Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces

Department of Defense Recovering Warrior Task Force

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Executive Summary

SUMMARY

The Recovering Warrior Task Force (RWTF) concludes its third year of effort with the Fiscal Year (FY) 2013 Annual Report. In its third year, the RWTF continued its assessment of the programs and services available to Recovering Warriors (RWs) and their family members, from case management through transition to the Department of Veterans Affairs (VA) and civilian life, in accordance with the RWTF's congressional mandate. Additionally, the RWTF continued four lines of inquiry:

- Issues unique to Reserve Component (RC) RWs and families, through visits to three Joint Forces Headquarters (JFHQs), an Army Community Based Warrior Transition Unit (CBWTU), Navy Medical Hold West, one of the largest Navy Operational Support Centers (NOSC), and several installations with high proportions of RC RWs in their transition units. These visits included briefings from program and unit staff; most also included focus groups with RC RWs.
- Parity concerns for remotely located RWs and families, through visits to a CBWTU with up to a quarter of its RWs living in rural areas and a WTU located in Alaska.
- Transition outcomes, by pulsing the Department of Defense (DoD) and VA proponents who provide post-transition support on the needs of those they are serving. The DoD proponents included Navy Wounded Warrior–Safe Harbor non-medical care managers and Anchor Program mentors, Army Wounded Warrior (AW2) Advocates, Air Force Wounded Warrior (AFW2) non-medical case managers (NMCMs), and others who work with RWs and their families after they transition out of the military. VA proponents included staff of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Programs, VA Caregiver Support Programs, and others.
- Timely publication of the most relevant and salient policies that affect the RW and his/her family.

Among the matters Congress directed the RWTF to examine is the effectiveness of the Interagency Program Office (IPO) in achieving fully interoperable electronic health records by September 30, 2009.[1] In February 2013, DoD and VA announced their plan to move away from creating a single shared electronic health record (EHR) to building on existing technology by integrating the current DoD and VA health care data systems.[2] The change, which will lead to faster and less expensive implementation, involves using already available core applications and adding modules and applications as needed, rather than building a system from scratch.[3] Although many have expressed disappointment regarding the scale-back of integrated EHR plans[4, 5, 6, 7, 8, 9, 10], the RWTF believes that, regardless of which path is taken, an integrated system is needed to ensure a successful continuum of care from the time a Service member is injured to the time they are released from military service and become a veteran. Irrespective of how this goal is achieved, it is imperative that it be accomplished.

This year's recommendations build upon those made in the previous two years with attention to lessons learned across DoD over the last twelve years and the changing landscape of services and supports. Based upon the data collected and analyzed, the RWTF offers XX recommendations,

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listed below. These recommendations include xx, xx, and xx (insert several over-arching themes from voted recommendations). Findings for each of these recommendations are presented in Chapter 2.

Restoring Wellness and Function

1. Xx
2. Xx
3. Xx
4. Xx
5. Xx

Restoring into Society

6. Xx
7. Xx
8. Xx
9. Xx
10. Xx

Optimizing Ability

11. Xx
12. Xx
13. Xx
14. Xx
15. Xx

Enabling a Better Future

16. Xx
17. Xx
18. Xx
19. Xx
20. Xx

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Introduction

CHAPTER 1

Congress directed the Department of Defense (DoD) to establish the Recovering Warrior Task Force (RWTF) to assess the effectiveness of DoD policies and programs for the care, management, and transition of Recovering Warriors (RWs) and make recommendations for improvement.[11, 12] The legislation specified over a dozen specific topics that the RWTF is to examine each year. (See Appendix A, Legislation, paragraph (c)(3)(matters A-Q).) The RWTF submitted its first Annual Report to the Secretary of Defense on September 2, 2011, and its second Annual Report on August 31, 2012, providing a total of 56 recommendations over the two reports.

Congress established important feedback mechanisms for the DoD to respond to the RWTF's recommendations.[13] DoD is required to provide Congress an assessment of the RWTF recommendations at 90 days, and an implementation plan at 180 days, after RWTF submission of the report to the Secretary of Defense. The RWTF is disappointed that the DoD missed the due date to provide the RWTF 2012 Report implementation plan to the Congressional committees. The RWTF carefully reviews these assessments and implementation plans to track the impact of its recommendations on RW programs, services, and initiatives, and to inform future data collection efforts and recommendations. Charts indicating the status of each of the FY2011 and FY2012 recommendations are presented in Chapter 2.

With DoD support, the RWTF was able to execute an aggressive FY2013 agenda, including 14 visits to 21 installations and VA facilities to conduct 30 focus groups and receive over 120 briefings onsite, and six business meetings including almost 50 briefings and panels. The RWTF pursues headquarters-level perspectives and those of providers, RWs, and family members at the installation level because Members continue to observe that the impression at the top does not always match the experiences and sentiments on the ground. In addition to Army and Marine Corps sites, visits included opportunities to visit headquarters operations for Air Force Warrior and Survivor Care and Navy Wounded Warrior-Safe Harbor (NWW-SH) as well as joint environments including Walter Reed National Military Medical Center (WRNMMC), to explore the care and management of RC RWs in and out of RW units, to speak with VA proponents and assess DoD/VA collaboration at the local level, and to see Physical Evaluation Board (PEB) locations for all three Services. These visits allowed for a broad perspective on the Services' RW units and programs.

In FY2013, the RWTF continued to explore the DoD-VA transition experience, transition outcomes, and strategies to improve transition. The concept of ensuring a seamless transition from DoD to VA appeared as early as 2003.[14] In January of 2005, the VA established its Seamless Transition Office to bring Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) resources together to ease Service members' transitions[15], and in July 2006, the DoD and VA co-chairs of the Health Executive Council called upon the Joint Executive Council to establish a VA/DoD Joint Seamless Transition working group[16]. The RWTF supports and continues to follow the DoD/VA Care Coordination Committee (IC3) chartered January 8, 2013. IC3's efforts to provide an overarching interagency guidance document with "one mission-one policy-one plan" is the way forward for seamless transition.[17, 18]

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While concerned with the current state of programs and services for the RW community, the RWTF also has an eye on the future. Each year's efforts identifies problems and challenges that should be immediately addressed as well as strategies for the future care of today's RWs. Approaching its fourth and final year, the RWTF is acutely aware that it, along with DoD and the Services, must critically assess the lessons learned in RW care, management, and transition to determine which policies, programs, and services should be endorsed and sustained for the long term, so they will be available to support current and future generations of RWs. At the same time, the RWTF is looking at the fiscal adequacy of DoD RW resources going forward. Although the RWTF heard from headquarters-level proponents that sequestration was not directly impacting RW program budgets[19, 20, 21, 22], second- and third-order effects such as misguided hiring freezes and fewer post-transition federal job opportunities are impacting RWs[23, 24]. It is critical that RW programs and services retain their expertise and honor the investments made by DoD and the Services in these last dozen years, while appropriately responding to sequestration and fiscal constraints. The RWTF continues to emphasize, as it has since Year 1, the importance of timely publication of relevant policy. Publishing timely guidance not only standardizes care but also reduces redundancies and marshals resources across DoD, VA, and the Services—all high priorities in our current fiscal environment.

Chapter 2 of this report presents the RWTF's XX FY2013 recommendations and associated findings. Chapter 2 concludes with promising practices that are making a difference for RWs and families, and charts tracking the status of the FY2011 and FY2012 RWTF recommendations (Exhibits 1 and 2). Full appendices with supporting documentation are available in the on-line version of the final report posted on the RWTF's website. Among these, Appendix C, Reference Handbook, provides an overview of the topics Congress directed the RWTF to examine, Appendix G lists the information sources used to assess congressionally mandated and other topics, and Appendix L identifies the topics addressed in each RWTF recommendation.

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The Recovering Warrior Task Force's (RWTF) following XX recommendations are supported by findings from a variety of sources, including focus group and mini-survey results gathered by the RWTF from Recovering Warriors (RWs) and family members, briefings from site-level staff, briefings from each of the Services, briefings from other relevant individuals and organizations within and beyond the Department, and published articles and reports. The recommendations are organized under four domains reflecting a holistic, progressive, and RW-centered conceptualization of the recovery and transition process: Restoring Wellness & Function, Restoring into Society, Optimizing Ability, and Enabling a Better Future. Appendix D contains more detailed information about the method by which the RWTF collected and analyzed data to inform these recommendations and findings. Best practices and charts that track the status of the FY2011 and FY2012 RWTF recommendations are presented at the end of the chapter.

Restoring Wellness and Function

This domain includes topics central to the restoration of the physical and mental health of the RW and foundational to recovery, rehabilitation, and reintegration. This includes units and programs for RWs; medical care case management; posttraumatic stress disorder (PTSD); and the Centers of Excellence – the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE PH & TBI), as well as the Vision, Hearing, and Traumatic Extremity Injury and Amputation Centers of Excellence (VCE, HCE, EACE).

RECOMMENDATION D1

The Office of the Assistant Secretary of Defense for Health Affairs (OSD(HA)) and the CoE Oversight Board should develop a Department of Defense Instruction (DoDI) that empowers the CoEs and the Oversight Board and facilitates the translation of CoE discoveries into practice across DoD.

Requested Agencies to Respond: OASD(HA)

> **Finding:** The RWTF recognizes the resources provided to the CoEs and is eager to see that investment systematically improve the care of all RWs with psychological, brain, extremity, hearing, and vision injuries. Although each CoE has made progress[25, 26, 27, 28], the Veterans of Foreign Wars (VFW) identified the CoE's progress as one of its top concerns in testimony to Congress[29] and, in briefings to the RWTF, VCE and HCE both expressed the continuing need for a mechanism for implementing their recommendations[30, 31]. The RWTF believes each CoE is approaching the point at which they must measure their progress not by such developmental milestones as concepts of operation and initial operating capabilities but by outputs and outcomes such as consistent application of research to practice and impact on the care and rehabilitation of injured Service members. The Oversight Board, if empowered to create joint policy through DoD instruction, would be able to facilitate this translation of CoE findings into policies and practices that improve care.[32] Currently, CoE successes are facilitated by

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relationships and networking, as in the case of the Fox eye shield.[33] Due to the work of the VCE, Individual First Aid Kits (IFAKs) are currently deployed with a Fox shield in Navy and Air Force units.[34, 35] Unfortunately, the VCE continues to struggle to get this practice implemented consistently across all the Services.[36] A DoD Instruction documenting 1) the authorities of OSD(HA) and the CoE Oversight Board, and their process for translating CoE findings to DoD-wide practices, and 2) the Services' requirements to support these initiatives will ensure that DoD's considerable investment in the CoEs generates improved care and rehabilitation of injured Service members. DoDIs are essential to facilitating the promulgation of information and best practices across the Department of Defense.

In FY2011, the RWTF recommended the alignment of each CoE under a Service as an Executive Agent. This recommendation has been successfully completed. The DCoE PH and TBI successfully published a DoD Directive empowering the Army as Executive Agent to provide logistical support including a structure for manning and funding channels to compete for resources, but appropriately routes policy decisions through OSD(HA), so that what DCoE PH and TBI identifies as best practices can be implemented throughout the DoD.[37] This is the practice that needs to be implemented for the remaining CoEs and established in a DoDI. The intent is that the Service Executive Agent streamlines daily function while OSD(HA) oversight allows rapid translation of discoveries into DoD-wide practice.[38]

RECOMMENDATION D2

DoD and VA should establish formal policies that emulate the best practices established to transfer/transition catastrophically wounded service members between DoD-VA and VA-DoD for Service members with low-acuity conditions.

Requested Agencies to Respond: DoD Office of Warrior Care Policy (WCP)

Finding: Existing guidance does not ensure warm handoffs of RWs between DoD and VA Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) offices. Neither DoDI 1300.24, Recovery Care Program[39], nor DoDI 6025.20, Clinical Case Management[40], describes how the DoD recovery team should work with OEF/OIF/OND case managers to facilitate continuity of care. The RWTF is encouraged, however, by the work of the Joint Executive Committee (JEC) DoD/VA Interagency Care Coordination Committee (IC3) to develop a lead coordinator role, which is driven in part to address the lack of consistent warm handoffs within DoD and between the Departments, and guiding policy to ensure such warm handoffs.[41, 42] The RWTF will watch with great interest over the coming year as IC3 refines and rolls out this much needed bridging function across case managers and locations.

While the lead coordinator role appears to be a step in the right direction, the RWTF believes truly seamless transfers will require closer collaboration between the Departments than seen to date—indeed almost a blurring of the lines between the two. To accomplish this, DoD and VA should consider placing DoD recovery team staff and VA OEF/OIF/OND case managers in joint "federal" offices within the Military Treatment Facilities (MTFs) that will not only foster earlier, systematic, and more substantive communication and coordination regarding cases in the transition pipeline, but also help VA staff to proactively engage with RWs upstream. Among the

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arrangements this joint transition team should address is helping RWs use their TRICARE benefit to obtain care for lingering medical conditions while they are awaiting their compensation ratings or, at the very least, ensuring there is no wait for VA healthcare appointments once RWs retire or separate.

