



August 13, 2013



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

Dear Mr. Chairman:

The enclosed report responds to section 1661 of the National Defense Authorization Act for Fiscal Year 2008 (Public Law 110-181), which requires the Secretary of Defense and the Secretary of Veterans Affairs to develop a joint response on Phase II of a two-part study completed by the Institute of Medicine (IOM) in March 2013.

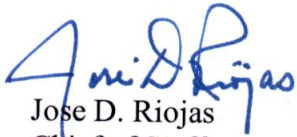
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Phase II of the IOM study concludes with 21 recommendations, in 7 major areas, for consideration by DoD/VA to help guide future research and service to address the full scope of issues faced by Service members, Veterans, their families, and communities. The DoD/VA have implemented multiple programs and high-priority strategic initiatives that demonstrate ongoing improvement efforts related to the areas addressed in the IOM's recommendations to include:

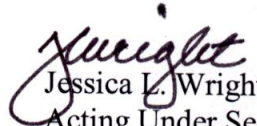
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- Increased interoperability of information between the Departments; and
- Partnerships with other Departments (Health and Human Services; Education) to develop standards for clinical data capture to inform research, reporting of adverse events, and public health applications.

Thank you for your interest in the health and well-being of our Service members, Veterans, and their families. A similar letter is being sent to the leadership of the congressional defense and Veterans committees.

Sincerely,



Jose D. Riojas
Chief of Staff
Department of Veterans Affairs



Jessica L. Wright
Acting Under Secretary of Defense
for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable James M. Inhofe



August 13, 2013



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

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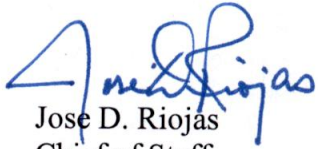
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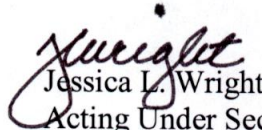
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Jose D. Riojas
Chief of Staff
Department of Veterans Affairs



Jessica L. Wright
Acting Under Secretary of Defense
for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member



August 13, 2013



The Honorable Barbara A. Mikulski
Chairwoman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Madam Chairwoman:

The enclosed report responds to section 1661 of the National Defense Authorization Act for Fiscal Year 2008 (Public Law 110-181), which requires the Secretary of Defense and the Secretary of Veterans Affairs to develop a joint response on Phase II of a two-part study completed by the Institute of Medicine (IOM) in March 2013.

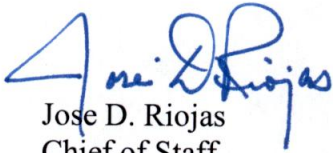
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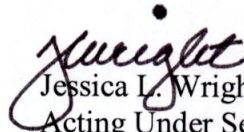
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Jose D. Riojas
Chief of Staff
Department of Veterans Affairs



Jessica L. Wright
Acting Under Secretary of Defense
for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Richard C. Shelby
Vice Chairman



August 13, 2013



The Honorable Harold Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed report responds to section 1661 of the National Defense Authorization Act for Fiscal Year 2008 (Public Law 110-181), which requires the Secretary of Defense and the Secretary of Veterans Affairs to develop a joint response on Phase II of a two-part study completed by the Institute of Medicine (IOM) in March 2013.


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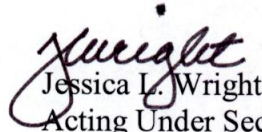
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Sincerely,



Jose D. Riojas
Chief of Staff
Department of Veterans Affairs



Jessica L. Wright
Acting Under Secretary of Defense
for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member



August 13, 2013



The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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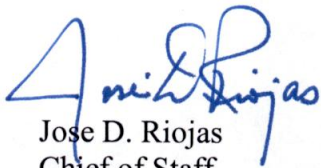
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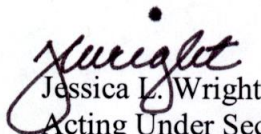
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Jose D. Riojas
Chief of Staff
Department of Veterans Affairs



Jessica L. Wright
Acting Under Secretary of Defense
for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Michael H. Michaud
Ranking Democratic Member



August 13, 2013



The Honorable Bernard Sanders
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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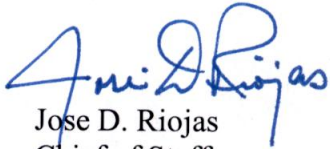
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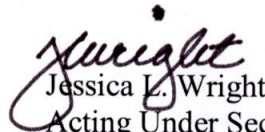
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Jessica L. Wright
Acting Under Secretary of Defense
for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Richard M. Burr
Ranking Member

REPORT TO CONGRESS

National Defense Authorization Act for Fiscal Year 2008, Section 1661

Study of Physical and Mental Health and Other Readjustment Needs of Members and Former Members of the Armed Forces Who Deployed in Operation IRAQI FREEDOM and Operation ENDURING FREEDOM and Their Families



May 2013

The estimated cost of report or study for the Department of Defense is approximately \$19,000 for the 2013 Fiscal Year. This includes \$0 in expenses and \$19,000 in DoD labor.

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Executive Summary

KEY MESSAGES

- The Department of Defense (DoD) and Department of Veterans Affairs (VA) submit this report in accordance with the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008, which directs the Secretary of Defense, in consultation with the Secretary of Veterans Affairs, to enter into an agreement with the National Academies to conduct a study of the readjustment needs of members and former members of the Armed Forces who were deployed in Operation IRAQI FREEDOM (OIF) or Operation ENDURING FREEDOM (OEF) and their families.
- The study, which was assigned by the National Academies to the Institute of Medicine (IOM), consisted of two phases. The first phase of the study was published in March 2010. The second phase was published in March 2013; this report is written in response to Phase II of the study and completes the requirements specified in the NDAA.
- The DoD and VA appreciate the efforts of the IOM, and concur with the recommendations for further areas of research and services related to readjustment needs of Service members, Veterans, and their families.
- Since the commencement of the study over two years ago, the DoD and VA have addressed the issues raised in the study and, as a result, enhanced the quality of life of our Service members, Veterans, and their families. Key initiatives that address the recommendations include:
 - Joint funding of research consortia to understand the chronic effects of Traumatic Brain Injury (TBI) and Posttraumatic Stress Disorder (PTSD);
 - Development and implementation of 28 Integrated Mental Health Strategic Actions to improve access, quality, effectiveness, and efficiency of mental health treatments across the Departments;
 - Joint development of Clinical Practice Guidelines (CPG) to advance implementation of evidence-based treatments in mental health;
 - Promotion of effective family programs to promote resilience and encourage help-seeking;
 - Enhancement and standardization of transition services prior to separation through the Transition Assistance Program (TAP);
 - Increased interoperability of information between the Departments; and
 - Partnerships with other Departments (Health and Human Services; Education) to develop standards for clinical data capture to inform research, reporting of adverse events, and public health applications.

KEY POINTS

- Phase II of the IOM readjustment study provides a comprehensive assessment of the physical, psychological, social, and economic effects of deployment, and identifies gaps in care for Service members, Veterans, and their families.
- In pursuit of this assessment, the IOM considered approximately 3,000 scientific articles/reports; collected data from the DoD and VA; and conducted ethnographic research to examine the effects of deployment on military communities.
- Phase II of the study concludes with 21 recommendations, in 7 major areas, for further areas of research and service.

- In this report, the DoD and VA respond to the recommendations in the seven major areas: (1) Outcomes; (2) Treatment; (3) Military Families; (4) Community; (5) Socioeconomic Impacts; (6) Access and Barriers to Care; and (7) Proposed Data Analysis. Detailed responses to all 21 recommendations are located in Appendix A, but briefly these efforts include:
 - 1) **Outcomes:** While many Service members and Veterans return from deployment relatively unscathed by their experience, others return from deployment with complex health outcomes that present life-long challenges and hinder readjustment. The DoD and VA recognize the need to understand the long-term effects of TBI, and psychological health (PH) disorders like PTSD, and are partnering in FY 2013 to jointly fund the “Consortium to Alleviate PTSD,” as well as the “Chronic Effects of Neurotrauma Consortium.” Concurrently, the DoD has invested more than \$20 million in longitudinal studies on readjustment needs of Service members and their families since September 2010. In order to address Military Sexual Trauma (MST), the DoD Sexual Assault Prevention and Response Office (SAPRO), with support from the Services, seeks to improve readjustment outcomes for Service members, Veterans, and their families.
 - 2) **Treatment:** The impact of participation in OIF and OEF over the past 10 years has placed a significant burden on the DoD and VA health care systems for screening, assessment, and treatment of PH disorders and TBI. In pursuit of addressing these demands, and augmenting integration and coordination between the Departments, the DoD and VA developed 28 Integrated Mental Health Strategies (IMHS) to improve access, quality, effectiveness, and efficiency of mental health treatment for Service members and Veterans. The DoD and VA also collaborate to promote implementation of evidence-based practices to treat Service members and Veterans with mental health and readjustment needs. Specifically, the DoD and VA advance best practices for evidence-based treatment through joint development of CPGs. The Departments have developed more than 60 clinical support tools to accompany the CPGs, in areas related to: major depressive disorder (MDD); substance use disorder (SUD); PTSD; bipolar disorder; and concussion/mild TBI (mTBI). In addition, the Departments currently offer extensive training for use of CPG-recommended evidence-based practices.
 - 3) **Military Families:** Military families, encompassing traditional and nontraditional families, often endure the adverse consequences of deployments (for example, health effects, family violence, and economic burdens). The DoD and VA recognize the need to support families, and focus on promoting effective family resilience programs (IMHS #16) and exploring methods to help family members identify mental health needs in Service members and Veterans by providing education and coaching (IMHS #17). These programs assist in the prevention of mental health issues for Service members, Veterans, or their families. In addition, DoD sponsors projects and programs that emphasize family concerns, to include: the Military Operational Medicine Research Program (MOMRP; 30 active research projects focused on military families); Families OverComing Under Stress (FOCUS); and the Family Advocacy Program (FAP; focus on prevention of family violence).
 - 4) **Community:** Published data on the effects of deployments on local communities are sparse. Historically, very little funding has been available for research as it relates to readjustment and local communities. Educational functioning of children of military

families is a primary focus of DoD efforts. The DoD has partnered with the National Guard and Reserve communities to provide resources to support school districts that educate children of military families. The DoD has awarded grants to school districts aimed at minimizing the effects of transitions and deployments. VA is also standing up a new Office of Community Engagement (OCE) to promote effective partnerships between communities and VA. However, the DoD and VA recognize that there is a gap in services for communities impacted by deployments, and intend to further explore this topic.

- 5) **Socioeconomic Impacts:** Unemployment and underemployment are acute challenges for military Veterans. The DoD and VA have partnered with other government entities in the Veterans Initiative Joint Task Force (VIJTF) to transform the TAP. TAP bolsters and standardizes the transition services that Service members receive prior to separating from the military to promote employment-readiness, and prepares Service members for higher education, career training, or starting a business. In addition, the DoD's *inTransition* program provides telephonic coaching support to Service members receiving mental health services as they transition between health care systems or providers, to include support to Service members with employment-related issues.
- 6) **Access and Barriers to Care:** The DoD and VA have a rich history of exchanging electronic health record data that dates back to 2001. These data exchanges have been expanded over time and continue to operate today. In recent years, the Departments have also begun exchanging electronic health record data with private health care providers who also render care to our patients. The availability of this data to our providers supports improved patient care for our shared patients. While the Departments have much success with interoperability, continued focus on improving these data exchanges is a priority. The DoD/VA Interagency Program Office (IPO) leads the development and implementation of systems, capabilities, and initiatives that allow for information interoperability between the Departments in order to better provide for Service members, Veterans, and other eligible beneficiaries. In addition, the DoD and VA are currently engaged in efforts to promote access to care by reducing mental health stigma, and encouraging treatment for mental health disorders including SUDs. In particular, the Departments support the provision of integrated and standardized services that can help reduce stigma associated with seeking care (IMHS #23), and improving access to (and quality of) care for women's mental health by identifying disparities in (and barriers to) care (IMHS #28).
- 7) **Proposed Data Analysis:** Analysis of data and databases available in the DoD, VA, and other federal agencies can augment understanding of the mental health and readjustment needs of Service members, Veterans, and their families. In response to the President's Executive Order, "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families," the DoD and VA partnered with Health and Human Services and the Department of Education to develop standards so that clinical data captured in an electronic health record during episodes of care can be supplemented with additional data for clinical research, adverse event reporting, and public health purposes. In addition, the DoD and VA established the Mental Health Interagency Task Force to improve collaborative efforts between the Departments for data sharing. This includes strategy development to overcome challenges with the interchange of information, including challenges with sharing data with academic and industry partners. In addition,

the DoD and VA worked with corporate partners to make their Health Data Dictionaries (data fields and definitions) available on public platforms.

DoD/VA POSITION IMPACT

- Approximately 2.5 million Service members had been deployed to OEF, OIF, and Operation NEW DAWN (OND) as of March 2013.
- The urgency of addressing readjustment issues is heightened by the large population affected; the multiple and frequent deployments of personnel to Afghanistan and Iraq; and the long-term effects that many of the issues might have on Service members, Veterans, and their families.
- As some data have shown that the readjustment and reintegration needs of Service members and Veterans peak several decades after a war, the DoD and VA are dedicated to managing current issues facing Service members, Veterans, and their families, and planning for future resources.

