



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

2012-2013 Annual Report



September 3, 2013

The estimated cost of report or study for the Department of Defense is approximately \$2,613,000 for the 2013 Fiscal Year. This includes \$2,470,000 in expenses and \$143,000 in DoD labor.  
Generated on 2013Jul31 RefID: 1-EC0BDB6

# DoD Recovering Warrior Task Force

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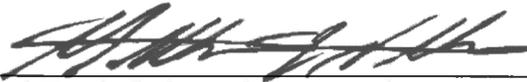
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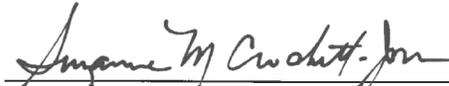
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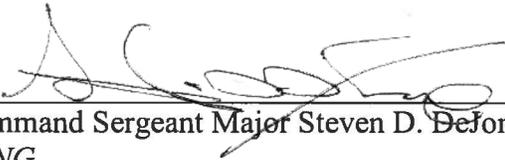
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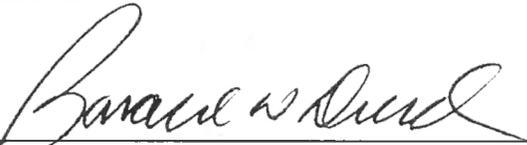
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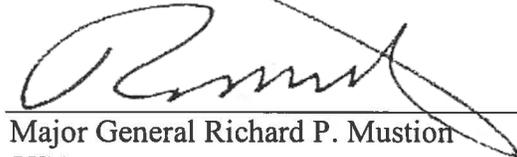
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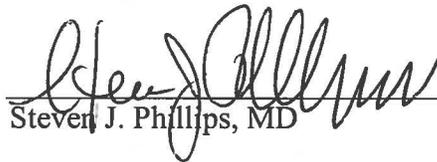
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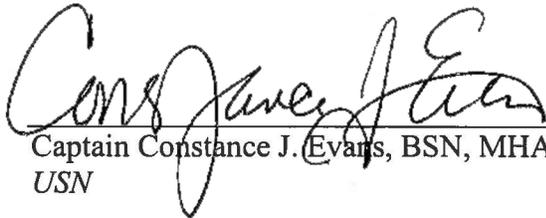
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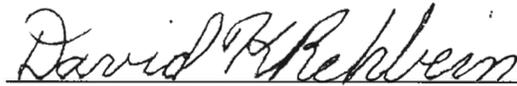
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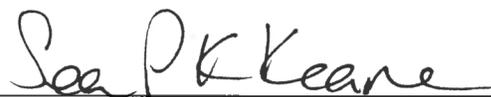
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The Recovering Warrior Task Force (RWTF) concludes its third year of effort with the Fiscal Year (FY) 2013 Annual Report. In its third year, the RWTF continued its assessment of the programs and services available to Recovering Warriors (RWs) and their 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 to RWs. 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 (EHR) by September 30, 2009.<sup>1</sup> In February 2013, DoD and VA announced their plan to move away from creating a single shared EHR and instead will build upon existing technology by integrating current DoD and VA health care data systems.<sup>2</sup> 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.<sup>3</sup> Many have expressed disappointment regarding the scale-back of integrated EHR plans<sup>4, 5, 6, 7, 8, 9, 10</sup>; regardless of which path is taken, the RWTF believes an interoperable system is required to ensure a successful continuum of care from the time a Service member is injured to the time he or she is released from military service and becomes a veteran. However 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, as well as the changing landscape of services and supports. Based upon the data collected and analyzed, the RWTF offers 21 recommendations, listed below. Findings for each of these recommendations are presented in Chapter 2.

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The RWTF's recommendations are organized according to the primary agency to which they are addressed: Office of the Assistant Secretary of Defense (OASD) for Health Affairs (HA); OASD for Reserve Affairs (RA) and the Services; National Guard Bureau (NGB); Office of the Deputy Assistant Secretary of Defense for Warrior Care Policy (ODASD(WCP)); ODASD(WCP) and the Services; the Services; and "multiple agencies." RWTF would like the designated primary agencies to formulate the responses to the recommendations and, if appropriate, execute the implementation plan. In instances where more than one primary agency is cited (e.g., ODASD(WCP) and the Services), the RWTF would like the first, higher-level, organization to lead the response to the recommendation by coordinating the input from other agencies and developing a unified response. The RWTF also would like the lead agency to oversee and champion implementation, if indicated. VA is specifically offered the option to respond to two recommendations. Although the RWTF is a DoD task force, VA is an integral part of the transition experience; thus VA is represented on the RWTF and in the RWTF's data collection efforts.

### Recommendations for the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA))

1. OASD(HA) and the Centers of Excellence (CoE) Oversight Board will develop a Department of Defense Instruction (DoDI) that empowers the CoE and the Oversight Board and directs the Services to translate CoE discoveries into practice across DoD.
2. OASD(HA) must develop and implement measures of effectiveness that ensure consistency, completeness, and currency of training for clinical case managers.
3. OASD(HA) should implement comprehensive policy standardizing the provision of evidence-based posttraumatic stress disorder (PTSD) psychotherapies addressing the needs of Service members and the providers treating them. Specifically:
  - A dedicated "Trainer and Champion" for the effective delivery of evidence based PTSD psychotherapies at each military treatment facility (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 all contract providers to have military culture training and EBP training.
  - Requiring intensive outpatient PTSD treatment programs to develop at least one class for caregivers, spouses, and family members designed to educate and engage them in their RW's treatment.
4. DoD must ensure traumatic brain injury (TBI) treatments meet the needs of RWs and must standardize, document, and track the efficacy of TBI treatment.

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## Recommendations for the Office of the Assistant Secretary of Defense for Reserve Affairs (OASD(RA)) and the Services

5. DoD will issue policy guidance for Services to ensure continuous active duty orders for RC RWs encompass a complete period for care, as guided primarily by a medical care plan. In addition, Services must establish a mechanism that enforces renewal of orders prior to 30 days of expiration.
6. The RWTF observed inconsistencies in the interpretation and application of laws governing IDES with respect to RC and Active Component (AC) RWs. The RWTF recommends VA and DoD, in concert with Congress, review laws related to the following:
  - Presumption of soundness
  - Service aggravation provisions
  - Application of other policies that specify current activation and/or years on active service requirements.
7. To ensure all eligible RC members have access to the healthcare and benefits based on their active-duty service, DoD must standardize the Line of Duty (LOD) policy and implement a single electronic LOD processing system.

## Recommendations for the National Guard Bureau (NGB)

8. NGB directs each state JFHQ to establish formal strategic relationships with the Veterans Integrated Service Network (VISN), the Veterans Affairs Medical Centers (VAMCs) and the local VA OEF/OIF/OND Offices in their areas. These strategic relationships will facilitate:
  - Referrals
  - Timely behavioral health services
  - Communication when Guard Members are at risk for behavioral health reasons
  - Transfer of documentation for LOD and fitness for duty determinations.
9. Recognizing there have been 24 additional Directors of Psychological Health (DPHs) funded, various states have identified that one DPH is not adequate. NGB should conduct a zero-based review of the staffing requirements for states/territories for DPHs and adjust as necessary to meet care demands.

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## Recommendations for the Office of the Deputy Assistant Secretary of Defense for Warrior Care Policy (ODASD(WCP))

10. DoD must establish policy to ensure the accuracy, timeliness, accessibility, and relevancy of information sources. Specifically:
  - Define roles and responsibilities of online resources and call centers established by DoD and the Services for the RW community; include common measures of effectiveness across all resources.
  - Promote and improve marketing for the Wounded Warrior Resource Center 800 number (1-800-342-9647) as the single primary telephone resource for all RWs and their families.
  - Maximize availability of this information to include mobile platforms.
  - Ensure the National Resource Directory's (NRD's) capacity to serve as a one-stop website source. At minimum, this should include executing a comprehensive marketing strategy targeting RWs and family members across the country, and a mechanism to track its success in engaging RWs and family members.
11. ODASD(WCP) should work with VA to grant Veterans Tracking Application (VTA) access to more providers and locations supporting RWs in the Integrated Disability Evaluation System (IDES), to include Medical Evaluation Board (MEB) attorneys and CBWTUs.
12. Congress should eliminate the Temporary Disability Retirement List (TDRL).
13. DoD must ensure all medical conditions are documented by MEBs and the quality of the documentation for each condition will facilitate timely and accurate decisions by the Physical Evaluation Board (PEB) and ratings by VA. MEB processes must be standardized across Services and measures of effectiveness established to ensure application of this policy.
14. ODASD(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).

## Recommendations for the Office of the Deputy Assistant Secretary of Defense for Warrior Care Policy (ODASD(WCP)) and the Services

15. The Office of the Under Secretary of Defense for Personnel and Readiness (OUSDP&R)) 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, services provided, and payment processes should be the same across Services.

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16. 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.

### Recommendations for the Services

17. Air Force liaisons at 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 WWII Airmen and their families.

18. Services must resource locations that have difficulty recruiting civilian staff with predominantly uniformed providers as clinical and non-clinical behavioral health staff.

19. There is a disparity in the ambient knowledge of the RC as compared to the AC as to non-medical case management. The Services will establish a protocol that ensures non-medical information is resident, current, and accessible in RC organizations.

20. To increase both family member involvement in the recovery process and family member awareness of available resources, there should be 100 percent outreach to attend in-processing and IDES orientation for family members or designated caregivers. One-hundred percent outreach is defined as positive contact and two-way communication between the person providing the outreach and the person receiving it. Communication will be consistent across Services and within the programs that family member and caregiver participation is expected. Measures of effectiveness will be implemented to document family involvement and attendance.

- 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.

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## Recommendation for multiple agencies

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

- Directive-Type Memorandum (DTM) 11-015, Integrated Disability Evaluation System (IDES)
- Army Warrior Transition Command (WTC) 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
- DoDI on VA Vocational, Rehabilitation & Employment (VR&E) counseling for Service members transitioning through IDES
- DoDI on Reserve Component incapacitation status.

Charts indicating the status of the FY2011 and FY2012 RWTF recommendations are presented at the end of Chapter 2 (Exhibits 1 and 2).

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.<sup>11, 12</sup> The legislation specified over a dozen 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 (SecDef) 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 DoD to respond to the RWTF's recommendations.<sup>13</sup> DoD is required to provide Congress an assessment of the RWTF recommendations at 90 days, and an implementation plan at 180 days, after RWTF's submission of the report to the SecDef. The RWTF is disappointed that 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 Department of Veterans Affairs (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 Service 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 were made to Air Force Warrior and Survivor Care headquarters, Navy Wounded Warrior-Safe Harbor (NWW-SH) headquarters, and joint environments including Walter Reed National Military Medical Center (WRNMMC). The RWTF had the opportunity to explore the care and management of RC RWs in and out of RW units, speak with VA proponents, assess DoD/VA collaboration at the local level, and visit 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 with the creation of the VA Taskforce for the Seamless Transition of Returning Service Members.<sup>14</sup> The work of the Taskforce was continued by a Seamless Transition Working Group and, for a time, the Seamless Transition Office.<sup>15, 16</sup> Currently, the Joint Executive Council (JEC) directly engages issues related to seamless transition.<sup>17</sup> 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.<sup>18, 19</sup>

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While concerned with the current state of programs and services for the RW community, the RWTF 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<sup>20, 21, 22, 23</sup>, second- and third-order effects such as misguided hiring freezes and fewer post-transition federal job opportunities are impacting RWs<sup>24, 25</sup>. 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 FY2011, 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 21 FY2013 recommendations and associated findings. Chapter 2 concludes with promising practices that are making a difference for RWs and families, charts tracking the status of the FY2011 and FY2012 RWTF recommendations (Exhibits 1 and 2), and a topline overview of the FY2014 research plan. 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.