In the past decade, the VA established VA Liaison for Healthcare positions within major MTFs[43] and OEF/OIF/OND case management programs within VA Medical Centers[44] to facilitate the transfer of inpatient and outpatient healthcare of OEF /OIF/OND and non-OEF/OIF/OND active duty Service members, mobilized Reservists and National Guard, and Veterans from a MTF to a VA facility[45]. The VA Liaison for Healthcare is charged with collaborating with MTF staff for discharge planning, meeting with Service members and their family to comprehensively assess needs, making the referral to the receiving VA facility and coordinating initial VA appointments[46], to include providing contact information for the OEF/OIF/OND Program Manager and Case Manager at the receiving VA facility[47]. Thirty liaisons are assigned to 18 major MTFs; 212 MTFs within and outside the continental U.S. do not have VA Liaisons for Healthcare.[48, 49] Where liaisons do exist, they are not necessarily well utilized by DoD care teams[50], and some have suggested that the information the liaisons transfer tends to be more administrative than substantive[51]. The customized Comprehensive Recovery Plan (CRP) required by DoDI 1300.24, for example, often is excluded from the documentation VA receives from DoD.[52]

VA health care facilities across the country are staffed with OEF/OIF/OND Care Management Teams comprising Program Managers, Case Managers, and Transition Patient Advocates, whose mission is to welcome OEF/OIF/OND veterans, coordinate patient care, and help patients navigate the VA health care system.[53] An FY2012 briefing presented to the RWTF further specified that OEF/OIF/OND Case Managers coordinate care and services for *seriously* injured/ill OEF/OIF/OND veterans and arrange the first outpatient appointment for *pre-separating* Service members.[54] The RWTF has discovered the RW's DoD recovery team members (e.g., medical care case manager or nonmedical case manager) do not necessarily interface with this office or other VA providers on the RW's behalf, and often RWs and their families are unaware of the OEF/OIF/OND Care Management office.[55] Thus direct communication between the losing DoD care team—the people who are most familiar with the RW's and family's circumstances and needs—and the gaining VA OEF/OIF/OND care management team—the entities responsible for ensuring continuity of medical and non-medical attention for this patient and family unit through the VA system—is not consistently taking place. Further, there is no formal mechanism that systematically alerts the OEF/OIF/OND office to inbound RWs.[56]

In the absence of a warm handoff collaboratively orchestrated by DoD and VA providers in advance of the RW's transition, the seams between the two departments can feel formidable to RWs and their families. Many of the RWs and families the RWTF spoke to in focus groups, at both AC and RC locations, felt uninformed and anxious about where they are in the transition process and what will follow.[57, 58] Many RWs lacked confidence about how the transfer from DoD care to VA care would work.[59]

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I mean, the only thing I'm worried about is switching doctors. That's one of my big things. I've seen one doctor throughout this process. I know doctors change and all that good stuff, but the fact of the matter is I'm meeting a new person about treatments from here on out. (Recovering Warrior)

RECOMMENDATION D3

DoD must identify crucial RW unit and program information and disseminate to RWs and their families via mobile platforms. The effectiveness of this information dissemination must be measured in ways that alert DoD and Service leadership to information gaps and enable rapid corrective action.

Requested Agencies to Respond: WCP

Finding: RWs and families do not have the information they need and are not adequately engaged with the resources available to them, indicating that current strategies for disseminating information are insufficient. While transition units have been distributing phones and even iPads for communication and information access[60, 61, 62, 63], gaps remain in what RWs and family members know about both the recovery, rehabilitation, and transition process and available resources. Many RWTF focus group participants stated that the information provided to them during Warrior Transition Unit (WTU) or Medical Hold (MEDHOLD) orientation does not meet their needs; for some there was too much information too soon, and for others too little information was provided.[64] The overwhelming majority of RC participants responded that they are not aware of any RC-specific programs.[65] Family members also said available information does not meet their needs; many have a significant number of questions that are not being answered and do not know what information resources are available to them.[66]

The biggest thing is ensuring that information is put out correctly and on time. I hate not knowing anything. (Recovering Warrior)

Families … would [attend an information session] if it was within reasonable driving distance and worthwhile. We throw a lot of stuff at families that isn't worthwhile. (Family Member)

When you first get here, all the briefings, they basically pound it into your head. It's too much to take at once. Spread it out; not have 15 people brief you in an hour-and-a-half. (Recovering Warrior)

Since its inception, the RWTF has been concerned about information dissemination to RW families. The RWTF does not believe family members should have to rely on their Service member or each other for information and is troubled by continuing difficulties in outreach to family members.

Both the National Resource Directory (NRD) and Military OneSource (MOS) have a role in providing information to RWs and their families. The RWTF has found these resources to be of limited use among RWTF focus group participants. Among RWs, five percent had used NRD, 50 percent of those users found it very or extremely helpful; 42 percent had used MOS, 46 percent of those users found it very or extremely helpful.[67] Among family members, 4/70

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had used NRD and only 1/2 found it very helpful; 30/70 had used MOS and only 7/27 found it very or extremely helpful.[68]

When considering communications dissemination methods, it is critical to take the use of mobile devices into account. The Pew Internet and American Life Project recently released findings describing smartphone ownership and use. Since 2011, every major demographic group has seen growth in smartphone use, especially users in their 20's and 30's. This holds true across income, race, and education levels with almost 80 percent of the under 35 population owning a smartphone.[69] For smartphone users in their 20's, 88 percent are using their phones to meet immediate information needs.[70] Content can be made available via a custom application, such as the DoD Compensation and Benefits Handbook app[71] and the Marine Corps Wounded Warrior Regiment (WWR) app[72, 73], both free and both launched in 2012[74, 75, 76]. Content can also be made available via a website optimized for viewing on mobile devices, which does not require a separate download and is more accessible through search engines and promotable with social media.[77] The Military OneSource website is mobile-accessible, with Quick Response (QR) codes in articles to direct traffic to the site.[78] NRD has also created a mobile website for those accessing the website via mobile devices.[79] However, as noted, neither of these resources currently meets the needs of RWs and family members. Responsive web design enables users on any device to access information seamlessly[80], and in combination with tools like Google Analytics, can maximize access while giving the website owner insights into how the tool is being used and where[81]. DoD must develop a promotion plan for this new information dissemination solution that takes into consideration the information seeking patterns of Recovering Warriors and family members, leveraging social media, in- person, and direct-to-consumer outreach tactics to ensure this resource reaches RWs and families where they are.

DoD must also be responsible for measuring the efficacy of this information dissemination solution. This measurement should provide DoD and Service leadership a dashboard view of information gaps to enable rapid policy and practice changes in response to the data. Current survey efforts by DoD and the RW units and programs are not sufficiently assessing the adequacy of information provided to RWs and families. The RWTF requested information on and assessed the Army WTU and Medical Evaluation Board (MEB) surveys, the Navy Wounded Warrior–Safe Harbor (NWW-SH) Enrollee and Caregiver surveys, the RAND/Air Force Wounded Warrior survey, and the WWR's care coordination surveys on RCCs, Section Leaders, and District Injured Support Coordinators (DISCs). Only the Navy surveys family caregivers, and their low response rate (7%) limits the utility of the data collected. The Army MEB survey is currently the only one of these surveys with a knowledge test to assess if RWs have correct information; the other surveys focus only on satisfaction with services and the staff providing support.

RECOMMENDATION D4

Air Force liaisons at the Walter Reed National Military Medical Center (WRNMMC) and Landstuhl Regional Medical Center (LRMC) must have a minimum tour length of 24 months to provide more continuity for WII Airmen and their families.

Requested Agencies to Respond: United States Air Force (USAF)

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Finding: Air Force liaisons at WRNMMC and LRMC are not able to provide continuity and adequate support to RWs and their families because the position turns over frequently.[82, 83] Andrews AFB currently provides the WRNMMC liaison position, but the term is too short.[84] At LRMC, Air Force liaisons are assigned for six months with only a one-week overlap.[85] A significant portion of the liaison's assignment is spent in train-up, and RWs and families with acute needs during these train-up times are not getting the best possible services and support.[86, 87, 88] The RWTF believes that extending the Air Force liaisons' assignments at WRNMMC and LRMC would increase their number of productive months on the job and enhance the quality of service that the liaisons deliver to RWs and families.

RECOMMENDATION D5

OSD(HA) and TRICARE Management Activity (TMA) should develop and implement a Joint in-person training and collaboration program for clinical case managers of RWs across DoD, and should develop standard measures of effectiveness for clinical case managers of RWs.

Requested Agencies to Respond: OASD(HA)

Finding: The RWTF recognizes that DoD already has fairly extensive mandatory online training for Medical Care Case Managers (MCCMs).[89] Expanding existing MCCM training by bringing together MCCMs from all Service branches and components will help to standardize MCCM methods, disseminate best practices, and ensure parity of MCCM support across the Services and components. It also will enrich their mutual understanding and capacity for collaboration. For example, MCCMs who play critical roles in the transition of RC RWs from the MTF to community-based care, such as WTU Nurse Case Managers (NCMs), Community-Based Warrior Transition Unit (CBWTU) NCMs, and Case Managers (CMs) with the National Guard Reserve Component Managed Care (RCMC) Program[90], will have the opportunity to meet and discuss interdependent processes. The RWTF notes that the Veterans Health Administration recently generated its own standardized MCCM training module.[91] The RWTF also urges that DoD establish, as part of its performance measurement plan, a common method for assessing MCCM effectiveness. Using a common method—a DoD, rather than Service-specific, data collection tool—will better enable the Department and the Services to monitor, standardize, and optimize MCCM performance. To its credit, in spring 2013, DoD published policy guidance for clinical case managers (DoDI 6025.20). The RWTF believes an in-person, joint MCCM training and standard measures of effectiveness are a logical extension of DoD's ongoing efforts to establish robust medical care case management throughout the Department, and a step toward fuller implementation of the intent of DoDI 6025.20.[92]

In the RW arena, MCCMs are a success story. Across three years of RWTF site visits, MCCMs are identified by RWTF RW focus group participants as one of the most valuable members of the RW's recovery team.[93, 94, 95] On the FY2013 mini-survey administered to RWTF focus group participants, nearly two-thirds of RWs working with a MCCM rated their MCCM as very or extremely helpful.[96]

However, this year the RWTF noted disparities across locations. Just over 33 percent of Navy mini-survey respondents and 53 percent of Marine Corps mini-survey respondents, as compared to over 79 percent of Army mini-survey respondents, rated their MCCM as very or extremely

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helpful.[97] At two Army sites, several family members said they were not using Special Compensation for Assistance with Activities of Daily Living (SCAADL) because the NCM did not provide them accurate or timely information when they inquired about it.[98] In these instances, the NCM was described as more of a barrier to SCAADL than a facilitator.[99]

I went to try to apply to SCAADL because I had to quit my job to take care of him/her. I was told it wasn't around by the NCM but it was. His/her chain of command told me that I should be receiving it. I inquired about it again and the same NCM told me since it wasn't around when we got here so I didn't qualify for it. (Family Member)

The RWTF also observed upstream and downstream challenges that Army NCMs face when transitioning RC RWs from WTUs to CBWTUs. A WTU NCM said there is too much to do and too little time to prepare RWs before they leave for the CBWTU.[100] At the CBWTU, the NCM confirmed that a large proportion of RWs arrive still needing care for their unfitting conditions—care that may not be readily available outside the MTF.[101]

The challenges in implementation of medical care case management described above highlight the additional need for in-person, joint training to standardize MCCM methods, disseminate best practices, and ensure parity of MCCM support across the Services and components.

RECOMMENDATION D6

DoD should issue unifying policy standardizing the provision of evidence-based PTSD psychotherapies, addressing the needs of Service members and the providers treating them.

- A dedicated "Trainer and Champion" for the effective delivery of evidence based PTSD psychotherapies at each MTF.
- Standardized Armed Forces Health Longitudinal Technology Application (AHLTA) templates in which providers can capture standard outcome data.
- A process to rapidly examine treatment outcomes and adjust treatment protocols and programs to maximize treatment efficacy.
- Allowing providers to set appointment durations consistent with evidenced-based psychotherapies (EBP) guidelines.
- Requiring that all contract providers have military culture training and EBP training.
- Requiring intensive outpatient PTSD treatment programs to develop one required class for spouses designed to educate and engage them in their RW's treatment.

Requested Agencies to Respond: OASD(HA)

Finding: The RWTF continues to believe in the importance of promulgating policy to promote parity across the Services, ensure communication between DoD and the Services, and streamline and standardize care.[102] The lack of standardization across PTSD treatment programs[103] indicates the need for a guiding policy on the care of RWs with PTSD.

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Significant progress has been made in training providers in EBPs; the Services report the vast majority of their behavioral health providers have received training in at least one EBP[104, 105, 106, 107], and the Center for Deployment Psychology (CDP) reports having trained more than 8000 providers[108]. However, a single dose of training is not sufficient for sustaining skills; providers need to continue to use their training, access consultation and practice tools like checklists, and have the support and understanding of leadership.[109] While the Services' providers are receiving EBP training, there is no oversight standard or tracking method to ensure providers are correctly applying the training, and few are fully leveraging the consultation and other supports available through the CDP.[110] A trainer and champion at each MTF would make consultation more accessible to providers, promote awareness and use of EBPs, and advocate to healthcare and line leadership for the supports providers need to succeed in their delivery of EBPs.[111]

Others have also called for this level of support for behavioral health providers. In a 2010 memorandum, ASD (HA) recommended having a senior clinician consultant in each MTF and consultation available for each newly trained provider.[112] Similarly, the Army Task Force on Behavioral Health called for each installation to have a behavioral health clinical coordinator to advise the commander, ensure command support for compliance with behavioral health policies, and have visibility of the different resources at the installation.[113] The lack of an overarching policy to integrate the initiatives prevents them from being universally adopted and institutionalized.

Most sites the RWTF visited during FY2013 reported they review clinical documents in order to assess provider use of EBP; however, there are no standard charting procedures or forms in place to ensure treatment data is recorded in measurable and consistent ways across patients and providers.[114] The EBPs for PTSD call for specific steps in each treatment session; developing standardized AHLTA templates would facilitate compliance with EBPs and enable providers to track treatment progress and capture results of any assessments administered in each session. This ongoing data collection could be used to assess both fidelity to EBPs and treatment outcomes, at patient-, provider-, and systems-levels.[115]

A process to rapidly examine treatment outcomes and adjust protocols is essential to further standardize and maximize treatment efficacy across DoD. The Army and Navy have developed programs to address these issues; however, they do not span the enterprise.[116] Camp Pendleton has implemented the Psychological Health Pathways (PHP) program to track improvement and outcomes of therapy.[117] Similarly, the Army has implemented the Behavioral Health Data Portal (BHDP) in use at more than 30 MTFs to track patient outcomes, satisfaction, and risk factors.[118] The RWTF recognizes PHP and BHDP as best practices (see Best Practices at the end of this chapter for more information on PHP and BHDP).

Relative Value Units (RVUs), an output metric for healthcare providers, do not provide the flexibility needed for patients requiring more intensive attention.[119, 120, 121] At several locations visited by the RWTF, briefers indicated the providers were not set up for successful use of EBPs or did not feel adequately supported when delivering EBPs or providing supervising or consultation to EBP providers.[122] For example, providers did not receive extra RVU credit for conducting 90-minute sessions as per the EBP manual, rather than the typical 60-minute sessions, and senior EBP practitioners did not receive RVU credit for providing supervision or consultation.

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PTSD treatment is a difficult process for RWs, and undergoing treatment with a provider unfamiliar with military culture creates an additional barrier to treatment. A lack of cultural competence among civilian providers was mentioned by installation-based providers briefing the RWTF as one of the many reasons PTSD services are not better utilized.[123] CDP has recognized this concern and has included a military cultural competency module within the 1-week training for civilian providers.[124] CDP also noted that some providers are brought in on contract without military cultural competence training and without time built into the contracts for such training.[125] The RWTF believes all contract employees providing behavioral health services should be culturally competent.