APPENDIX A

IOM Report Recommendations and DoD/VA Response

OUTCOMES: Recommendation #1

The committee recommends that the Department of Defense and the Department of Veterans Affairs sponsor longitudinal studies to answer many of the questions regarding long-term effects of traumatic brain injury, posttraumatic stress disorder, and other mental-health disorders. Such studies should strive to improve the validity of exposure measurements, identification and use of biomarkers, and recruitment and retention of subjects. Attention should be paid to whether the outcomes of traumatic brain injuries depend on the severity and number of such injuries, on the presence of comorbid conditions, and on sex and ethnicity.

Interagency Response (Joint DoD and VA)

In pursuit of augmenting understanding of the long-term effects of TBI, PTSD, and other mental health conditions, the DoD and VA are partnering in FY 2013 to jointly fund the “Consortium to Alleviate PTSD,” as well as the “Chronic Effects of Neurotrauma Consortium.” Both initiatives include identification and use of biomarkers, and enable intensive evaluations of the effects of comorbid conditions.

DoD Response

The DoD has invested more than \$20 million in longitudinal studies on readjustment needs of Service members, Veterans, and their families since September 2010. Example studies include: the Study to Assess Risk and Resilience in Service Members; the Millennium Cohort Study; RAND Corporation’s Deployment Life Study (DLS); and the DoD’s 15-year longitudinal study on TBI incurred by members of the Armed Forces during OIF and OEF.

The objective of the 15-year longitudinal study, now in its 4th year, is to augment understanding of the long-term effects of TBI. The study is comprised of an integrated collection of three research sub-studies developed to respond to the John Warner National Defense Authorization Act for FY 2007, section 721. To date, the study has driven the completion of 24 research projects resulting in 11 publications and 24 scientific conference presentations. Data analysis thus far reveals that a high proportion of Service members who sustain mild, moderate, and severe TBIs continue to report significant symptoms (cognitive, physical, and behavioral) up to 5 years post-injury, requiring continued care and support.

One of the sub-studies, the “Natural History Study,” specifically addresses the long-term physical and mental health effects of TBI incurred by members of the Armed Forces during service in OIF/OEF. The study’s purpose is to: (a) document the natural recovery of TBI for up to 15 years post-injury; and (b) identify the long-term health care, mental health care, and rehabilitation needs of Service members that sustained a TBI. Preliminary findings inform the existing knowledge base on the relationship between TBI outcomes and: (a) severity and number of injuries; (b) the presence of comorbid conditions; and (c) sex and ethnicity.

The DoD-funded RAND Corporation's DLS examines the effects of deployment on the emotional and physical health of military families over the course of 3 years. RAND's detailed analysis of the data is expected by FY 2016.

These studies are in addition to the supplemental FY 2007 DoD funding of \$300 million for PTSD and TBI research, and FY 2009 funding of \$55 million for PH and TBI research.

VA Response

VA has many ongoing longitudinal studies. Additional studies will be supported if they are determined to be scientifically meritorious through our standard peer review process. Highlights of ongoing longitudinal efforts include multiple cohorts of Vietnam-era Veterans who are being studied to evaluate physical and mental health status now, and changes over time since initial evaluation in the 1980s (CSP 569 & 579 Women Vietnam Veterans Longitudinal Study and National Vietnam Veterans Longitudinal Study). These studies will provide valuable information directly responsive to the IOM's recommendation, including for TBI, PTSD, and other disorders. Other ongoing longitudinal studies are focusing on recent deployments. These will examine changes from a pre-deployment baseline assessment to the post-deployment status, also addressing the IOM recommendation (for example, CSP 566). VA Research is responsive to this recommendation through support of other biomarker-related studies that are utilizing information from genetic and imaging data to further understand consequences of exposure, and in utilization of biomarkers for diagnosis or treatment. In all research studies, VA places emphasis on recruitment to ensure the question can be answered sufficiently. However, longitudinal efforts have an even more highly focused issue regarding retention in the study. VA investigators use a variety of proven methodologies to track and maintain cohorts, CSP 569 is a particular example that has been actively maintained for research purposes for over 20 years.

In the area of research on the long-term effects of TBI, VA currently has ongoing studies. VA investigators are studying biomarkers of transition to Alzheimer disease and chronic traumatic encephalopathy in Veterans with mild cognitive impairment who also have additional diagnoses of PTSD and/or TBI, as well as relating these biomarkers to the severity of disease and its progression and VA investigators are developing new methods that will utilize state-of-the-art imaging to aid in the diagnosis of chronic TBI-related brain loss. VA researchers are also investigating the long-term systemic effects of TBI by studying the hormonal imbalances caused by damage to the pituitary gland and how these imbalances affect rehabilitation. Other examples of VA-funded studies include: Cortical Excitability: Biomarker and Endophenotype in Combat Related PTSD; Mild TBI and Biomarkers of Neurodegeneration; Proteomic Identification of Plasma TBI Biomarkers; and Tau Biomarkers Following Blast mTBI in OEF/OIF Veterans.

VA has designed several conflict-era cohort studies to follow Veterans longitudinally: the Army Chemical Corps Vietnam Era Veteran Health Study; the Longitudinal Health Study of Gulf Era Veterans; and the Surveillance Study for a New Generation of U.S. Veterans (OEF/OIF). The Vietnam and 1991 Gulf War studies have followed the same panel for approximately one and two decades, respectively. The Army Chemical Corps study is currently collecting data for a second time, and the 1991 Gulf War study is collecting a third wave of data from the same panel. These studies have gathered information from population-based samples of Veterans, not limited to those using VA health care. This makes an important contribution to VA's understanding of the health care status and health care needs of the entire population, including both users and non-users of VA services. The surveys have included items on mental health, including PTSD,

physical health, functional health, and additional measures of health risk behavior. The New Generation Study of the OEF/OIF/OND cohort surveyed a sample of 60,000 Veterans, approximately half of which deployed, and it included the mTBI clinical screening questions used in VA medical centers, providing an opportunity to assess screening positivity for mTBI in the population. The next iteration of the New Generation survey is in the planning phase, with an expectation of fielding the survey in FY 2014. The longitudinal nature of these studies permits assessment of the validity of measures through sub-studies such as CSP 458, which included physical exams of Gulf War Veterans from the Longitudinal Health Survey panel, and additional opportunities through data linkage to assess diagnostic and treatment trajectories among the VA users in the survey panels.

OUTCOMES: Recommendation #2

The committee recommends that the Department of Defense develop policies to eliminate military sexual trauma as research demonstrates that it is associated with poor readjustment and mental-health and physical-health outcomes. The committee further recommends that the department reinforce existing policies on military sexual trauma by adding specific mandatory evaluation criteria regarding how well military leaders address the issue, for example, in the formal performance-appraisal and promotion systems.

DoD Response

Elimination of MST remains a top priority for the DoD, as evidenced by numerous policies adopted since 2010 that address training specific to the commander's role in sexual assault prevention and response, including: (1) new requirement for pre-command training of commanders; (2) victim privilege and advocate certification; (3) expedited transfers of victims and/or alleged offenders; (4) case file retention; (5) specialized training requirements for first responders; and (6) greater emphasis of prevention and awareness. These DoD policies aim to ensure that sexual assault victims receive timely and high-quality treatment, and that commanders at every level are held responsible for managing cases of sexual assault.

The DoD Directive (DoDD) 6495.01 (January 23, 2012), "Sexual Assault Prevention and Response (SAPR) Program," requires that the SAPR program provide the necessary and appropriate support for victims of sexual assault; specifically, if the victim is a Service member, the DoDD requires that SAPR support the Service member to be fully mission-capable and engaged. Furthermore, the program ensures that care provided to a sexual assault victim be "gender-responsive, culturally-competent, and recovery-oriented."

The DoDD also requires that a trained sexual assault response capability be made immediately available for each report of sexual assault in all locations, including deployed locations. The intent of immediate intervention is to prevent loss of life or suffering resulting from physical injuries, sexually transmitted infections, pregnancy, and psychological distress. In addition, the DoDD mandates that acute sexual assault victims be given treatment priority, and be considered medical emergency cases regardless of whether physical injuries are evident.

On March 28, 2013, the DoD issued comprehensive procedures for the SAPR program in the DoD Instruction (DoDI) 6495.02, "Sexual Assault Prevention and Response Program Procedures." The DoDI mandates a 24/7 response capability for evaluation and treatment of sexual assault, including the ability to receive a Sexual Assault Forensic Examination.

Regardless of rank or grade, Service members are required to comply with verbal/written orders, policies, operating instructions, and regulations related to standards of conduct and performance. Each Service maintains a “Service-unique” evaluation system, and publishes guidance for documenting serious and repeated failures of individual members to comply with verbal and written orders, policies, operating instructions, and regulations. If an individual’s performance evaluation report documents serious or repeated infractions over time, this reduces the Service member’s opportunity for selection for key positions, career development, and promotion.

The DoD policy guidance related to Military Equal Opportunity (including the prevention of sexual harassment) reinforces guidance issued by the Services related to evaluation and performance reports. The DoDD 1350.2, “Department of Defense Military Equal Opportunity (MEO) Program,” charges Secretaries of the Military Departments with ensuring that all rating and reviewing officials evaluate a Service member's compliance with DoD and Component directives prohibiting unlawful discrimination and sexual harassment, and document serious or repeated deviations in performance reports.

Lastly, on May 7, 2013, the Secretary of Defense directed a series of measures to, among other purposes, enhance commander accountability and provide commanders with greater insight into the command climate. The DoD will also require that the results of FY 2013 National Defense Authorization Act-mandated annual command climate surveys be provided to both the next higher echelon of command and the surveyed commander. This provision will be implemented by July 31, 2013. In addition, the Service Chiefs, through their respective Secretaries of the Military Departments, will develop methods to assess the performance of military commanders in establishing command climates of dignity and respect, and in incorporating SAPR prevention and victim care principles in their commands. The Service Chiefs will report on the methods developed by November 1, 2013.

VA Response: The VA has no response; this recommendation is solely for the DoD.

TREATMENT: Recommendation #3

The committee recommends that the Department of Defense and the Department of Veterans Affairs select instruments and their threshold for mental health screening and assessment in a standardized way on the basis of the best available evidence. The committee also recommends that the two departments ensure that treatment offerings are aligned with the evidence base, particularly before national rollouts, and that all patients receive first-line treatments as indicated.

Interagency Response (Joint DoD and VA)

The DoD and VA actively promote implementation of evidence-based practices to treat Service members and Veterans with mental health and readjustment needs. The DoD and VA advance best practices for evidence-based treatment through joint development of CPGs. Specifically, the DoD and VA have developed CPGs for MDD, SUD, PTSD, bipolar disorder, and concussion/mTBI.

In addition, joint task force initiatives exist between the DoD and VA to align screening assessments where appropriate, and to continue to incorporate emerging first-line treatments into

clinical practice as the evidence base evolves. The Departments use many similar screening and assessment methods and instruments, although there are some differences between the Departments, dependent on the needs of each Department's unique population. The literature shows that optimal scoring thresholds vary between populations (for example, active military as compared to Veterans); therefore, each department chooses scoring thresholds that result in the best screening, diagnosis, and treatment for their specific beneficiaries.

To further augment integration and coordination between the Departments, the DoD and VA are working jointly on the DoD/VA IMHS. The IMHS includes 28 specific initiatives aimed at improving access, quality, effectiveness, and efficiency of mental health treatment for Service members, Veterans, and their families. This overarching strategic plan includes a joint review of mental health screening policies and procedures in order to enhance successful transition between the DoD and VA (IMHS #1); identification of quality measures for mental health services based on DoD/VA CPGs; and related evidence-based practices for coordinated use between the Departments (IMHS #10). Lastly, the Departments are working together to evaluate patient outcomes from mental health care services, and coordinate the use of outcome data for clinical decision support, quality improvement, program evaluation, and comparative effectiveness studies (IMHS #12). The DoD/VA work group addressing these initiatives will be making recommendations for common assessment methods regarding symptoms and functioning in the coming months.

Guidelines recommend that providers begin therapy with first-line treatments; however, clinicians also need to use ongoing assessments to determine effectiveness and tolerance of treatments for each patient. There are multiple efforts underway in the DoD and VA to ensure that treatment offerings are aligned with the evidence base. For example, IMHS #26 promotes the translation of mental health-related research into innovative actions, programs, and policies for Service members, Veterans, and their families. The IMHS #26 working group will develop recommendations for coordinated adoption of models and practices that promote translation of research into practice between the Departments.

DoD Response

The DoD places high priority on early detection of potential health problems, as evidenced by extensive screening methods that are based on best available clinical evidence. More specifically, the DoD has a robust mental health screening and assessment program across the deployment cycle. Per DoDI 6490.12 (February 26, 2013), "Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation," all Service members who deploy in connection with a contingency operation receive a person-to-person, privately-administered mental health assessment before deployment, and three times after return from deployment in order to facilitate early identification and treatment of mental health conditions, including PTSD, depression, and SUDs. Currently, the Military Health System (MHS) is implementing primary care screening for common PH disorders as part of its Patient Centered Medical Home (PCMH) initiative.

The DoD has also developed a "PTSD Pathway to Care" treatment module that employs a standard evidence-based process, aligned with the DoD/VA CPG for PTSD, military policy, and PH care standards. The treatment module is designed to deliver treatment for PTSD while collecting data at regular intervals related to outcomes, quality, cost, patient satisfaction, and access to care.