The Recovering Warrior Task Force's (RWTF's) 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 of Defense (DoD), and published articles and reports. Appendix D contains more detailed information about the methods by which the RWTF collected and analyzed data to inform these recommendations and findings. Best practices, charts that track the status of the FY2011 and FY2012 RWTF recommendations, and a topline overview of the FY2014 research plan are presented at the end of the chapter.

## Recommendations for the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA))

RWTF's four recommendations for OASD(HA) pertain to the Centers of Excellence (CoE), Medical Care Case Managers (MCCMs), and treatment for posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI).

### RECOMMENDATION 1

OASD(HA) and the Centers of Excellence (CoE) Oversight Board will develop a Department of Defense Instruction (DoDI) that empowers the CoE and the Oversight Board and directs the Services to translate CoE discoveries into practice across DoD.

Requested Agencies to Respond: OASD(HA)

**Finding:** The RWTF recognizes the resources provided to the CoE 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<sup>26, 27, 28, 29</sup>, the Veterans of Foreign Wars (VFW) identified the CoE's progress as one of its top concerns in testimony to Congress<sup>30</sup> and, in briefings to the RWTF, the Vision Center of Excellence (VCE) and the Hearing Center of Excellence (HCE) both expressed the continuing need for a mechanism for implementing their recommendations<sup>31, 32</sup>. 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.<sup>33</sup> Currently, CoE successes are facilitated by relationships and networking, as in the case of the Fox Eye Shield.<sup>34</sup> Due to the work of the VCE, Individual First Aid Kits (IFAKs) are currently deployed with a Fox Shield in Navy units.<sup>35, 36</sup> Unfortunately, the VCE continues to struggle to get this practice implemented consistently across all the Services.<sup>37</sup> A

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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 CoE generates improved care and rehabilitation of injured Service members. DoDIs are essential to facilitating the promulgation of policy 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 Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (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.<sup>38</sup> This is the practice that needs to be implemented for the remaining CoE 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.<sup>39</sup>

## RECOMMENDATION 2

OASD(HA) must develop and implement measures of effectiveness that ensure consistency, completeness, and currency of training for clinical case managers.

Requested Agencies to Respond: OASD(HA)

**Finding:** The RWTF recognizes DoD has fairly extensive mandatory online training for Medical Care Case Managers (MCCMs).<sup>40</sup> The RWTF urges DoD to 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, performance measurement tool—will better enable the Department and the Services to monitor MCCM performance and, in turn, inform uniformly high-quality MCCM training. To its credit, DoD published policy guidance for clinical case managers (DoDI 6025.20) in spring 2013. The RWTF believes the implementation of measures of effectiveness is a logical extension of DoD's ongoing efforts to establish robust medical care case management throughout DoD, and it is a step toward fuller implementation of the intent of DoDI 6025.20.<sup>41</sup>

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.<sup>42, 43, 44</sup> On the FY2013 mini-survey administered to RWTF focus group participants, nearly two-thirds of RWs working with an MCCM rated their MCCM as very or extremely helpful.<sup>45</sup>

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 helpful.<sup>46</sup> At two Army sites, several family members said they were not using Special Compensation for Assistance with Activities of Daily Living (SCAADL) because the Nurse Case Manager (NCM) did not provide them accurate or timely information when they

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inquired about it.<sup>47</sup> In these instances, the NCM was described as more of a barrier to SCAADL than a facilitator.<sup>48</sup>

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*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)*

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The RWTF also observed upstream and downstream challenges that Army NCMs face when transitioning RC RWs from WTUs to Community Based Warrior Transition Units (CBWTUs). A WTU NCM said there is too much to do and too little time to prepare RWs before they leave for the CBWTU.<sup>49</sup> 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 military treatment facility (MTF).<sup>50</sup>

The challenges and variations in implementation of medical care case management described above highlight the importance of consistent, complete, and current MCCM training. The implementation of common measures of MCCM effectiveness will provide the Department continuous feedback for refining and updating MCCM training curriculum as needed.

### RECOMMENDATION 3

OASD(HA) should implement comprehensive policy standardizing the provision of evidence-based post-traumatic stress disorder (PTSD) psychotherapies addressing the needs of Service members and the providers treating them. Specifically:

- 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 all contract providers to have military culture training and EBP training.
- Requiring intensive outpatient PTSD treatment programs to develop at least one class for caregivers, spouses, and family members 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

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and standardize care.<sup>51</sup> The lack of standardization across PTSD treatment programs<sup>52</sup> indicates the need for a guiding policy on the care of RWs with PTSD.

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<sup>53, 54, 55, 56</sup>, and the Center for Deployment Psychology (CDP) reports having trained more than 8,000 providers<sup>57</sup>. 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.<sup>58</sup> 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.<sup>59</sup> 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.<sup>60</sup>

Others have also called for this level of support for behavioral health providers. In a 2010 memorandum, OASD(HA) recommended having a senior clinician consultant in each MTF and consultation available for each newly trained provider.<sup>61</sup> 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.<sup>62</sup> 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 are recorded in measurable and consistent ways across patients and providers.<sup>63</sup> 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.<sup>64</sup>

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.<sup>65</sup> Camp Pendleton has implemented the Psychological Health Pathways (PHP) program to track improvement and outcomes of therapy.<sup>66</sup> 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.<sup>67</sup> 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.<sup>68, 69, 70</sup> 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.<sup>71</sup> For example, providers did not receive extra RVU credit for conducting 90-

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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.

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.<sup>72</sup> CDP has recognized this concern and has included a military cultural competency module within the one-week training for civilian providers.<sup>73</sup> 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.<sup>74</sup> 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 PTSD.<sup>75</sup> Veterans have identified PTSD as a stressor amongst the family and expressed interest in additional participation of the family in treatment.<sup>76</sup> 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.<sup>77</sup> 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.<sup>78</sup> 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.<sup>79</sup> 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.<sup>80</sup> In focus groups, the majority of family members were not aware of any available supports for family members of RWs with PTSD.<sup>81</sup> 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 4

DoD must ensure TBI treatments meet the needs of RWs and 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.<sup>82</sup> 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.<sup>83</sup> At

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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.<sup>84</sup>

Furthermore, RW and family member focus group participants indicated current TBI treatment practices are not meeting their needs.<sup>85, 86</sup> 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.<sup>87</sup> 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.<sup>88</sup> In one case in particular, an RW reported that a Department of Veterans Affairs (VA) doctor was stunned that DoD had not diagnosed TBI.<sup>89</sup> 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.<sup>90</sup> 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.<sup>91</sup> Family members were not aware of any support services for family members of RWs with TBI.<sup>92</sup> 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.<sup>93, 94</sup>

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*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)*

*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)*

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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.

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## Recommendations for the Office of the Assistant Secretary of Defense for Reserve Affairs (OASD(RA)) and the Services

RWTF offers three recommendations for OASD(RA) and the Services, with the intent that RA will take the lead in coordinating/integrating the response and overseeing/championing implementation. These recommendations pertain to continuous active-duty orders for Reserve Component (RC) RWs, the impact of Integrated Disability Evaluation System (IDES) laws on RC RWs, and Line of Duty (LOD) policy/process.

### RECOMMENDATION 5

DoD will issue policy guidance for Services to ensure continuous active duty orders for RC RWs encompass a complete period for care, as guided primarily by a medical care plan. In addition, Services must establish a mechanism that enforces renewal of orders prior to 30 days of expiration.

Requested Agencies to Respond: United States Army (USA), United States Navy (USN), United States Air Force (USAF), United States Marine Corps (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.<sup>95</sup>

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*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)*

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Expired orders also interrupt pay.<sup>96</sup> While the RWTF did not hear of cases where orders actually expired, and benefits and pay were gapped, even the threat this may occur does place 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.

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## RECOMMENDATION 6

The RWTF observed inconsistencies in the interpretation and application of laws governing IDES with respect to RC and Active Component (AC) RWs. The RWTF recommends VA and DoD, in concert with Congress, review laws related to the following:

- Presumption of soundness
- Service aggravation provisions
- Application of other policies that specify current activation and/or years on active service requirements.

Requested Agencies to Respond: OASD(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.<sup>97</sup> In Congressional testimony, the president of 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.<sup>98</sup> DoD or Congress should examine relevant laws and policies for RC inequities and make modifications as warranted.

Per 10 United States Code (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.<sup>99</sup> 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.

Veterans Affairs Schedule for Rating Disabilities (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.”<sup>100</sup> RC RWs who are no longer on orders risk losing the guaranteed 50 percent rating.<sup>101, 102</sup> 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 by the Medical Evaluation Board (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.<sup>103</sup>

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 LOD.<sup>104</sup> While this

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policy gives the Services the means to ensure Reservists are evaluated and rated while in an active status, it is not consistently enforced.<sup>105</sup> Reservists lacking LOD documentation or severe symptoms are deactivated only to later be referred into the IDES in a Reserve status.<sup>106</sup> The RWTF encountered many such Reservists during its FY2013 Joint Forces Headquarters (JFHQ) site visits.<sup>107</sup>

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.<sup>108</sup> 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.<sup>109</sup>

The IDES timetable allows 10 days for the Service member, or a designated representative, to rebut the Informal Physical Evaluation Board (IPEB) determination (fit or unfit).<sup>110</sup> 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.<sup>111</sup> The 10-day limit for compiling medical records for IDES is insufficient, however, for RC RWs whose records are likely to be dispersed across military, VA, and/or civilian hospitals.<sup>112</sup> Overall, the medical evidence that RC RWs are able to submit is often poorer than that of their AC counterparts.<sup>113</sup>

## RECOMMENDATION 7

To ensure all eligible RC members have access to the healthcare and benefits based on their active-duty service, DoD must standardize the LOD policy and implement a single electronic LOD processing system.

Requested Agencies to Respond: OASD(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<sup>114</sup>, and DoD Directive 1242.01, Reserve Component Medical Care and Incapacitation Pay for Line of Duty Conditions<sup>115</sup>.

