, or 27 percent. During the same period, monthly usage in the form of individual queries increased from 116,000 to 147,000, or 27 percent. Increasing the number of active users has enabled MEDPDB to increase price product reductions across both Departments. The VA/DoD combined cost avoidance during FY 2010 was $13.2 million as indicated in Figure 7. Additionally, in FY 2010 VA and DoD transitioned over $16.8 million in customer buys from less efficient local purchase processes to more beneficial eCommerce venues.

Figure 7 – Cost Avoidance

Quarter	DOD	VA	Total
1	$2,337,384	$809,066	$3,146,450
2	$1,829,334	$947,033	$2,776,368
3	$2,326,793	$918,453	$ 3,245,247
4	$2,531,761	$1,526,679	$4,058,441
Total	$9,025,273	$4,201,232	$13,226,505

The joint VA/DoD JIF partnership continued to provide an active and effective Federal forum to promote industry adoption of global health care data standards and a health care Product Data Utility network that will benefit both Service members and Veterans. DoD continued working with health care industry standards groups and VA and DoD suppliers on implementing global

data standards and data sharing. As a result, major health care industry providers are now endorsing use of uniform health care global data standards. VA and DoD are strategically positioned to take maximum advantage of these new standards, which will enhance both Departments' capability to realize best possible pricing for quality medical surgical products.

In FY 2010, the A&MMMWG continued to expand the DoD Healthcare Global Data Synchronization Network pilot. This pilot was initiated by the WG in 2007 and now includes over 75 participants, an additional growth of 27 in FY 2010. Groups participating in the pilot include manufacturers, prime vendors, major Group Purchasing Organizations and hospitals. The DoD test successfully acted as a catalyst with industry stakeholders to advance the U.S. health care industry's adoption of global data standards for product identification and uniform trading partner organizational identifiers. The major health care medical surgical group purchasing organizations mandated that all their providers must use trading partner identifiers (Global Location Numbers (GLNs)) by 2010 and standard product identifiers (Global Trade Item Numbers) by 2012. Nine of the top twenty VA/DoD suppliers are prepared to meet the December 2010 sunrise for GLN capability.

Additionally, the international health care standards group is now working toward implementation and use of global data standards throughout the medical supply chain. The genesis of all these accomplishments was DoD's initiative to work with industry and identify a global data standards solution to benefit all supply chain trading partners. The VA/DoD MEDPDB partnership continues to provide a test bed for the entire health care industry to successfully implement global data standards that will greatly benefit VA and DoD operational effectiveness and efficiencies for years to come.

In FY 2010, VA and DoD completed deployment and training of the jointly developed Web-based product pricing and sourcing tools to all 269 VA and DoD sites. Since the project's inception in 2003, the tools have generated over $54 million in product price reductions and encouraged $41 million in purchases through more efficient electronic capabilities.

The VA/DoD program continued to benefit from previously developed data synchronization pricing and site data enhancement applications (eZSAVe). MEDPDB is one of the seven approved VHA strategies for reporting data as part of the VA Secretary's cost saving/avoidance report to the OMB. MEDPDB was accepted as an authoritative database by the staff certifying the data. As a result, VA savings increased by $2.6 million from FY 2009 due to mandated use of the tool. A&MMMWG continued to incorporate commercial benchmarking data into MEDPDB customer product resource/pricing capabilities. More than 290,916 records for top VA and DoD products now have a synchronized commercial match, an increase of over 65,000 records from FY 2009, with 45 percent having certified master packaging and an incorporated price point. In FY 2010 the initiative was improved through enhancements based upon VA and DoD customer needs and requirements. Highlights include the ability to analyze VA spending by budget code, vendor, or site, the integration of commercial pricing and related data, and improved algorithms for calculating average price and best price. In addition, DoD theater users in Iraq and Afghanistan can locate items stocked by the suppliers more easily, decreasing item retrieval time and increasing the availability of supplies to treat patients.

A total of 11 DoD MTFs and 93 VA sites received new user and follow up training in eZSAVe pricing/sourcing capabilities in FY 2010. The training also included MEDPDB sourcing/readiness capabilities since the eZSAVe application is now merged into one Web platform. As a result, both VA and DoD customers at these sites have access to multiple MEDPDB capabilities, e.g., spend analysis, best Federal price, assemblage management, product price reductions, etc., through a single access log on capability.