VA Response

VA began implementing systematic screening procedures for high prevalence mental health conditions in 2002 with depression, added screening for PTSD among OIF/OEF/OND Veterans, and then population-based screening for alcohol misuse in 2004, and extended PTSD screening to Veterans from all periods of service in 2006. VA continues to use evidence-based screening procedures for Veterans at risk for PTSD using the Primary Care-Posttraumatic Stress Disorder screen; for depression using the two-item Patient Health Questionnaire; and for alcohol misuse using the Alcohol Use Disorders Identification Test. Current measures and thresholds for follow-up in clinical settings are based on recommendations in the respective VA/DoD CPGs, and will be reconsidered as those recommendations are reevaluated pending new evidence.

Consistent with the forthcoming VA/DoD Guideline on Prevention of Suicide, VA uses results of screening for depression and PTSD to prompt clinical follow-up that includes suicide risk evaluation, since there are no evidence-based “screens” for suicide risk.

Initiatives to coordinate use of outcome measures, including screening instruments and quality measures of specific relevance to DoD and VA, are included as part of the DoD/VA IMHS as Strategic Actions (SA) # 10 and #12. These SAs “coordinate mechanisms for evaluation of patient outcomes from mental health care services, and the use of outcome data for clinical decision support, quality improvement, program evaluation, and comparative effectiveness studies.”

Veterans Health Administration (VHA) has taken significant steps to promote the availability of evidence-based psychotherapies (EBPs) as first-line treatments to Veterans, to include: implementing national competency-based training programs in a variety of EBPs; establishing national policy requiring the availability of these treatments; and placing a Local EBP Coordinator at each VA medical center. The dissemination of EBPs in VHA, which began in 2006, has significantly increased the availability of these therapies in the system. For example, all facilities have implemented Cognitive Processing Therapy (CPT) and/or Prolonged Exposure Therapy (PE), two of the most effective treatments for PTSD. Further, VHA has provided training in one or more EBPs to more than 6,400 VA staff.

While implementation of EBPs for the overall system has considerably increased as a result of VHA’s EBP dissemination efforts, there is variability in the magnitude of EBP delivery at individual facilities. Increasing the magnitude of EBP delivery across sites is a major current focus of VHA. One major initiative designed to promote the magnitude of EBP delivery is the implementation of EBPs, initially focusing on PTSD, through telemental health modalities. More than 100 staff have been hired or reassigned to focus on the delivery of CPT and/or PE telemental health services. In addition, the VA has established three pilot regional CPT and PE telemental health clinics to augment the local delivery of these therapies and expand the reach of these therapies to Veterans in rural areas. Another mechanism to promote local implementation of these therapies is the issuance of VHA Handbook 1160.05, *Local Implementation of Evidence-Based Psychotherapies for Mental and Behavioral Health Conditions*. This Handbook specifies the procedures for fully implementing the requirements of the *Uniform Mental Health Services in VA Medical Centers and Clinics Handbook* (VHA Handbook 1160.01) and the VHA Mental Health Initiative Operating Plan that mandate specific EBPs be available for Veterans with various mental or behavioral health conditions at all facilities. Specifically, VHA

Handbook 1160.05 delineates the responsibilities and processes involved in executing this mandate at the local level, including staffing needs, clinic and scheduling requirements, treatment planning and clinical implementation issues, and training needs. Further, technical assistance and support on best practices for promoting local implementation of EBPs are being provided to sites. Lastly, VHA has developed session-by-session EBP documentation templates that will allow for precise tracking of EBP delivery. This is currently not possible through the use of Current Procedural Terminology codes, which do not specify the type of psychotherapy provided. The documentation templates will be released by the end of FY 2013.

In response to the IOM committee's comments concerning the evidence-base for (and inclusion of) Acceptance and Commitment Therapy (ACT) for depression in VHA's EBP dissemination efforts, it is significant to note that national program evaluation data from VHA's ACT for Depression Training Program reveal that the implementation of ACT with Veterans with depression has led to significant overall reductions in depression of close to 40 percent, and to improvements in quality of life. These are similar to outcomes associated with the delivery of Cognitive Behavioral Therapy for depression among Veterans throughout VHA. Furthermore, with respect to the IOM's statement concerning low EBP completion rates, program evaluation data from VHA's EBP training programs indicate that approximately 70 percent of Veterans, across multiple therapies, completed treatment or finished early due to symptom relief. This compares favorably to psychotherapy attrition rates reported in the literature. For example, a meta-analysis of 125 studies reported a mean psychotherapy dropout rate of 47 percent and reported a mean dropout rate for Cognitive Behavioral Therapy of 44 percent.

TREATMENT: Recommendation #4

The committee recommends that the Department of Defense and the Department of Veterans Affairs incorporate continued supervision and education into programs that train clinicians in the use of selected assessment instruments and evidence-based treatments. Once clinicians are trained, the two departments should systematically and periodically evaluate them to assess the degree to which therapeutic interventions are accurately implemented according to a manual, protocol, or model as supported by evidence. The committee also recommends that the two departments place greater focus on coordinated, interdisciplinary care to ensure optimal treatment for service members and veterans.

Interagency Response (Joint DoD and VA)

The DoD and VA provide extensive training opportunities, continued education, and supervision/consultation for providers, while coordinating training in evidence-based practices. This includes the design and implementation of a joint system to support the delivery of evidence-based practices, which includes a shared "formulary" of therapies and joint training opportunities (IMHS #9). For FY 2013-15, the DoD/VA Joint Strategic Plan (JSP) objectives for healthcare delivery in the DoD and VA include training 25 additional trainers/consultants in evidence-based practices for PTSD, MDD, and other PH conditions by September 30, 2013, and an additional 25 trainers/consultants by September 30, 2014. The JSP also aims to train 600 providers in evidence-based practices for PTSD by September 30, 2013, and an additional 1,000 staff by September 30, 2014.

A number of current initiatives and studies address the degree to which therapeutic interventions are accurately implemented. The DoD/VA Joint Incentive Fund proposal for decentralized

training in EBPs received preliminary approval for funding to decentralize training and consultation in the DoD and VA; establish local evidence-based practice “Champion-Consultants;” and enhance the VA’s decentralized consultation infrastructure. Adherence to evidence-based practices will be monitored through documentation that the evidence-based practice was used with fidelity to the protocol, as assessed by an evidence-based practice checklist.

DoD Response

The DoD provides extensive training and ongoing education and consultation to providers with an established goal to train every provider who treats patients with PTSD in at least one evidence-based PTSD treatment. Specifically, as part of IMHS #9, the DoD has added 37 new professionals to provide training and consultation in evidence-based practice implementation. Also under IMHS #9, the DoD has undertaken a series of site visits in order to identify barriers to (and factors for) successful evidence-based practice implementation across a variety of locations. Between 2007 and 2012, the DoD trained more than 9,000 providers in evidence-based practices, and currently provides opportunities to receive ongoing case consultations from Center of Deployment Psychology experts.

A number of studies and programs assess adherence to protocol within the Services and across the DoD. The Air Force has collaborated with researchers at Pennsylvania State University to examine provider fidelity to treatment protocols, and outcomes for patients who have received these treatments by an Air Force mental health provider. In 2012, the DoD contracted with the RAND Corporation to: (a) determine the degree to which Navy Substance Abuse Rehabilitation Program (SARP) personnel who received training in the evidence-based co-occurring Disorders Program successfully implemented the program at their respective SARPs; and (b) to identify factors that helped or hindered implementation. In July 2012, the DoD implemented a Tri-Service training program for Internal Behavioral Health Consultants who provide training, consultation, and sustainment training webinars in the PCMH.

The DoD values the importance of integrated care, and is expanding its efforts to coordinate care across disciplines; a number of DoD programs offer coordinated, interdisciplinary care to Service members with PH conditions. The Navy developed the Psychological Health Pathways program to meet the MHS objective for a best practice PH treatment and care management system. The program improves continuity, coordination, and collaboration between and across disciplines, clinics, and Military Treatment Facilities (MTF), and is facilitated by the use of care conferences. Examples of integrated interdisciplinary programs of care include: the Army’s Re-Engineering Systems of Primary Care Treatment in the Military program; and the Air Force Behavioral Health Optimization Program, which integrate behavioral health into primary care with a team-based management approach. The DoD, through the National Intrepid Center of Excellence (NICoE), delivers comprehensive and holistic interdisciplinary PH and TBI care, conducts focused research, and exports knowledge to benefit Service members and their families. There are now several NICoE “satellites” in various stages of development that will extend this interdisciplinary care model to military installations across the United States.

VA Response

VA provides ongoing consultation and education in providing training and support to clinicians learning evidence-based treatments. Intensive weekly consultation is a core, required component

of VHA's competency-based EBP training programs. The consultation process in these training programs typically includes specific ratings of and feedback on clinicians' therapy skills. Program evaluation results from VHA's EBP training programs consistently show that ongoing consultation on the delivery of newly learned EBPs is essential to the development of competency in these treatments. In addition to the formal consultation included in the EBP training programs, VHA has been working to implement longer-term consultation support to provide opportunities for consultation to clinicians well after they complete the training programs, and for other clinicians who may have received formal EBP training in VHA. Longer-term consultation supports include regular, open telephone consultation calls held for different EBPs whereby clinicians can call in at established times to ask questions about the therapy or about specific cases. The VA National Center for PTSD has also established a PTSD consultation service whereby clinicians can contact the program for consultation support related to PTSD care.

Furthermore, VA and DoD have established a joint EBP clinician portal to provide consultation support to VA and DoD mental health providers, as part of the DoD/VA IMHS. Specifically, clinicians in the two systems can post questions on a bulletin board or contact someone for consultation support. The EBP documentation templates will allow for ongoing assessment of fidelity to EBP treatment protocols. By delineating the specific therapy components on which therapists are to report during each session of the protocol, the templates will allow for assessment of the extent to which the therapy has been implemented as designed and shown to be effective. VA has provided EBP documentation templates it has developed to the DoD as part of the two agencies' close collaboration in developing common and coordinated systems of EBP training and implementation that is part of the DoD/VA IMHS.

As VHA has transitioned to its medical home model, the Patient Aligned Care Team (PACT), care for mental disorders and health-related behavior changes have become core components of the interdisciplinary team. In addition to social work, clinical pharmacy, and clinical dietetics, the interdisciplinary PACT includes psychologists, clinical social workers, and psychiatrists as embedded team members. Most common, uncomplicated mental disorders (depression, anxiety, at-risk drinking, and others) can be adequately addressed within the PACT, utilizing the mental health providers. Health behavior coordinators assist the rest of the primary care team to address such behaviorally sensitive conditions as chronic pain, insomnia, and obesity. These embedded mental health providers increase the number of Veterans to receive mental health care by providing it in the same setting and at the same time as the Veteran is in the primary care clinic. VA and DoD are actively collaborating to develop a shared set of screening and other measures to assure standardization across the two systems of care.

When additional services are needed to meet the Veteran's goals and needs, another care team may be called in for assistance. Interdisciplinary mental health teams are currently working to improve the provision of coordinated care for Veterans requiring longer-term mental health care. Additional specialty providers that may be included on care teams are pain and/or SUD specialists, rehabilitation specialists, family members, and other non-VA health care professionals. All of these team members work with the Veteran to coordinate a wide variety of health care resources in order to optimize the Veteran's health and recovery.

TREATMENT: Recommendation #5

The committee recommends that the Department of Defense and the Department of Veterans Affairs conduct systematic assessments to determine whether screening and treatment interventions are being implemented according to clinical guidelines and department policy. Data systems should be developed to assess treatment outcomes, variations among treatment facilities, and barriers to the use of evidence-based treatment.

Interagency Response (Joint DoD and VA)

DoD/VA IMHS #10 and #12 recommend criteria and processes for the development and use of quality and outcomes measures for PH care across the DoD and VA. Both strategic actions establish mechanisms for the ongoing alignment of standardized mental health measures between both Departments. In pursuit of lowering barriers to implementation of evidence-based practices, the DoD and VA have developed more than 60 clinical support tools to accompany the DoD/VA CPGs; the clinical support tools package the material of the CPGs in user-friendly formats, and target a variety of audiences' needs and levels of expertise. The Quality Management Division of the DoD tracks and trends the number of tools ordered from their website and the number of hits on the CPG-download website, and reports that data to the Health and Joint Executive Councils. From October 2012 to March 2013, the DoD and VA tallied 1,341,810 internet requests, and mailed 507,915 clinical support tools within the DoD.

DoD Response

Sound policy and guidelines, and adherence to those guidelines, are essential for quality screening and treatment of Service members. DoD programs and initiatives that assess adherence to DoD/VA CPGs exist, and mechanisms are in place to ensure policy implementation. The DoD has an extensive screening program, in full accordance with DoDIs, and several recently released policies specifically related to PH care. The DoD collects and analyzes data in regard to treatment outcomes, treatment variation, and elements that aid and hinder the use of evidence-based practices across treatment facilities. Specifically, the DoD collects and analyzes data on treatment outcomes through the Army Medical Research and Materiel Command, which includes 53 treatment studies in PTSD; 7 treatment studies in SUD; and 7 treatment studies related to suicide, anxiety, and depression.