In FY2013, the RWTF visited six RC locations, including three JFHQs, a Navy Operations Support Center (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.<sup>116</sup> <sup>117</sup> The Center for Army Lessons Learned described the LOD report as the “number one document that WT's (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.<sup>118</sup>

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*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)*

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Upon redeployment without LOD documentation, Reservists can be demobilized before their LOD conditions are identified or addressed.<sup>119, 120, 121</sup> This is not limited to the National Guard; for example, Navy NCMs told the RWTF that the demobilization process for Navy Reservists can fail to identify and address health issues.<sup>122</sup> 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.<sup>123, 124, 125</sup> A November 2012 Government Accountability Office (GAO) 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.<sup>126</sup> What is more, once Reservists are deactivated, it is difficult to reinstate their Title 10 orders.<sup>127, 128, 129</sup> This is true both for conditions that may have been overlooked at the demobilization site and for conditions that manifest later, such as PTSD.<sup>130, 131</sup> 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.<sup>132</sup>

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.<sup>133</sup> It may be many months post-deployment before symptoms emerge and more months still before the individual is ready to acknowledge them.<sup>134</sup> The diagnostic process is complex and lengthy but must be completed before an LOD determination can be made.<sup>135</sup> Medical documentation regarding the treatment of RWs being seen by civilian providers, including the VA, can be very difficult to obtain.<sup>136</sup> An interim LOD may be necessary in order for the RW to be assessed and a diagnosis determined.<sup>137</sup> The National Guard Bureau (NGB) indicated to the RWTF that DoDI 1241.2, Reserve Component Incapacitation System Management<sup>138</sup>, provides for such an interim LOD determination (paragraph 6.4.2)<sup>139</sup>, 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.<sup>140</sup> 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.

## Recommendations for the National Guard Bureau (NGB)

RWTF offers two recommendations for NGB, the first related to the relationship between JFHQs and local VA entities, and the second related to the Director of Psychological Health (DPH) program.

### RECOMMENDATION 8

NGB directs each state JFHQ to establish formal strategic relationships with the Veterans Integrated Service Network (VISN), the Veterans Affairs Medical Centers (VAMCs) and the local VA Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) offices in their areas. These strategic relationships will facilitate:

- Referrals
- Timely behavioral health services
- Communication when Guard Members are at risk for behavioral health reasons
- Transfer of documentation for LOD and fitness for duty determinations.

Requested Agencies to Respond: NGB, VA (optional)

**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.<sup>141</sup> 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.<sup>142</sup> 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.<sup>143</sup> This is a promising step toward communication and collaboration between these organizations. NGB and VA 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.<sup>144</sup> 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.<sup>145</sup> Given drilling RWs’ access to weapons, it is particularly vital that the

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JFHQ be notified if a still-serving combat veteran being treated at the VA is considered a threat to self or others.<sup>146</sup>

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.<sup>147</sup> 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.<sup>148</sup> VA providers expressed concerns about confidentiality and Health Insurance Portability and Accountability Act (HIPAA) constraints but also acknowledged that, with appropriate permissions, more sharing of information with the JFHQ might be possible.<sup>149</sup>

Additional strategic relationship-building by the JFHQs is needed. Just as the JFHQ shares a mutual population with the VA, so the JFHQ Army National Guard (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.<sup>150</sup> 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.<sup>151</sup> JFHQs have the means to support local RW families, facilitate RWs' transition out of the WTU, and otherwise address needs of Guard Soldiers 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.<sup>152</sup> Strategic relationships must be forged between JFHQ ARNG and servicing WTU entities, starting with the personnel branches (G1s) and WTB/WTU commanders.

## RECOMMENDATION 9

Recognizing there have been 24 additional DPHs funded, various states have identified that one DPH is not adequate. NGB should conduct a zero-based review of the staffing requirements for states/territories for DPHs and adjust as necessary to meet care demands.

Requested Agencies to Respond: NGB

**Finding:** The National Guard Bureau created the Psychological Health contract in order to task 54 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.<sup>153</sup> Behavioral health case management is also part of the DPH's responsibilities.<sup>154</sup> In 2013, NGB funded an additional 24 DPHs to high risk states, based on operational temp (OPTEMPO), mission sets, and suicide rates.<sup>155</sup> The RWTF believes the DPHs

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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<sup>156</sup> minus ARNG deployed<sup>157</sup> and ARNG assigned to WTUs or CBWTUs<sup>158</sup>). With PTSD prevalence estimated at up to one in five<sup>159</sup>, then at least that many (approximately 66,788) need DPH attention. The resulting average ratio of DPHs to target population is 1:856.<sup>160</sup>

Deactivated RC RWs 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).<sup>161</sup> The JFHQ briefers also expressed misgivings about the behavioral health resources at local VA medical centers, identifying concerns about the adequacy and rigor of PTSD treatment provided through the VA and availability of appointments.<sup>162</sup> 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.<sup>163</sup>

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

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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.<sup>164</sup> 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.<sup>165</sup> 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.

## **Recommendations for the Office of the Deputy Assistant Secretary of Defense for Warrior Care Policy (ODASD(WCP))**

The RWTF has five recommendations for ODASD(WCP). The first of these recommendations pertains to information resources for RWs and their families; the remaining four recommendations are related to IDES—specifically, the Veterans Tracking Application (VTA), Temporary Disability Retirement List (TDRL), MEB process, and IDES Satisfaction Survey.

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## RECOMMENDATION 10

DoD must establish policy to ensure the accuracy, timeliness, accessibility, and relevancy of information sources. Specifically:

- Define roles and responsibilities of online resources and call centers established by DoD and the Services for the RW community; include common measures of effectiveness across all resources.
- Promote and improve marketing for the Wounded Warrior Resource Center (WWRC) 800 number (1-800-342-9647) as the single primary telephone resource for all RWs and their families.
- Maximize availability of this information to include mobile platforms.
- Ensure the National Resource Directory's (NRD's) capacity to serve as a one-stop website source. At minimum, this should include executing a comprehensive marketing strategy targeting RWs and family members across the country and a mechanism to track its success in engaging RWs and family members.

Requested Agencies to Respond: ODASD(WCP)

**Finding:** A variety of 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), WWRC (now MOS Wounded Warrior Specialty Consultations<sup>166</sup>), NRD, Service Family Assistance Centers (FACs) and hotlines. To that end, the RWTF gathers 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, differences across Services, as well as a general lack of awareness and under-utilization among RWs and family members.<sup>167, 168, 169, 170, 171, 172</sup> (See Appendix K, “Other Results,” for further data regarding utilization and assessment of these information resources.) The RWTF is also concerned about the frustration and confusion experienced by RWs and family members due to the sheer number of existing information resources.<sup>173</sup> A DoD Instruction will reduce redundancies, eliminate gaps, create efficiencies, clarify roles and responsibilities across DoD, and increase knowledge of and access to information resources by RWs and family members. The DoDI should identify common utilization and satisfaction metrics to be gathered and reported in order to allow ongoing assessment and comparison of the effectiveness of information resources for RWs and family members.

The RWTF's concerns about the adequacy of existing information resources are magnified by the substantial unmet information needs it observes within the RW community. RWTF RW<sup>174</sup> and family member<sup>175</sup> 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 16 and 20.) Both AC and RC RWs said that they had to search for information on steps to take throughout the recovery process.<sup>176</sup> The proposed DoDI will provide the 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)*

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MOS Wounded Warrior Specialty Consultation Services, which RWs and their families can access via MOS, provides immediate assistance related to health care, facilities, and benefits, working collaboratively with Service-level RW units and programs and the VA. Among RWTF RW mini-survey participants, 40 percent indicated they had used this information resource; by comparison, only five percent indicated they had used the NRD.<sup>177</sup> The RWTF is encouraged by this indicator of MOS Wounded Warrior Specialty Consultation Services utilization and independent impressions of its consultation process, and believes that, through targeted, vigorous marketing, the WWRC can become the “go to” information resource for the RW community.

When considering how to maximize information dissemination, it is critical to take into account the burgeoning use of mobile devices. According to the Pew Internet and American Life Project, since 2011, every major demographic group has seen growth in smartphone use, especially users in their 20’s and 30’s.<sup>178</sup> This holds true across income, race, and education levels with almost 80 percent of the under 35 population owning a smartphone. For smartphone users in their 20’s, 88 percent are using their phones to meet immediate information needs.<sup>179</sup> Content can be made available via a custom application, such as the DoD Compensation and Benefits Handbook app<sup>180</sup> and the Marine Corps Wounded Warrior Regiment (WWR) app<sup>181, 182</sup>, both free and launched in 2012<sup>183, 184, 185</sup>. 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.<sup>186</sup> While the MOS website and NRD are both mobile-accessible,<sup>187, 188</sup> as noted, neither currently meets the needs of RWs and family members. Responsive web design enables users on any device to access information seamlessly<sup>189</sup>, 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<sup>190</sup>. DoD’s promotion plan for mobile devices must take into consideration the information seeking patterns of RWs and family members, leveraging social media, in-person, and direct-to-consumer outreach tactics to ensure information reaches RWs and families where they are.

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.<sup>191</sup> 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.<sup>192, 193, 194, 195, 196, 197</sup> In FY2012, the RWTF recommended that DoD market the NRD portal with a goal to double its usage.<sup>198</sup> Although ODASD(WCP) reported in FY2013 that the NRD has approximately 100,000 visits per month<sup>199</sup>, ODASD(WCP) cannot discern how many of these visits were RW visits versus family member visits and how many unique RWs/family members these visits represent. Additionally, ODASD(WCP) described a marketing strategy that included NRD commercials in the National Capital Region (NCR), 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.<sup>200</sup> However, it is unclear whether these marketing efforts are reaching individuals outside the NCR. The RWTF believes a comprehensive marketing strategy that targets RWs and family members across the

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country, and takes into account their information-seeking patterns, is needed to ensure the NRD's capacity to serve as a one-stop source for information and referral for this population.

Additionally, the RWTF recommends DoD develop a mechanism to track the success of the NRD marketing campaign in reaching RWs and family members. The RWTF notes that ODASD(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<sup>201</sup>, and approximate number of visits per month in 2013<sup>202</sup> (though not unique visits). Google Analytics could be further used to track total number of user visits, number of pages viewed, and where users are located.<sup>203</sup> ODASD(WCP) might also consider establishing custom URLs to better analyze changes in RW/family member user groups responding to the marketing campaign.<sup>204</sup>

## RECOMMENDATION 11

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

Requested Agencies to Respond: ODASD(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 consistently heard about how difficult it is to get visibility of the status of an RW case in IDES, particularly at the DES Rating Activity Site (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.<sup>205</sup> That the VA does not regularly update eBenefits pages adds to RWs' sense of a “black hole.”<sup>206</sup>

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*(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)*

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Because the VTA is updated to show the Service member's status throughout IDES processing,<sup>207</sup> 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.”<sup>208</sup> In combination with ODASD(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.<sup>209, 210</sup>

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 Physical Evaluation Board Liaison Officers (PEBLOs)

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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).<sup>211</sup> 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.).<sup>212</sup> Another site observed that the wait between seeing the narrative summary (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.<sup>213</sup>

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 NARSUM will be completed."<sup>214</sup> 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 12

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

Requested Agencies to Respond: ODASD(WCP)

**Finding:** Upon completion of the Physical Evaluation Board (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).<sup>215</sup> 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.<sup>216</sup> 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.<sup>217</sup> 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.<sup>218</sup> 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 IDES.<sup>219</sup> 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 (approximately 28%).<sup>220</sup> In order to afford RWs the best disability evaluation possible, the RWTF recommends elimination of TDRL and urges Congress to take this action.

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## RECOMMENDATION 13

DoD must ensure that all medical conditions are documented by MEBs and the quality of the documentation for each condition will facilitate timely and accurate decisions by the PEB and ratings by VA. MEB processes must be standardized across Services and measures of effectiveness established to ensure application of this policy.