PTSD can have a significant impact on family members, who are too often uninvolved in treatment. Research has established that negative family interactions are associated with poorer treatment outcomes for the individual with PSTD.[126] Veterans have identified PTSD as a stressor amongst the family and expressed interest in additional participation of the family in treatment.[127] Treatment approaches may entail varying levels of family member involvement, from managing family member expectations about PTSD and treatment to targeting improvement in both PTSD symptoms and in family functioning.[128] The National Intrepid Center of Excellence (NICoE) takes a patient- and family- centered approach to PTSD and TBI care; requiring family member attendance when feasible and actively involving the family in treatment.[129] Approximately 20-25 percent of the patients bring their family (including spouse, children, parents, siblings, or other members of their support system) for a least part of their care at NICoE.[130] Among the sites visited by the RWTF, there are few programs that directly involve the family member in treatment or education, and even fewer that offer support for family members whose RW has PTSD.[131] In focus groups, the majority of family members were not aware of any available supports for family members of RWs with PTSD.[132] The RWTF believes intensive outpatient PTSD EBP programs should have at least one class where spouses are required to attend, to educate them on the treatment process and engage them in supporting their RW.

RECOMMENDATION D7

Services should establish manning documents for remote hospital locations that provide for predominately uniformed providers as clinical and non clinical behavioral health staff.

Requested Agencies to Respond: US Army (USA), US Navy (USN), USAF, Marine Corps (USMC)

Finding: Remote locations face unique challenges staffing behavioral health services. This year, the RWTF visited a remotely located WTU in Alaska. The visit to the WTU at Joint Base Elmendorf Richardson (JBER), in Anchorage, Alaska, included video teleconferences (VTCs) with personnel at the WTU's Bravo Company, located in Fairbanks, Alaska. Staff at both Alaska locations noted a limited pool of qualified civilian behavioral health providers and an increasing caseload of RWs presenting with behavioral health issues.[133] JBER in particular mentioned great difficulty in filling contract positions in a remote environment and had a particularly under-resourced TBI program.[134, 135] The Army Behavioral Health Task Force (ABHTF) expressed a similar concern, noting behavioral health provider hiring difficulties for MTFs in remote locations was impacting continuity of care for RWs.[136]

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RECOMMENDATION D8

To ensure TBI treatments meet the needs of RWs with TBI, Army, Navy, and Air Force must standardize, document, and track the efficacy of TBI treatment.

Requested Agencies to Respond: OASD(HA)

Finding: The RWTF acknowledges the publication of the DoDI that manages the care and treatment of mild TBI in-theater (DoDI 6490.11). The RWTF frequently hears in the field that this guidance has been a "game changer" in the immediate treatment of TBIs. With the current recommendation, the RWTF seeks to standardize care, treatment and processes for TBI treatment in the MTF setting. In a briefing given in 2011, the RWTF was made aware of a lack of standardization within TBI care.[137] During FY2013 site visits, insufficient standardization was still evident, as the RWTF noted no apparent standard TBI protocol or treatment design, documentation of TBI treatment, or tracking of efficacy of TBI treatment across DoD once members have returned to home station and are attempting to resume everyday activities.[138] At the sites visited, the available TBI services varied greatly; for example, some treatment regimens consisted of as little as one visit a week for three to five weeks, while others entailed as much as 10 hours a week for up to 20 weeks.[139]

Furthermore, RW and family member focus group participants indicated current TBI treatment practices are not meeting their needs.[140, 141] Participants across several sites stated they had difficulty arranging to be evaluated for TBI, even though they had experienced trauma in theater and/or currently suffered from symptoms that suggested TBI.[142] Additionally, despite struggling with symptoms that cause hardship in their everyday lives, RW participants stated that evaluation results often indicated symptoms were not severe enough to warrant TBI diagnosis, or evaluations were too general and did not acknowledge symptoms being experienced by the participants.[143] In one case in particular, a RW reported that a VA doctor was stunned that DoD had not diagnosed TBI.[144] In addition to such difficulties obtaining evaluation and treatment for TBI symptoms, RW focus group participants expressed dissatisfaction related to ineffective treatment, ineffective or under-qualified providers, as well as a lack of access to timely referrals, appointments and follow-up.[145] Family member focus group participants echoed that available TBI treatments do not meet RWs' needs, noting that RWs often face long waits for appointments, poor continuity of care with providers, and insufficient effort from providers.[146] Family members were not aware of any support services for family members of RWs with TBI.[147] RWTF mini-survey results corroborated RWs' and family members' dissatisfaction with TBI services, with no more than one-half (48% of RWs; 13/25 family members) rating them as very or extremely helpful.[148, 149]

I can speak to this. There is very little support here for TBI. They started a therapy group for TBI a few weeks ago. That is the first thing they have offered for TBI in [over a year here]. (Recovering Warrior)

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I know for me they didn't diagnose me with TBI or PTSD. When I went to my VA appointment…they were just supposed to be getting last minute details. Should've been 30 minutes and it turned it into two hours. And his exact words, the VA psychiatrist was "How did they not diagnose you with TBI!?" (Recovering Warrior)

My spouse has TBI. The services for the spouses seem to be lacking [here]. When my spouse's home s/he's emotional and I'm going through emotional stuff too with my children. I don't want a list or a class; I know all the resources they have available. I want something beyond that, nobody has given me that. (Family Member)

The current landscape of TBI treatment is inconsistent across Services and installations and insufficient in meeting the needs of RWs with TBI and their families. In order to promote effective TBI treatment, the Services need to standardize core elements of their treatment protocols, document how treatment is delivered, and track patient outcomes.

Restoring into Society

Topics in this domain address needs beyond medical care, including needs related to reintegrating into families and communities. This includes non-medical case management, support for family caregivers, information resources, and support for the RC.

RECOMMENDATION D9

DoD should ensure implementation of the Joint Federal Travel Regulations (JFTR) and Joint Travel Regulations (JTR) for family members of RWs is consistent across Service branches. Utilization of Invitational Travel Orders (ITO) and Non-Medical Attendant (NMA) orders and payment processes should be the same across Services.

Requested Agencies to Respond: WCP, USA, USN, USAF, USMC

Finding: During FY2013 site visits, the RWTF found that ITO and NMA coverage and processes were not consistent for all eligible family members across Service branches. For example, when a RW moves from a MTF to a VA or civilian hospital, orders for family caregivers are not executed uniformly across the Services. When a Soldier moves from an MTF to a VA polytrauma center, another VA inpatient facility or a civilian inpatient facility, ITOs end for the three or fewer family members at bedside, and one (or two, for those with more severe conditions) family members are placed on NMA orders.[150] In effect, this means one or two of the family members are sent home, while one or two continues with the RW to the new facility on NMA orders. Furthermore, once family members are off ITOs, they cannot be re-initiated should the RW return to an MTF for treatment.[151] However, the other Services keep up to three family members on ITOs as long as the RW is moving between in-patient facilities.[152] This disparity across the Services is attributed to Army Regulation 600-8-1, which deems transfers to VA or civilian facilities equivalent to transfer to outpatient status, regardless of whether the RW will receive inpatient care at the receiving facility.[153]

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Additionally, the RWTF was told that the amount of time it takes to generate orders to allow family members to get to their RW's bedside varied within Services and between Services.[154] For Army family members, the process is dependent upon the requirement by Army Human Resources Command for Form 2984 to be signed by attending/accepting physicians before cutting orders for family members. As a result of this requirement, family members of RWs scheduled to arrive at WRNMMC on a weekend often are unable to be bedside when their RWs arrive. These delays do not apply with very seriously injured or critical care transport team patients. In comparison, the US Special Operations Command is able to ensure family members are present whenever the RW arrives.

The RWTF also was made aware of inequities in reimbursement processes at certain installations.[155] At Fort Bragg and possibly other Army posts, family members on travel orders are required to itemize and submit receipts rather than receiving a flat per diem rate for meals and incidentals, potentially resulting in Army family members receiving less daily compensation and experiencing greater administrative burden.[156] At Walter Reed National Military Medical Center, some family members are sent to a nearby Marriott Hotel for lodging.[157] However, only the Army has an arrangement directing the hotel to accept family members' ITOs in lieu of payment for lodging expenses.[158] In contrast, family members of RWs in other Services must provide their own credit card or a pre-paid debit card given to them, such as the card provided by the Navy.[159] Paying up front with a personal credit card is a significant financial burden for some families.

The RWTF found significant dissatisfaction with payment and reimbursement processes in general. Participants in RWTF family member focus groups reported difficulties related to travel expenses, particularly for family members of Reserve Component personnel recovering at locations distant from their home of record.[160] Family members described having to cover the cost of the travel with no assistance or reimbursement from the military. In one instance, the family member was unable to cover this expense and the RW and family did not see each other for a protracted period.[161]

I do have complaints on travel. When my [spouse] started the MED board I had to make [multiple] trips to Fort [Name] and financially they were not able to pay for me to go. I thought that was totally out of line. The spouse needs to be there with the Soldier. (Family Member)

The RWTF believes that the application of the travel regulations and other supports to family caregivers needs to be standardized across the Services.

RECOMMENDATION D10

Implementation of the SCAADL benefit must be optimized through:

- A legislative change to exempt SCAADL from income taxes.
- Enhanced marketing to the eligible population.
- Electronic application process in AHLTA for Primary Care Manager (PCM) access.

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Requested Agencies to Respond: OSA(HA), WCP, USA, USN, USAF, USMC

Finding: SCAADL is an important benefit that provides monthly compensation to catastrophically injured RWs whose family member is providing high level care similar to that found at a hospital or nursing home. An RW and family member panel told the RWTF that many family caregivers of RWs receiving SCAADL have given up their careers or reduced their own work hours in order to support their RWs[162], making SCAADL a significant source of income. During RWTF focus groups, some family members specifically mentioned unmet financial needs related to caregiving and their reduced ability to work.[163] SCAADL payments are taxable[164, 165, 166], however, and the RWTF is concerned that the tax burden considerably diminishes the value of the SCAADL benefit to RWs and families. In briefings to the RWTF, the Army and Marine Corps stressed that the reduction in net SCAADL payment due to taxation has a significant negative impact on the RWs and family members receiving it.[167, 168]

In US tax code, SCAADL payments are listed as "special pay" under the heading "taxable income" with an exception written as "unless the pay is for service in a combat zone."[169] Also in the tax code, "disability, including payments received for injuries incurred as a direct result of a terrorist or military action" is listed under "other pay" in "excluded items" or tax-free payments.[170] The RWTF recommends that SCAADL legislation be changed to eliminate the tax burden just as "disability" noted above is excluded. This recommendation is supported by the Report of the Eleventh Quadrennial Review of Military Compensation, which also recommends making SCAADL payments tax exempt as is done with the VA caregiver compensation.[171]

The RWTF also believes that the number of Army SCAADL recipients is low relative to the number of WTU enrollees and is concerned that eligible RWs and families are going unserved. Only approximately seven percent of those within the WTU system—the largest of the Services' Wounded Warrior units and programs— have submitted applications for SCAADL and only approximately five percent were receiving SCAADL payments as of November 12, 2012.[172] To ensure that eligible RWs and families are aware of SCAADL resources, the RWTF believes that marketing must be increased. A large number of family member focus group participants stated they did not know what supports were available.[173] In several instances, family members suggested they were not using SCAADL because they were not provided accurate or timely information when they inquired about it.[174] The RWTF also observed a lack of familiarity with SCAADL across ARNG, ANG, and Navy Operations Support Center (NOSC) briefers[175], suggesting there may be eligible RC RWs who are unfamiliar and unconnected with the SCAADL benefit.

They told me I couldn't fill out the form (for SCAADL). My [spouse] can't put on his/her socks and shoes, but s/he can bathe and dress himself/herself so we can't put in the form. Even though s/he can't work and can't drive. (Family Member)

Yes (we applied for SCAADL), but I didn't get any help with it (The family members was not able to get the benefit). (Family Member)

Over the course of FY2013 site visits the RWTF also noted that increasing collateral duties for medical care case managers (MCCMs), such as completing SCAADL applications and

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supervising NMAs, were burdensome to them and were hampering their effectiveness.[176] The RWTF recommends that, at all installations, the PCM have final decision authority on SCAADL, and that an electronic SCAADL application process be developed in AHLTA to improve MCCM/PCM access and reduce the burden of completing non-electronic SCAADL paperwork.

RECOMMENDATION D11

In order to increase both family member involvement in the recovery process and family member awareness of available resources, the Services will include family members in the initial unit/program orientation and the initial briefing upon entry into IDES:

- Army and Marine Corps family members: in-processing at the WTU/CBWTU/WWR and the initial IDES briefing with the Physical Evaluation Board Liaison Officer (PEBLO).
- Air Force and Navy family members: initial RCC/NMCM contact and the initial IDES briefing with the PEBLO.
- The RC family member will attend in person when the RW is attending in person. RC family members will receive Temporary Duty Assignment (TDY) orders for this purpose.

Requested Agencies to Respond: WCP, USA, USN, USAF, USMC

OR

RECOMMENDATION D12

In order to increase both family member involvement in the recovery process and family member awareness of available resources, the Services should consistently communicate to RWs that their designated family member is expected to accompany him/her, at minimum, to the initial unit/program orientation (i.e., at the WTU/CBWTU/WWR or, for Air Force/Navy, the initial RCC/NMCM contact) and the initial briefing upon entry into IDES (i.e., for all Services, initial briefing with PEBLO). (RC family members are expected to attend in person when the RW is attending in person and will receive TDY.)

Requested Agencies to Respond: WCP, USA, USN, USAF, USMC

OR

RECOMMENDATION D13

In order to increase both family member involvement in the recovery process and family member awareness of available resources, the Services should conduct 100% outreach to designated family members of newly enrolled RWs, defined as positive contact and two-way communication between the person providing the outreach and the person receiving it. The purpose of the outreach is threefold:

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- Invite and encourage family member/family caregiver to attend the initial unit/program orientation (i.e., at the WTU/CBWTU/WWR or, for Air Force/Navy, the initial RCC/NMCM contact) and the initial briefing upon entry into IDES (i.e., for all Services, initial briefing with PEBLO). (RC family members may attend in person when the RW is attending in person and will receive TDY.)
- Encourage family member/family caregiver to accompany RW on all other appointments if RW is amenable.
- Provide family member/family caregiver a POC for information and support for RW needs as well as their own.