The clinical pathway for PTSD, recently developed in the DoD and planned for implementation across the Services, automatically assesses fidelity to CPGs. The DoD, in collaboration with TriService Workflow, will create "alternative input method" forms for the clinical pathway to document types of evidence-based therapies employed at each visit. Adherence to CPGs can then be tracked in and across facilities, and analyzed for their relationship to clinical outcomes. Similarly, the DoD contracted with the RAND National Defense Research Institute to assess fidelity to CPGs for PTSD and MDD, and the relationship between CPG adherence and clinical outcomes. The study aims to identify strengths and improvement opportunities in the delivery of PH care; describe variability in quality of care across the MHS; and develop recommendations for ongoing monitoring of CPG adherence.

Two recent policies affected PH care in the DoD. The DoDI 6490.12 (February 26, 2013), "Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation," established the policy for person-to-person mental health assessments for each

Service member deployed in connection with a contingency operation, as required by section 1074m of title 10, U.S. Code. Deployment mental health assessments are standardized through required web-based training. As of March 2013, more than 8,200 providers were trained and certified to administer deployment mental health assessments. A data call was requested of the Services to provide information about implementation and evaluation of deployment mental health assessments. The DoD reported that all Services have complied with the implementation of the deployment mental health assessments.

Another DoD policy issuance currently in coordination, “Integration of Behavioral Health Personnel Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings,” will prescribe standards for routine screening of MDD, PTSD, and SUD in the PCMH.

VA Response

VA monitors the implementation of mental health screening and treatment recommendations through two inter-related processes: site visits to facilities, and ongoing reviews of clinical and administrative data.

Site visits: Site visits review implementation of the Uniform Mental Health Services Handbook, including requirements for screening and treatment within mental health. In FY 2012, VHA conducted structured site visits at all 140 VHA Healthcare Systems to collect baseline data. Site visits will be continued on a three-year cycle with approximately one-third of facilities visited each year.

Before each site visit, the Office of Mental Health Operations staff reviews clinical and administrative information from both the VA and external agencies such as the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities to identify areas of strength and areas of concern. The on-site protocol includes meetings with facility leadership; mental health leadership; mental health program leadership; front-line staff, including clerks and schedulers; Veterans who receive mental health care and their families or supportive others; and community stakeholders and partners. During the visit, the site visit team reviews the delivery of evidence-based screening and treatments across treatment settings with standardized questions.

Best practices and concerns are identified at each site visit. VHA requires facilities to develop actions plans to address areas identified as problematic. Best practices are posted on a website for dissemination across VHA. In addition, for areas identified as systemic weaknesses, VHA develops targeted national facilitation processes to assist facilities and Veterans Integrated Service Networks (VISNs) with improving implementation. In FY 2013, VHA is implementing targeted facilitation for implementation of EBP.

Review of clinical and administrative data: VA monitors the performance of facilities, VISNs, and the system as a whole in meeting screening requirements on an ongoing basis. Currently, screening rates are 98.3 percent for PTSD; 96.0 percent for depression; and 96.9 percent for alcohol-related problems.

As described above, VA is developing a system of charting templates for EBP that is expected to be operational before the end of FY 2013. When available, these templates will allow tracking

of the provision of these treatments on a session-by-session basis, as well as by the delivery of full episodes of care.

VA currently evaluates the use of psychopharmacological treatments by identifying deviations from evidence-based practice. Examples include: identifying individual patients receiving potentially suboptimal treatment (for example, multiple antipsychotic medications); identifying facilities that appear to under-utilize specific treatments (for example, opiate agonist treatment for opiate abuse or dependence); and identifying system-wide patterns that may reflect underuse of promising agents (for example, clozapine for treatment-resistant schizophrenia).

VA recognized the need to become more outcome-oriented and is now working to transform both its clinical services and its system for program evaluation to accomplish this. VHA is currently conducting a pilot project to develop and evaluate a system that can reliably measure patient self-reports of treatment outcomes in both those who remain in treatment and those who drop out.

Over the next several years, VA will be expanding use of outcome-oriented measures in three phases. By the end of FY 2013, VA will include a series of outcome-oriented measures on a nationally accessible mental health dashboard available to program offices, VISNs and facilities. At the same time, VA is developing a proposal to extend the current pilot project to allow measurement of mental health treatment outcomes both nationally and by VISN. Based on the pilot, the system will utilize telephone contact with a representative sample of Veterans to obtain repeated self-reports on mental health symptoms and functional status. Finally, VA will be developing and reviewing the business case for establishing the information technology infrastructure that would be needed to obtain patient self-reports on mental health outcomes from patients across the system as a whole. The goal of this effort would be to allow the use of outcomes data for both performance evaluation and clinical decision support.

MILITARY FAMILIES: Recommendation #6

The committee recommends that the Department of Defense ensure that policies, programs, and practices aim to support and strengthen military families, including nontraditional ones.

Interagency Response (Joint DoD and VA)

Military Families, encompassing traditional and nontraditional families, often endure the adverse consequences of deployments (for example, health effects, family violence, and economic burden). The DoD and VA have collaborated in the promotion of effective family resilience programs in each Service and the VA (IMHS #16). The Departments identified three promising resilience model programs/services that target family resiliency within the Services, non-government community, and the VA.

DoD Response

The DoD has a multitude of instructions and regulations that guide activities to support and strengthen military families, including nontraditional ones. In response to these policies, the DoD has launched projects to enhance Service member readiness, and quality of life for military families. The DoD is addressing family functioning as it relates to combat deployments, (to

include number of deployments), and to high-operational tempo in Navy, Marine Corps, Army, and Air Force Active Duty and Reserve components.

FOCUS, one of the DoD's vanguard programs for family PH care and resiliency, applies a three-tiered approach to care that includes: (1) community education; (2) psycho-education for families; and (3) brief treatment interventions for families. These three approaches have resulted in statistically significant changes to outcomes, including improved family functioning and decreased anxiety and depression in both parents and children. The FOCUS program takes a de-stigmatized approach to care, and operates within the community context. High levels of leadership, including the Executive Office of the President of the United States and the Office of the First Lady, recognize the program as the model for prevention and intervention of PH services for military families. To date, more than 400,000 Service members, families, providers, and community members have received brief treatment intervention services through FOCUS.

With regard to policies for nontraditional families, including same-sex domestic partners and their children, the DoD has recently begun the process of updating relevant policies to include those members of the military family, and expects completion of these updates by August 2013. Many forms of support are already available to extended family members or members of the Service member's informal support system. Limitations exist when the support calls for the expenditure of funds or other resources; relief from those constraints must be granted in order to extend services to these individuals.

Effective September 20, 2011, the DoD's Family Advocacy Program Instruction 6400.1-M-1, "Manual for Child Maltreatment and Domestic Abuse Incident Reporting System," was revised to reflect the repeal of "Don't Ask, Don't Tell." Since the repeal, each Service's respective FAP has actively trained personnel on the extension of services to all eligible beneficiaries; initiated culturally sensitive treatment trainings; and initiated training on ethical considerations when serving same-sex couples.

The DoD family research portfolio currently has 30 active research projects that aim to support and strengthen military families by enhancing soldier effectiveness and health. Areas of research cover a range of basic epidemiological studies to enhance understanding of risk and resilience factors of military families and communities that support families of Service members, through studies on interventions to enhance resilience; prevention of relationship problems, and support for families during deployment. While nontraditional families have not been a primary focus of the research portfolio, the DoD concurs that this is an important issue to address.

The translation of evidence-based research information by the DoD's Consortium for Health and Military Performance is key to promoting a healthy, ready, resilient, and capable fit force and strong families. The family research domain is designed to strengthen families and relationships through education and skills-based information and resources. Examples of programs for relationship enhancement and strengthening include FOCUS, Strong Bonds, and Comprehensive Soldier Fitness for Families with a focus on nutrition and physical fitness (for warfighters and family members). These resources also address the needs of both traditional and non-traditional families and will further expand the information provided for nontraditional families.

VA Response: The VA has no response; this recommendation is solely for the DoD, but does incorporate interagency efforts.

MILITARY FAMILIES: Recommendation #7

The committee recommends that the Department of Defense use evidence-based primary prevention programs and treatments that have been specifically evaluated in service members and their families and that are focused on preventing and treating mental-health and relationship problems.

Interagency Response (Joint DoD and VA)

The DoD and VA have collaborated in the development of IMHS #17, which focuses on exploring methods to help family members identify mental health needs in Service members and Veterans by providing education and coaching. IMHS #17 also recommended enabling providers of family education and other family services in the DoD to support family members in identifying mental health needs for Service members. Review of existing efforts determined that a range of resources and support are available to enable providers within each Department to empower family members.

DoD Response

Prevention of child abuse, child neglect, and domestic abuse/intimate partner violence, and promotion of healthy relationships, is a priority for the DoD; as such, a number of efforts aim to enhance family relationships and address the impact of deployments on military families. As referenced in Recommendation #6, a family research portfolio includes evaluation of prevention and treatment programs that support Service members and their families. To address gaps related to risk and protective factors for military families, the DoD developed a theoretical model promoting family resilience.

The DoD is developing the Joint Service Family Advocacy Strategic Plan for Prevention to address child maltreatment and domestic abuse/intimate partner violence. A working group composed of representatives from each Service, DoD FAP personnel, and subject matter experts from federal partners (for example, the Centers for Disease Control and Prevention (CDC), the Administration for Children and Families, and the Defense Centers for Excellence for Psychological Health and Traumatic Brain Injury) assisted with this major undertaking. In February 2013, the group convened to draft the FY 2013-2018 Joint Service Family Advocacy Strategic Plan for Prevention. The Strategic Plan for Prevention will translate the vision of being “a military community that fosters healthy relationships: safe, resilient, and ready” into a practical roadmap for prevention efforts. Its objective is to emphasize the use of evidence-based and evidence-informed practices and programs that promote healthy relationships, and are responsive to the needs of Service members and their families. Goals include: highlighting current strengths and utilizing existing resources; delivering evidence-based, results-oriented standardized prevention activities; promoting a culture of shared responsibility for healthy and respectful relationships; employing targeted, well-coordinated strategies to evaluate programs; and ensuring responsible stewardship of funds. A steering committee will monitor plan implementation with DoD oversight.

In FY 2012, the DoD Cost Assessment and Program Evaluation identified two standardized prevention initiatives for implementation and evaluation across the DoD. These two initiatives were authorized for a 5-year period beginning in FY 2014. Each of the Services has also implemented Service-relevant prevention programs based on needs assessments of their target

populations; in addition, installation FAPs are required to develop localized annual prevention plans in concert with the installation leadership.

As this recommendation addresses prevention programs, it is worth mentioning that the Total Force Fitness concept is the model used by the DoD to promote a holistic focus on all aspects of human performance and highlights the importance of not focusing on just one specific aspect of health, wellness, and performance, but rather on the whole person – by focusing on physical fitness, nutrition/dietary needs, psychological health, environment, and relationships – for optimal wellness and performance. Rather than targeting problems, this initiative helps Service members and their families focus on positives to optimize their personal and family performance through the information and resources available. The DoD is initiating a Family Readiness Group/Spouse Group activity that uses tip cards containing evidence-based information for enhancing physical, nutritional, psychological, environmental, and relational fitness, as well as information for optimizing children’s wellness. The DoD also supports Service-specific educational campaigns aimed at providing physical fitness and nutrition information for performance optimization specifically for military families and children.

The Services execute evaluations of resilience and prevention programs across a variety of areas. For example, the Navy’s FOCUS program evaluates outcomes and examines retrospective data on outreach events/activities, community resources, referrals to the program, program enrollment, participants’ satisfaction with the program, perceived and actual impact in family functioning, and community awareness of the program. The Air Force’s Comprehensive Airmen Fitness program evaluation is a fidelity assessment and short-term outcomes evaluation that examines program fidelity and program impact on Airmen’s resilience knowledge and PH outcomes. Also in the Air Force, the First Term Airmen Center Resilience Training evaluation examines short term outcomes and training dosage. The Army has an Ask, Care, and Escort suicide intervention program that uses a training process evaluation and fidelity assessment to examine participant satisfaction and knowledge gained, as well as the extent to which trainers adhere to program components. The Army’s Soldier 360 program evaluation uses retrospective data to examine short-term outcomes related to physical and PH variables, and self-reported changes in participants’ beliefs and attitudes with respect to social, spiritual, and financial health. The Marine Corps’ Never Leave a Marine Behind (NLMB) program evaluation examines the extent to which program participants adequately utilize skills learned in the NLMB suicide prevention training program after participation in training.

The DoD also supports Service-specific strategies for the use of evidence-based preventive interventions that were adapted to meet the specific needs of military families facing combat operational stress associated with wartime deployments. FOCUS utilizes core intervention components, including psychoeducation, emotional regulation skills, goal-setting skills, problem-solving skills, traumatic stress reminder management techniques, and family communication skills. The Army is reconfiguring its Child and Family Behavioral Health Services to emphasize rapid consultation and education within the PCMH and other medical clinics. In addition, the School Behavioral Health program places behavioral health staff in schools on Army installations to provide easy access to children for prevention efforts, and consultation with teachers and administrators. For several years, the Air Force has supported research and pilot studies to evaluate evidence-based primary prevention programs and treatments for Service members and their families.

VA Response: The VA has no response; this recommendation is solely for the DoD, but does incorporate interagency efforts.

MILITARY FAMILIES: Recommendation #8

The committee recommends that the Department of Defense and other relevant federal agencies fund methodologically rigorous research on the social, psychological, and economic effects of deployments on families, including nontraditional families.