Plans are underway to integrate the Common Catalog functionality into VA and DoD logistics systems. In FY 2010, VA/DoD transitioned their joint MEDPDB from a commercial environment to within the DoD medical business environment. During this effort, MEDPDB processes were updated to conform to DoD systems platform requirements, e.g., technical, operational authorities, information assurances, etc., in order to operate within DoD's secure operational systems' environment and control. This transition to a more secure operating environment will continue into FY 2011 as the entire MEDPDB build process is afforded the protection of the DoD firewall.

Sub-goal 5.4
VA and DoD will collaborate to improve business practices related to financial operations.

HEC Financial Management Working Group

The Financial Management WG (FMWG) completed the financial reconciliation methodology for the North Chicago FHCC demonstration project. The reconciliation methodology will be used as an assessment tool to validate the financial responsibility between the two Departments and will become the basis for transferring funds into the Joint Demonstration Fund for the FHCC in future FYs.

Sub-goal 5.5
Successfully manage the VA/DoD Joint Incentive Fund for health care sharing.

HEC Financial Management Working Group

The FMWG has implementation responsibility for the VA/DoD Health Care Sharing JIF. The FMWG reviewed and scored JIF submissions for FY 2010. The panel recommended 13 new projects to the HEC for approval. Approved projects were funded, meeting the goal of allocating 80 percent of funds within 60 days. The FMWG will monitor implementation throughout the life of the project.

Sub-goal 5.6
Identify, document, and increase joint facility utilization and resource sharing.

HEC Joint Facility Utilization and Resource Sharing Working Group

In FY 2010, the HEC Joint Facility and Resource Sharing WG (JFURS WG) continued their Joint Marketing Opportunities (JMO) activities to optimize sharing opportunities between VA and DoD. The JMO efforts serve to improve collaboration between VA and DoD medical facilities where demand and economies of scale can be optimized to achieve the overarching objectives of maintaining or increasing access to care, reducing infrastructure, improving efficiency and/or streamlining governance, and strengthening provider practices and quality while mitigating the

impact of deployment. Five potential joint markets and individual sites were identified for FY 2010: Fayetteville, North Carolina; San Diego, California; Oklahoma City, Oklahoma; Omaha, Nebraska; and Phoenix, Arizona. During site visits, based on the needs of the individual markets, the JMO team recommended possible joint initiatives and the development or the enhancement of joint executive committees to facilitate ongoing communication, develop new joint initiatives, and monitor progress on shared objectives. Each potential joint market has completed or is in the process of completing Interim Progress Reviews which will delineate potential opportunities for enhanced joint facility utilization and resource sharing. One significant outcome from the JMO team effort is the submission of a FY 2011 JIF proposal from the 72nd Medical Group (MDG), Tinker AFB and the Oklahoma VAMC for a joint Magnetic Resonance Imaging (MRI) machine. This was a direct result of the JMO visit, discussion of the JIF process, and the team's ability to assist the local site with developing their proposal.

In April 2010, pursuant to section 706 of the NDAA for FY 2009, an Executive Agreement for the North Chicago FHCC demonstration project was signed by the Secretaries of VA and DoD. The FHCC combines manpower and resources from Naval Health Clinic Great Lakes and the North Chicago VAMC. This fully integrated health care center will provide care to Active Duty Service members, including Navy recruits attending boot camp at Naval Station Great Lakes, as well as military family members, retirees, and Veterans. This new health care center will ensure a patient-centered environment for all who are served at the facility.

In May 2010, the Alaska VA Health Care System opened a new VA Outpatient Clinic in Anchorage. This new facility was built on an 11 acre parcel of Air Force land located just outside the Muldoon entrance to Elmendorf AFB. The new, larger clinic will expand services and improve the environment of care for Veterans and their families.

In September 2010, VA selected the construction contractor to build the Denver VAMC replacement hospital and initiate pre-construction services. The new hospital will be on the same campus as the University of Colorado Hospital complex in Aurora, site of the former Fitzsimons Army Medical Center (AMC). This project provides collaboration and joint operation of both VA and Buckley AFB/DoD medical services on the new site.

Also, in September 2010, Naval Health Clinic Charleston (NHCC) and the Ralph H. Johnson VAMC (RHJVAMC) CBOC opened a new Joint Ambulatory Care Clinic for patient care in Goose Creek, located onboard Naval Weapons Station, Charleston, South Carolina. The clinic was built as a joint venture with the Naval Health Clinic Charleston. The new, larger clinic will expand services and improve the environment of care for Veterans and their families.