Requested Agencies to Respond: WCP, USA, USN, USAF, USMC

Finding: The RWTF recommends that DoD ensure family members participate in initial unit/program orientations, including transition unit in-processing such as into a WTB, CBWTU, or WWR Battalion or Detachment for Soldiers and Marines, initial RCC/NMCM contact for Sailors and Airmen, as well as the initial IDES briefing. Family member involvement at these critical points in the recovery process would increase family member knowledge of units and programs as well as family member knowledge of resources for caregivers. The RWTF notes NICoE represents a potential model for greater family member participation, as family members (including spouses, children, parents, siblings, or other members of the support system) are required to attend with RWs, when feasible.[177]

The RWTF acknowledges that some RW family members are receiving the information they need. A number of RWTF family member focus group participants stated that available information meets their needs and described regularly receiving information that is both accurate and useful.[178] In addition, RWTF family member mini-survey results indicated that more family members were satisfied/very satisfied than dissatisfied/very dissatisfied with information/education to help family members care for their Service members (33/69 versus 21/69) and information/education about available benefits and services (35/69 versus 20/69).[179]

At the same time, over the past three years, the RWTF has found that many family members feel uninformed about and/or disconnected from resources and benefits available to family caregivers and/or their RWs.[180, 181, 182, 183, 184] A large number of FY2013 family member focus group participants stated that they do not know what supports are available to them; have a significant number of questions that are not being answered; and do not get the appropriate information at the right time, or receive inaccurate information.[185, 186] Family members stated they primarily receive information from their RWs, and emphasized the limitations of relying on RWs who may forget information, may be unwilling to disclose information, or may be unaware of available resources.[187]

Spouses need case managers too (laughter and agreement from the group). (Family Member)

No one is addressing my issues. We are just as stressed as our spouses. (Family Member)

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I've had a really good experience. That's why I haven't said much. When my [spouse] checked in, I had the option to take the tour of the facility, and if s/he used it, then I could use it. I get all the emails. I see all the stuff that they do. None of it really applies to me. I don't know, I'm satisfied with how things have gone for us. (Family Member)

Service-level policy holds unit commanders responsible for outreach to family members.[188, 189, 190] Service-level briefings to the RWTF either indicated they had 100 percent family member involvement in the CRP/CTP and IDES processes or did not comment on the percentage of families involved.[191, 192, 193, 194] Site-level briefers indicated that, while family members are invited to participate in events such as the unit in-processing, CRP/CTP meetings, and IDES in-processing, attendance is low.[195] It is important to note that the RWTF lacks visibility of how family members are encouraged/invited to attend. Family member focus group findings corroborate that a majority of family members are not included in in-processing, IDES, and perhaps most notably, are largely uninvolved in the CRP/CTP process.[196] Most family member focus group participants stated they were unfamiliar with term CRP/CTP; the RWTF infers that family members may not have been adequately informed of their option to participate in this process.

I'm not included in it (the CTP process). (Family Member)

Not a clue. (Family Member)

Similar concerns have been raised by other entities. A November 2012 Warrior-Family roundtable determined that caregivers were not receiving the information they need during the right stage of recovery due to, "a disconnect between policy and the translation at the grass roots level where the care is occurring or programs are being implemented," resulting in, "barriers in outreach, communication, and implementation."[197] The Military Coalition (TMC) called upon Congress and DoD to integrate family caregivers into the rehab and recovery team and to ensure family caregivers are informed about care, treatment, DES, and the CRP.[198]

As shown in a number of studies, on-site family support helps RWs during the recovery process and is associated with improved recovery[199, 200], reduced medication use[201], and more expedient return to work[202]. Healthy family functioning as a whole is associated with a lower level of disability/functional impairment and higher employability.[203] Consistent with these studies, RW focus group data indicated that being separated from family members had a negative impact on the RW's recovery.[204] The RWTF believes the full benefit of DoD's considerable investment of time and money in the RW units and programs cannot be fully realized without family member involvement.

With my recovery, if I didn't have my family here, I would be going in the opposite direction—I wouldn't have even been close. (Recovering Warrior)

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RECOMMENDATION D14

DoD should consolidate current Service resources and establish a new centralized resource with a single toll-free number and/or website that gives RWs and families a one-stop source for information, referral, and advocacy.

Requested Agencies to Respond: WCP

Finding: Several information resources, websites, and call centers are available to educate and support RWs and their families during the recovery process. Congress specifically instructed the RWTF to explore the effectiveness of Military OneSource (MOS), Wounded Warrior Resource Center (WWRC), Family Assistance Centers (FACs), Service hotlines, and the NRD. The RWTF gathered data about these resources from DoD, the Services, and the RW community. It is apparent to the RWTF that there is redundancy in these information resources, as well as a general lack of awareness and under-utilization among RWs and family members. RWTF focus group mini-survey respondents indicated higher RW and family member utilization of MOS, the WWRC, and FACs than Service hotlines or the NRD.[205, 206] (See Appendix K, Other Results, for further data regarding utilization and assessment of Military OneSource, Wounded Warrior Resource Center, Family Assistance Centers, Service hotlines, and NRD.)

The Marine Corps, Army, and Navy Wounded Warrior – Safe Harbor have Service hotlines that operate 24/7, including the Marine Corps Sergeant Merlin German Wounded Warrior Call Center which is also used for outreach[207], the Army Wounded Soldier and Family Hotline (WSFH) which is used for concerns about medical care[208], and the recently established Navy Wounded Warrior Call Center[209]. The Air Force Wounded Warrior website provides key links and telephone numbers, but does not operate a Service-specific Wounded Warrior hotline.[210] Very few of the RWTF's RW or family member mini-survey respondents indicated having used a Service hotline.[211, 212] Similarly, RW and family member mini-survey respondents have consistently reported extremely low awareness and utilization of the NRD during each year of data collection.[213, 214, 215, 216, 217, 218]

The RWTF is concerned about a lack of parity in information resources across the Services as well as frustration and confusion for RWs and family members due to the sheer number of existing information resources. As noted, the NRD does not address these concerns. The RWTF believes that consolidating current Service resources and establishing a new centralized resource with a single toll-free number/and or website would be the most efficient solution and would create a "one-stop shop" for RWs and their family members for information on resources and benefits. This recommendation is consistent with the recent DoD/VA Interagency Care Coordination Committee (IC3) undertaking to provide "one mission, one policy, and one plan" for RWs and their family members across DoD and VA.[219, 220]

The new centralized resource should be designed to best take into account the burgeoning use of mobile devices, particularly by users in their 20s and 30s.[221] Certain existing information resources already do this, such as the DoD Compensation and Benefits Handbook app[222] and the WWR app[223], both free and both launched in 2012. The Military OneSource website is mobile-accessible; Military OneSource uses QR codes in articles about the site to direct traffic to the site.[224] NRD has also created a mobile website for those accessing the website via mobile

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devices.[225] However, neither of these resources currently meets the needs of RWs and family members, as suggested by their limited use and satisfaction among RWTF focus group participants. Responsive web design enables users on any device to access information seamlessly[226], and in combination with tools like Google Analytics, can maximize access while giving the website owner insights into how the tool is being used and where[227]. (See also Recommendation D3 for further discussion about leveraging technology for information dissemination.)

OR

RECOMMENDATION D15

The DoD Office of Warrior Care Policy (WCP) should write a DoDI on the roles and responsibilities of online resources and call centers established by DoD and the Services for the RW community.

Requested Agencies to Respond: WCP

Finding: The RWTF is concerned about a lack of parity in information resources across the Services as well as frustration and confusion experienced by RWs and family members due to the sheer number of existing information resources. A DoD Instruction will reduce redundancies, eliminate gaps, create efficiencies, clarify roles and responsibilities across the Department, and increase knowledge of and access to information resources by RWs and family members. The DoDI should identify utilization and satisfaction metrics to be gathered and reported in order to allow ongoing assessment of the effectiveness of information resources for RWs and family members.

Very few of the RWTF's RW or family member mini-survey respondents indicated having used a Service hotline.[228, 229] Similarly, RW and family member mini-survey respondents have consistently reported extremely low awareness and utilization of the NRD during each year of data collection. [230, 231, 232, 233, 234, 235] (See Appendix K, Other Results, for further data regarding utilization and assessment of Military OneSource, Wounded Warrior Resource Center, Family Assistance Centers, Service hotlines, and NRD.)

Furthermore, there are substantial unmet information needs within the RW community, in large part due to the very low levels of awareness and utilization of existing information resources. RWTF RW[236] and family member[237] focus group findings revealed significant unmet needs for information at various stages of the recovery process, including during orientation, during the process of finding providers, and during IDES. (See also recommendations D11, D12, and D13 for additional information on family members' unmet needs related to information.) Both AC and RC RWs said that they were not provided information on steps to take throughout the recovery process.[238] They felt that they gathered needed information on their own. The proposed DoDI will provide the inter-Service coordination needed to reverse low utilization by the RW community and, in so doing, close the information gap.

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You find out stuff as you go instead of knowing what you need to know beforehand. The policies change frequently and no one knows the straight answer. (Recovering Warrior)

My confidence is high. Learning that the information is out there made me feel that as long as I am proactive about it I will find out what I need to know. Doing that makes me feel confident. (Recovering Warrior)

OR

RECOMMENDATION D16

DoD should take steps to ensure NRD's capacity to serve as a one-stop source for information and referral for RWs and families. At minimum, these steps should include executing a comprehensive marketing strategy targeting RWs and family members across the country and a mechanism to track its success in reaching RWs and family members.

Requested Agencies to Respond: WCP

Finding: The NRD is a government web portal maintained by DoD, DOL, and VA connecting Wounded Warriors, Service members, Veterans, and their families to more than 14,000 services/resources at the national and state level.[239] The RWTF is concerned about the extremely low awareness and utilization of the NRD consistently reported by RWs and family members in the focus group mini-surveys in each year of data collection. Among RWs, in FY2011 only seven percent (8/123) reported use[240], in FY2012 only eight percent (12/159) reported use[241], and in FY2013 only five percent (10/203) indicated use the NRD[242]. Of the RWs who reported use of the NRD, the number who rated the NRD as very or extremely helpful included 5/8 in FY2011[243], 7/11 in FY2012[244], and 5/10 in FY2013[245]. Among family members, in FY2011 0/13 reported use[246], in FY2012 only 1/45 reported use[247], and in FY2013 only 4/72 indicated use of the NRD[248]. Of the 5 family members who reported use across the three years, two individuals (one in FY2012[249] and one in FY2013[250]) rated the NRD as very or extremely helpful. Of note, in a Navy Wounded Warrior – Safe Harbor survey of enrollees and family members, 22 percent of RWs[251] and 38 percent of family members reported being aware of the NRD[252]. While higher than the awareness levels reported in RWTF mini-surveys, the RWTF stills views such awareness levels as insufficient.

In FY2012, the RWTF recommended that DoD market the portal with a goal to double its usage.[253] While DoD WCP reported the NRD has approximately 100,000 visits per month[254], the RWTF remains concerned that WCP lacks the ability to discern how many of these visits were from RWs versus RW family members and how many unique RWs/family members these visits represent. The RWTF believes a comprehensive marketing strategy is needed to ensure the NRD's capacity to serve as a one-stop source for information and referral for RWs and families. DoD WCP described a marketing strategy that included NRD commercials in the National Capital Region, utilization of social media, distribution of NRD postcards and Fact Sheets, NRD demonstrations at the quarterly RCC trainings, and increased campaigns to get NRD widgets onto websites of Senators, Congress members, and corporations.[255] However, the RWTF is

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concerned that these marketing efforts may not be reaching individuals who live in geographical areas outside of the National Capital Region. The RWTF recommends DoD execute a new comprehensive marketing strategy for the NRD targeting RWs and family members across the country. The marketing strategy should take into consideration the information seeking patterns of RWs and family members and leverage social media, in- person, and direct-to-consumer outreach tactics to ensure the NRD reaches RWs and families where they are.

Additionally, the RWTF recommends DoD develop a mechanism to track the success of the marketing campaign in reaching RWs and family members. The RWTF notes that DoD WCP uses Google Analytics to record the number of NRD users/hits, such as the total number of separate computers to access NRD in FY2011[256], and approximate number of visits per month in 2013[257] (though not how many of these visits were unique). Google Analytics could be further used to track total number of user visits, number of pages viewed, and where users are located.[258] DoD WCP might also consider establishing custom URLs to better analyze changes in a specific group of users, such as RWs responding to the marketing campaign.[259] The RWTF feels such a tracking mechanism can provide critical data concerning how to successfully promote the NRD to RWs and families across the country.

Optimizing Ability

Topics included in this domain address a central aspect of successful transition to civilian life – preparing for employment after military service. This includes vocational programs and services as well as TAP and other systems to ease the DoD/VA transition. The RWTF recommends timely renewal and implementation of formal policies related to vocational and employment services (see Recommendation D29).

Enabling a Better Future

This domain includes topics in which DoD and VA collaborate to shape policies and programs with a long term impact on RWs, during military service and after transition to civilian life. These topics include the Interagency Program Office (IPO); the Integrated Disability Evaluation System (IDES) and the legal support provided during IDES; the Wounded, Ill, and Injured Committee (WIIC) of the Joint Executive Council (JEC); the overall coordination between DoD and VA; and Transition Outcomes, to gain perspective on DoD programs and services from providers who see RWs through and following the DoD-VA transition.

RECOMMENDATION D17

WCP should work with VA to grant Veterans Tracking Application (VTA) access to more providers and locations supporting RWs in IDES, to include MEB attorneys and CBWTUs.

Requested Agencies to Respond: WCP

Finding: During its first two years of data collection, the RWTF frequently heard about the length of time it takes to get through the disability evaluation system; this year the RWTF

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consistently heard about how difficult it is to get visibility of the status of an RW case in IDES, particularly at the D-RAS stage. RW focus groups held by the RWTF revealed that many RWs experienced what some described as a "black hole" when they have to wait for results (e.g., from boards or medical tests) and/or responses to forms they have completed.[260] That the VA does not regularly update eBenefits pages adds to RWs' sense of a "black hole."[261]

(IDES packet went to) Someone at the AMEDD [U.S. Army Medical Department] facility, but then the packet went into a black hole…(Recovering Warrior)

When the packet leaves here, (gestures that one loses sight of its status). (Recovering Warrior)

Because the VTA is updated to show the Service member's status throughout IDES processing,[262] the RWTF believes wider access to the VTA would allow for increased visibility of progress through IDES. By granting VTA access to more IDES support roles such as legal staff and CBWTU staff, RWs will be better informed and less likely to experience the "black hole."[263] In combination with WCP's May 2013 expansion of the IDES case workbook, which provides additional detail on where each packet is in the IDES process (e.g., 'VA preliminary rating time' in days, 'IPEB to DRAS Transit Time,' 'VA Preliminary Rating Core Time'), wider access to VTA will give RWs better access to information about the status of their case.[264, 265]

Further challenges that may be ameliorated by wider VTA access for IDES providers include managing the IDES timeline and the potential negative impact of an uncertain timeline on RW well-being. A joint base noted that PEBLOs never know how long processing of any particular packet will take and have no direct line of communication to D-RAS to check on the status (though all PEBLOs should have access to VTA).[266] The same site noted that individual IDES sites are not authorized to contact D-RAS to inquire into a case's status, regardless of how many months it has been dormant. Briefers at this site further pointed out how important it is for RWs to be informed of the status of their case, especially during the last phases of the IDES process, in order for them to plan appropriately (e.g., enroll in education programs, seek civilian employment, etc.).[267] Another site observed that the wait between seeing the NARSUM and receiving orders can be difficult for RWs who are often anxious about the process but have no control over it nor visibility of their case's status.[268]

In addition, VTA access for lawyers would help to address RWTF's FY2012 Recommendation 34: "The Services should ensure that 100 percent of RWs are individually contacted by an MEB outreach lawyer (in-person, phone, email, mail, etc.) upon notification to the PEBLO that a narrative summary (NARSUM) will be completed."[269] With access to VTA, all legal staff would be able to immediately identify Service members referred to IDES and reach out to them with information and contact information.