DoD Response

The DoD recognizes the importance of funding methodologically rigorous research, and studying the impact of deployment on family structures, including nontraditional family structures. The DoD funded the aforementioned RAND Corporation's Deployment Life Study, which examined the impact of deployment on the health and well-being of military families. This study recruited approximately 9,600 Army, Navy, Marine Corps, and Air Force families, followed them across an OEF/OIF deployment cycle, and assessed a number of outcomes over time. Preliminary results address the importance of assessing the needs of traditional and nontraditional families. In addition, RAND is currently conducting a study for the DoD on the availability and efficacy of appropriate PH treatment and services for the military culture, including for geographically distant Service members and their families.

The MOMRP family portfolio has active research aimed at supporting and strengthening military families. The research addresses family needs throughout the deployment life cycle, analyzing the impact of deployment, the impact of combat injury on overall family functioning, and the unique needs of families with children. While nontraditional families have not been a primary focus of the portfolio, the DoD concurs that this is an important issue to address.

The DoD's Millennium Cohort Study is the largest long-term health study in U.S. military history. It began in 2001 and will continue through 2022, with a participation goal of 200,000 Service members and 10,000 military family members. The Family Study is designed to determine if, and how, deployment experiences and Service member readjustment issues impact family health and well-being. The Family Study also provides a unique opportunity to explore the impact of relationship quality on the physical and psychological health of Service members, their spouses, and children. Some of the areas the study will analyze include PTSD, TBI, depression, and alcohol misuse. Due to the long-term nature of this study, data and findings are not yet available.

In addition, a 2012 study titled "Psychological Health of Military Children: Longitudinal Evaluation of a Family-Centered Prevention Program to Enhance Family Resilience" evaluated the impact of the Navy's FOCUS program on the psychological adjustment of military children. The two primary goals of this study were: (1) understanding distressed relationships among family members; and (2) determining the pathways of program impact on childhood adjustment. Distress was found to be a significant factor among the military families, civilian parents, and children. FOCUS was also found to have improved family functioning, which in turn significantly reduced childhood distress following program participation.

The Air Force has funded rigorous research on the relationship between deployment and family violence. These studies investigate spouse abuse and child maltreatment before, during, and after deployment. Four manuscripts have been approved for publication, while two additional studies are in progress. The published articles indicated that the impact of combat-related deployment on spouse abuse rates is variable in incidents involving moderate to severe abuse, and that alcohol use in violence incidents is relatively more likely post-deployment, suggesting a need for focused prevention and intervention efforts.

VA Response: The VA has no response; this recommendation is solely for the DoD.

MILITARY FAMILIES: Recommendation #9

The committee recommends that the Department of Defense place a high priority on reducing domestic abuse because it degrades force readiness and the well-being of military family members.

DoD Response

The DoD remains steadfast in its commitment to the prevention of (and response to) family maltreatment (including domestic abuse and child abuse/neglect) as demonstrated by its requirements for military leaders to confront and refer suspicions of abuse, and engage Service members in assessment and treatment processes. Additionally, the DoD actively collects and critically reviews incidence and prevalence data; researches best practices; promotes evidence-based intervention programs; and emphasizes the availability of adequately trained personnel to provide the services.

The DoD has partnered with the CDC to conduct a study that would determine a baseline for the prevalence of intimate partner violence in the military in comparison to the general population, which will result in revision of programs, policies, and practices. Prior research has been completed on the effects of multiple deployments on domestic violence and child abuse and neglect, and further research is in progress.

The DoD invests significant resources to specifically address family maltreatment as a significant public health concern at all military bases. In addition, the DoD is dedicated to solidifying a coordinated community response in which command, law enforcement, investigative agencies, and the DoD collectively respond to high-risk incidents. The High Risk for Violence Response Team, the Child Sexual Maltreatment Response Team, and the Family Advocacy Command Assistance Team are examples of well-established military community response mechanisms developed by the DoD to protect families and ensure partnership among the various response agents.

DoD prevention strategies emphasize: raising community awareness; ensuring trained commanders and professional staff are ready to recognize and respond to family maltreatment; providing education and support to couples and parents; empowering victims while providing instrumental support (such as transitional compensation); and leveraging the shared resources of the military and civilian communities. In February 2013, the DoD convened a stakeholder group to develop a Joint Service Family Advocacy Strategic Plan for Prevention, as referenced in Recommendation #7. This plan will further emphasize prevention and risk management related to domestic abuse. The DoD also conducts an annual review of domestic abuse fatalities to

assess program response; identify topics for further research; and draw from lessons learned to make more immediate program improvements.

VA Response: The VA has no response; this recommendation is solely for the DoD.

COMMUNITY: Recommendation #10

The committee recommends that the Department of Defense, the Department of Veterans Affairs, and other relevant federal agencies fund research on the effects of Operation Enduring Freedom and Operation Iraqi Freedom deployments on communities. Such research should include current indicators of community well-being, such as measures of economic performance, availability of social and support services, law-enforcement activity, and school and educational functioning.

DoD Response

Published data on the effects of deployments on local communities are sparse. Historically, very little funding has been available for research as it relates to readjustment and local communities. Educational functioning of children of military families is a primary focus of DoD efforts. The Department partners with the National Guard and Reserve communities to provide resources to support school districts that educate children of military families. The DoD has awarded grants to school districts aimed at minimizing the effects of transitions and deployments. This includes strategies to promote a sense of community or address challenges that exist for children enrolled in military connected schools and perceived supports for military families in their community.

In addition, a number of programs exist through which the DoD can examine the support established to assist National Guardsmen and their families in local communities. The DoD and Department of Agriculture are collaborating to provide evidence-based community capacity building strategies, online curriculum, and individual and community readiness inventory tools for leadership, management, and service providers of the military and family support programs (Joint Forces Headquarters and Reserve Family Programs).

VA Response

VA conducts medical research to improve the health and treatment options for Veterans who receive their care in VA. Other agencies have the needed research infrastructure for conducting community-based research of this nature that VA lacks.

While more research needs to be done to fully understand the effects of deployment on communities, anecdotally, there is significant variability in indicators of community well-being as a result of deployment, as well as variability in the response of the community in supporting Veterans, Service members, and their families. Certain communities seem to demonstrate more resiliency than others, and some communities have self-organized to promote a smoother reintegration experience for returning Service members.

VA is standing up a new Office of Community Engagement (OCE) to promote the growth of effective partnerships between the community and the VA that will enhance the health and well-being of Veterans and their family members. One goal of the OCE will be to identify communities that are models in supporting the reintegration of Veterans, and determine the

factors in those communities that are contributing to their positive outcomes. The intent of this effort is to develop training and tools built from these models that will help VA strengthen communities in other areas; leverage existing partnerships to expand resources and access to care; and serve as a resource for VA and for other entities interested in partnering with VA.

SOCIOECONOMIC IMPACTS: Recommendation #11

The committee recommends that the Department of Defense and the Department of Veteran Affairs evaluate the effectiveness of transitions-assistance programs to ensure that they are effective in reducing unemployment among returning veterans of Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn.

Interagency Response (Joint DoD and VA)

Unemployment and underemployment are acute problems for military Veterans. The DoD and VA have partnered with the Departments of Labor and Education, in coordination with the President's Improvement Council and Domestic Policy Council, to form the VIJTF to transform the TAP. TAP bolsters and standardizes the transition services that Service members receive prior to separating from the military to promote employment readiness, and prepares Service Members for higher education, career technical training, or starting a business. Although tracking outcomes of Service members after they have left the military is challenging, VIJTF will continue to explore methods to evaluate program effectiveness. In addition, the redesigned TAP allows for a "warm handover" of Service members who do not meet Career Readiness Standards or have needs that may put them at risk of other negative transition outcomes, to other organizations and agencies, such as the VA, that can provide services and support.

This revision of TAP was released in January of 2013 and will be fully operational at all military installations by the end of 2014. Evaluations of the program are planned to occur on a quarterly basis, and will include Service member feedback on the employment-related modules. Given the recent rollout of the redesigned program, it is premature to determine if the program is effectively reducing unemployment and aiding Service members' accomplishment of post-transition employment goals.

DoD Response

The DoD continues to prioritize transition assistance programs, and provide quality information, services, and training to reduce the rate of unemployment among returning Service members. For transitioning Service members who are currently engaged in mental health services, the DoD's *inTransition* program provides support to Service members with employment-related issues. The *inTransition* program also assists Service members by maintaining their continuity of mental health care during times of transition.

VA Response

As the implementation process for Transition Goals Plan Success (Transition GPS) continues, VA expects to gain insight into the effectiveness of the newly enhanced transition assistance programs. VA, together with its partner agencies, will analyze performance metrics and satisfaction surveys, and as required, will modify the program to address needs of Service members, and ensure Career Readiness Standards and program goals are met. Once the new

program is fully operational, VA can establish baselines and begin to assess effectiveness of reducing unemployment among Veterans.

SOCIOECONOMIC IMPACTS: Recommendation #12

The committee recommends a comprehensive evaluation of the effects of the Post 9/11 GI Bill on the educational attainment of Veterans and eligible family members.

Interagency Response (Joint DoD and VA)

In accordance with Executive Order 13607, “Establishing Principles of Excellence for Educational Institutions Serving Service Members, Veterans, Spouses, and Other Family Members,” VA is working with the DoD and the Department of Education to develop and collect outcome measures. The agencies have been concentrating on information that will produce a more complete picture of educational outcomes for military and Veteran students, as well as information that will enable students to make more meaningful comparisons between educational institutions when selecting a school. The agencies worked together to develop proposed measures, and are currently in the process of standardizing definitions and developing methodologies to standardize the measures across all Federal military and Veteran education programs.

DoD Response: The DoD has no response; this recommendation is solely for the VA, but does incorporate interagency efforts.

VA Response

VA has taken several actions to monitor the effectiveness of the Post-9/11 GI Bill in order to find areas for improvement, and increase the support provided to Veterans (and their dependents).

VA has developed a longitudinal study to track three cohorts of beneficiaries over a 20-year span. The three cohorts are representative samples of those who began using their Post-9/11 GI Bill benefits in FY 2010, FY 2012, and FY 2014. VA will identify a sample of 7,000 Veterans per cohort who will be surveyed annually during the course of the study. The survey will measure outcomes in four key areas: employment, educational attainment, income, and home ownership. The first survey is scheduled to begin in FY 2013, and will include individuals who began training in FY 2010 and FY 2012.

VA also has a contract with the National Student Clearinghouse (NSC) to obtain “Degree Attainment” information. Under the contract, VA provides a total of 5,000 records to the NSC for review. The NSC then identifies the number of recipients who attained a degree. In FY 2011, VA provided records for individuals participating in the Montgomery GI Bill Programs and the Reserve Educational Assistance Program. The NSC found enrollment and/or degree records for 4,177 of the 5,000 individuals submitted by VA (83.5 percent). Of these, 1,391 individuals completed degrees or certificates (33.3 percent of the found cohort). An individual is considered to have completed a degree if a record of any postsecondary award (including a certificate) is found in the NSC database. It generally takes students four to six years to complete a degree. As the Post-9/11 GI Bill is entering its fourth year in FY 2013, VA will begin collecting degree attainment data for this program using the NSC contract.

Further, VA is working with Student Veterans of America (SVA) and the NSC to create an education completion database for Post-9/11 GI Bill and Montgomery GI Bill beneficiaries. VA will provide information for up to 1 million beneficiaries to the NSC. The NSC will perform a data match of beneficiaries against its database to determine how many beneficiaries have graduated and/or completed a program of education. This service is being generously funded by a gift to be provided to NSC on behalf of VA by SVA.

SOCIOECONOMIC IMPACTS: Recommendation #13

The committee reiterates its call for comprehensive long-term forecasts of the costs of the Veterans Health Administration's medical care of the Veterans Benefits Administration's disability benefits associated with combat deployments; these forecasts should be conducted annually and should be released publicly by the Department of Veterans Affairs and confirmed by an independent external authority.

DoD Response: The DoD has no response; this recommendation is solely for the VA.

VA Response

The IOM committee views the current evidence on the costs of caring for injured Veterans as an overwhelming challenge. There is a need to assess the costs of caring for injured Veterans systematically and publicly. The Congressional Budget Office publicly assesses short-term and medium-term costs, and, as VA stated in response to the IOM's Phase I report, already produces some forecasts of health and disability spending. But in requesting this information, it appears that the IOM committee continues to believe that long-term planning for Veterans' care requires public long-term cost forecasts in the same way that Social Security and Medicare require them, and that these forecasts should take a similar form to be internally and externally useful.

In requesting forecasts similar to Social Security Administration and Medicare, the IOM appears to be asking VA to perform 75-year projections as are done for these programs.

First, one of the aims of these kinds of projections is to assess the actuarial status of the funds that pay for these programs. VA health care is not a mandatory program (unlike Social Security and Medicare) and is not paid for via trust fund. As such, there is not "actuarial status" to report for VA.

Second, it is not clear how this information will inform the IOM in its role to accomplish the requirement articulated in Section 1661 of the National Defense Authorization Act for FY 2008, (i.e., that the Secretary of Defense, in consultation with the Secretary of Veterans Affairs, enter into an agreement with the National Academies for a study of the physical-health, mental-health, and other readjustment needs of members and former members of the Armed Forces who were deployed in OIF or OEF, their families, and their communities as a result of such a deployment). It seems a longitudinal study that follows the OEF/OIF/OND Veterans as they proceed through the future decades would more directly address the requirement of the law.