Sub-goal 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

The JFURS WG continued to discuss the importance of metric development with all sites to ensure that sharing initiatives can be documented and performance can be evaluated and measured. The Enhanced Document and Referral management tool (eDR) became fully

functional in the Hawaii joint market in September 2010. The JMO team will conduct a site visit to Hawaii in early FY 2011 to evaluate the tool and its ability to provide accurate document and referral management data capture and retrieval. If the eDR tool is found to be successful for use in measuring sharing initiative metrics, the tool may be explored further for functionality and exportability at other VA/DoD sharing and joint venture locations.

HEC Pharmacy Ad Hoc Working Group

In FY 2010, the HEC Pharmacy WG identified pharmaceuticals and commonly used products and manufacturers for potential joint contracting action and continued to seek new joint contracting opportunities. The WG achieved all performance measures related to joint contracts. A review of purchases for new and existing joint contracts yielded 84 joint national contracts. Forty-eight joint national contracts were awarded. As of the third quarter of FY 2010, VA spent a $127 million on joint national contracts, and DoD spent $10.3 million. In quarters one through three, VA joint national contract prime vendor purchases represented 4.38 percent of total prime vendor purchases; DoD purchases represented 0.69 percent. VA identified zero drugs within the top 25 drugs as measured by acquisition dollar volume that lost patent exclusivity; DoD identified and reviewed one drug losing patent exclusivity. VA identified 42 new molecular entities used in the ambulatory setting for contracting opportunities. All 42 entities have been reviewed or are currently under review. DoD identified and reviewed six new entities. Fifty-one joint national contracts expired in FY 2010. All 51 expiring joint national contracts were reviewed for renewal, re-procurement or termination. Joint contracting efforts maximize leverage with the pharmaceutical industry, resulting in lower pharmaceutical procurement prices and significant cost avoidance for both Departments. Cost avoidance increases the opportunity to continue to sustain the robust pharmacy benefits provided to both VA and DoD beneficiaries.

GOAL 6
JOINT MEDICAL CONTINGENCY/READINESS CAPABILITIES

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

The objective established at the beginning of FY 2010 is to incorporate VHA capabilities into applicable DoD functional, concept, and operations plans by the end of the FY. Interim steps were established to achieve this objective including milestones to be reached in 2010 and 2011.

Addressing 2010 milestones, VA and DoD surveyed existing U.S. Northern and Transportation Command functional, concept and operations plans in order to determine current DoD bed and patient transport flow requirements and to ascertain the combatant commands' contingency requirements that could be supported by VHA. Neither combatant command has identified any VA support requirements in their current plans. For 2010, the Departments also pledged to review the DoD Mobility Capabilities and Requirements Study (MCRS) upon its completion. The MCRS was completed in early 2010 but the follow-on study, which includes aeromedical evacuation and bed requirements, will be completed in December 2010. Initial indications are that the follow-on study will quantify overall requirements in sufficient detail to determine the level of VHA support that will be required during major contingency operations.

While these planning and programming review efforts evolved in FY 2010, both Departments continued to pursue training and exercise programs geared to ensure the preparedness of current contingency assets. Education and training specialists from both Departments worked closely to conduct a comprehensive curriculum review of both the introductory and refresher courses available for VA and DoD personnel at Primary Receiving Centers and Federal Coordinating Centers. Unfortunately, catastrophic flooding at the training site forced the cancellation of both courses this FY. Training was rescheduled for November 2010. Efforts to leverage patient reception exercise activities met with better results in FY 2010. Full scale patient reception exercises were independently conducted at various Federal Coordinating Centers throughout the year and a comprehensive VA and DoD patient movement system exercise was conducted in conjunction with the National Disaster Medical System and the Louisiana Medical Institution Evacuation Plan exercise in May 2010.

DoD recognizes VHA is an essential partner in supporting its medical requirements during major wartime contingencies. The medical activities of both Departments will continue planning, training, and exercising together to be prepared to meet any potential contingency requirement.

ADDITIONAL ACCOMPLISHMENTS

While the JSP FY 2010-2012 serves as a guide for reporting JEC accomplishments, the opportunities for collaboration in FY 2010 extended beyond the boundaries of the JSP and allowed the Departments to engage in further collaborative initiatives as demonstrated below:

North Chicago Federal Health Care Center Operations

The North Chicago FHCC demonstration project is the culmination of over five years of collaboration between VA and DoD. FHCC first clinically and administratively integrated facility of its kind in the nation, highlighted by a single governance structure covering personnel, IM/IT and financial integration. The facility will serve both VA and DoD beneficiaries as an integrated entity. The North Chicago FHCC demonstration project held a dedication ceremony on October 1, 2010.