RECOMMENDATION D18

Congress should eliminate the Temporary Disability Retirement List (TDRL).

Requested Agencies to Respond: WCP

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Finding: Upon completion of the PEB phase of IDES, the Service member may be 1) returned to duty, 2) placed on TDRL, 3) separated from the military, or 4) medically retired (i.e., placed on the permanent disability retirement list/PDRL).[270] If put on TDRL, a determination will be made within five years as to whether or not an RW is fit for duty, or will be separated or medically retired.[271] However, very few TDRL members are found fit upon TDRL review, making TDRL a costly and seemingly ineffective option. During the first quarter of FY2013, over three-quarters (78%) of TDRL Service members were moved to the PDRL, and about one-fifth were either kept on the TDRL (10%) or separated with benefits (11%); fewer than five percent were returned to duty.[272] As very few TDRL members are ultimately found fit, the RWTF questions the usefulness of the program. Additionally, the RWTF has been briefed that TDRL reviews are time consuming, complex, and do not cover all conditions.[273] Furthermore, after TDRL the Services use the Legacy Disability Evaluation System (LDES) and the Service member may get a lower rating than what he or she would have received had they gone through the Integrated Evaluation System (IDES).[274] Despite the low percentage of Service members returned to duty, and the inefficient nature of the process, the percentage of Service members assigned to TDRL remained stable between February 2012 and February 2013 (~28%).[275] In order to afford RWs the best disability evaluation possible, the RWTF recommends elimination of TDRL and urges Congress to take this action.

RECOMMENDATION D19

DoD must ensure that all medical conditions are covered by MEBs and that the quality of the documentation for each condition will facilitate timely accurate ratings by the VA.

Requested Agencies to Respond: USA, USN, USAF, USMC

Finding: As the primary purpose of IDES is to determine fitness for duty, the IDES applies VA ratings for all conditions that make an RW unfit for continued service. However, the RWTF has been made aware that all conditions are not always covered in the MEB phase and several rules and regulations governing inclusion of medical conditions are not currently being enforced, including:

- DoDI 1332.38 (E3.P1.2.3.) requires that MEBs and TDRL reviews cover all medical conditions with full clinical data.
- 10 USC 1216 requires that all medical conditions must be considered in the fitness determination decision.
- DoDI 1332.38 (E3.P3.4.4) states that unfitness can be caused by conditions not independently unfitting nor even referable to the DES.[276]

The RWTF noted that the Army's most recent IDES/MEB Integrated Narrative Summary Guidebook requires that diagnoses both meeting and not meeting medical retention standards are included in the NARSUM.[277] The RWTF believes this practice is a good step toward ensuring all medical conditions are addressed by the MEB. (See Recommendation D29, Publish timely guidance for the care of RWs.) The RWTF believes enforcement of these rules and regulations by DoD could greatly enhance the experience of RWs during IDES. For example, failure to cover all conditions in the MEB phase oftentimes leads to delays when the

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PEB must reach back for additional information on conditions that were not covered in the MEB/NARSUM, thus leading to delays in IDES processing.[278] These delays could be eliminated by ensuring all conditions are covered in the MEB phase, and assembling all RW medical records as early as possible.

I don't understand the system at all. If they say you have two things and you give them a stack of papers that shows you have six, you don't understand. Now I have to wait for my percentage to come out. They say it won't change anything. It does change things. (Recovering Warrior)

RECOMMENDATION D20

WCP should invite all RWs to complete each phase of the IDES survey (MEB, PEB, and Transition Phase surveys) regardless of whether they completed the survey for the previous phase(s).

Requested Agencies to Respond: WCP

Finding: WCP's ongoing IDES Satisfaction survey is used to track Service member satisfaction with the Integrated Disability Evaluation System.[279] The Defense Manpower Data Center (DMDC) administers these voluntary surveys via telephone to IDES participants at the completion of each major IDES phase: the Medical Evaluation Board (MEB), the Physical Evaluation Board (PEB), and the Transition Phase just prior to return to duty or transition to veteran status.[280] The RWTF views these IDES surveys as an important source of data for DoD, and is concerned by the significant drop in participation from the MEB phase survey to the Transition phase survey. Between the inception of the survey and September 30, 2011, eligible respondent counts decreased from 9,567 for the MEB Phase survey to 3,482 for the Transition Phase survey (a decrease of approximately 64%).[281] Diminishing participation between the MEB Phase survey and Transition Phase survey is likely due to two major factors: a) survey non-response (an RW simply decides not to participate again) and b) a rule in the methodology allowing only those who completed the previous phases of the survey to complete the next phase of the survey (i.e., if a RW completed the MEB Phase survey, but not the PEB Phase survey, he/she is not eligible to take the Transition Phase survey).[282] The exclusion of IDES participants who have not completed the previous survey inevitably leads to significantly lower responses for the final (Transition Phase) survey, which is administered when RWs have been through the entire process and are likely to have the best insight about the system as a whole. The 'whole story' may be captured by allowing all Service members/veterans who have been through IDES to complete each phase of the survey regardless of whether they completed the survey for the previous phase(s).

Compounding the missed opportunity for tapping a valuable perspective, lower responses to the Transition survey have led to results that are not reportable due to low respondent counts. For example, data collected between July and September 2011 on helpfulness of DES program staff (e.g., PEBLO, VA Military Service Coordinator (MSC)) to the Service member's family during the transition phase was not reportable for Army National Guard, Navy Reserve, Marine Corps Reserve, Air National Guard, and Air Force Reserve due to very small sample sizes ($n<30$).[283] Opening participation to all Service members in the Transition Phase will increase survey participation and thus potentially reduce if not eliminate non-reportable data.

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Non-reportable data is not unique to DoD's IDES Satisfaction Survey. Many estimates of the TRICARE Management Activity Telephone Survey of Ill or Injured Service Members Post-Operational Deployment, which includes items on Service member experiences with the disability evaluation system, are not reportable due to low respondent counts.[284]

RECOMMENDATION D21

WCP should initiate a legal support working group in which IDES lawyers develop recommendations for changes to IDES processes and laws.

Requested Agencies to Respond: WCP

Finding: The FY2013 installation visits catalyzed the RWTF's appreciation for the experience and vantage point of DoD's IDES lawyers, who are immersed in the IDES process from start to finish. The IDES lawyers have tremendous insight into what works and does not work in the IDES process, the influence of applicable laws, and how best to facilitate a fair and appropriate outcome for RWs. Convening a legal working group would provide a formal vehicle for capturing their collective expertise to inform changes to IDES processes and laws as well as for promoting best practices. The working group could also address the question of how best to train DoD's IDES lawyers.

This is one of the best legal supports I've seen in [10-20] years. (Recovering Warrior)

MEB appeal counsel at [post in southern city] was on leave so they transferred me to a [west coast post] counsel and s/he was very helpful, went above and beyond. (Recovering Warrior)

The value lawyers bring to the IDES process is underscored by the number of Formal PEBs (FPEBs) that are requested and do not convene. Once Service members meet with a lawyer prior to their FPEB, many gain a deeper understanding of their case and realize their final outcome/rating will not change. Many then decide not to move forward with a FPEB. Of 1,290 FPEB requests in FY2012, 1,077 resulted in resolution; only 213 of those cases went through an FPEB.[285]

The RWTF observed further evidence of the value of IDES legal staff at a number of installations. Briefers at some installations stated that legal is the first contact for Service members entering IDES.[286] At some installations, legal staff is co-located with other IDES stakeholders. The RWTF learned of a comprehensive IDES briefing for RWs, developed by an IDES lawyer at Fort Bragg.[287, 288] The RWTF recognizes this comprehensive briefing as a best practice. (See Best Practices at the end of this chapter for more information on this briefing.)

IDES lawyers have satisfied customers, which further legitimizes the value of their IDES subject matter expertise. In the overwhelming majority of RWTF focus group sessions, participants indicated that available legal support meets their needs.[289] Participants stated legal support has "worked miracles," answered any and all questions, and gone "above and beyond." RWTF mini-survey results reinforced the focus group participants' positive experiences with legal support;

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over two-thirds (68%) of RW respondents who had first-hand experience with legal support during the MEB phase of IDES indicated it was very/extremely helpful.[290]

RECOMMENDATION D22

The Services should institute a mechanism to alert senior leadership of all cases when RC RW medical continuation orders are not renewed within 30 days of expiration.

Requested Agencies to Respond: USA, USN, USAF, USMC

Finding: The active-duty orders of Recovering RC personnel often do not span the full length of time needed to complete the care plan. The RWTF heard during site visits with three Service branches that this places RC RWs at risk of expired orders, falling out of Defense Enrollment Eligibility Reporting System (DEERS) and the appointment system, and interrupted health care.[291]

My [child] fell off of TRICARE cause I got new orders, so I just had them take it out of my checking account. I called [insurance] and they told me to call TRICARE, and when I called TRICARE, they told me to call [insurance]. (Recovering Warrior)

Expired orders also interrupt pay.[292] While the RWTF did not hear of cases where orders actually expired, and benefits and pay were gapped, even the threat that this may occur places an unnecessary and unacceptable stress on RWs and those who care for them. DoD needs to standardize the window within which RC RW medical continuation orders must be renewed and establish a mechanism, possibly a dashboard interface, to raise the visibility of this issue and allow senior leaders to monitor compliance.

RECOMMENDATION D23

The Services' RW units and programs, (i.e., Army Warrior Transition Command (WTC), NWW-SH, Air Force Warrior and Survivor Care, WWR), should establish a mechanism to push appropriate information to state and regional RC locations so they can better address the non-medical needs of RC RWs and families.

Requested Agencies to Respond: USA, USN, USAF, USMC

OR

RECOMMENDATION D24

The Services should launch mobile training teams to state and regional RC locations so they can better address the non-medical needs of RC RWs and families.

Requested Agencies to Respond: USA, USN, USAF, USMC

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Finding: The RWTF's FY2013 site visits included six RC locations: three JFHQs, a NOSC, a Navy MEDHOLD unit, and an Army CBWTU. The RWTF was gratified during visits to these sites that RC leadership appears to be well versed in IDES terms, processes, and roles. For example, when leadership was asked how their wounded, ill, and injured are informed of their right to request an independent physician or find dedicated IDES legal counsel to review their MEB packet, they consistently replied that this occurs through the servicing MTF and/or PEBLO[293], demonstrating a level of understanding of IDES that the RWTF did not observe in previous years. In RWTF focus groups with AC and RC members, the large majority of participants indicated familiarity with the term *Disability Evaluation System,* or *DES*.[294] When AC and RC focus group participants in the IDES process were asked what types of support and assistance was available to them and from whom, the most consistent response, by a significant margin, was the PEBLO.[295]

The RWTF did not observe the same level of RC awareness of other RW policies and benefits. The RWTF was distressed to discover little knowledge of key resources such as SCAADL, the RCC, Service members' Group Life Insurance Traumatic Injury Protection (TSGLI), and the CRP.[296] At least one organization was unaware that its headquarters had released an important policy update.[297] The RWTF is concerned that limited awareness of RW policies and benefits within RC organizations may impact access to resources for their RC RWs and families. The information presented in the following paragraphs lends credence to the concern that the RC RW community is not as connected to RW resources as they could be, or as their AC counterparts are.

While the RWTF does not know how many RC personnel qualify for entry into the Services' respective RW programs (Army WTU/CBWTU, Air Force Warrior and Survivor Care, NWW-SH, WWR), there is some indication that the proportion of RC in these programs may be lower than expected in certain Services. For example, although Reservists comprise 15 percent of the Navy[298] and 12 percent of Navy wounded in action[299], they make up only 8 percent of NWW-SH enrollees[300]. Similarly, although Reservists comprise 13 percent of the Marine Corps[301] and 10 percent of Marine Corps wounded in action[302], they make up only 3 percent of Marines joined to the WWR[303]. (See Appendix K, Other Results, for full results by component.)

The RWTF also notes that only approximately one in five RC Sailors in MEDHOLD East and West (19%) are receiving NWW-SH NMCM support.[304] Additionally, the RWTF is uncertain whether in all Services the number of RC personnel receiving SCAADL payments is commensurate with the number who qualify. For example, RC personnel comprise 53 percent of the Army WTUs and CBWTUs[305] but only 28 percent of Army SCAADL recipients[306]. Similarly, RC personnel comprise 21 percent of Air Force Warrior and Survivor Care enrollees[307] but only eight percent of Air Force SCAADL recipients[308]. (See Appendix K, Other Results, for percentages for each component.)

Results of the FY2013 mini-survey the RWTF administered to the approximately 200 FY2013 RW focus group participants underscore a disparity between AC and RC access to non-medical supports. With respect to use of care coordinators and NMCMs, there was consistently higher use of Recovery Care Coordinators (RCCs) (44% of AC, 14% of Reserve, 22% of Guard) and Service specific non-medical case managers for AC respondents.[309] Although the large majority of all three components indicated no first-hand experience with programs that provide support

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for family caregivers, the proportion lacking first-hand experience was higher among the Reserve and Guard than the AC (75% of AC, 90% of Reserve, 90% of Guard).[310]

A theme of insufficient support or awareness of resources emerged from the RC RW focus group discussions. The ARNG members who participated in the JFHQ focus groups were unable to identify anyone who is providing them non-medical case management. Furthermore, these individuals did not recognize the term Transition Assistance Advisor (TAA),[311] which is the individual(s) in each state that the NGB Warrior Support Office charges with facilitating RWs' non-medical transition.[312]

As far as my unit too, when you are doing something medically you're on your own. Most of it I've done through LOD. VA helps. For the surgeries, it has been on my own, information gathered by myself. VA has also helped me once I got channeled to it. (Recovering Warrior)

According to the results of the DoD-wide TRICARE Management Activity (TMA) Survey of Ill or Injured Service Members Post-operational Deployment, Army AC Service members were significantly more satisfied with DoD support in transitioning from the DoD to the VA health care system than Army RC Service members (81% versus 56%, $p<.01$).[313]

(Final D23 Findings)

The RWTF believes systematically informing and updating state and regional RC locations regarding available non-medical resources for RWs and their families is an important step toward closing the gap in the awareness of, use of, and satisfaction with these resources by the RC RW community.