The VA currently performs 20-year projections of Veteran health care demand, enrollment, and cost; these projections are updated annually. The projections could be extended to longer durations (for example, 75 years), but the projections beyond 20 years would by necessity be crude and overly general. Asking for this type of projection (again) begs the question of how

responding specifically to this recommendation would address the requirements of the Section 1661.

The VA Enrollee Health Care Projection Model informs the budget formulation process, and supports strategic and capital planning, which is different from what the IOM is proposing: long-term (75-year) forecasts of VHA and Veterans Benefits Administration (VBA) costs associated with combat deployments. The model projections are period-of-service specific for OEF/OIF/OND Veterans, and consideration of the OEF/OIF/OND population is an integral part of VA's strategic planning process.

Current model projections are not as clinically robust as the IOM proposes. The current model is a population-based model, rather than a diagnosis-based projection model. If VA would respond to this IOM recommendation, VHA believes a separate projection/effort would make sense. "Medical Costs of War in 2035: Long-Term Care Challenges for Veterans of Iraq and Afghanistan," (Geiling, Rosen, Edwards; Military Medicine, Vol. 177, November 2012) seems to address the IOM's concerns as well. The article does not include projections per se, but it analyzes war-related costs for Veterans of Iraq and Afghanistan, with a focus on the future and what to expect in terms of the health status of recent Veterans when they reach middle age.

The VA actuarial model projects the total Veteran population, and provides agency decision makers with key demographic characteristics such as age, gender, period of service, and ethnicity within various geographic levels. Unlike Social Security, which is a universal national program with time-tested actuarial models that predict with high confidence future enrollment and monetary outlays, the demand for VA disability compensation benefits is evolving and greatly influenced by Veterans seeking compensation several times over their life span for the residual effects of injuries and illnesses that were sustained or aggravated while on active duty status.

VBA will collaborate with the VA Office of the Actuary to address this recommendation. However, VBA does not intend to differentiate the annual delivery of financial benefits to only Veterans with combat deployments. As the IOM is aware, there are signature injuries or illnesses associated with combat environments. Unlike workman's compensation program benefits, there are long-term financial liabilities impacting VA that will increase exponentially in the future based on the unprecedented number of rating decisions over the past five years. VBA will strive to improve its analytical modeling capabilities to project expenditures associated with different military conflicts; however, the VBA cannot release future year budget forecasts for disability compensation funding requests. Until such time that VA has a robust actuary model in place, it would be premature to engage the services of an independent external authority.

ACCESS AND BARRIERS TO CARE: Recommendation #14

The committee recommends improved coordination of care and services between the Department of Defense and the Department of Veterans Affairs medical treatment facilities, including the completion of an interoperable or single combined electronic health record for all care that begins with entry into military service and continues throughout care in the Department of Veterans Affairs system after transition.

Interagency Response (Joint DoD and VA)

The DoD and VA have a rich history of exchanging electronic health record data that dates back to 2001. These data exchanges have been expanded over time and continue to operate today. In recent years, the Departments have also begun exchanging electronic health record data with private health care providers who also render care to our patients. The availability of this data to our providers supports improved patient care for our shared patients.

While the Departments have much success with interoperability, continued focus on improving these data exchanges is a priority. The DoD/VA IPO leads the development and implementation of systems, capabilities, and initiatives that allow for information interoperability between the Departments in order to better serve Service members, Veterans, and other eligible beneficiaries. The integrated Electronic Health Record (iEHR) project is a collaborative partnership between the VA and DoD, with management and oversight by the IPO, intended to modernize health care information records and to achieve significant improvement in the capturing, storing, and sharing of electronic health information. Once finalized, the intent of the iEHR is to improve the quality of health care, improve provider and patient experiences, and facilitate the availability of a comprehensive health record for beneficiaries. The iEHR is also intended to enable patients to be more involved in their own healthcare.

As part of the iEHR activities, the IPO is leading an effort to increase data sharing and improved patient care through standards-based data interoperability. The Departments are accelerating the correlation of clinical terminology within at least seven clinical data domains: laboratory, pharmacy, problem list, allergies, immunizations, vitals, and note titles. The Janus Joint Legacy Viewer (JLV), designed to provide an integrated, chronological view of real-time patient information from all MTFs and VA Healthcare facilities on a single screen, will ensure that shared data is available for both VA and DoD providers. The JLV will promote a more converged pathway for information exchange between the Departments. The JLV will deploy at seven sites between April and July 2013.

In addition, the DoD and VA recently established the Interagency Care Coordination Committee, which has implemented the “Lead Coordinator” concept in both Departments. This program requires the DoD and VA to use the same terminology and identify a care coordination point of contact for each Service member, Veteran, and their family members.

Finally, the Joint DoD-VA Health Executive Council Health Information Sharing Task Force completed a detailed assessment that analyzed the benefits of health information sharing for Service members and Veterans. The assessment included a review of current DoD and VA health information sharing exchanges (for example, legal, regulatory, and policy standards) and health data sharing initiatives that support clinical care, as well as the development of recommendations for a joint way forward.

ACCESS AND BARRIERS TO CARE: Recommendation #15

The committee recommends that the Department of Defense continue to promote an environment that reduces stigma and encourages treatment for mental-health and substance-use disorders. The committee recommends that the department undertake a systematic review of its policies regarding mental-health and the relation between treatment-seeking and military advancement. The committee recommends that the Department regularly issue reports

describing actions taken with regard to its policies and procedures to determine progress in this area.

DoD Response

The DoD is currently engaged in multiple efforts to promote access to care by reducing mental health stigma, and encouraging treatment for mental health and SUD problems. These efforts include: early identification and intervention; policy reviews and revisions; and the implementation of applicable strategies to create an environment that reduces stigma, encourages help-seeking behaviors, and promotes resilience.

In the past year, the DoD has expanded primary care behavioral health programs to increase access, overcome stigma, and improve quality of primary care assessments and interventions. The Army, Navy, and Air Force are implementing two models of integrated behavioral health and primary health care: the Primary Care Behavioral Health (PCBH) and the Care Management (CM) models. The PCBH model of service delivery integrates clinical psychologists and clinical social workers into primary care clinics as internal behavioral health consultants. The CM model is a population-based continuity of care model that uses systematic pathways to improve identification, management, and follow up for discrete clinical problems, such as depression or PTSD. The Services are expanding it to include clinical pathways for alcohol misuse and generalized anxiety.

Moreover, the DoD and Department of Health and Human Services initiated an agreement whereby the Public Health Service (PHS) would detail mental health providers to DoD military medical treatment facilities to increase access to PH and TBI care due to shortages created by deployed military providers. Currently, 176 PHS officers are assigned at more than 62 military installations

The DoD is currently working on integrating the Screening, Brief Intervention, Referral and Treatment model into primary care settings. The model is an evidence-based approach designed to identify individuals with greater risk of alcohol-related problems, and to provide brief counseling in a less judgmental and stigmatizing manner. Finally, the DoD and VA are moving forward with a joint plan to conduct chaplains' training on mental health issues with the goal of improving the integration of chaplains and mental health services. Based on the work of working group for IMHS #23 on Chaplain Roles in Integrated Mental Health Care, this effort will promote the provision of integrated and standardized services that can help reduce stigma.

In regard to policy review, the DoD is undertaking a systematic review of mental health-related policies with reference to stigma. Current efforts include a review of more than 12,100 DoD-wide and Service-specific policies that may impact stigma associated with barriers to seeking care, or promotion of self-help strategies. In a similar effort, the DoD examined SUD programs and relevant policies, and developed a comprehensive plan for the enhancement of services. Additionally, the recommendations made by a previous IOM study, "Substance Use Disorders in the U.S. Armed Forces," led to provisional changes and reviews to existing policies that are currently in coordination. Finally, a review of DoD-affiliated PH initiatives is being conducted to identify programs that have a designated purpose of reducing stigma; PH media campaigns are also being reviewed with the goal of crafting communications framework that promotes help-seeking behavior.

The DoD actively engages in the review and revision of its policies regarding mental health and substance abuse treatment with the goal of promoting help-seeking behavior, and removing barriers to care. DoDI 6490.04 (March 4, 2013), "Mental Health Evaluations of Members of the Military Services," allows relaxation of command-directed evaluation requirements, and permits commanders to discuss the option of mental health care with subordinates. DoDI 6490.08 (August 11, 2011), "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members," specifically states that "health care providers shall follow a presumption that they are not to notify a Service member's command when the Service member obtains mental health care or substance abuse education services," unless this presumption is overcome by specifically listed requirements (for example, threat of harm to self, harm to others).

Question #21 of the Questionnaire for National Security Positions (Standard Form 86 or SF 86) asks whether the applicant has consulted with a health care professional regarding an emotional or mental health condition, or was hospitalized for such a condition, within the 7 years prior to filling out the SF 86. Subsection 3.1(e) of Executive Order 12968 states in part that: "No negative inference concerning the standards in this section may be raised solely on the basis of mental health counseling." In fact, seeking professional care for mental health issues is a positive course of action that, by itself, will not jeopardize a security clearance and is viewed as a positive indication that the applicant recognizes a problem may exist and is willing to take steps towards resolving it. In 2008, Question #21 of the Standard Form 86 was revised, at DoD request, to exclude any requirement to report counseling related to combat-related adjustment. Previously, only reporting counseling related to marital, family, and grief counseling had been excluded. A guidance memorandum issued by the DoD in 2009 reiterated the national policy found in Executive Order 12968 that "counseling in and of itself is not a reason to deny or revoke security clearance." A further DoD guidance memorandum dated September 4, 2012, and titled "Department of Defense Guidance on Question 21, Standard Form 86, Questionnaire for National Security Positions," reaffirmed the policy protections established by the Standard Form 86 and made clear that interim security clearances could not be denied solely based on an individual answering "yes" on Standard Form 86, Question #21. The protections in the SF 86 medical information release form limit the questions investigators may ask health care practitioners regarding mental health counseling to whether the person under investigation has a condition that could impair his or her judgment, reliability, or ability to properly safeguard classified national security information. This question is to determine if such treatment or counseling is relevant to the adjudication for eligibility for access to classified information or sensitive national security position. If the practitioner answers "no" to this question, no further questions are authorized. Currently, the DoD has been active in interagency working groups considering several different revised future versions of Question 21 that would preserve and enhance these protections and further eliminate any stigma from counseling.

The August 31, 2012, Executive Order, "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families," created the Military and Veterans Mental Health Interagency Task Force to make recommendations to the President on strategies to improve mental health and substance abuse services for Service members, Veterans, and their families. It also charges the DoD to implement a 12-month campaign with focus on "positive benefits of seeking care and encourage Veterans and Service members to proactively reach out to support services."

Other examples of DoD and Service-wide efforts that promote help-seeking behavior and access to care include the Real Warriors Campaign (www.realwarriors.net), a multimedia public awareness campaign that encourages help-seeking behavior among Service members, Veterans, and military families coping with PH concerns, and promotes Service members' awareness and use of available resources. The campaign is an integral part of the DoD's overall effort to reduce stigma and encourage Service members and their families to seek appropriate care and support for "invisible wounds."

The Army's Stigma Reduction Campaign Plan describes the mission for its Health Promotion & Risk Reduction Campaign as minimizing all forms of stigma related to help-seeking behavior by employing initiatives that combat cultural and institutional barriers to help-seeking. The goals of the campaign are to encourage commanders and leaders to support and promote help-seeking behaviors by creating environments that foster safety, loyalty, dignity, and respect; to review and change policies and procedures in order to remove barriers and promote awareness and accountability and yield cultural and institutional changes in values, practices, policies, and procedures; and to conduct periodic evaluations of current policies and programs, assess the impact of new initiatives, and monitor metrics to gauge effectiveness of efforts to reduce stigma through FY 2020.

The Air Force Surgeon's General Mental Health Consultants continually evaluate the Air Force environment and look for opportunities to minimize barriers to accessing mental health care through policy development and program implementation. For example, frontline supervisor training was implemented in 2010 to ensure that supervisors in at-risk career fields (for example, special operations) have key skills to identify and intervene with troops experiencing difficulty. Addressing mental health stigma within installations is also the focus of recently funded program improvement projects. For example, through a research partnership with Pennsylvania State University, data related to mental health care barriers collected from Air Force communities will be used to develop a community outreach toolkit.

The Navy Medicine's Psychological Health Advisory Board is compiling all Navy and Marine Corps directives that place professional limitations on Service members who participate in mental health care or receive a mental health-related diagnosis. For example, those who work in specialized areas such as nuclear power, aviation, submarines, or special operations may be subject to institutional stigma, in that they might have duty restrictions placed on them if they are diagnosed with a mental health disorder. The goal of Navy Medicine is to promote the paradigm that duty restrictions are made on the basis of functional impairment rather than treatment status. These recommendations are expected to be in place by the end of FY 2013.

VA Response: The VA has no response; this recommendation is solely for the DoD.

ACCESS AND BARRIERS TO CARE: Recommendation #16

The committee recommends that the Department of Defense and the Department of Veterans Affairs conduct a needs assessment to determine the numbers and types of providers needed to address the long-term health needs of Operation Enduring Freedom, Operation Iraqi Freedom and Operation New Dawn active-duty service members and veterans. The Department of Defense and the Department of Veterans Affairs should determine the optimal team composition—for example, MDs, PhDs, RNs, master's-trained professionals, and peer

counselors—needed to ensure that providers function efficiently and perform at the upper level of their credentials and privileges.