The FY 2010 NDAA provides authority for the implementation of a DoD/VA Medical Facility Demonstration Project in North Chicago. This legislation resulted from the collective efforts of OMB, congressional staff, DoD, Department of the Navy, Bureau of Medicine and Surgery, Navy Medicine East, VISN 12, VHA and VA Central Office to address the complex issues of combining specific functions of two Federal agencies. Widespread collaboration was necessary to address the issues surrounding the complex integration of the two Federal agencies with different missions.

The FY 2009 NDAA directed the creation of an Executive Agreement to lay out all policies and procedures for the operation of the FHCC. The Executive Agreement was developed and approved by both Department Secretaries in April 2010 and contains Executive Decision Memoranda for pharmacy formulary, pharmacy prime vendor utilization, and budget/reconciliation. A Total Workforce Management and Personnel Plan was developed and approved to outline the requirements and the associated mechanism for complying with total force manpower management reporting, as required by the Executive Agreement.

The chartered FHCC Advisory Board held its inaugural meeting October 2009. The Advisory Board represents national VA and Navy leadership in providing input on strategic direction for the FHCC in accomplishing its mission and vision with a focus on access, quality, patient satisfaction, efficiency, readiness, employer of choice and functional status.

Health Care Resource Sharing

10th MDG, U.S. Air Force (USAF) Academy/Eastern Colorado HCS

In January 2010, the 10th MDG at the USAF Academy and the VA Eastern Colorado Health Care System (VAECHCS) signed a sharing agreement that opens the door to sharing general and specialty surgical services at the 10th MDG with the VAECHCS Colorado Springs Community Based Outpatient Clinic (CBOC). The purpose of this sharing agreement is to improve patient access to these services and to relieve a backlog of patients awaiting uncomplicated and elective surgeries in the VA system. The Veterans using this service will be primarily Southern Colorado residents who would otherwise have to travel approximately 100 miles to the Denver VAMC, sometimes in very inclement weather. This provides a valuable service for Veterans

living in the Southern Colorado surrounding area and provides 10th MDG physicians and support staffs with the opportunity to increase the numbers and types of cases seen thereby improving clinical currency and readiness requirements.

USAF School of Aerospace Medicine, Brooks City Base/STVHCS

In June 2010, the USAF School of Aerospace Medicine (USAFSAM) at Brooks City Base, Texas entered into a sharing agreement with STVHCS where a USAFSAM ophthalmologist/oculoplastic surgeon will participate in clinical and teaching activities at the Audie L. Murphy VAMC (ALMVAMC). The sharing agreement is the result of a need for a clinical instructor in Oculoplastic and Reconstructive Surgery at the ALMVAMC's Ophthalmology residency program. In turn, this agreement enhances and helps maintain the USAFSAM provider's proficiency in the area of oculoplastic and reconstructive surgery while providing a much needed service in this clinical specialty that benefits both the students and VA patients at ALMVAMC.

U.S. Naval Hospital (USNH) Guam/VA Guam CBOC

USNH Guam provides specialty outpatient, inpatient, laboratory, radiologic and pharmacy services on a reimbursable and space available basis for Veterans under a long-standing agreement. The Veterans primary care clinic, the only VA health care services available on the island, is currently housed within a wing of the Naval Hospital. However, a brand new CBOC, located just outside the Naval Hospital compound, had its grand opening on Veterans Day 2010.

Naval Branch Health Clinic Key West/VA Key West CBOC

Naval Branch Health Clinic (NBHC) Key West and the Miami VA HCS Key West CBOC continue to work closely as a team providing quality health care services to the VA and eligible DoD beneficiaries. NBHC occupies a 57,000 square foot building with 10 percent of the total facility utilized by the VA Outpatient Clinic. The sharing agreement provides MH, physical therapy, pharmacy, laboratory, and radiology services to both VA and DoD beneficiaries. The VA also provides TRICARE primary care, physical therapy, and psychiatry outpatient services to eligible personnel. Optometry, spirometry, and audiology are provided by NBHC Key West on a space available basis.