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

**Finding:** During the MEB phase of IDES, “medical examinations are conducted and decisions are made by the MEB regarding a Service member’s ability to continue to serve in the military.”<sup>221</sup> If the MEB determines that the RW falls below medical retention standards, the case is forwarded to the PEB.<sup>222</sup> During the PEB phase, “decisions are made about the Service member’s fitness for duty, disability rating, and DOD and VA disability benefits.”<sup>223</sup>

The RWTF has been made aware, however, that all conditions are not always covered in the MEB phase and several policies governing inclusion of medical conditions are not consistently enforced, including:

- DoDI 1332.38 (E3.P1.2.3.) requires that “MEBs, TDRL physical examinations, and Reserve component physical examinations shall document the full clinical information of all medical conditions the Service member has and state whether each condition is cause for referral into the DES.”<sup>224</sup>
- 10 USC 1216 requires that “In making a determination of the rating of disability of a member of the armed forces . . . , the Secretary concerned shall take into account all medical conditions, whether individually or collectively, that render the member unfit to perform the duties of the member's office, grade, rank, or rating.”<sup>225</sup>
- The 2008 NDAA, Section 1612, states that impartial medical reviews should ensure the MEB findings, “. . . adequately reflect the complete spectrum of injuries and illness of the service member.”<sup>226</sup>
- DoDI 1332.38 (E3.P3.4.4) states that “A member may be determined unfit as a result of the overall effect of two or more impairments even though each of them, standing alone, would not cause the member to be referred into the DES or be found unfit because of physical disability.”<sup>227</sup>

These policies underscore the importance of documenting full clinical information covering the complete spectrum of all medical conditions, even those that are not independently unfitting, during the MEB phase. However, the RWTF believes ambiguity in the DODI and statute creates inconsistencies in how the Services conduct MEBs. Attention to consistent implementation of MEB processes across the Services, and monitoring of these processes on a continuous basis, are essential.

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*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)*

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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.<sup>228</sup> The RWTF believes this practice is a good step toward ensuring all medical conditions are addressed by the MEB. (See Recommendation 21, Publish timely guidance for the care of RWs.)

The RWTF believes consistent enforcement of these policies by DoD also will enhance the experience of RWs during IDES. For example, failure to cover all conditions in the MEB phase oftentimes leads to delays when the PEB must reach back for additional information on conditions that were not covered in the MEB/NARSUM, thus leading to delays in IDES processing.<sup>229</sup> 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.

## RECOMMENDATION 14

ODASD(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: ODASD(WCP)

**Finding:** ODASD(WCP)'s ongoing IDES Satisfaction survey is used to track Service member satisfaction with the Integrated Disability Evaluation System.<sup>230</sup> The Defense Manpower Data Center (DMDC) administers these voluntary surveys via telephone to IDES participants at the completion of each major IDES phase: MEB, PEB, and the Transition Phase just prior to return to duty or transition to veteran status.<sup>231</sup> 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%).<sup>232</sup> 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).<sup>233</sup> 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 completed 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 ( $n < 30$ ).<sup>234</sup>

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Opening participation to all Service members in the Transition Phase will increase survey participation and thus potentially reduce if not eliminate non-reportable data.

Non-reportable data are 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.<sup>235</sup>

## Recommendations for the Deputy Assistant Secretary of Defense for Warrior Care Policy (ODASD(WCP)) and the Services

In addition to the five recommendations offered solely for ODASD(WCP) (above), RWTF offers two recommendations for ODASD(WCP) and the Services to address. Both recommendations pertain to support for RW families; the first addresses coverage for family member travel and the second addresses SCAADL.

### RECOMMENDATION 15

The Office of the Under Secretary of Defense for Personnel and Readiness (OUSD(P&R)) 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, services provided, and payment processes should be the same across Services.

Requested Agencies to Respond: ODASD(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.<sup>236</sup> 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.<sup>237</sup> However, the other Services keep up to three family members on ITOs as long as the RW is moving between in-patient facilities.<sup>238</sup> 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.<sup>239</sup>

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.<sup>240</sup> For Army family members, the process is dependent upon the requirement by Army Human

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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 Walter Reed National Military Medical Center (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.<sup>241</sup> 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.<sup>242</sup> At Walter Reed National Military Medical Center, some family members are sent to a nearby Marriott Hotel for lodging.<sup>243</sup> However, only the Army has an arrangement directing the hotel to accept family members' ITOs in lieu of payment for lodging expenses.<sup>244</sup> 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.<sup>245</sup> 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.<sup>246</sup> 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.<sup>247</sup>

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*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)*

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

## **RECOMMENDATION 16**

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: ODASD(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<sup>248</sup>, 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.<sup>249</sup> SCAADL payments are taxable<sup>250, 251, 252</sup>, 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.<sup>253, 254</sup>

In U.S. 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.”<sup>255</sup> 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.<sup>256</sup> 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.<sup>257</sup>

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.<sup>258</sup> 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.<sup>259</sup> 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.<sup>260</sup> The RWTF also observed a lack of familiarity with SCAADL across ARNG, ANG, and NOSC briefers<sup>261</sup>, suggesting there may be eligible RC RWs who are unfamiliar and unconnected with the SCAADL benefit.

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*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)*

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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 supervising NMAs, were burdensome to them and were hampering their effectiveness.<sup>262</sup> The

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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.

## Recommendations for the Services

RWTF offers four recommendations for the Services. The first is specific to Air Force liaisons at two specific medical facilities. The remaining three recommendations target all the Services and span diverse topic areas: filling behavioral health provider positions, non-medical case management knowledge within RC organizations, and family member involvement in the recovery process and awareness of available resources.

### RECOMMENDATION 17

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

Requested Agencies to Respond: USAF

**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.<sup>263, 264</sup> Andrews AFB currently provides the WRNMMC liaison position, but the term is too short.<sup>265</sup> At LRMC, Air Force liaisons are assigned for six months with only a one-week overlap.<sup>266</sup> 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.<sup>267, 268, 269</sup> 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 18

Services must resource locations that have difficulty recruiting civilian staff with predominantly uniformed providers as clinical and non-clinical behavioral health staff.

Requested Agencies to Respond: USA, USN, USAF, 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.<sup>270</sup> JBER in particular mentioned great difficulty in filling contract positions in a remote environment and had a particularly under-resourced TBI program.<sup>271, 272</sup> 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.<sup>273</sup>

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## RECOMMENDATION 19

There is a disparity in the ambient knowledge of the RC as compared to the AC as to non-medical case management. The Services will establish a protocol that ensures non-medical information is resident, current, and accessible in RC organizations.

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

**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 (WII) 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<sup>274</sup>, 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*.<sup>275</sup> 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.<sup>276</sup>

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.<sup>277</sup> At least one organization was unaware that its headquarters had released an important policy update.<sup>278</sup> 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<sup>279</sup> and 12 percent of Navy wounded in action<sup>280</sup>, they make up only eight percent of NWW-SH enrollees<sup>281</sup>. Similarly, although Reservists comprise 13 percent of the Marine Corps<sup>282</sup> and 10 percent of Marine Corps wounded in action<sup>283</sup>, they make up only three percent of Marines joined to the WWR<sup>284</sup>. (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.<sup>285</sup> 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<sup>286</sup> but only 28 percent of Army SCAADL recipients<sup>287</sup>. Similarly, RC personnel comprise 21 percent of Air Force Warrior and Survivor Care enrollees<sup>288</sup> but only eight percent of Air Force SCAADL recipients<sup>289</sup>. (See Appendix K, Other Results, for percentages for each component.)

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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.<sup>290</sup> Although the large majority of all three components indicated no first-hand experience with programs that provide support 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).<sup>291</sup>

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)<sup>292</sup>, which is the individual(s) in each state that the NGB Warrior Support Office charges with facilitating RWs' non-medical transition<sup>293</sup>.

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*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)*

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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%,  $p < .01$ ).<sup>294</sup>

The RWTF believes each Service's implementation of a protocol for ensuring current and complete non-medical information is resident within the staffs of RC organizations is an important step toward closing the gap in the awareness of, use of, and satisfaction with non-medical resources by the RC RW community.

## **RECOMMENDATION 20**

To increase both family member involvement in the recovery process and family member awareness of available resources, there should be 100 percent outreach to attend in-processing and IDES orientation for family members or designated caregivers. One-hundred percent outreach is defined as positive contact and two-way communication between the person providing the outreach and the person receiving it. Communication will be consistent across Services and within the programs that family member and caregiver participation is expected. Measures of effectiveness will be implemented to document family involvement and attendance.

- 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.)

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- Encourage family member/family caregiver to accompany RW on all other appointments if RW is amenable.

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

**Finding:** Since its inception, the RWTF has been concerned that RW family members lack the information they need and are not adequately connected to the resources available to them. The RWTF also is concerned by continuing difficulties in outreach to this vulnerable population. Accordingly, the RWTF strongly recommends DoD institutionalize systematic outreach with RW family members to optimize their participation 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 will 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.<sup>295</sup> Common metrics will allow for consistent monitoring and reporting of 100 percent outreach, family member participation in initial in-briefs, and family member awareness and use of available resources.

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.<sup>296</sup> 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 (35/67 versus 20/68).<sup>297</sup>

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.<sup>298, 299, 300, 301, 302</sup> 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.<sup>303, 304</sup> 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.<sup>305</sup>

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*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)*

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Service-level policy holds unit commanders responsible for outreach to family members.<sup>306, 307, 308</sup> 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.<sup>309, 310, 311, 312</sup> 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.<sup>313</sup> 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.<sup>314</sup> 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.

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

*Not a clue. (Family Member)*

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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.”<sup>315</sup> 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.<sup>316</sup>

As shown in a number of studies, on-site family support helps RWs during the recovery process and is associated with improved recovery<sup>317, 318</sup>, reduced medication use<sup>319</sup>, and more expedient return to work<sup>320</sup>. Healthy family functioning as a whole is associated with a lower level of disability/functional impairment and higher employability.<sup>321</sup> Consistent with these studies, RW focus group data indicated that being separated from family members had a negative impact on the RW's recovery.<sup>322</sup> 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.

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*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 for multiple agencies

RWTF believes strongly in the importance of published policy to standardize care, management, and transition of RWs. Its final recommendation is for the agencies responsible for publishing seven pending policy documents.

### RECOMMENDATION 21

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

- Directive-Type Memorandum (DTM) 11-015, Integrated Disability Evaluation System (IDES)
- Army Warrior Transition Command (WTC) 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
- DoDI on VA Vocational, Rehabilitation & Employment (VR&E) counseling for Service members transitioning through IDES
- DoDI on Reserve Component incapacitation status.

Requested Agencies to Respond: OUSD(P&R), OASD(HA), OASD(RA), Office of the Assistant Secretary of Defense for Readiness and Force Management (OASD(R&FM)), ODASD(WCP), USA, USN, USAF, and VA (optional)

**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, WTC 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

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establishes policy, assigns responsibilities, and prescribes procedures for the IDES.<sup>323</sup> 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 IDES procedures, the Navy and the Air Force have not yet published Service-level guidance in accordance with the DTM.