DoD Response

The DoD established a mental health recruiting and retention strategy to help develop new programs to attract and retain uniformed and civilian mental health professionals. The Directive-Type Memorandum 09-007 (January 29, 2010), “Estimating and Comparing the Full Costs of Civilian and Military Manpower and Contract Support,” established the Health Profession Incentive Working Group to adjust incentives and pay annually to maximize recruitment and retention of those with skill sets in demand. This action is expected to significantly enhance the DoD’s ability to recruit and retain mental health professionals, particularly clinical psychologists and clinical social workers, through direct accession recruitment.

To conduct a needs assessment, the DoD used the Psychological Health Risk-Adjusted Model for Staffing (PHRAMS), which is able to provide a forecast for the total staffing requirements to determine the optimal team composition and meet the annual need for PH services by beneficiaries over a 5-year period for each type of specialty provider (for example, psychiatrists, psychologists, psychiatric nurse practitioners, and clinical social workers), and for others who provide PH services as part of the care they offer (for example, primary care providers and chaplains). Currently, a projection of requirements for each mental health specialty has been made for the Services from 2009 through 2014, including mental health specialty providers embedded into operational units and integrated into primary care clinics.

PHRAMS also calculates staffing requirements at the primary planning unit (PPU) level, usually the parent MTF, and reports requirements at that level or at various aggregated levels (for example, region, multi-service market area, branch of Service, or the DoD-wide level). It assigns beneficiaries to risk groups based on demographic and military-related risk factors associated with using PH services. For each PPU, PHRAMS calculates the total staffing needed by the risk-adjusted population of beneficiaries assigned by the model to that PPU. The current version of PHRAMS is under review for formal adoption by the Services in determining provider requirements across the major PH disciplines.

The DoD currently has two large studies in place to address mental health staffing issues. The first, conducted by the Sociotechnical Systems Research Center at the Massachusetts Institute of Technology, seeks to examine systems-level approaches to the provision of mental health care throughout the DoD. Inherent in this study are the questions of how many providers are needed to meet the DoD’s mission, where they should be stationed, how they should interact, and what their optimal makeup should be, given a particular location’s needs.

A second study, started in 2011, is conducted by the Center for Naval Analysis and the Navy Bureau of Medicine and Surgery to determine how many providers are necessary to meet the needs of sailors, marines, and their family members who require treatment, and the number of providers that will be necessary in the future to meet the needs of Service members returning from overseas contingency operations. This research relies heavily on the PHRAMS software, which has been developed by the DoD’s Tricare Management Activity to estimate mental health provider requirements.

The Army Medical Command (MEDCOM) continues to refine its behavioral health staffing model to accurately predict future requirements for behavioral health providers for all beneficiaries. The multidisciplinary organization of Departments of Behavioral Health and key clinical programs emphasize all providers working at the “top of their license” as part of a larger team. MEDCOM is developing a series of innovative analytic tools, called the Behavioral Health Matrix, that will map population Behavioral Health needs by installation, and determine which Behavioral Health assets are required to meet the clinical need. The estimated date of completion is July 2013.

Certain Behavioral Health Service Line programs, such as Embedded Behavioral Health, have empirically derived standard staffing models. The Embedded Behavioral Health Program, for example, has a 13 personnel standard staffing model for Brigade Combat Teams, including a core team of 7 providers.

VA Response

In the ever-changing environment of healthcare and wellness, VA continues to adapt to meet the needs of those entrusted to its care. Optimal team compositions (in terms of numbers of professionals of the various categories of care providers) are determined initially by review of the literature suggesting models and mixes of professions, and by study of the staffing requirements. Needs are determined prospectively by projections of those anticipated to seek care in VA, and in real-time by ensuring those enrolled will have their needs met by the sufficient analysis of challenges in access to care. Those challenges require readjustments and realignments to ensure the services and support provided match the needs of those presenting for care and partnership in health. The goal for all of these providers to be practicing “at the top of their licenses” is well known across VA. VA engages in ongoing Systems Redesign initiatives in clinical areas to understand the work being done, to streamline processes, and to promote maximized functioning of those caring for Veterans, while promoting continuity of care in those relationships.

Since 2008, primary care PACTs that focus on the care of OEF/OIF/OND Veterans have been configured to include (or have ready access to) social workers, mental health specialists, behavioral health therapists, and rehabilitation teams with expertise in TBI management. For those Veterans with more complex needs, primary care PACTs customize care by engaging all levels of clinical care staff including specialty care Nurse Practitioners and other Advanced Practice Registered Nurses, specialty care case managers, health coaches, and additional VA programs and resources to ensure comprehensive, personalized care. Since the onset of PACT in 2010, expertise in post-deployment care has become more widely disseminated, and PACTs assume more of the responsibility to ease the transition to civilian life for retuning combat Veterans.

VA is currently working on a staffing model to provide guidance on the ratio of providers to Veteran patients. This guidance will be based on requiring specific core skills, including peer counseling, to be available within a team. VHA has chosen this approach in order to allow flexibility of hiring for sites based on the availability of local professional resources. Similarly, specialty care and other services are engaged in development of similar models for staffing.

ACCESS AND BARRIERS TO CARE: Recommendation #17

The committee recommends that the Department of Defense, the Department of Veterans Affairs, and other federal agencies fund research to determine whether culturally sensitive clinicians and treatment approaches improve retention in care and improve clinical outcomes.

Interagency Response (Joint DoD and VA)

The DoD and VA seek to improve the access to (and quality of) care for women's mental health by addressing disparities and barriers to care (IMHS #28). The IMHS #28 working group identified the need for further areas of research and made recommendations for processes, procedures, and programs that support mental health services and research for female Service members and Veterans. Additionally, IMHS #28 called for ongoing surveillance, program evaluation, and identification of opportunities to improve both prevention of sexual assault and treatment for MST-related conditions in order to better serve those who have experienced MST (both males and females). During the past 2 years, the IMHS #28 working group has brought the DoD and VA subject matter experts together to identify the gaps that may exist in the continuum of PH care available to female Service members and Veterans. The working group is also examining gaps in care and treatment and plans to recommend best practices, policy changes, and system improvements for both Departments to be generated in FY 2013.

Both the DoD and VA are vigorously addressing the need for clinicians and treatment approaches that are culturally sensitive to improve clinical outcomes. IMHS #25, Military Culture Training, makes policy recommendations to the two Departments regarding training requirements for all new civilian and contractor employees. Another focus of IMHS #25 is to develop and provide high-quality training on military culture, deployment stress, and related mental health issues facing Service members, Veterans, and their families. These trainings will provide accurate and relevant information to DoD and VA provider organizations, advocacy groups, and civilian providers with the intent of advancing care through increased sensitivity toward Service member and Veteran-specific issues. Clinical providers are offered continuing medical education or continuing education credits upon completion of the training — an important incentive for retention and participation.

DoD Response

Since September 2010, more than \$48 million in funding had been directed to 42 active studies focused on families, women, and/or minorities, with more than \$2.4 million invested in research on the needs of cultural minorities.

The DoD is conducting a study for FY 2012-2013 that addresses the mental health needs of rural and remote Service members and families by assessing the mental health care needs, access to care, cultural issues, and family support affecting treatment preferences and care-seeking.

The DoD has also funded a study to better understand the mental health needs of Service members who are women, racial, ethnic, and/or sexual orientation minorities, and evaluate the psychological health, treatment needs, perceived access to treatment, and mental health service utilization of these diverse groups.

In addition to the efforts detailed above, the DoD provides training in military culture competence for civilian mental health providers to assist them in better understanding, communicating, and effectively interacting with Service members and their families.

VA Response

VA has funded some research in this area. For example, there is a pilot study to examine diverse racial/ethnic variation in family functioning post-deployment. This study addresses VA priorities regarding the need to conduct research on returning Veterans and families from diverse racial/ethnic groups. Findings will provide preliminary data that may potentially allow development of tailored rehabilitation treatments that address specific troublesome areas of family functioning

In addition to research, VA strives to ensure that the best possible services are provided to all Veterans. This includes the services provided through VHA's Readjustment Counseling Service (RCS) Vet Centers. Vet Centers are community-based counseling centers that provide a wide range of social and psychological services, including professional readjustment counseling, to those that have served in combat theaters or areas of hostilities, counseling for MST-related mental health conditions, and bereavement counseling for families who experience an active duty death. This program also facilitates community outreach and the brokering of services with community agencies that link Veterans with other needed VA and non-VA services. A core value of the Vet Center program is to promote access to care by helping Veterans and families overcome barriers that impede them from using those services. For example, all Vet Centers have service availability after normal business hours and on Saturdays.

RCS strives to maintain a deep understanding of cultural needs of all Veterans and families that receive readjustment counseling services to include ensuring that Vet Center staff represents the Veteran populations they serve. During FY 2012, RCS client services and staff demographic levels both exceeded the overall Veteran population representation for all ethnic groups. RCS maintains a workforce comprised of 18.6 percent African American; 10.2 percent Hispanic; 3.3 percent Asian/Pacific Islander; and 1.6 percent American Indian. This demonstrates a strong commitment to diversity and an accurate reflection of the Veterans VA serves (U.S Census: 16.8 percent African American Veterans; 11.1 percent Hispanic Veterans; 3.5 percent Asian/Pacific Islander Veterans; and 1.6 percent American Indian Veterans). Furthermore, over 72 percent of all Vet Center staff are Veterans themselves, and a large majority of these individuals served in combat theaters or areas of hostility. This ability to ensure the Veteran-to-Veteran connection is paramount to helping to reduce stigma as well as increasing retention in services. The U.S. Medicine Institute for Health Studies, with participants from the DoD, the Substance Abuse and Mental Health Services Administration (SAMHSA) and VA, reported "VHA's Vet Centers have proven a 'best practice' model in fostering peer-to-peer relationships for those with combat stress disorders. The best way to overcome concerns about stigmatization is through person-to-person contact with someone who has recovered." The Vet Center program is also the gold standard in both internal and external VA surveys measuring Veteran and employee satisfaction.

RCS maintains nine national working groups that provide the RCS Chief Officer with recommendations on how to better serve specific Veteran populations. The work groups are broken into the following Veteran cohorts: African American Veterans; American Indian Veterans; Asian-Pacific Islander Veterans; Disabled Veterans; Hispanic Veterans; Homeless Veterans; Lesbian, Gay, Bisexual, and Transgendered (LGBT) Veterans; OEF/OIF/OND Veterans; and Women Veterans. The work groups regularly provide RCS with better tools to reach out to these specific Veteran populations and to ensure that the RCS staff understands the needs of these Veterans.

Within the clinical, training, and outreach realm (i.e., in addition to research), VHA encourages cultural competency with regard to race and ethnicity, as well as other elements of diversity including gender, sexual orientation, age, and understanding of military culture. A few examples of the many VA efforts in this realm are described briefly here. VA has worked with the Indian Health Service (IHS) to create a DVD for clinicians (VA and IHS staff) that is designed to provide practical information about services available for American Indian Veterans, as well as to enhance cultural awareness of traditional American Indian healing techniques. The Office of Rural Health (ORH) completed a survey in October 2012 identifying American Indian traditional practices (for example, Sweat Lodge; Drum ceremonies, Traditional Healers) in 19 of the VA's 21 VISNs. The survey can be accessed on the ORH Native Domain website at: <http://www.ruralhealth.va.gov/native/services.asp>. A survey by the VA's Chaplain Service, using different criteria from the ORH survey, identified access to traditional healing services in all 21 VISNs. Due to the spiritual nature of American Indian healing practices VA's Chaplain Service provides Guidelines for Traditional Practitioners on these services and the processes for identifying and, through local American Indian tribes, verifying the competency of Traditional Healers. This guidance can be accessed through the National Chaplain Center website: www.va.gov/chaplain.

As part of its efforts to provide high quality and culturally competent care to LGBT Veterans, the VA's Office of Patient Care Services has two national LGBT program coordinators. The coordinators lead clinical training efforts, respond to queries from throughout the VA system of care, and advise Patient Care Services on policy and procedures relevant to LGBT issues.

VA policy requires that mental health services be provided in a manner that recognizes that gender-specific issues can be important components of care. To help prepare clinicians for the increase in women Veterans in their clinics, Mental Health Services launched a Women's Mental Health Monthly Teleconference in August of 2012 that is available to all VA staff. This teleconference covers mental health topics that are particularly salient to the care of women Veterans, and highlights known gender differences (for example, prevalence of disorders, symptoms presentations, etc.). In September 2012, VA launched a national women's mental health distribution list as another means to distribute this type of educational information to providers. This distribution list already has more than 500 members.

In addition to the military culture training that VA is developing jointly with the DoD, VA has also developed several resources to help clinicians become sensitive to military culture and improve retention in treatment. One resource is a web-based community provider toolkit found at (www.mentalhealth.va.gov/communityproviders/). The free, downloadable toolkit includes key tools to support the mental health services that community clinicians provide to Veterans, including information on connecting with VA; understanding military culture and experience; and tools for working with a variety of mental health conditions. Further, VA's National Center for PTSD has a brief course on military culture that is currently available through its PTSD 101 web-based learning program. This course, "PTSD 101: Understanding Military Culture," presents important information regarding military demographics, branches, rank, status, and stressors and offers CEUs. Finally, the VA has developed mandatory training for all health professions staff and trainees working in VA medical centers. The web-based "Military Cultural Awareness" course provides a common foundation for all VA employees. This course offers an overview of common military culture and courtesies, roles and ranks within the military, differences between the branches of the armed services, some of the conflicts in which Veterans

have served, and why this information is important in helping VA employees better serve the needs of Veterans and their families. Further, VA has recognized the essential need for clinicians to understand military culture, and has recently established a workgroup to evaluate existing military culture training available to clinicians and determine both the additional resources needed and the effectiveness of the spread mechanisms in use in better serving Veterans and their families.