NBHC Key West actively engages in collaborative hands-on training with staff at Naval Air Station Key West (NAS Key West) while complying with building security, safety, and environment of care provisions. In FY 2010, NBHC Key West provided anti-terrorism training to VA and together the DoD/VA team successfully completed an interactive drill hosted by NAS Key West. Training is continually provided for hurricane preparedness and the Miami VA HCS provided Prevention and Management of Disruptive Behavior training to NBHC Key West assuring the utmost safety and security of all staff and patients. Daily communication between clinics and quarterly meetings with Miami and NBHC Key West leadership resulted in providing high quality, safe patient care for VA and DoD beneficiaries. The joint clinic has enhanced the ability to provide services to both the VA and DoD beneficiaries with the two Departments working closely together to make the work look and feel seamless.

Naval Health Clinic, Charleston/Ralph H. Johnson VAMC Goose Creek Clinic

On September 21, 2010, Naval Health Clinic Charleston (NHCC) and the Ralph H. Johnson VAMC (RHJVAMC) CBOC opened a new Joint Ambulatory Care Clinic for patient care in Goose Creek, located onboard Naval Weapons Station, Charleston, South Carolina. NHCC provides primary care services to 15,500 enrolled TRICARE Prime patients and specialty care outpatient services to 26,000 TRICARE Prime patients enrolled at the NHCC and the 628th MDG, Charleston AFB. The RHJVAMC CBOC offers primary care and mental health services to 8,000 enrolled VA beneficiaries. Through resource sharing agreements, NHCC and RHJVAMC provide joint services in cardiology, orthopedics and phlebotomy. Continued shared services include the mobile MRI services purchased through a JIF initiative in April 2008. To date over 4,000 services valued at over $2.9 million have been provided to joint beneficiaries.

Brooke AMC/Walter Reed AMC/Center for the Intrepid (CFI)/Providence VAMC

In FY 2010, AMEDD had the highest number ever of active resource sharing agreements, with seven new agreements added in 2010. The AMEDD also participates in collaborative investigation and analysis of new innovative sharing opportunities that benefit both Departments' beneficiary populations. An example of this new technology is an advanced prosthetic arm being developed between the Army, VA, DARPA, and a contracted firm. Patients and staff at the CFI, Department of Orthopedics and Rehabilitation, Brooke AMC, and Walter Read AMC have been collaborating with VA researchers on a study to refine a very advanced, high-tech, prototype prosthetic arm. The prosthetic arm will make it possible for wounded warriors to accomplish tasks never thought possible and is one of the biggest innovations in prosthetic arms since World War II. Currently, joint research teams are working to conduct a large-scale clinical "optimization" study of the arm in order to enhance the final design and development of the device.

JIF

38 U.S.C. Section 8111(d) authorizes the DoD/VA Health Care Sharing JIF to provide seed money for creative sharing initiatives at facility, intra-regional and national levels to facilitate the mutually beneficial coordination, use, or exchange of health care resources, with the goal of improving the access to, and quality and cost effectiveness of, health care provided to beneficiaries of both Departments. The minimum contributions to the fund are $15 million from each Department between FY 2004 – FY 2015 ($30 million per year).

Now in the eighth year of implementation, the Departments have contributed a total of $364 million to the fund. To date, 108 projects totaling $363 million have been approved and are in various stages of progress. VA performs the financial administration of the JIF, per the MOA, covering the program. The following are some innovative projects initiated in FY 2010.

> #### *VA/DoD National - IM/IT Interim Pharmacy Solution*
> This project proposes to establish an IM/IT interim pharmacy solution that is focused on and will ensure the successful activation of the North Chicago FHCC demonstration project by December 2010. The goal is for VA and DoD to work jointly to arrive at solutions to meet the pharmacy requirements of both Departments by providing one-year pharmacy staffing to implement a "work-around" to a gap in IT capability. This gap created several unacceptable patient safety risks that could only be overcome by having licensed pharmacists manually input the necessary functions that will be performed automatically when the IT solution is deployed. Cost: $1,000,000

Alaska VAMC/3rd MDG, Elmendorf AFB – Pain Management

This initiative adds pain management services to 3rd MDG to recapture both Air Force private sector care and VA fee patients currently being referred to the private sector. The project will allow the 3rd MDG to contract for one anesthesiologist and one support nurse. Cost: $1,217,600