- **WTC 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.<sup>324</sup>
- **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.<sup>325</sup> As full implementation of Transition GPS is not expected until October 2014,<sup>326</sup> 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, ODASD(WCP)<sup>327</sup>, the Army<sup>328</sup>, the Air Force<sup>329</sup>, and the Marine Corps<sup>330</sup> indicated they all await further implementation guidance from DoD on non-federal internships. ODASD(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<sup>331</sup>. 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,<sup>332</sup> underscoring that current opportunities are insufficient. Expanding internship and apprenticeship opportunities beyond the federal sector would increase the availability of meaningful vocational opportunities for RWs.<sup>333,334</sup> Thus, for the second consecutive year, the RWTF recommends DoD publish implementation guidance on non-federal internships.

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*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)

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*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)*

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- **DoD/VA Interagency Complex Care Coordination Policy for Service Members and Veterans.** The DoD/VA Interagency Care Coordination Committee (IC3) was created to 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.<sup>335, 336</sup> 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<sup>337</sup> 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.
- **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.<sup>338</sup> 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<sup>339, 340, 341</sup>, 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<sup>342</sup>, and mini-survey results from participants with first-hand experience with VR&E indicated high satisfaction<sup>343</sup>. 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.<sup>344</sup> The RWTF also observed poor coordination between VR&E counselors and other installation staff, or poor integration of VR&E into the IDES process.<sup>345</sup> Publication of the DoDI will further formalize and standardize VR&E for current Service members and assist in overcoming implementation barriers.

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*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)*

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- **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 Medical Care and Incapacitation Pay for Line of Duty Conditions”) into a single issuance to better support RC needs related to incapacitation status.<sup>346</sup> 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. The section concludes with a topline overview of the FY2014 research plan.

## 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<sup>347, 348, 349</sup> and that are not able to consistently meet the needs of RWs<sup>350, 351, 352</sup> and their families<sup>353, 354, 355</sup>. 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.

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*My (Service) member just gets medication. I don’t feel like the treatment is helping. (Family Member)*

*The medication isn’t working and it has side effects. (Family Member)*

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## ***Psychological Health Pathways (PHP)***

PHP was implemented in 2009<sup>356</sup> on the campus of Naval Medical Center San Diego (NMCS D)<sup>357</sup>. 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.<sup>358</sup>

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 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.<sup>359</sup> 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.<sup>360</sup> The Commanding Officer or the medical care team is notified when multiple appointments are missed.<sup>361</sup>

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.<sup>362</sup> The program is designed to be flexible and tailored to the resources at any given clinic or treatment facility as it expands beyond NMCS D.<sup>363</sup>
- **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.<sup>364</sup>
- **Data Management:** Coordinated and centralized data capture. Data are collected starting with initial contact, to include demographics and self-report outcome measures, re-evaluation measures, and clinical treatment reviews.<sup>365</sup> The outcome measures collected throughout treatment inform clinician and program treatment decisions, program evaluations, and staffing and funding decisions.<sup>366</sup>

## ***Army Behavioral Health Data Portal (BHDP)***

The Army BHDP allows behavioral health providers to document treatment progress and clinical outcomes.<sup>367</sup> As of late 2012, the BHDP was in use at 31 MTFs.<sup>368</sup> 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.<sup>369</sup>

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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.<sup>370</sup> Providers are alerted to adjust treatment if the patient is not meeting the expected treatment response.<sup>371</sup> In the future, the program will also link to deployment health assessments to compile a more robust record of Soldiers' behavioral health.<sup>372</sup>

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.<sup>373</sup>

### ***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.<sup>374</sup> (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.<sup>375</sup> 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."<sup>376</sup> The IBHS serves NCNG members and their families who are currently serving or left military service within the last six months.<sup>377</sup> 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.<sup>378</sup> Members of other Service branches and components are not turned away.<sup>379</sup> Participation in IBHS services is voluntary, confidential, and free of charge.<sup>380</sup> Not only is the IBHS completely separate from the fitness for duty determinations and the command-directed referral process<sup>381</sup>, but IBHS records are maintained separately from documentation maintained by the JFHQ State Surgeon's Office.<sup>382</sup>

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.<sup>383</sup> The IBHS portal voice mail greeting refers callers to alternatives including the National Veteran's Crisis Line and Military OneSource.<sup>384</sup> 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.<sup>385</sup> Since inception, the IBHS has fielded 1,891 calls and conducted 825 clinical assessments and 877 consultations.<sup>386</sup> Consultations are protected by appropriate levels of professional ethics.<sup>387</sup>

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The IBHS is staffed by qualified professionals.<sup>388</sup> 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.<sup>389</sup>

Following initial assessment and referral, IBHS clinical staff may provide eligible individuals counseling services or “bridging behavioral or crisis support”<sup>390</sup> services. IBHS also refers to such 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.<sup>391</sup> IBHS also addresses non-medical needs that may be associated with behavioral health issues.<sup>392</sup> 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.<sup>393</sup>

### 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<sup>394, 395</sup>, as well as during briefings at a majority of sites visited<sup>396, 397</sup>, 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 Operation Warfighter (OWF) and E2I.

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*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)*

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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.<sup>398</sup> 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.

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## 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.<sup>399</sup> FY2011 and FY2012 RWTF focus group participants expressed similar confusion about the IDES process.<sup>400, 401</sup> 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.<sup>402, 403</sup> 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:

- 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 21)
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 21)
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.	Met. (however see FY2013 Rec 21)
9. Audit records for completed evidence based PTSD treatment	Partially concurs.	Continue to follow.
10. Adopt a common comprehensive recovery/transition plan format	Non-concurs.	Continue to follow. (see FY2013 Rec 21)
11. Provide more access to and input into CRP for RWs and families	Partially concurs.	Continue to follow.
12. Redefine WII Category 2	Partially 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.
15. Designate principal point of contact for family/caregiver	Concurs.	Continue to follow.
16. Educate family members/caregivers about VA/other resources	Concurs.	Continue to follow. (see FY2013 Rec 10, 16, 20)
17. Provide PEBLO briefing for EFMP families	Concurs.	Met.
18. Unify families/caregiver with RW	Concurs.	Continue to follow. (see FY2013 Rec 15)
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.
22. Establish policies for issue of Title 10 orders and use of INCAP pay	Concurs.	Continue to follow. (see FY2013 Rec 21)

<b>FY2012 Recommendation</b>	<b>Summary of DoD Response</b>	<b>Status</b>
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 21)
25. Expand DoD/VA MOU on RW access to VR&E counseling	Concurs.	Continue to follow. (see FY2011 Rec 18 and FY2013 Rec 21)
26. Update DoDD and DoDI on TAP	Concurs.	Continue to follow. (see FY2013 Rec 21)
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.
30. Utilize WCP survey to improve IDES program	Concurs.	Continue to follow. (see FY2013 Rec 14)
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.
34. Provide legal outreach to RWs	Partially concurs.	Continue to follow. (see FY2013 Rec 11)
35. Market VA services and benefits to DoD leadership at all levels	Partially concurs.	Continue to follow.

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

<b>FY2011 Recommendation</b>	<b>Summary of DoD Response</b>	<b>Status</b>
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)

<b>FY2011 Recommendation</b>	<b>Summary of DoD Response</b>	<b>Status</b>
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 and FY2013 Rec 20)
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
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 and FY2013 Rec 21)
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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## **OVERVIEW OF FY2014 RESEARCH PLAN**

FY2014 will represent the fourth and final year of effort for the RWTF, which was charged in its founding legislation to each year examine 16 topic areas related to the care, management, and transition of RWs. The RWTF will build upon knowledge gained and methods honed over the past three years, employing a rigorous data collection and analysis plan that involves focus groups and briefings during visits to Army, Navy, Air Force, and Marine Corps sites; headquarters-level briefings during business meetings; data calls; and review of extant military surveys, scholarly articles, official reports, Congressional testimony, and other sources. Site visits will afford the opportunity to hear firsthand the perspectives of both the providers and customers of RW units, programs, and services across Active and Reserve Component locations. The RWTF recognizes that VA and DoD are partners in the care and transition of RWs; accordingly, consistent with prior years, site visit and business meeting agendas will include input from VA proponents. In addition, this year, the RWTF will visit one or more VA polytrauma centers treating active-duty personnel. The RWTF will synthesize the quantitative and qualitative results gathered through these various methods to generate and substantiate its final set of recommendations.

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## Notes

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<sup>1</sup> NDAA of 2010, Pub. L. No. 111-84, 123, Stat. 2190, §724 (2010) (a)(2).

<sup>2</sup> Kime, P. (February 7, 2013). Va, DoD pull back on electronic health records. Retrieved February, 14, 2013, from <http://www.federaltimes.com/article/20130207/IT03/302070004/VA-DoD-pull-back-electronic-health-records?odyssey=tab%7Ctopnews%7Ctext%7CIT>

<sup>3</sup> To Receive Testimony on the Active, Guard, Reserve, and Civilian Personnel Programs in Review of the Defense Authorization Request for Fiscal Year 2014 and the Future Years Defense Program: Hearing before the Senate Armed Services Committee, Subcommittee on Personnel, 113th Cong. (April 17, 2013) (Testimony from Jonathan A Woodson, Assistant Secretary of Defense for Health Affairs, Director, TRICARE Management Activity, Department of Defense).

<sup>4</sup> Kime, P. (February 7, 2013). Va, DoD pull back on electronic health records. Retrieved February, 14, 2013, from <http://www.federaltimes.com/article/20130207/IT03/302070004/VA-DoD-pull-back-electronic-health-records?odyssey=tab%7Ctopnews%7Ctext%7CIT>

<sup>5</sup> Vogel, S. (February 8, 2013). Retreat by VA and DoD on electronic health records criticized. Retrieved February 14, 2013, from <http://www.washingtonpost.com/blogs/federal-eye/wp/2013/02/08/retreat-by-va-and-dod-on-electronic-health-records-criticized/>

<sup>6</sup> Garamone, J. (February 14, 2013). DOD, VA to speed integration of health records. Retrieved February 14, 2013, from <http://www.woundedwarrior.af.mil/news/story.asp?id=123336370>

<sup>7</sup> Shane, L. III. (February 7, 2013). Effort to integrate DOD, VA medical records draws criticism. Retrieved February 14, 2013, from <http://www.stripes.com/effort-to-integrate-dod-va-medical-records-draws-criticism-1.206961>

<sup>8</sup> Legislative presentation of AMVETS, Air Force Sergeants Association, Paralyzed Veterans of America, Jewish War Veterans, Gold Star Wives, Fleet Reserve Association, Vietnam Veterans of America, and the National Association of State Directors of Veterans Affairs: Joint hearing before the US Senate and House Committees on Veterans Affairs, 113th Cong. (March 6, 2013). (Testimony from Mark A. Kilgore, National President, Fleet Reserve Association).

<sup>9</sup> Legislative presentation of Military Officers Association of America, Retired Enlisted Association, Non Commissioned Officers Association, Blinded Veterans Association, Military Order of the Purple Heart, Wounded Warrior Project, Iraq and Afghanistan Veterans of America, American Ex-Prisoners of War: Joint hearing before the US Senate and House Committees on Veterans Affairs, 113th Cong. (February 28, 2013). (Testimony from SgtMaj (Ret.) H. Gene Overstreet, President, Non Commissioned Officers Association).