ACCESS AND BARRIERS TO CARE: Recommendation #18

The committee recommends that the Department of Defense and the Department of Veterans Affairs consider ways to remove barriers and improve women's access to and use of health care in their systems. The two departments should examine issues related to women's circumstances and stressors—such as military workplace stress, sexual harassment and assault, posttraumatic stress disorder, and preliminary trauma—in an effort to reduce disparities and to provide health care that is sensitive to their needs and preferences.

Interagency Response (Joint DoD and VA)

As described in the response to Recommendation #17, the focus of IMHS #28 is to explore gender differences in delivery and effectiveness of mental health services. In addition, DoD and VA are partnering to identify the most recent evidence on barriers to care and strategies pertinent to the military mental health environment; this effort is in response to DoDI 6000.14 (September 26, 2011), "DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS)," which stresses the importance of providing gender-sensitive, individualized health care to all Service members.

DoD Response

Reducing barriers to care for women and improving access to such care is paramount to ensuring that women's health issues are appropriately addressed. The DoD is committed to ensuring that the necessary care and support are readily available to women who may have experienced abusive relationships, workplace stress, and sexual harassment/assault. The DoD is also actively involved in combating stigma associated with accessing mental health care, and is dedicated to providing evidence-based care and support for trauma victims.

Recommendation #2 describes several DoD policies relevant to this recommendation, including: DoDD 6495.01 (January 23, 2012), "Sexual Assault Prevention and Response (SAPR) Program;" DoDI 6495.02 (March 28, 2013), "Sexual Assault Prevention and Response Program Procedures;" and DoDD 1350.2, (August 18, 1995), "Department of Defense (DoD) Military Equal Opportunity (MEO) Program." The third policy cited charges DoD component leads with promoting equal opportunity and eliminating unlawful discrimination and sexual harassment in the DoD.

DoDD 1350.2 clearly defines sexual harassment, identifies this behavior as a form of unlawful discrimination, and delineates procedures for handling informal and formal complaints. Additionally, the policy charges Military Department Secretaries with specific responsibilities, among which are: (1) ensuring victims' support programs provide counseling, information, referral, and other assistance to Service members who have experienced unlawful discrimination or sexual harassment; (2) establishing toll-free or local hot (or advice) lines that provide

information on how and where to file complaints and what kinds of behaviors constitute unlawful discrimination and sexual harassment; (3) requiring commanders to assess their organizational equal opportunity climate (which includes prevention of sexual harassment), as part of their assumption of command, and scheduling follow-up assessments periodically during their command tenure; and (4) ensuring that all rating and reviewing officials evaluate a member's compliance with DoDDs prohibiting unlawful discrimination and sexual harassment, and document serious or repeated deviations from such directives in performance reports.

VA Response

Many of the IOM recommendations are fully aligned with VHA care transformation efforts. VA is expanding access for women Veterans by insuring the implementation of comprehensive primary care for women Veterans (defined as care for acute and chronic disease, preventive care, and gender specific care), provided by trained designated women's health providers at all sites of care. VA is also enhancing access to advanced gynecologic care at all medical centers, and providing maternity care and seven days of newborn care (usually provided offsite and paid by VA) for eligible women Veterans. VA has launched a campaign to change the language, practice, and culture to be more inclusive of women Veterans, and is correcting all deficiencies in privacy and environment of care for women Veterans. These changes have resulted in a significant growth in women Veterans' use of VA services. Over 57 percent of women Veterans of OEF/OIF/OND have enrolled for VA care.

Additionally, in an effort to understand barriers to care for women Veterans, VA conducted the 2008 National Survey of Women Veterans — a telephone survey of more than 3,000 women Veterans, including VA users and non-users, to identify demographic and military service characteristics, health status, and barriers to VA health care use. From this study, VA determined that information needs about VA eligibility and services were not being met for a substantial portion of women Veterans. The most commonly cited barriers to VA health care use at that time were that many women did not think they were eligible for VA services; many women were not familiar with how to apply for benefits; and the location of the nearest VA was often perceived by women to be too far from their homes.

To reduce these barriers, VA launched the national Women Veteran's Call Center in 2011 to place outgoing calls to women Veterans to provide information about VA services and eligibility to all women Veterans. This call center is being revamped, and was expanded in April of 2013 to include an incoming Women Veterans Call Center where women can be directly referred for local services or eligibility information.

To gather additional information about remaining barriers to care, VA is preparing to launch a second National Survey of Women Veterans (required by Congress public law 111-163). The survey has been developed and will be carried out in FY 2013-14 as a one-hour telephone interview of over 8,400 women Veterans.

VA recognizes that both male and female Veterans who experienced sexual harassment and assault during their military service (referred to as "military sexual trauma" or "MST" by VA) may face some unique barriers in accessing care. VA has attempted to address these issues in a variety of ways, including screening all Veterans seen for health care for MST, providing care free of charge for all MST-related conditions, and appointing a MST coordinator at every VA health care facility to assist Veterans in accessing care. VA's national MST support team

conducts an “Answer the Call” campaign to monitor Veterans’ ability to reach MST coordinators when contacting VA medical centers and engages in a range of other activities related to outreach and access to care. VA Mental Health Services has a strong working relationship with the DoD’s SAPRO, and has developed educational initiatives to ensure transitioning Service members, in particular, are aware of the MST-related services available through VA.

VA also recognizes that gender differences can play a role in how men and women access, experience, and respond to care. Having trauma-informed and gender-sensitive mental health treatment programming available is key to ensuring that the needs of women Veterans secondary to stress and trauma exposure are adequately addressed. To this end, current VA policy requires that mental health services be provided in a manner that recognizes that gender-specific issues can be important components of care. To enhance the knowledge of VA providers in the provision of gender sensitive care for women, Mental Health Services began hosting a teleconference educational series to provide information and training to VA staff about issues specific to women's mental health in 2012. Additionally, Mental Health Services recently completed a national survey of all VA mental health leaders on existing services, challenges, and best practices for the delivery of gender-sensitive mental health care. Mental Health Services is now in the process of analyzing the data; these findings will inform future recommendations for delivery of gender-sensitive mental health care in VA.

PROPOSED DATA ANALYSIS: Recommendation #19

The committee recommends that the Department of Defense and the Department of Veterans Affairs support comprehensive analyses of relevant data that reside in the two departments and other agencies of the federal government. Their databases should be linked and integrated so that they can be used effectively to address questions regarding readjustment that are not answered in the peer-reviewed literature.

Interagency Response (Joint DoD and VA)

Analysis of data and databases available in the DoD, VA, and other federal agencies can augment understanding of the mental health and readjustment needs of Service members, Veterans, and their families. In response to President Obama’s Executive Order, “Improving Access to Mental Health Services for Veterans, Service Members, and Military Families,” the DoD and VA partnered with Health and Human Services and the Department of Education to develop standards so that clinical data captured in an electronic health record during episodes of care can be supplemented with additional data for clinical research purposes, adverse event reporting, and public health.

DoD Response

As the lead Service for the MHS Clinical Enterprise Intelligence initiative, the Air Force has developed and secured funding for the Health Service Data Warehouse (HSDW). The HSDW is an integrated longitudinal store of data collected from a multitude of health information systems designed specifically for the purpose of clinical analytics and research.

In addition to the databases listed in Appendix F of the IOM study, there are additional databases related to TBI and other issues that may offer data relevant to readjustment. The joint DoD/VA Psychological Health and Traumatic Brain Injury Registry (“DoD-VA PH-TBI Registry” or

“Registry”) is an enterprise-wide effort to bring together health care and outcome data from a variety of sources in conjunction with Federated Registry infrastructure used by other registries. The development and sustainment of the Registry is recognized as a core task that supports the DoD’s mission to advance excellence in PH and TBI prevention and care in meeting the needs of Service members and their families. The Registry will increase the Department’s capacity to track treatment results and assess treatment quality. Development efforts are being undertaken as part of the Integrated Health Registry Framework sponsored by the DoD, and will also incorporate data from the Defense and Veterans Eye Injury and Vision Registry, and other Centers of Excellence and MHS registries.

Publicly accessible databases (for example, National Institutes of Health (NIH) RePorter, which is used by the VA and NIH) serve as repositories for information on government-sponsored research. Components of the DoD research portfolio are available on publicly accessed websites; however, the DoD is working to move its research onto the NIH RePorter via Electronic Research Administration Commons, thus promoting an even higher level of transparency and analysis across agencies.

The Federal Interagency Traumatic Brain Injury Research (FITBIR) Informatics System was established to provide a repository for TBI clinical research. Qualified researchers can request access to data stored in FITBIR and/or data stored at federated repositories. FITBIR was funded by the DoD and subsequently developed and managed by the NIH. Clinical data are entered into FITBIR utilizing the TBI Common Data Elements, which were developed to allow greater comparability of TBI research data.

VA Response

VA supports the goal of making the results of its scientific research available and useful to the public, industry, and the scientific community with the fewest constraints possible (see *Memorandum for the Heads of Executive Departments and Agencies* from the Director of the Office of Science and Technology Policy, Executive Office of the President, dated February 22, 2013). VA is currently developing a comprehensive plan to achieve this goal as expeditiously as possible. The plan will include recommendations for creating one or more machine-readable archives for storage, documentation, manipulation, and distribution of data from VA-funded research, and will incorporate current interagency data sharing efforts that are being developed as part of the National Research Action Plan (NRAP) prepared in response to the August 31, 2012 Executive Order, “Improving Access to Mental Health Services for Veterans, Service Members, and Military Families.”

PROPOSED DATA ANALYSIS: Recommendation #20

The committee recommends that the Secretary of Defense and the Secretary of Veterans Affairs establish an interagency work group to identify and examine the feasibility of linking data that exist in Executive Branch departments and agencies throughout the federal government. The work group should be tasked to explore issues related to coordination among agencies, for example, defining common goals, establishing common policies and procedures, creating mechanisms for data sharing, establishing records systems, and overcoming legal impediments and meeting legal requirements. The work group should provide the Secretaries with options and recommendations for establishment of a sustainable program for long-term

cooperation and data sharing to improve understanding of the outcomes of military service and readjustment after combat deployment.

Interagency Response (Joint DoD and VA)

The Executive Order, “Improving Access to Mental Health Services for Veterans, Service Members, and Military Families,” provided guidelines for reducing barriers between Executive Departments to meet the mental health and substance abuse needs of Service members, Veterans, and their families. The DoD and VA established the Mental Health Interagency Task Force to improve collaboration between the Departments for data sharing and overcome challenges associated with the interchange of information. The Interagency Task Force established an Interagency Research Working Group (IRWG) that was tasked to develop the NRAP. A key goal of the NRAP is the improvement of data sharing between agencies and academic and industry researchers to accelerate the progress, and reduce redundant efforts without compromising privacy. The NRAP was submitted on time as required by the Executive Order.

PROPOSED DATA ANALYSIS: Recommendation #21

The committee recommends that clear procedures be developed for accessing data held by the Department of Defense, the Department of Veteran affairs, and other federal agencies. The procedures should appear on each agency’s website with access to its data dictionaries. That would enable researcher and others wishing to access data to understand all the requirements before they begin data gathering efforts and would provide information about the types of data that are available and how to access them.

Interagency Response (Joint DoD and VA)

The DoD and VA are committed to promoting data sharing to facilitate research progress. Examples of this commitment are the IRWG described in Recommendation #20, and the use of a web-based health data directory to inform researchers and promote data-gathering techniques. As discussed in Recommendation #20, the IRWG has drafted the NRAP that will directly address the procedures of information sharing through publicly accessible repositories of research information like the NIH RePorter. The DoD is in the process of moving its research information to this system.

The IRWG has also addressed the need to standardize and share study data through the use of centralized repositories. The aforementioned FITBIR is an example of a data repository for TBI research.

To further promote data gathering efforts, the DoD and VA have partnered with 3M Health Information Systems, Inc., to develop a public Health Data Dictionary (HDD), titled HDD Access. HDD Access is a web-based program that can be freely accessed online, and allows researchers to browse and view housed health data terminology content. Additionally, the content stored in HDD Access provides researchers with the foundation to enhance health care analytics and promote research of DoD and VA-related health care topics.

DoD Response

In addition to the abovementioned interagency efforts, the DoD's Armed Forces Health Surveillance Center (AFHSC) is the central epidemiological resource for the U.S. Armed Forces that provides regularly scheduled and customer-requested analyses, and reports to policy makers, medical planners, and researchers. Also available on the AFHSC website are annual and monthly reports that provide DoD surveillance data to the general public. Similar to academic journals, AFHSC reports can be cited and used to support research efforts.

VA Response

VA is currently developing a comprehensive plan to enable data sharing as expeditiously as possible. The plan will include recommendations for creating one or more machine-readable archives for storage, documentation, manipulation, and distribution of data from VA-funded research, and will incorporate current interagency data sharing efforts that are being developed as part of the NRAP prepared in response to the August 31, 2012 Executive Order, "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families."