OR

(Final D24 Findings)

The RWTF believes systematically training state and regional RC stakeholders who interface with RC RWs and families regarding available non-medical RW resources is an important step toward closing the gap in the awareness of, use of, and satisfaction with these resources by the RC RW community.

RECOMMENDATION D25

Congress should modify IDES laws to eliminate Reserve inequities related to presumption of soundness, service aggravation provisions, and application of other policies that specify current activation and/or years on active service requirements.

Requested Agencies to Respond: OSD(RA)

Finding: Several IDES laws and related DoD policies that may result in Reserve inequities were brought to the attention of the RWTF this year.[314] In Congressional testimony, the president of

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the National Guard Association of the United States noted that, according to the VA, disability benefit compensation claims from RC veterans of the Global War on Terror are denied at four times the rate of claims from AC veterans.[315] DoD or Congress should examine relevant laws and policies for RC inequities and make modifications as warranted.

Per 10 USC 1207A, Service members who are currently activated and have at least eight years of active service are eligible for disability retirement for a pre-existing condition that was identified while not on active duty.[316] This law penalizes Reservists who have sufficient years of active service but are not currently activated. For example, if an arthritis condition that makes a Reservist unfit is identified while s/he is activated, the arthritis condition can be included in the disability evaluation. However, once that Reservist is deactivated, the arthritis condition is not considered and no longer counts toward the disability rating.

VASRD 4.129 requires a minimum disability rating of 50 percent if the RW has PTSD so severe s/he must be removed from active status: "When a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veteran's release from active military service, the rating agency shall assign an evaluation of not less than 50 percent and schedule an examination within the six month period following the veteran's discharge to determine whether a change in evaluation is warranted."[317] RC RWs who are no longer on orders risk losing the guaranteed 50 percent rating.[318, 319] A Navy case study helps to illustrate the impact of this policy: An RC's Sailor's Post Deployment Health Reassessment (PDHRA) screening in January 2012 was positive for PTSD and alcohol use. The Sailor was released from active duty (REFRAD) and received care from the VA. The Sailor's mental health evaluation for the MEB took place in December 2012. If the Sailor were still on active duty, s/he would have automatically been entitled to a 50 percent disability rating.[320]

The inequity in both these laws comes into play upon the Reservist's deactivation. The RWTF notes that DoDI 1241.2, Reserve Component Incapacitation System Management, gives the Service Secretaries the authority to order RC members to active duty or continue them on active duty for treatment of an injury, illness, or disease incurred in the line of duty (LOD).[321] While this policy gives the Services the means to ensure Reservists are evaluated and rated while in an active status, it is not consistently enforced.[322] Reservists lacking LOD documentation or severe symptoms are deactivated only to later be referred into the IDES in a Reserve status.[323] The RWTF encountered many such Reservists during its FY2013 JFHQ site visits.[324]

Going through IDES in a Reserve status potentially results not only in the loss of active duty IDES protections, but also the loss of no-cost medical treatment, and active duty pay and benefits.[325] The RWTF is aware of at least one case that was brought to the Court of Federal Claims, which ruled that the Service member was improperly separated from active duty and credited the Service member with back pay and allowances.[326]

The IDES timetable allows 10 days for the Service member or a designated representative to rebut the IPEB determination (fit or unfit).[327] In cases where the Service member is found fit for continued service by the IPEB, the 10-day allocation may be used to gather and submit new information that the IPEB did not previously consider.[328] The 10-day limit for compiling medical records for IDES is insufficient, however, for RC RWs whose records are likely to be dispersed

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across military, VA, and/or civilian hospitals.[329] Overall, the medical evidence that RC RWs are able to submit is often poorer than that of their AC counterparts.[330]

RECOMMENDATION D26

The National Guard Bureau (NGB) and each state JFHQ leadership should build formal strategic relationships with the Veterans Integrated Service Network (VISN), the Veterans Medical Center (VAMC) and the local VA OEF/OIF/OND Offices in their areas in order to facilitate referrals, timely behavioral health services, communication when Guard Members are at risk for behavioral health reasons, and transfer of documentation for LOD and fitness for duty determinations.

Requested Agencies to Respond: NGB

Finding: It was apparent from the RWTF's interactions with JFHQ and VA personnel during FY2013 site visits that, for the most part, these key players in the care of RC RWs were not regularly communicating.[331] The State Surgeon's Office and the OEF/OIF/OND Office—the specific entities within the JFHQs and VAMCs that could greatly benefit from working interdependently—lacked established channels of communication, much less mutual understanding or formal agreements.[332] At the same time, NGB indicated that with the VA it is developing a duty-to-warn initiative that will establish the criteria for mandatory reporting by VA providers to JFHQs regarding at-risk cases.[333] This is a promising step toward communication and collaboration between these organizations. NGB and the Department of Veterans Affairs should capitalize on this first step and provide top-down leadership for the establishment of formal strategic relationships, ongoing contact and dialogue, and coordinated processes at every level, with emphasis on where the rubber meets the road, between the JFHQ State Surgeon's Office and the VA OEF/OIF/OND Office.

The RWTF visited three JFHQs during FY2013, for a total of eight JFHQ visits over the past three years. It was apparent from many of the FY2013 JFHQ briefings that, despite these two organizations' mutual concern for this common population, the JFHQs have difficulty obtaining needed information from the VA. JFHQs' inability to obtain medical documentation from the VA can delay LOD determinations and IDES processes.[334] JFHQs have no systematic visibility of the RWs who are receiving VA care, even if the referral originated at the JFHQ, which inhibits medical officers' or other appropriate JFHQ personnel's ability to monitor and intervene when an RW is at risk.[335] Given drilling RWs' access to weapons, it is particularly vital that the JFHQ be notified if a still-serving combat veteran being treated at the VA is considered a threat to self or others.[336]

In conjunction with the JFHQ site visits, the RWTF also visited several VAMCs and received briefings from VA proponents including OEF/OIF/OND Program Managers and Case Managers, VA Caregiver Program Case Managers, and others. By and large, the OEF/OIF/OND Program Offices indicated they tend to have little or sporadic communication with the JFHQs, to include the JFHQ Directors of Psychological Health.[337] One VA care provider explained they communicate directly with command when military patients who enter through a TRICARE referral miss appointments, but they cannot do so when military patients enter through combat veteran status.[338] VA providers expressed concerns about confidentiality and Health Insurance Portability and Accountability Act (HIPAA) constraints but also

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acknowledged that, with appropriate permissions, more sharing of information with the JFHQ might be possible.[339]

Additional strategic relationship-building by the JFHQs is needed. Just as the JFHQ shares a mutual population with the VA, so the JFHQ ARNG shares a mutual population with servicing Army WTUs. This common population confronts certain Guard-unique challenges that the WTU is not necessarily equipped to address. RWTF RW mini-survey results highlighted, for example, how challenging it is to provide family caregiver support for families who are not co-located with their RW at the WTU. Thirteen percent of AC assigned to WTUs reported first-hand experience with family caregiver support, as compared to none of the Reserve and National Guard.[340] On the RC side, the JFHQ and line unit often are not told when Guard members are released from WTUs, which disadvantages both the Service member and the National Guard.[341] JFHQs have the means to support local RW families, facilitate RWs' transition out of the WTU, and otherwise address needs of Guard Solders assigned to WTUs, but cannot do so absent two-way communication with these units. Unfortunately, the RWTF's FY2013 JFHQ site visits suggested that interaction and communication between JFHQ Army entities and WTUs is inconsistent at best.[342] Strategic relationships must be forged between JFHQ ARNG and servicing WTU entities, starting with the G1s and WTB/WTU commanders.

RECOMMENDATION D27

NGB should increase staffing for Directors of Psychological Health.

Requested Agencies to Respond: NGB

Finding: The National Guard Bureau created the Psychological Health contract in order to task 54 Directors of Psychological Health (DPHs)—one for each state/territory—to develop community-based behavioral health networks, educate Guard members and families, assess and refer Guard members and families, conduct leadership education and training, and build psychological health fitness and resilience and minimize stigma.[343] Behavioral health case management is also part of the DPH's responsibilities.[344] In 2013, NGB funded an additional 24 DPHs to high risk states, based on OPTEMPO, mission sets, and suicide rates.[345] The RWTF believes the DPHs can and should play a key role in building the behavioral health care infrastructure within the states and territories; however, the DPH contract is not currently resourced adequately for the full breadth of this mission or the size of the target population. For a general order of magnitude, DPHs appear responsible for approximately 333,939 ARNG members (ARNG end strength[346] minus ARNG deployed[347] and ARNG assigned to WTUs or CBWTUs[348]). With PTSD prevalence estimated at up to one in five[349], then at least that many (approximately 66,788) need DPH attention. The resulting average ratio of DPHs to target population is 1:856.[350]

Deactivated RC who return to their home communities have less access to behavioral health care than the personnel who continue to receive their care at the MTF. Fairly consistently during JFHQ site visits and briefings from the ARNG and ANG, National Guard proponents identified a shortage of local qualified behavioral health providers trained in evidence-based psychotherapies (EBPs).[351] The JFHQ briefers also expressed misgivings about the behavioral health resources at local VA medical centers, identifying concerns about the adequacy and rigor

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of PTSD treatment provided through the VA and availability of appointments.[352] Some speculated that the National Guard's and the VA's therapeutic objectives for NG members seeking behavioral health care may not be fully aligned.[353]

I've been suffering for two years with this PTSD. I can't heal. (Recovering Warrior)

The CBWTU that the RWTF visited during FY2013 indicated that local VA PTSD resources are not commensurate with the level of need among the Soldiers assigned to the CBWTU.[354] They send their Service members needing in patient or comprehensive treatment to Laurel Ridge, Texas or NICoE.

During a JFHQ site visit, a State Surgeon told the RWTF that with additional staff he could show dramatic improvement in his state's ability to manage the behavioral health needs of its ARNG population.[355] This particular State was not eligible for one of the newly hired 24 DPHs. The RWTF believes that State Surgeon spoke for many JFHQs across the country and NGB must provide the JFHQs additional DPH support to enable them to more effectively meet the behavioral health needs of their ARNG populations—through engagement with Guard members and their families via assessment, referral, and case management, as well as through engagement with local civilian behavioral health providers and cultivation of local evidence-based treatment capacity.

RECOMMENDATION D28

To ensure all eligible RC members have access to the healthcare and related resources they have earned while activated, DoD must standardize the LOD policy and build a single electronic LOD processing system.

Requested Agencies to Respond: OSD(RA)

Finding: LOD determinations are the gateway to appropriate healthcare and benefits for RC members who incur or aggravate conditions while on active duty, yet the LOD process is not implemented uniformly. DoD's LOD policy is currently captured in DoD Instruction 1241.2, Reserve Component Incapacitation System Management[356], and DoD Directive 1242.01, Reserve Component Medical Care and Incapacitation Pay for Line of Duty Conditions[357].

In FY2013, the RWTF visited six RC locations including three JFHQs, a Navy NOSC, Navy MEDHOLD West, and an Army CBWTU. The RWTF's FY2013 understanding of LOD issues stems largely from briefings at these sites and nine additional RC site visits the RWTF conducted in FY2011 and FY2012. RC proponents' grievances with the existing LOD process center on how the process, or how it is implemented, tends to obstruct—rather than facilitate—access to care and benefits for deserving Reservists.

LOD documentation for Reservists is supposed to begin in theater, but frequently does not.[358, 359] The Center for Army Lessons Learned described the LOD report as the "number one document that WTs (warriors in transition) and WTUs need, yet parent RC units consistently fail to provide…" and noted "without this form, medical authorities cannot complete the medical

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evaluation board (MEB) process, doctors may not obtain the WT's medical history, and benefits can be delayed or denied."[360]

Let units know to do a better job of taking care of Soldiers. When I was injured my unit didn't do anything. The LOD had been closed for no update. I had to go through the process of re-opening the LOD to get into the MEB process that I should have been in. I fault the unit for not taking care of me for that. For me, that's been key. The unit doesn't know anything about handling it or what is going on. There is a huge information gap somewhere in the process. (Recovering Warrior)

Upon redeployment without LOD documentation, Reservists can be demobilized before their LOD conditions are identified or addressed.[361, 362, 363] This is not limited to the National Guard; for example, Navy NMCMs told the RWTF that the demobilization process for Navy Reservists can fail to identify and address health issues.[364] Once demobilized without an LOD, Reservists' access to medical care for conditions they incurred or aggravated while on Title 10 is jeopardized. Local health care resources may be meager. Reservists may have to travel long distances to obtain care; they may have a co-pay; they do not receive the level of case management provided active-duty RWs; they lose the active-duty pay and other benefits to which they are entitled.[365, 366, 367] A November 2012 Government Accountability Office report independently observed that RC access to DoD and VA resources is impeded when it has not been established that the Service member's condition was incurred/aggravated in the line of duty.[368] What is more, once Reservists are deactivated, it is difficult to reinstate their Title 10 orders.[369, 370, 371] This is true both for conditions that may have been overlooked at the demobilization site and for conditions that manifest later, such as PTSD.[372, 373] Staff at one JFHQ mentioned they are case managing 13 RWs who are being treated locally for PTSD, of whom nine belong at the WTU.[374]

For a variety of reasons, the LOD process is particularly problematic for PTSD cases. It is difficult to trace psychological symptoms to a specific incident/date in theater.[375] It may be many months post-deployment before symptoms emerge and more months still before the individual is ready to acknowledge them.[376] The diagnostic process is complex and lengthy but must be completed before an LOD determination can be made.[377] Medical documentation regarding the treatment of RWs being seen by civilian providers, including the VA, can be very difficult to obtain.[378] An interim LOD may be necessary in order for the RW to be assessed and a diagnosis determined.[379] NGB indicated to the RWTF that DoDI 1241.2, Reserve Component Incapacitation System Management[380], provides for such an interim LOD determination (paragraph 6.4.2)[381], although it is unclear to the RWTF whether RC proponents in the field are familiar with it.