<sup>10</sup> Legislative presentation of AMVETS, Air Force Sergeants Association, Paralyzed Veterans of America, Jewish War Veterans, Gold Star Wives, Fleet Reserve Association, Vietnam Veterans of America, and the National Association of State Directors of Veterans Affairs: Joint hearing before the US Senate and House Committees on Veterans Affairs, 113th Cong. (March 6, 2013). (Submission for the Record of LTG (Ret.) Guy C. Swan, Vice President, Association of the United States Army).

<sup>11</sup> NDAA of 2010, Pub. L. No. 111-84, 123, Stat. 2190, §724 (2010) (a)(2).

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<sup>12</sup> For the purposes of this report, the RWTF considers “Warrior” synonymous with “member of the Armed Forces.”

<sup>13</sup> NDAA of 2010, Pub. L. No. 111-84, 123, Stat. 2190, §724 (2010) (a)(2).

<sup>14</sup> Back from the battlefield: Are we providing the proper care for America’s Wounded Warriors? Hearing of the Senate Committee on Veterans’ Affairs, 109th Cong. (March 17, 2005) (Testimony of Jonathan B Perlin, Acting Under Secretary for Health, Department of Veterans Affairs).

<sup>15</sup> Oversight hearing on DOL/DoD/VA collaboration and cooperation to meet the employment needs of returning servicemembers, 110<sup>th</sup> Congress. (June 13, 2007) (Testimony of Michael L. Dominguez, Principal Deputy Under Secretary for Personnel and Readiness, Department of Defense).

<sup>16</sup> Department of Veterans Affairs Response to RWTF FY2013 draft report. July 18, 2013.

<sup>17</sup> Ibid.

<sup>18</sup> DoD and VA (n.d). DoD-VA Instruction (Draft): Interagency Complex Care Coordination Policy for Service Members and Veterans.

<sup>19</sup> Guice, K. and Riojas, J.D. Briefing to the RWTF. VA-DoD Warrior Care Coordination. April 2, 2013.

<sup>20</sup> Col Buhl, W. Briefing to the RWTF. Marine Corps WWR Response to RWTF FY12 Recommendations. February 27, 2013.

<sup>21</sup> Tillery, R. Briefing to the RWTF. Air Force Personnel Center. February 20, 2013.

<sup>22</sup> BG Bishop, D., LTC Brusher, E., Coffey, R., COL Jones, J., LTC Baker, J., Tuddenham, M., LTC Dudek, D., and Adams, N. Briefing to the RWTF. Army Response to RWTF FY12 Recommendations. February 26, 2013.

<sup>23</sup> CAPT Hall, S. Briefing to the RWTF. Navy Wounded Warrior – Safe Harbor. December 6, 2012.

<sup>24</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>25</sup> To Continue to Receive Testimony on the Active, Guard, Reserve, and Civilian Personnel Programs in Review of the Defense Authorization Request for Fiscal Year 2014 and the Future Years Defense Program: Hearing before the Senate Armed Services Committee, Subcommittee on Personnel, 113th Cong. (April 24, 2013) (Testimony from the Honorable Juan M. Garcia III, Assistant Secretary of the Navy for Manpower and Reserve Affairs; VADM Scott R. Van Buskirk, Chief of Naval Personnel, US Navy; and LtGen Robert E. Milstead, Jr, Deputy Commandant for Manpower and Reserve Affairs, US Marine Corps).

<sup>26</sup> CAPT Hammer, P.S., Cernich, A., Engel, C.C., and COL Grimes, J.B. Briefing to the RWTF. Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCOE) Update. January 15, 2013.

<sup>27</sup> COL Gagliano, D.A. and Lawrence, M.G. Briefing to the RWTF. Vision Center of Excellence. January 14, 2013.

<sup>28</sup> Lt Col Packer, M.D. Briefing to the RWTF. Hearing Center of Excellence. January 14, 2013.

<sup>29</sup> Randolph, B.J. Briefing to the RWTF. Extremity Trauma and Amputation Center of Excellence. January 14, 2013.

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- <sup>30</sup> Legislative presentation of Veterans of Foreign Wars: Joint hearing before the US Senate and House Committees on Veterans Affairs, 113th Cong. (March 5, 2013) (Testimony from John E Hamilton, Commander-in-Chief, Veterans of Foreign Wars).
- <sup>31</sup> COL Gagliano, D.A. and Lawrence, M.G. Briefing to the RWTF. Vision Center of Excellence. January 14, 2013.
- <sup>32</sup> Lt Col Packer, M.D. Briefing to the RWTF. Hearing Center of Excellence. January 14, 2013.
- <sup>33</sup> Lockette, W. Briefing to the RWTF. Military Health System (MHS) Centers of Excellence (CoE) Oversight Board. April 2, 2013.
- <sup>34</sup> COL Gagliano, D.A. and Lawrence, M.G. Briefing to the RWTF. Vision Center of Excellence. January 14, 2013.
- <sup>35</sup> Ibid.
- <sup>36</sup> Miles, D. (January 9, 2013). War yields lessons in preventing, treating eye injuries. Retrieved July 2, 2013, from <http://www.defense.gov/News/NewsArticle.aspx?ID=66715>
- <sup>37</sup> COL Gagliano, D.A. and Lawrence, M.G. Briefing to the RWTF. Vision Center of Excellence. January 14, 2013.
- <sup>38</sup> DoD (January 2, 2013). DoD Directive 600.17E: Executive agent for the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE).
- <sup>39</sup> Ibid.
- <sup>40</sup> Quisenberry, G.C. Briefings to the RWTF. Clinical case management services. February 22, 2012.
- <sup>41</sup> DoD (April 9, 2013). DoD instruction 6025.20: Medical management (MM) programs in the direct care system (DCS) and remote areas.
- <sup>42</sup> RWTF RW focus group results, November 2012-March 2013.
- <sup>43</sup> RWTF RW focus group results, October 2011-March 2012.
- <sup>44</sup> RWTF Service member focus group results. March/April 2011.
- <sup>45</sup> RWTF RW mini-survey results, November 2012-March 2013. Mini-surveys were completed by 205 Service members and 72 family members. Due to the smaller sample size of family members, survey findings for this group are shown in the report as ratios instead of percentages.
- <sup>46</sup> Ibid.
- <sup>47</sup> Ibid.
- <sup>48</sup> RWTF family member focus group results, November 2012-March 2013.
- <sup>49</sup> Site briefings to the RWTF, November 2012-March 2013.
- <sup>50</sup> Ibid.
- <sup>51</sup> Department of Defense Recovering Warrior Task Force (August 31, 2012). 2011-2012 Annual Report. Washington, DC: Author.
- <sup>52</sup> Site briefings to the RWTF, November 2012-March 2013.
- <sup>53</sup> Briefing submitted to the RWTF. Air Force Back-up Slides. February 26, 2013.
- <sup>54</sup> Briefing submitted to the RWTF. Army Back-up Slides. February 26, 2013.

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- <sup>55</sup> Ibid.
- <sup>56</sup> Briefing submitted to the RWTF. Navy Back-up Slides. February 27, 2013.
- <sup>57</sup> Brim, W. Briefing to the RWTF. Center for Deployment Psychology. April 3, 2013.
- <sup>58</sup> Ibid.
- <sup>59</sup> Ibid.
- <sup>60</sup> Ibid.
- <sup>61</sup> DoD Memorandum (December 13, 2010). Guidance for mental health provider training for the treatment of post-traumatic stress disorder and acute stress disorder.
- <sup>62</sup> Army Task Force on Behavioral Health (January 2013). Corrective action plan. Retrieved June 3, 2013, from <http://www.armyg1.army.mil/documents/ATFBH%20Corrective%20Action%20Plan%205%20March%202013.pdf>
- <sup>63</sup> Site briefings to the RWTF, November 2012-March 2013.
- <sup>64</sup> Brim, W. Briefing to the RWTF. Center for Deployment Psychology. April 3, 2013.
- <sup>65</sup> Site briefings to the RWTF, November 2012-March 2013.
- <sup>66</sup> Ibid.
- <sup>67</sup> Mental Health Research: Hearing before the House Armed Services Committee, Subcommittee on Military Personnel, 113th Cong. (April 10, 2013) (Testimony from LTG Patricia D. Horoho, Surgeon General, U.S. Army).
- <sup>68</sup> CAPT Kass, S.M., Kelly, J.P., and CAPT Koffman, R.L. Briefing to the RWTF. National Intrepid Center of Excellence. January 14, 2013.
- <sup>69</sup> Brim, W. Briefing to the RWTF. Center for Deployment Psychology. April 3, 2013.
- <sup>70</sup> Site briefings to the RWTF, November 2012-March 2013.
- <sup>71</sup> Ibid.
- <sup>72</sup> Site briefings to the RWTF, October 2011-March 2012.
- <sup>73</sup> Brim, W. Briefing to the RWTF. Center for Deployment Psychology. April 3, 2013.
- <sup>74</sup> Ibid.
- <sup>75</sup> Weidow, L.H. and Buglewicz, L.J. State of Science Symposium. Medical Rehabilitation of Wounded, Injured, and Ill Women. May 8, 2013.
- <sup>76</sup> Batten, S.V., Drapalski, A.L., Decker, M.L., DeVica, J.C., Morris, L.J. and Mann, M.A. (2009). Veteran interest in family involvement in PTSD treatment. *Psychological Services*, 6(4), 184-189.
- <sup>77</sup> Weidow, L.H. and Buglewicz, L.J. State of Science Symposium. Medical Rehabilitation of Wounded, Injured, and Ill Women. May 8, 2013.
- <sup>78</sup> CAPT Kass, S.M., Kelly, J.P., and CAPT Koffman, R. L. Briefing to the RWTF. National Intrepid Center of Excellence. January 14, 2013.
- <sup>79</sup> Ibid.