James A. Haley Veterans' Hospital/6th MDG, MacDill AFB – Physical Therapy

This initiative provides expanded access to physical therapy services for DoD beneficiaries and Veterans at the 6th MDG. The 6th MDG Physical Therapy department has sufficient facility capacity to absorb more workload but requires additional staffing to do so. The initiative calls for funding of two physical therapists and four physical therapy technicians. Cost: $1,114,773

Charleston VAMC/NHC Charleston/437th MDG – Optometry

This initiative proposes for VA to stand up a joint Optometry Clinic and provide services to DoD beneficiaries and Veterans. The proposal requests funding for five full time employees, equipment, IM/IT support, furniture, staff training/travel and other miscellaneous supplies. The staffing requirements include two optometrists, two optometry technicians, and an administrative clerk. Cost: $931,472

O'Callaghan Federal Hospital/99th MDG, Nellis AFB – Dialysis

This initiative proposes to implement a joint outpatient and inpatient dialysis service that provides dialysis for DoD beneficiaries and Veterans. The outpatient service will provide initial (first 90 days) dialysis treatment. The project also includes minor renovation of existing space to establish two treatment stations, storage, clean/dirty utility areas, and furniture. Staffing requirements are two registered nurses, four dialysis technicians, and one administrative technician. Cost: $1,790,750

San Diego VAMC/NMC San Diego – Linear Accelerator

This initiative will build upon the successful radiation therapy services at NMC San Diego by adding another linear accelerator. This expansion would allow both organizations to have shared ownership of an important medical infrastructure asset that allows leverage of economies of scale to the aggregate benefit of both Departments. Cost: $5,811,300

VA Gulf Coast Veterans HCS (VAGCVHCS)/81st MDG Keesler – Sleep Lab

This initiative is to sustain the existing sleep lab operations at the 81st MDG and provide additional staff to increase the overall number of available annual appointments. This project will also fund four additional technologists (two VA and two DoD), a VA program assistant and upgrade for the existing equipment for the Joint Sleep Diagnostic/Treatment Laboratory located at the VAGCVHCS Biloxi, Mississippi Campus. Cost: $ 733,252

JEC Separation Health Assessment Working Group

The JEC leadership created the VA/DoD Separation Health Assessment WG to address concerns about the lack of a standardized health assessment process for all separating Service members. The Co-Chairs of the WG include senior representatives from VA and DoD. The working group's mission was to evaluate current separation/transition-related physical and mental health assessment processes and their use; identify gaps and inefficiencies; identify governance issues; and clarify monitoring and reporting procedures. The WG submitted recommendations at the September 10, 2010 JEC which included a joint VA/DoD MOU outlining the WG's formal commitment to full implementation of a Transition/Separation Health Assessment Program. The JEC Separation Health Assessment WG will draft subsequent policies based on JEC guidance and develop recommendations for official monitoring and reporting capabilities for quarterly review by the BEC and HEC.

BEC - TAP Steering Committee Working Group

The JEC Meeting held March 30, 2010, highlighted mandatory TAP as one of three topics of consideration of the Deputy Secretary of the VA in support of JSP Goal 3, "Seamless Coordination of Benefits". As a result of this meeting, the BEC was instructed to coordinate with the TAP Steering Committee, to examine trends of TAP attendance and determine if the issue of participation for the VA Benefits briefing is one of availability or choice.

In an effort to increase participation for TAP, the TAP Steering Committee was asked to develop a plan to achieve a 100 percent goal for Service member participation in the VA Benefits Briefing or receive VA benefits information online prior to separation. The BEC was asked to develop an implementation plan in collaboration with the DOL on how to assess the quality of the TAP program and customer satisfaction. The other areas of focus include: VA Communications; possible incentives for TAP participation; a revamp of the VA portion of TAP and the Disabled Transition Assistance Program; research on TAP trends and participation rates; availability of resources; and developing an implementation plan to evaluate the quality of TAP Services and customer satisfaction. The results of the implementation will be reported in the FY 2011 AR.

SECTION 3 – NEXT STEPS

The accomplishments described in this year's *Department of Veterans Affairs* (VA)/*Department of Defense* (DoD) *Joint Executive Council* (JEC) *Fiscal Year* (FY) *2010 Annual Report* demonstrate concerted efforts within VA and DoD to improve the multiple areas of joint responsibility that directly affect the care and benefits of Service members and Veterans. This report provides updates in strategic areas that will continue to evolve until these joint initiatives become fully institutionalized into everyday operations. Both Departments are sincerely committed to maintaining and improving the collaborative relationships that make this progress possible.