Recent Congressional testimony presented by the National Guard Association of the U.S. reinforces the presented LOD findings. Specifically, it highlighted the lack of a reliable method for preserving the records of RC personnel in theater, inadequate medical screening at the demobilization site, and under identification of service-connected conditions at separation.[382] Inasmuch as the LOD is the gateway to active-duty health care and benefits for Reservists who qualify, it must be a viable process. A standardized and easy-to-implement electronic LOD processing system must be developed and implemented. Implementation should include

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extensive RC LOD awareness training across both the Active and Reserve Components and user training for appropriate AC and RC stakeholders.

RECOMMENDATION D29

DoD, VA, and the Services should publish timely guidance to standardize care to RWs:

- DTM 11-015, Integrated Disability Evaluation System (IDES).
- MEDCOM Policy Memo 11-098, Comprehensive Transition Plan Policy and CTP-Guidance (CTP-G).
- DTM 12-007, Implementation of Mandatory Transition Assistance Program Participation for Eligible Service Members.
- DoDI 1322.bb, Implementation Guidance for Job Training, and Employment Skills Training (JTEST) Authority for Eligible Service Members.
- DoD /VA Interagency Complex Care Coordination Policy for Service Members and Veterans.
- DoD Instruction (DoDI) on VA Vocational, Rehabilitation & Employment (VR&E) counseling for Service members transitioning through IDES.
- DoD Instruction (DoDI) on Reserve Component incapacitation status.

Requested Agencies to Respond: DoD, Office of the Under Secretary of Defense for Personnel and Readiness (OUSD(P&R)), VA, USA, USN, USAF

Finding: Published timely guidance standardizes care and promotes parity across the Services; marshals resources; facilitates information flow between DoD, VA, and the Services; and reduces redundancies. It is incumbent upon DoD, VA, and the Services to provide the most robust RW programs and services possible, and to adequately support the programs and services with written policy. In its FY2012 report, the RWTF identified three unpublished policy documents that were subsequently published. The RWTF continues to believe that in order for RWs and their family members to receive the maximum benefit from the programs and services available to them, DoD, VA, and the Services must prioritize the publishing and dissemination of new and renewed/revised written guidance. Immediate attention should be focused on expiring policies and those awaiting publication, such as DTM 11-015, MEDCOM Policy Memo 11-098, DTM 12-007, DoDI 1322.bb, the DoD /VA Interagency Complex Care Coordination Policy, the DoDI on VA Vocational, Rehabilitation & Employment, and the DoDI on RC incapacitation status.

– **DTM 11-015, Integrated Disability Evaluation System (IDES) and Navy and Air Force Service-level Guidance.** The current policy guidance on the Integrated Disability Evaluation System, DTM 11-015, is scheduled to expire on August 1, 2013. DTM 11-015 establishes policy, assigns responsibilities, and prescribes procedures for the IDES.[383] It is imperative this publication not expire. As a DTM, it has a span of only six months and has been extended several times; the RWTF urges publication of the permanent DoDI as soon as possible. The RWTF also notes that, although the DTM requires each Service to establish

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IDES procedures, the Navy and the Air Force have not yet published Service-level guidance in accordance with the DTM.

- **MEDCOM Policy Memo 11-098, Comprehensive Transition Plan Policy and CTP-Guidance (CTP-G).** The current Army Comprehensive Transition Plan Policy and CTP-Guidance (CTP-G), MEDCOM Policy Memo 11-098, is scheduled to expire on November 29, 2013. MEDCOM Policy Memo 11-098 standardizes staffing and establishes common understanding of programs and procedures at each of the 29 WTUs and nine CBWTUs, including implementation of the CTP.[384]
- **DTM 12-007, Implementation of Mandatory Transition Assistance Program Participation for Eligible Service Members.** The current policy guidance on implementation of the new mandatory Transition Assistance Program (called Transition GPS), DTM 12-007, was originally scheduled to expire on May 21, 2013. The RWTF recognizes DoD's successful efforts to extend DTM 12-007 prior to its expiration through May 21, 2014. Transition GPS is still undergoing its roll out and expired policy could have been damaging to its implementation.[385] As full implementation of Transition GPS is not expected until October 2014,[386] the RWTF notes that May 21, 2014 is still not an appropriate expiration date for this policy guidance. The RWTF recommends the publication of the permanent DoDI.
- **DoDI 1322.bb, Implementation Guidance for Job Training, and Employment Skills Training (JTEST) Authority for Eligible Service Members.** In briefings to the RWTF, WCP[387], the Army[388], the Air Force[389], and the Marine Corps[390] indicated they all await further implementation guidance from DoD on non-federal internships. WCP stated the forthcoming DoDI 1322.bb, Implementation Guidance for Job Training, and Employment Skills Training (JTEST) Authority for Eligible Service Members will provide the necessary implementation guidance[391]. DoD must clarify what, if any, additional policy is needed and ensure that RWs quickly gain access to non-federal internships. If DoDI 1322.bb will provide the needed guidance, it must be published without delay. RWs who participated in RWTF focus groups were as likely to say that currently available vocational opportunities met their needs as not,[392] underscoring that current opportunities are insufficient.

Pretty much, except I've noticed on the internships, I've noticed that not everyone wants to do a federal internship. They might want to do something else. I've noticed the internships are mostly federal. (Recovering Warrior)

Specifically for internships; you're only allowed to get them at Federal jobs. In Alaska, where the population is smaller, there are less Federal jobs available. They should open it up to State jobs and some of the larger corporations around here. It's difficult to get Federal jobs in this remote area. (Recovering Warrior)

Expanding internship and apprenticeship opportunities beyond the federal sector would increase the availability of meaningful vocational opportunities for RWs.[393, 394] Thus, for the second consecutive year, the RWTF recommends DoD publish implementation guidance on non-federal internships.

- **DoD /VA Interagency Complex Care Coordination Policy for Service Members and Veterans.** The DoD/VA Interagency Care Coordination Committee (IC3) was created to

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establish interagency guidance and a common governance structure, develop an interagency community of practice, develop a single comprehensive interagency recovery plan, and develop a sustainable model for both peacetime and wartime support requirements.[395, 396] Currently, the IC3 is developing the DoD /VA Interagency Complex Care Coordination Policy for Service Members and Veterans, a source document for current and future policy that implements the new operational model of complex care coordination. The Policy defines terms and common guidelines and assigns responsibilities during care coordination. In an April 2013 presentation to the RWTF, the IC3 co-chairs noted that IC3 goals align with a number of RWTF recommendations[397] and priority issues, such as information dissemination, standardization across the Services, and synchronization among care coordinators and non-medical case managers. Publication of the DoD /VA Interagency Complex Care Coordination Policy for Service Members and Veterans is needed to improve quality and parity across RW programs and services in all of these areas.

– **DoD Instruction (DoDI) on VA Vocational, Rehabilitation & Employment (VR&E) counseling for Service members transitioning through IDES.** In an April 2013 briefing to the RWTF, DoD stated a DoDI, "on the vocational rehabilitation and employment counseling for Service members transition from IDES" was in coordination and should be published by the end of the fiscal year.[398] The RWTF places significant value on VR&E, having recognized the key role VR&E plays in supporting transitioning RWs and will continue to play after the current conflict ends and drawdowns are completed. The RWTF has sought and received briefings on the availability of VR&E at numerous site visits[399, 400, 401], and made recommendations on VR&E in both the FY2011 and FY2012 reports. RWTF RW focus group participants more often than not stated that job readiness activities including VR&E met their needs[402], and mini-survey results from participants with first-hand experience with VR&E indicated high satisfaction[403].

I will be doing VR&E eventually. I was a full time crew chief, and I will need training after they retire me. My job doesn't transfer to the civilian world, I'll never [redacted] again, so I have to transition to a civilian job. VR&E will retrain me and I will go back to college. (Recovering Warrior)

However, despite such positive satisfaction, mini-survey results also indicated that VR&E utilization was low; only 18 percent of respondents had first-hand experience. Site briefers identified a number of barriers that likely contribute to the low utilization. At several installations, the chain of command and RWs displayed a lack of awareness of VR&E and/or a misunderstanding of the program.[404] The RWTF also observed poor coordination between VR&E counselors and other installation staff, or poor integration of VR&E into the IDES process.[405] Publication of the DoDI will further formalize and standardize VR&E for current Service members and assist in overcoming implementation barriers.

– **DoD Instruction (DoDI) on Reserve Component incapacitation status.** In FY2012, the RWTF recommended that DoD establish policies that allow for the rapid issuance of Title 10 orders to RC RWs who have sustained line of duty injuries/illnesses (Recommendation 22). RWTF FY2013 site visits to JHFQs in Arkansas, Iowa, and North Carolina served to reinforce the salience of this recommendation. In its April 2013 response to the FY2012 recommendations, DoD concurred with Recommendation 22 and stated implementation would involve consolidating existing policy (DoDI 1241.2, "Reserve Component Incapacitation System Management,"and DoDD 1241.01, "Reserve Component

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Medical Care and Incapacitation Pay for Line of Duty Conditions") into a single issuance to better support RC needs related to incapacitation status.[406] The RWTF appreciates DoD's concurrence on FY2012 Recommendation 22 and urges DoD to publish the new policy as soon as possible.

Summary

The final section of this chapter includes best practices and charts that document RWTF's FY2012 and FY2011 recommendations, summarize DoD's formal responses, and note the RWTF's assessment of each recommendation's current status.

BEST PRACTICES

The RWTF defines best practices to include promising models, innovations, and initiatives that are believed to promote effective services for the RW community and have the potential to be replicated, whether or not they have been tested for applicability beyond their current implementation. The RWTF encountered most of these best practices during site visits. They inform the recommendations made this year and provide some of the direction for next year's efforts.

PTSD Services

The RWTF has made several recommendations to improve the services for RWs with PTSD, addressing access to care, EBP training for all DoD behavioral health providers, and non-completion of treatment protocols. In three years of site visits, the RWTF has observed PTSD treatment programs that vary in their attentiveness to treatment outcomes[407, 408, 409] and that are not able to consistently meet the needs of RWs[410, 411, 412] and their families[413, 414, 415]. The RWTF believes that without measuring outcomes and monitoring effectiveness, programs cannot respond and adapt to patient needs and therefore cannot reach their full potential. The following best practices in PTSD services address the need for monitoring care, measuring outcomes, and adapting treatment programs individually and at systems levels to improve services and ensure effectiveness.

My family member just gets medication. I don't feel like the treatment is helping. The medication isn't working and it has side effects. (Family Member)

Psychological Health Pathways (PHP)

PHP was implemented in 2009[416] on the campus of Naval Medical Center San Diego (NMCSD)[417]. The mission of the program is to provide education, build resilience, aid research and promote best practices in the treatment of combat and operational stress injuries.[418]

The RWTF particularly appreciates PHP's use of outcome measures and its approach to non-completion. The collection of data, described more fully under the three pillars below, has led to changes in how treatment is delivered and has improved treatment outcomes. For example, a therapist was removed when multiple patients' data indicated insufficient improvement, and the

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treatment program was modified to address sleep symptoms when data revealed many RWs were experiencing disturbed sleep.

RWs in PHP are notified at the outset of treatment of the expectations for compliance, and are asked to sign an agreement giving permission to notify the command of missed appointments.[419] This requirement has not been a deterrent to participation; in fact, the demand for this program has grown with cohort sizes and number of cohorts increasing each year. The program offers multiple treatment options to allow for use of a variety of modalities before reaching a determination of treatment non-completion. For example, in the event a RW in the trauma track is not compliant with weekly sessions, the RW will return to the outpatient clinic provider for supportive therapy and monitoring.[420] The Commanding Officer or the medical care team are notified when multiple appointments are missed.[421]

The program utilizes three interdependent pillars to standardize care regardless of location:

- Clinical Pathways: a standardized set of clinical practices from the initial collection of demographics and screening measures used to assess individual treatment outcomes, through final transition of care.[422] The program is designed to be flexible and tailored to the resources at any given clinic or treatment facility as it expands beyond NMCSD.[423]
- Care Management: Facilitation of patient advocacy, education, tracking, reporting and timely access to providers and resources. Case managers are able to work collaboratively with the patient and mental health providers to facilitate coordination and continuity of care.[424]
- Data Management: Coordinated and centralized data capture. Data is collected starting with initial contact, to include demographics and self-report outcome measures, re-evaluation measures, and clinical treatment reviews.[425] The outcome measures collected throughout treatment inform clinician and program treatment decisions, program evaluations, and staffing and funding decisions.[426]

Army Behavioral Health Data Portal (BHDP)

The Army BHDP allows behavioral health providers to document treatment progress and clinical outcomes.[427] As of late 2012, the BHDP was in use at 31 MTFs.[428] The intent of the program is to track patient outcomes, satisfaction, and risk factors. This tracking improves communication among providers and commanders and increases the availability of data on individual patients and on overall program/treatment efficacy.[429]

Patients self-report behavioral health data in a secure web application, and providers can quickly access the benchmarked data to assess clinical progress and the patient's response to current interventions, informing their clinical decisions in real time.[430] Providers are alerted to adjust treatment if the patient is not meeting the expected treatment response.[431] In the future, the program will also link to deployment health assessments to compile a more robust record of Soldiers' behavioral health.[432]

The Army Task Force on Behavioral Health recommended Army-wide implementation of the BHDP to improve efficacy and documentation of behavioral health care provided to Soldiers.[433]

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Behavioral Health Teleconferences with Network Providers

The Fort Carson Director of Behavioral Health holds weekly teleconferences with the network providers treating RWs with PTSD in inpatient settings.[434] (As of the RWTF's January 2013 visit to Fort Carson, 25 RWs were receiving inpatient PTSD care on the network.) Together, the Director of Behavioral Health and network providers go over each patient's status, ensuring frequent and open communication and collaboration on the RW's treatment and progress. These teleconferences allow the Behavioral Health Director to maintain accountability and oversight over the quality of inpatient PTSD care provided to RWs outside the MTF.