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- <sup>80</sup> Site briefings to the RWTF, November 2012-March 2013.
- <sup>81</sup> RWTF family member focus group results, November 2012-March 2013.
- <sup>82</sup> CDR Handrigan, M.T. Panel presentation to the RWTF. Cognitive rehabilitation in mTBI: DoD demonstration project. May 19, 2011.
- <sup>83</sup> Site briefings to the RWTF, November 2012-March 2013.
- <sup>84</sup> Ibid.
- <sup>85</sup> RWTF RW focus group results, November 2012-March 2013.
- <sup>86</sup> RWTF family member focus group results, November 2012-March 2013.
- <sup>87</sup> RWTF RW focus group results, November 2012-March 2013.
- <sup>88</sup> Ibid.
- <sup>89</sup> Ibid.
- <sup>90</sup> Ibid.
- <sup>91</sup> RWTF family member focus group results, November 2012-March 2013.
- <sup>92</sup> Ibid.
- <sup>93</sup> RWTF RW mini-survey results, November 2012-March 2013.
- <sup>94</sup> RWTF family member mini-survey results, November 2012-March 2013.
- <sup>95</sup> Site visit briefings to the RWTF, November 2012-March 2013.
- <sup>96</sup> Ibid.
- <sup>97</sup> LTC (Ret.) Parker, M. Wounded Warrior Advocate, personal communication with the RWTF, April 17, 2013.
- <sup>98</sup> Legislative presentation of AMVETS, Air Force Sergeants Association, Paralyzed Veterans of America, Jewish War Veterans, Gold Star Wives, Fleet Reserve Association, Vietnam Veterans of America, and the National Association of State Directors of Veterans Affairs: Joint hearing before the US Senate and House Committees on Veterans Affairs, 113th Cong. (March 6, 2013) (Testimony from MG (Ret.) Gus Hargett, President, National Guard Association of the United States).
- <sup>99</sup> 10 U.S.C. §1207a (2012): Members with over eight years of active service: eligibility for disability retirement for pre-existing conditions. Retrieved June 18, 2013, from <http://www.gpo.gov/fdsys/pkg/USCODE-2011-title10/pdf/USCODE-2011-title10-subtitleA-partII-chap61-sec1207a.pdf>
- <sup>100</sup> VA (n.d.). 38 CFR Book C, Schedule for Rating Disabilities - Veteran's Affairs Schedule for Rating Disabilities (VASRD) 4.129 - Mental disorders due to traumatic stress. Retrieved June 18, 2013, from <http://www.benefits.va.gov/warms/bookc.asp#q>, p. 449.
- <sup>101</sup> Ibid.
- <sup>102</sup> LTC (Ret.) Parker, M. Wounded Warrior Advocate, personal communication with the RWTF, April 17, 2013.
- <sup>103</sup> Site briefings to the RWTF, November 2012-March 2013.

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- <sup>104</sup> DoD (May 30, 2001). DoD Instruction 1241.2: Reserve component incapacitation system management.
- <sup>105</sup> LTC (Ret.) Parker, M. Wounded Warrior Advocate, personal communication with the RWTF, April 17, 2013.
- <sup>106</sup> Ibid.
- <sup>107</sup> RWTF RW focus group results, November 2012 -March 2013.
- <sup>108</sup> LTC (Ret.) Parker, M. Wounded Warrior Advocate, personal communication with the RWTF, April 17, 2013.
- <sup>109</sup> Physical Evaluation Board Forum. (January 4, 2013). Air Force BCMR Decision on MEDCON/Separation Active Duty needing MEB/PEB. Retrieved July 1, 2013, from <http://www.pebforum.com/site/threads/air-force-bcmr-decision-on-medcon-separation-active-duty-needing-meb-peb.17934/#post-81008>
- <sup>110</sup> DoD (December 19, 2011; Rev. December 4, 2012). DoD Directive-Type Memorandum 11-015: Integrated Disability Evaluation System (IDES).
- <sup>111</sup> Ibid.
- <sup>112</sup> RWTF RW focus group results, November 2012-March 2013.
- <sup>113</sup> Briefing submitted to the RWTF. Army Back-up Slides. February 26, 2013.
- <sup>114</sup> DoD (May 30, 2001). DoD Instruction 1241.2: Reserve component incapacitation system management.
- <sup>115</sup> DoD (February 28, 2004; Certified current as of April 23, 2007). DoD Directive 1241.01: Reserve Component medical care and incapacitation pay for line of duty conditions.
- <sup>116</sup> Site briefings to the RWTF, November 2012-March 2013.
- <sup>117</sup> Site briefings to the RWTF, October 2011-March 2012.
- <sup>118</sup> United States Army Combined Arms Center, Center for Army Lessons Learned (January 2010). Warrior in transition (Chapter 2, Parent unit roles). Retrieved May 28, 2013, from [http://usacac.army.mil/cac2/call/docs/Warrior\\_in\\_Transition/toc.asp](http://usacac.army.mil/cac2/call/docs/Warrior_in_Transition/toc.asp), p. 1.
- <sup>119</sup> Site briefings to the RWTF, November 2012-March 2013.
- <sup>120</sup> RWTF transition outcomes briefing/panel results, October 2011-March 2012.
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<sup>129</sup> Site briefings to the RWTF, October 2011-March 2012.

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<sup>131</sup> Site briefings to the RWTF, October 2011-March 2012.

<sup>132</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>133</sup> Ibid.

<sup>134</sup> Ibid.

<sup>135</sup> Ibid.

<sup>136</sup> Ibid.

<sup>137</sup> Ibid.

<sup>138</sup> DoD (May 30, 2001). DoD Instruction 1241.2: Reserve component incapacitation system management.

<sup>139</sup> COL Faris, J.K. Deputy Surgeon Army National Guard, and Holdeman, R. Deputy Division Chief Personnel, personal communication with the RWTF, April 11, 2013.

<sup>140</sup> Legislative presentation of AMVETS, Air Force Sergeants Association, Paralyzed Veterans of America, Jewish War Veterans, Gold Star Wives, Fleet Reserve Association, Vietnam Veterans of America, and the National Association of State Directors of Veterans Affairs: Joint hearing before the US Senate and House Committees on Veterans Affairs, 113th Cong. (March 6, 2013) (Testimony from MG (Ret.) Gus Hargett, President, National Guard Association of the United States).

<sup>141</sup> Site briefings to the RWTF, November 2012-March 2013.

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<sup>145</sup> Ibid.

<sup>146</sup> Ibid.

<sup>147</sup> Ibid.

<sup>148</sup> Ibid.

<sup>149</sup> Ibid.

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<sup>152</sup> Ibid.

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<sup>153</sup> CAPT Hunter, J. Briefing to the RWTF. DoD Task Force on the Care, Management, and Transition of Recovering, Wounded, Ill, and Injured Members of the Armed Forces. March 31, 2011.

<sup>154</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>155</sup> COL Faris, J.K. Deputy Surgeon Army National Guard, and Holdeman, R. Deputy Division Chief Personnel, personal communication with the RWTF, April 11, 2013.

<sup>156</sup> Defense Manpower Data Center (March 31, 2013). March 2013 Contingency Tracking System: Current military strength and number of OEF/OIF/OND deployments. ARNG end strength=356,384. This figure does not include family members, whom DPHs also may serve.

<sup>157</sup> Defense Manpower Data Center (March 31, 2013). March 2013 Contingency Tracking System: Number of members deployed by Service component and month/year. ARNG currently deployed=19,251.

<sup>158</sup> Briefing submitted to the RWTF. Army Back-up Slides. February 26, 2013. ARNG in WTU or CBWTU=3,194.

<sup>159</sup> COL (Ret.) Ritchie, E.C. Briefing to the RWTF. Assessment of ongoing efforts in the treatment of PTSD. December 4, 2012.

<sup>160</sup> Estimated size of DPH target population:  $(356,384 - [19,251 + 3,194]) \times 20\% = 66,788$ ; estimated ratio of DPHs to target population: 78 to 66,788 or 1:856.

<sup>161</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>162</sup> Ibid.

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<sup>166</sup> Clouse, N. Office of the Secretary of Defense, Military Community and Family Policy, personal communication with the RWTF, July 29, 2013.

<sup>167</sup> RWTF Service member mini-survey results. March/April 2011.

<sup>168</sup> RWTF RW mini-survey results, October 2011-March 2012.

<sup>169</sup> RWTF RW mini-survey results, November 2012-March 2013.

<sup>170</sup> RWTF family member mini-survey results. March/April 2011.

<sup>171</sup> RWTF family member mini-survey results, October 2011-March 2012.

<sup>172</sup> RWTF family member mini-survey results, November 2012-March 2013.

<sup>173</sup> Cohoon, B. Briefing to the RWTF. National military Family Association: Transition outcomes and family caregivers. October 4, 2011.

<sup>174</sup> RWTF RW focus group results, November 2012-March 2013.

<sup>175</sup> RWTF family member focus group results, November 2012-March 2013.

<sup>176</sup> RWTF RW focus group results, November 2012-March 2013.

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<sup>177</sup> RWTF RW mini-survey results, November 2012-March 2013. The RWTF mini-survey referred to the Wounded Warrior Resource Center rather than MOS Wounded Warrior Specialty Consultations, the more current title, which may have confounded these results.

<sup>178</sup> Smith, A. (2013). Smartphone ownership 2013. Retrieved June 5, 2013, from: <http://www.pewinternet.org/Reports/2013/Smartphone-Ownership-2013.aspx>

<sup>179</sup> Raine, L., and Fox, S. (May 7, 2012). Just-in-time information through mobile connections. Retrieved June 13, 2013, from: <http://www.pewinternet.org/Reports/2012/Just-in-time.aspx>

<sup>180</sup> DoD (March 2, 2012). New mobile apps available to provide compensation and benefits information for wounded warriors. Retrieved December 7, 2012, from <http://warriorcare.dodlive.mil/2012/03/02/new-mobile-apps-available-to-provide-compensation-and-benefits-information-for-wounded-warriors/>

<sup>181</sup> Col Mayer, J.L. and Williamson, P.D. Marine Corps Wounded Warrior Regiment briefing to the RWTF. February 23, 2012.

<sup>182</sup> Capt Wolf, J. (March 14, 2012). Marine Wounded Warrior Regiment app assists wounded warriors, caregivers. Retrieved December 9, 2012, from <http://warriorcare.dodlive.mil/2012/03/14/marine-wounded-warrior-regiment-app-assists-wounded-warriors-caregivers/>

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<sup>184</sup> Col Mayer, J.L. and Williamson, P.D. Marine Corps Wounded Warrior Regiment briefing to the RWTF. February 23, 2012.

<sup>185</sup> Capt Wolf, J. (March 14, 2012). Marine Wounded Warrior Regiment app assists wounded warriors, caregivers. Retrieved December 9, 2012, from <http://warriorcare.dodlive.mil/2012/03/14/marine-wounded-warrior-regiment-app-assists-wounded-warriors-caregivers/>

<sup>186</sup> Klein, D. (February 2012). How to decide: Mobile websites vs. mobile apps. Retrieved June 13, 2013, from: <http://www.adobe.com/inspire/2012/02/mobile-websites-vs-mobile-apps.html>

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<sup>189</sup> Klein, D. (February 2012). How to decide: Mobile websites vs. mobile apps. Retrieved June 13, 2013, from: <http://www.adobe.com/inspire/2012/02/mobile-websites-vs-mobile-apps.html>

<sup>190</sup> Ibid.

<sup>191</sup> National Resource Directory (2012). Homepage. Retrieved January 9, 2012, from [www.nationalresourcedirectory.org](http://www.nationalresourcedirectory.org)

<sup>192</sup> RWTF RW mini-survey results, October 2011-March 2012.

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- <sup>193</sup> RWTF RW mini-survey results, November 2012-March 2013.
- <sup>194</sup> RWTF Service member mini-survey results. March/April 2011.
- <sup>195</sup> RWTF family member mini-survey results. March/April 2011.
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- <sup>197</sup> RWTF family member mini-survey results, November 2012-March 2013.
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- <sup>208</sup> Site briefings to the RWTF, November 2012-March 2013.
- <sup>209</sup> Voegtle, T. Deputy Director in charge of DES Operations Oversight, Warrior Care Policy, personal communication with the RWTF, April 15, 2013.
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- <sup>211</sup> Site briefings to the RWTF, November 2012-March 2013.
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- <sup>213</sup> Ibid.
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- <sup>229</sup> Tillery, R. Briefing to the RWTF. Air Force Personnel Center. February 20, 2013.
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<sup>246</sup> RWTF family member focus group results, November 2012-March 2013.