Moving forward, the JEC will continue to set the strategic direction using the revised Joint Strategic Plan (JSP) framework for joint coordination and sharing efforts between VA and DoD. The *VA/DoD JEC JSP* FY 2011-2013 updates and improves upon the objectives from the JSP FY 2010-2012 to focus on performance outcomes and will be published later this FY. These enhancements are designed to help VA and DoD demonstrate and track progress toward defined goals, objectives, and end-states, and provide the continuum to successfully meet the needs of Service members and Veterans.

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

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

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

I. PURPOSE

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

II. AUTHORITY

The Secretary of Veterans Affairs and the Secretary of Defense establish these guidelines pursuant to the authorities in and requirements of Title 38, United States Code, section 81 11 (38 U.S.C. 5811 I), 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 approve/disapprove VNDoD resource sharing agreements and joint ventures is delegated to the Secretaries of the Military Departments (or their designees) for DoD and to the appropriate VA Central Office designees for VA. The designated approval authority for both DoD and VA must approve or disapprove a proposed agreement within 45 days of receipt. If action is not communicated to both signatories to the agreement at the end of the 45-day period, the agreement is considered as approved on the 46th day.

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

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

V. EFFECTIVE DATE AND MODIFICATION OF GUIDELINES

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

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

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

_____/s/_____   _____/s/_____
Gordon H. Mansfield   Gordon England
Deputy Secretary of Veterans Affairs   Deputy Secretary of Defense
October 29, 2008   October 31, 2008

Appendix B
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 $ 76,246
Contract(s) Cost $ 38,383
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 2010 hourly rate structure for the metropolitan Washington, DC area. The calculated net labor costs were multiplied by the fiscal year 2010 fringe benefit amount of 36.25 percent. The reported information in the cost statement reflects the sum of direct labor hour costs and fringe benefits.

Glossary of Abbreviations and Terms

AY – Academic Year
AFB – Air Force Base
AHLTA – Armed Forces Health Longitudinal Technology Application
ALTBI – Assisted Living Traumatic Brain Injury Pilot Program
ALMVAMC – Audie L. Murphy VAMC
AMC – Army Medical Center
AMEDD – Army Medical Department
A&MMMWG – Acquisition and Medical Materiel Management Working Group
AR – VA/DoD JEC Fiscal Year 2010 Annual Report
BEC – Benefits Executive Council
BDD – Benefits Delivery at Discharge
BHIE – Bidirectional Health Information Exchange
CBOC – Community Based Outpatient Clinic
CBSWG – Communication of Benefits and Services Working Group
CCD – Catastrophic Cap and Deductible
CDR – Clinical Data Repository
CFI – Center for the Intrepid
CHAMP – Comprehensive High-level Activity Mobility Predictor
CHDR – Clinical Health Data Repository
CoE – Center of Excellence
CONOPS - Concept of Operations
CPC – Construction Planning Committee
CPGs – Clinical Practice Guidelines
CRP – Comprehensive Recovery Plan
CWG – Communications Working Group
DARPA – Defense Advanced Research Projects Agency
DCoE – Defense Centers of Excellence
DES – Disability Evaluation System
DHWG – Deployment Health Working Group
DoD – Department of Defense
DoDI – Department of Defense Instruction
DOL – Department of Labor
DS log-on – Defense Self-Service log-on
DTRS – Deployed Tele-Radiology System
DUA – Data Use Agreements
DVEIVR – Defense and Veterans Eye Injury and Vision Registry
EACE – Traumatic Extremity Injuries and Amputations Center of Excellence
EBP – Evidence Based Psychotherapy
eDR – Enhanced Document Referral
EHR – Electronic Health Record
EXCOM – Executive Committee
eZSAVe – Data Synchronization Pricing and Site Data Enhancement Application
FHCC – Federal Health Care Center
FHIE – Federal Health Information Exchange
FMWG – Financial Management Working Group