Reserve Component: North Carolina National Guard Integrated Behavioral Health System

The North Carolina State G-1 stated as part of the introduction to the RWTF visit that they spend approximately $3M a year of their own money on the Integrated Behavioral Health System (IBHS) and would rather give up a tank engine than this program.[435] Established by the NCNG November 1, 2010, the IBHS "is dedicated to helping NCNG Service members and their families by assessing for immediate behavioral health needs and offering connection and case management services to all NCNG support programs as well as federal, state, and community programs for both clinical and non-clinical needs."[436] The IBHS serves NCNG members and their families who are currently serving or left military service within the last six months.[437] The primary target population comprises individuals whose connection or re-connection with available services is inadequate or untimely, are in crisis, and/or are uninsured and not VA-eligible—for whom the IBHS provides short-term, crisis support services.[438] Members of other Service branches and components are not turned away.[439] Participation in IBHS services is voluntary, confidential, and free of charge.[440] Not only is the IBHS completely separate from the fitness for duty determinations and the command-directed referral process[441], but IBHS records are maintained separately from documentation maintained by the JFHQ State Surgeon's Office.[442]

The portal of entry into the IBHS is a confidential, toll-free call line monitored 24/7 by a qualified clinician. Calls must be returned within 30 minutes.[443] The IBHS portal voice mail greeting refers callers to alternatives including the National Veteran's Crisis Line and Military OneSource.[444] The IBHS provides consultation for callers who are concerned about someone else, such as callers from the chain of command or a battle buddy, and assessment for callers who are troubled themselves.[445] Since inception, the IBHS has fielded 1,891 calls and conducted 825 clinical assessments and 877 consultations.[446] Consultations are protected by appropriate levels of professional ethics.[447]

The IBHS is staffed by qualified professionals.[448] IBHS positions include: the State Behavioral Health Programs Director, who functions as administrative and clinical lead; the State Behavioral Health Programs Coordinator, who functions as the assistant to the Director; the Directors of Psychological Health who fill clinical roles including assessment, triage, referral, follow-up, crisis intervention, and critical incident stress management (CISM); behavioral health clinicians, who conduct short-term, crisis support services; and non-clinical behavioral health case managers, who follow up on clinical referrals and engage with non-clinical referral sources.[449]

Following initial assessment and referral, IBHS clinical staff may provide eligible individuals counseling services or "bridging behavioral or crisis support"[450] services. IBHS also refers to such

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counseling/non-clinical resources as Military Family Life Consultants, Military OneSource, employee assistance programs (for employed m-day Guard members), and Give an Hour, and such clinical resources as VA Medical Centers, VA Vet Centers, Department of Health and Human Services managed care organizations, TRICARE providers, and others.[451] IBHS also addresses non-medical needs that may be associated with behavioral health issues.[452] In addition to the services outlined above, IBHS staff members conduct educational and marketing briefs at Soldier Readiness Processing, demobilization, Yellow Ribbon Reintegration Program, and other events.[453]

Vocational and Transition Services: Fort Carson Access to Internships

While visiting Fort Carson, members of the RWTF observed a method of preserving employment opportunities for RWs who are not yet certain exactly when they will leave the military. The RWTF heard in RW focus groups this year and last[454, 455], as well as during briefings at a majority of sites visited [456, 457], that the uncertainty inherent in the IDES process hampers RWs' ability to seek employment. RWs often postpone pursuing employment because they are unable to commit to a start date until IDES is nearly complete. However, once IDES is nearly complete, RWs often find themselves with too little time left to participate in programs such as OWF and E2I.

Seemed like it took a decade to get to. It was more the length of the process. It left you in limbo in terms of employment. (Recovering Warrior)

The Transition Coordinator, Employment and Education Initiative (E2I) Coordinator, and VA VR&E staff at Fort Carson have developed a method of assisting RWs in IDES who have a specific job they wish to pursue.[458] In these cases, Fort Carson staff work with the employers to reconfigure the job opportunities into temporary unpaid internships for the RWs. As an internship, the employer is able to moderate the duration as necessary to accommodate the uncertain timeframe of the IDES process. The work contribution made by the RW during the internship allows the employer to hold the official position open until the RW is able to transition out of the military into the job full time, and the RW is able to receive training and gain experience during the internship. Because the RW is also participating in VR&E, s/he is able to receive a VA stipend during the internship. The RWTF has often advocated for greater collaboration between DoD and VA in preparing RWs for civilian life, and recognizes the efforts made at Fort Carson as an example of collaboration resulting in improved opportunities for RWs.

Legal Support in IDES: Fort Bragg Briefing for RWs Entering IDES

In FY2013 RW focus groups, a number of participants described general dissatisfaction with IDES, including an insufficient understanding of how the IDES functions.[459] FY2011 and FY2012 RWTF focus group participants expressed similar confusion about the IDES process. [460, 461] While visiting Fort Bragg, members of the RWTF learned of a comprehensive IDES briefing for RWs, developed by a Fort Bragg IDES lawyer, that is an impressive effort to provide the information needed about the IDES process.[462, 463] In particular, the RWTF considers the detailed content on how specific medical terminology translates into VA rating(s) to be invaluable. The following is illustrative of other specific information provided in this extensive briefing:

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- Soldiers provide medical conditions to the Army and VA in separate interviews, with the MEB doctor listing only disqualifying conditions and the VA MSC listing all service-connected conditions. Once the medical conditions have been listed/provided, no additions or updates can be made during the disability process; the RW must wait until after separation to add new conditions and file a new VA claim.
- The VASRD is used to assign a rating for each condition based on "loss of future wages;" personal amount of pain or pain medication are usually not considered (e.g., back pain is evaluated by range of motion, mental health by the Global Assessment of Functioning (GAF) score).
- The VA Compensation and Pension Exam considers each condition and evaluates it based on VA ratings. However, there is no consideration for the use or side effects of medications and the exam cannot be appealed.
- DA Form 3947 describes MEB findings. The only opportunity the Soldier has to appeal is when they are asked to sign DA Form 3947 (i.e., acceptance "terminates any future right of appeal"). If the Soldier does not sign, they have seven days to present an appeal.

This is critical information in which the Service member has a vested interest. The RWTF believes that all Service members entering IDES should receive this information, and information like it, that can materially influence the IDES outcome.

STATUS OF FY2012 AND FY2011 RECOMMENDATIONS

Exhibit 1: FY2012 RWTF Recommendations, DoD Responses, and Status

FY2012 Recommendation	Summary of DoD Response	Status
1. Publish RW policy/program guidance	All publications completed.	Met. (however see FY2013 Rec XX)
2. Standardize case management and care coordination roles	Being addressed by the Interagency Care Coordination Committee.	Continue to follow. (see FY2011 Rec 2 and FY2013 Rec XX)
3. Draft RW Bill of Rights or content of Commander Intent Letter	Warrior Care Policy office requirement.	Continue to follow. (see FY2011 Rec 5)
4. Co-locate/integrate DoD and VA rehabilitation capacity	Concurs. Awaiting Implementation Plan.	Continue to follow.
5. Establish WCP within USD(P&R) portfolio	Non-concurs.	Continue to follow.
6. Provide needed resources on station for 29 Palms	Still being addressed.	Continue to follow.
7. Extend TAMP to one year post deployment	Still being studied.	Continue to follow.
8. Ensure training for evidence based PTSD treatment/identification	Concurs. Being addressed by the Interagency Care Coordination Committee.	Met. (however see FY2013 Rec XX)
9. Audit records for completed evidence based PTSD treatment	Partially concurs. Being addressed by the Interagency Care Coordination Committee.	Continue to follow.
10. Adopt a common comprehensive recovery/transition plan format	Non-concurs.	Continue to follow.

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FY2012 Recommendation	Summary of DoD Response	Status
11. Provide more access to and input into CRP for RWs and families	Partially concurs.	Continue to follow.
12. Redefine WII Category 2	Concurs.	Continue to follow.
13. Send non-RCC RW proponents to joint DoD RCC training	Concurs.	Continue to follow.
14. Support to family members/caregivers unconstrained by HIPAA	Concurs.	Continue to follow. (see FY2013 Rec XX)
15. Designate principal point of contact for family/caregiver	Concurs.	Continue to follow. (see FY2013 Rec XX)
16. Educate family members/caregivers about VA/other resources	Concurs.	Continue to follow. (see FY2013 Rec XX)
17. Provide PEBLO briefing for EFMP families	Concurs.	Met.
18. Unify famiies/caregiver with RW	Concurs.	Continue to follow. (see FY2013 Rec XX)
19. Rename NRD and market the new portal	Non-concurs.	Continue to follow. (see FY2013 Rec XX)
20. Resource base family support centers and specify relationships with RW programs	Concurs.	Continue to follow.
21. Centralize case management for RC RWs on Title 10	Concurs.	Continue to follow. (see FY2013 Rec XX)
22. Establish policies for issue of Title 10 orders and use of INCAP pay	Concurs.	Continue to follow. (see FY2013 Rec XX)
23. Include RC unit in out-processing for RWs leaving Title 10	Concurs.	Met.
24. Publish interim guidance for NDAA 2012 Section 551	Concurs.	Continue to follow. (see FY2013 Rec XX)
25. Expand DoD/VA MOU on RW access to VR&E counseling	Concurs.	Continue to follow. (see FY2011 Rec 18 and FY2013 Rec XX)
26. Update DoDD and DoDI on TAP	Concurs.	Continue to follow. (see FY2013 Rec XX)
27. Establish DoD and VA Deputy Secretaries as Co-Chairs of JEC	Non-concurs.	Continue to address.
28. Evaluate processes to limit IDES population	Concurs.	Met.
29. Create electronic record for individual IDES information	Concurs. Pending pilot outcomes.	Continue to follow. (see FY2013 Rec XX)
30. Utilize WCP survey to improve IDES program	Concurs.	Continue to follow. (see FY2013 Rec XX)
31. Exclude terminal leave from calculation of IDES timelines	Non-concurs.	
32. Consider replacing Service FPEB with a joint FPEB	Still being studied.	Continue to follow.
33. Develop staffing models/ensure adequate PEBLO staffing	Still being studied.	Continue to follow.

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FY2012 Recommendation	Summary of DoD Response	Status
34. Provide legal outreach to RWs	Partially concurs.	Continue to follow. (see FY2013 Rec XX)
35. Market VA services and benefits to DoD leadership at all levels	Partially concurs.	Continue to follow.

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Exhibit 2: FY2011 RWTF Recommendations, DoD Responses, and Status

FY2011 Recommendation	Summary of DoD Response	Status
1. Define "Recovering Warrior"	DoD will review current terms	Continue to follow (see FY2012 Rec 2, 12)
2. Specify population-based standards and criteria.	Army Medical Command is participating in DoD/VA workgroups to develop guidelines. CTP being revised.	Continue to follow (see FY2012 Rec 2)
3. Develop standardized, data-driven protocols for condition-specific recovery care.	Army Medical Command is participating in DoD/VA workgroups to develop guidelines. CTP being revised.	Continue to follow
4. Create standards, and provide oversight and guidance, for the CRP and CTP.	USMC WWR took multiple steps to improve. USA WTC changed CTP on 12.1.11.	Continue to follow (see FY2012 Rec 10, 11)
5. WTC and WWR must define appropriate transition unit command climate and disseminate corresponding standards for achieving it.	WWR ensures the appropriate climate. WTC notes command and control for the for WTU/CBWTUs is in Army Medical Command.	Met (however see FY2012 Rec 3)
6. Enforce the existing policy guidance regarding transition unit entrance criteria.	WWR works to maintain awareness. Army fragmentary orders (FRAGOs) provide specific guidance.	Met (however see FY2012 Rec 12)
7. Ensure that there are sufficient numbers of medical care case managers available at WTUs, WWRs, and CBWTUs.	DoDI 1300.25 published	Met
8. Shape strategic solutions that address the unique needs of RC RWs.	There is only one standard. Working on restructuring the Remote Care program.	Continue to follow (see FY2012 Rec 21, 22, 23)
9. Provide the needed support for the Centers of Excellence (CoEs) to enable full operational capability.	CoE Advisory Board established. DCoE PH & TBI realigned. EACE funded.	Met
10. Ensure timely access to routine PTSD care across the continuum of Service.	Took multiple steps to ensure timely access	Continue to follow (see FY2012 Rec 7, 8, 9)
11. Standardize and define the roles/responsibilities of care coordinators, VA personnel, and NMCMs.	DoDI 1300.24 provides eligibility criteria. Fragmentary Order (FRAGO) 3 & Headquarters Department of Army (HQDA) Executive Order (EXORD) 118-07 provide guidance	Continue to follow (see FY2012 Rec 2)
12. Develop minimum qualifications, ongoing training, and skill identifiers specializing in recovery and transition for transition unit personnel.	USMC Section Leaders are a mix of RC & AC; moving toward only AC. WTC working to enhance training.	Continue to follow
13. As part of the intake process, and on a regular and recurring basis, review available resources for support, to include the NRD and Keeping It All Together, with the RW and the family caregiver.	WTC recognized the need to better educate Service members and families on transition. These are reflected in the 12.1.11 CTP guidance & policy.	Met (however see FY2012 Rec 19)
14. Empower family caregivers with the resources they need to fulfill their roles in the successful recovery of RWs.	WTC recognized the need to better educate SMs and families; reflected in the 12.1.11 CTP guidance & policy.	Continue to follow (see FY2012 Rec 14, 15, 16, 17, 18)
15. The DoD should expedite policy to provide special compensation for SMs with catastrophic injuries or illnesses requiring assistance in everyday living, as directed by Section 603 of the NDAA 2010.	DoD issued policy for Special Compensation for Assistance with Activities of Daily Living on 8.31.11. Eligible WII started receiving payments 9.15.11.	Met

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FY2011 Recommendation	Summary of DoD Response	Status
16. Continue to support the SFACs and take steps to increase utilization.	WTC working to educate and inform about SFACs.	Continue to follow (see FY2012 Rec 20)
17. Make TAP attendance mandatory for RWs within the 12 months prior to separation.	Section 221 of the Vow to Hire Heroes Act, Public Law 112-56, signed 11.21.11, contained a mandatory TAP provision.	Met (however see FY2012 Rec 26)
18. Ensure that the VA VR&E Program is available and accessible to RWs before their separation from the Services.	MOU signed 2.1.12 to implement at earliest opportunity. Process will be expanded further in FY2012.	Continue to follow (see FY2012 Rec 25)
19. Develop a uniform DoD manpower and staffing model for PEBLOs and legal support.	Army reviewing staffing needs in the DES. USAF increased staff.	Met (however see FY2012 Rec 33 & 34)
20. Pending the implementation of a common electronic health record (EHR), find interim solutions to grant access to EHR for disability assessment.	Working on multiple electronic health records systems with the VA.	Continue to follow
21. Consolidate the SOC functions into the JEC. The JEC will be co-chaired by the Deputy Secretaries of DoD and VA.	The SOC has become the WIIC of the JEC.	Continue to follow (see FY2012 Rec 27)

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