FOC – Full Operating Capability
FRC – Federal Recovery Coordinator
FRCP – Federal Recovery Coordination Program
FY – Fiscal Year
GAO – Government Accountability Office
GLN – Global Location Numbers
HAIG – Health Architecture Interagency Group
HAIMS – Healthcare Artifact and Image Management Solution
HCE – Hearing Center of Excellence
HCS – Health Care System
HDR – Health Data Repository
HEC – Health Executive Council
HPE – Health Professions Education
HHS – Department of Health and Human Services
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
IDA – Institute for Defense Analyses
IDES – Integrated Disability Evaluation System
IE – Information Exchange
IMHS – Integrated Mental Health Strategy
IM/IT – Information Management/Information Technology
IOC – Initial Operating Capability
IOM – Institute for Clinical System Improvements and the Institute of Medicine
IPEB – Informal Physical Evaluation Board
IPO – Interagency Program Office
IRB – Institution Review Board
IS/IT – Information Sharing/Information Technology
IT – Information Technology
JALFHCC – James A. Lovell Federal Health Care Center
JEC – Joint Executive Council
JFURS – Joint Facility Utilization and Resource Sharing
JIF – Joint Incentive Fund
JMO – Joint Market Opportunities
JSP – VA/DoD JEC Joint Strategic Plan
JTTR – Joint Theater Trauma Registry
JTTS – Joint Theater Trauma System
LMS – Learning Management System
LUT – Limited User Testing
MCRS – Mobility Capabilities and Requirements Study
MCS – Millennium Cohort Study
MDG – Medical Group
MEDPDB – Medical Surgical Product Data Bank
METRC – Major Extremity Trauma Research Consortium
MH – Mental Health

MHS – Military Health System
MOA – Memorandum of Agreement
MOTR – Military Orthopedic Trauma Registry
MOU – Memorandum of Understanding
MOVE! – VHA Weight Management Program
M&RA – Manpower and Reserve Affairs
MRI – Magnetic Resonance Imaging
MRWG – Medical Records Working Group
MSC – Military Service Coordinators
mTBI – Mild Traumatic Brain Injury
MTF – Military Treatment Facility
NARA – National Archives and Records Administration
NAS – Naval Air Station
NBHC – Naval Branch Health Clinic
NCAT – NeuroCognitive Assessment Tool
NDAA – National Defense Authorization Act
NHCC – Naval Health Clinic Charleston
NICoE – National Intrepid Center of Excellence
NMC – Naval Medical Center
NRD – National Resource Directory
NwHIN – Nationwide Health Information Network
OEF – Operation Enduring Freedom
OIF – Operation Iraqi Freedom
OMB – Office of Management and Budget
OND – Operation New Dawn
OTM – Ocular Trauma Module
PDHA – Post-Deployment Health Assessment
PDHRA – Post Deployment Health Reassessment
PEB – Physical Evaluation Board
PEBLO – Physical Evaluation Board Liaison Officers
PH – Psychological Health
PPDHA – Pre- and Post-Deployment Health Assessment
QMO – Office of Quality Management
PTSD – Post Traumatic Stress Disorder
RCC – Recovery Care Coordinator
RCP – Recovery Coordination Program
RCP-SS – Recovery Coordination Program Support Solution
RHJVAMC – Ralph H. Johnson VAMC
RMC – Records Management Center
RSMs – Recovering Service members
SAMHSA – Substance Abuse and Mental Health Services Administration
SCIP – Strategic Capital Investment Planning
SMC – Senior Management Committee
SME – Subject Matter Expert
SND – Suicide Nomenclature and Data
SOC – Senior Oversight Committee
SPARRC – Suicide Prevention and Risk Reduction Committee

STR – Service Treatment Record
STVHCS - South Texas Veterans Health Care System
TAP – Transition Assistance Program
TATRC – Telemedicine and Advanced Technology Research Center
TeamSTEPPS – Team Skills Training
TBI – Traumatic Brain Injury
TC2 – Theater Medical Information Program Composite Health Care System Cache
TIMPO – Tri-Service Infrastructure Management Program Office
Tip50 – Treatment Improvement Protocol
USAF – U.S. Air Force
USAFSAM – USAF School of Aerospace Medicine
USC – United States Code
VA – Department of Veterans Affairs
VAECHCS – USAF Academy and the VA Eastern Colorado Health Care System
VAGCVHC – VA Gulf Coast Veterans HCS
VAMC – VA Medical Center
VCA – VLER Capability Area
VBA – Veterans Benefits Administration
VCE – Vision Center of Excellence
VHA – Veterans Health Administration
VISN – Veterans Integrated Service Network
VistA – Veterans Health Information System Technology Application
VLER – Virtual Lifetime Electronic Record
VTA – Veterans Tracking Application
VTA IDES – Veterans Tracking Application for the Integrated Disability Evaluation System
WG – Working Group
WWCTP – Wounded Warrior Care and Transition Program
WWP – Wounded Warrior Program