<sup>247</sup> Ibid.

<sup>248</sup> Allen, J., Essex, C., Frost, C., and Ramsey, M. Panel presentation to the RWTF. Recovering Warriors and Family Members. December 5, 2012.

<sup>249</sup> RWTF family member focus group results, November 2012-March 2013.

<sup>250</sup> DoD (August 31, 2011; Rev May 24, 2012). DoD Instruction 1341.12: Special compensation for assistance with activities of daily living.

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<sup>255</sup> Department of the Treasury Internal Revenue Service (January 4, 2013). Armed Forces' Tax Guide. Retrieved May 29, 2013, from <http://www.irs.gov/pub/irs-pdf/p3.pdf>, p. 3-4.

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<sup>274</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>275</sup> RWTF RW focus group results, November 2012 -March 2013.

<sup>276</sup> Ibid.

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<sup>278</sup> Ibid. An ANG organization did not know that several months earlier the Air Force revised AF Instruction 34-1101, Air Force Warrior and Survivor Care, and the changes included an expansion of AFW2 eligibility to serve all Air Force WII.

<sup>279</sup> Defense Manpower Data Center (2011). 2011 Demographics: profile of the military community. Retrieved May 29, 2013, from

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<sup>285</sup> Briefing submitted to the RWTF. Navy Back-up Slides. February 27, 2013.

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<sup>288</sup> Briefing submitted to the RWTF. Air Force Back-up Slides. February 26, 2013.

<sup>289</sup> MSgt Noel, C. Panel presentation to the RWTF. Air Force Special Compensation for Assistance with Activities of Daily Living. December 5, 2012.

<sup>290</sup> RWTF RW mini-survey results, November 2012-March 2013. The fact that Army lacks an “RCC” position should not influence this finding since the number of AC Army and RC Army in the sample was comparable. The AC/RC disparity could reflect differences in need (e.g., among Reservists) or access barriers among ARNG who have been deactivated.

<sup>291</sup> Ibid.

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<sup>293</sup> Connor, Sr., M.J. Briefing to the RWTF. Transition Assistance Advisor (TAA) Program. December 4, 2012.

<sup>294</sup> Bannick, R.R. Briefing to the RWTF. TRICARE Management Activity telephone survey of ill or injured Service members post-operational deployment. April 3, 2013.

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<sup>296</sup> RWTF family member focus group results, November 2012-March 2013.

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- <sup>315</sup> MOAA and Zeiders Enterprises (November 9, 2012). Warrior-family symposium recap - takeaways and future applications. Retrieved April 11, 2013, from [http://www.moaa.org/uploadedFiles/MOAA\\_Main/Main\\_Menu/Access\\_Member\\_Benefits/Professionalism/Symposia/9%20Nov%202012%20WFR%20Summary.pdf](http://www.moaa.org/uploadedFiles/MOAA_Main/Main_Menu/Access_Member_Benefits/Professionalism/Symposia/9%20Nov%202012%20WFR%20Summary.pdf), p. 1.
- <sup>316</sup> To Receive Testimony on the Active, Guard, Reserve, and Civilian Personnel Programs in Review of the Defense Authorization Request for Fiscal Year 2014 and the Future Years Defense Program: Hearing before the Senate Armed Services Committee, Subcommittee on Personnel, 113th Cong. (April 17, 2013)(Testimony from MCPO (Ret.) Joseph L. Barnes, National Executive Director, Fleet Reserve Association; Mrs. Kathleen Moakler, Government Relations Director, National Military Family Association; Col (Ret.) Steve Stobridge, Director, Government Relations, Military Officers

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Association of America; and CAPT (Ret.) Marshall Hanson, Director, Legislative and Military Policy, Reserve Officers Association).

<sup>317</sup> Bradway, J.K., Malone, J.M., Racy, J., Leal, J.M., and Poole, J. (1984). Psychological adaptation to amputation: An overview. *Orthotics and Prosthetics*, 38 (3), 46-50. This study found that the integration of family into the support team is important to recovery post-amputation.

<sup>318</sup> Kulk, J.A. and Mahler, H.I. (1989). Social support and recovery from surgery. *Health Psychology*, 82 (2), 221-238. DOI: 10.1037/0278-6133.8.2.221. This study found that spousal support in the hospital is associated with lower pain medication usage and faster recovery post-surgery.

<sup>319</sup> Ibid.

<sup>320</sup> MacKenzie, E.J., Siegel, J.H., Shapiro, S., Moody, M., and Smith, R. T. (1988). Functional recovery and medical costs of trauma: An analysis by type and severity of injury. *Trauma*, 28 (3), 281-297. This study found that the presence of supportive family or friends is associated with return to work in trauma patients.

<sup>321</sup> Sander, A.M., Caroselli, J.S., High Jr, W.M., Becker, C., and Scheibel, R. (2002). Relationship of family functioning to progress in a post-acute rehabilitation programme following traumatic brain injury. *Brain Injury*, 16 (8), 649-657. DOI: 10.1080/02699050210128889.

<sup>322</sup> RWTF RW focus group results, November 2012-March 2013.

<sup>323</sup> DoD (December 19, 2011; Rev. December 4, 2012). DoD Directive-Type Memorandum 11-015: Integrated Disability Evaluation System (IDES).

<sup>324</sup> Army WTC (December 1, 2011). Army Warrior Transition Command Policy Memo 11-098: Comprehensive Transition Plan Policy and CTP-Guidance (CTP-G).

<sup>325</sup> Kelly, S. Briefing to the RWTF. Transition Assistance Program Re-Design. April 3, 2013.

<sup>326</sup> Ibid.

<sup>327</sup> Mason, S.R. Office of Warrior Care Policy, personal communication with the RWTF, March 7, 2013.

<sup>328</sup> COL Jones, J., LTC Brusher, E., and Adams, N. Briefing to the RWTF. Additional Questions for Army WTC. February 26, 2013.

<sup>329</sup> Briefing submitted to the RWTF. Air Force Back-up Slides. February 26, 2013.

<sup>330</sup> Briefing submitted to the RWTF. Marine Corps Back-up Slides. February 27, 2013.

<sup>331</sup> Mason, S.R. Office of Warrior Care Policy, personal communication with the RWTF, March 7, 2013.

<sup>332</sup> RWTF family member focus group results, November 2012-March 2013.

<sup>333</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>334</sup> Allen, J., Essex, C., Frost, C., and Ramsey, M. Panel presentation to the RWTF. Recovering Warriors and Family Members. December 5, 2012.

<sup>335</sup> DoD and VA (n.d). DoD-VA Instruction (Draft): Interagency Complex Care Coordination Policy for Service Members and Veterans.

<sup>336</sup> Guice, K. and Riojas, J.D. Briefing to the RWTF. VA-DoD Warrior Care Coordination. April 2, 2013.

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<sup>338</sup> Seymour, D. Briefing to the RWTF. DoD Response to the Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces. April 3, 2013.

<sup>339</sup> Site-level briefings to the RWTF. March/April 2011.

<sup>340</sup> Site briefings to the RWTF, October 2011-March 2012.

<sup>341</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>342</sup> RWTF RW focus group results, November 2012-March 2013.

<sup>343</sup> RWTF RW mini-survey results, November 2012-March 2013.

<sup>344</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>345</sup> Ibid.

<sup>346</sup> Seymour, D. Briefing to the RWTF. DoD Response to the Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces. April 3, 2013.

<sup>347</sup> Site-level briefings to the RWTF. March/April 2011.

<sup>348</sup> Site briefings to the RWTF, October 2011-March 2012.

<sup>349</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>350</sup> RWTF Service member focus group results. March/April 2011.

<sup>351</sup> RWTF RW focus group results, October 2011-March 2012.

<sup>352</sup> RWTF RW focus group results, November 2012-March 2013.

<sup>353</sup> RWTF family member focus group results. March/April 2011.

<sup>354</sup> RWTF family member focus group results, October 2011-March 2012.

<sup>355</sup> RWTF family member focus group results, November 2012-March 2013.

<sup>356</sup> Lt. Keener, J. (n.d.) NMCS D's New Psychological Health Pathways Program. Naval Medical Center San Diego. Retrieved June 17, 2013, from <http://www.med.navy.mil/sites/nmcsd/Pages/News/news-20100525.aspx>

<sup>357</sup> Weinstock, M. (February 6, 2013) Center for Deployment Psychology, staff voices: Q & A on Navy Medicine's Psychological Health Pathways Program. Retrieved June 17, 2013, from <http://deploymentpsych.org/members/education/cdp-blog-content/staff-voices-content/staff-voices-q-a-on-navy-medicine2019s-psychological-health-pathways-pilot-program>

<sup>358</sup> Ibid.

<sup>359</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>360</sup> Ibid.

<sup>361</sup> Ibid.

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<sup>362</sup> Weinstock, M. (February 6, 2013) Center for Deployment Psychology, staff voices: Q & A on Navy Medicine's Psychological Health Pathways Program. Retrieved June 17, 2013, from <http://deploymentpsych.org/members/education/cdp-blog-content/staff-voices-content/staff-voices-q-a-on-navy-medicine2019s-psychological-health-pathways-pilot-program>

<sup>363</sup> Ibid.

<sup>364</sup> Ibid.

<sup>365</sup> Ibid.

<sup>366</sup> Mental Health Research: Hearing before the House Armed Services Committee, Subcommittee on Military Personnel, 113th Cong. (April 10, 2013) (Testimony from VADM Matthew L. Nathan, Surgeon General, U.S. Navy)

<sup>367</sup> BG Bishop, D., LTC Brusher, E., Coffey, R., COL Jones, J., LTC Baker, J., Tuddenham, M., LTC Dudek, D., and Adams, N. Briefing to the RWTF. Army Response to RWTF FY12 Recommendations. February 26, 2013.

<sup>368</sup> Mental Health Research: Hearing before the House Armed Services Committee, Subcommittee on Military Personnel, 113th Cong. (April 10, 2013) (Testimony from LTG Patricia D. Horoho, Surgeon General, U.S. Army).

<sup>369</sup> Ibid.

<sup>370</sup> Medical Operational Data System. Behavioral Health Data Portal. Retrieved June 17, 2013, from <http://www.mods.army.mil/>

<sup>371</sup> Ramirez-Wylie, J A. and Garrett, A. (December 4, 2012). New behavioral health data portal launches patient centered care effort at Fort Leonard Wood. Army.mil. Retrieved June 17, 2013, from <http://www.army.mil/article/92339/>

<sup>372</sup> Ibid.

<sup>373</sup> Army Task Force on Behavioral Health (January 2013). Corrective action plan. Retrieved June 3, 2013, from <http://www.armyg1.army.mil/documents/ATFBH%20Corrective%20Action%20Plan%205%20March%2013.pdf>, p.28.

<sup>374</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>375</sup> North Carolina National Guard Psychological Services Section (February 28, 2013). NCNG Integrated Behavioral Health System Standard Operating Procedures.

<sup>376</sup> Nissen, S.W., Briefing to the RWTF. North Carolina National Guard State Behavioral Health Programs Director. February 28, 2013. (slide 3)

<sup>377</sup> North Carolina National Guard Psychological Services Section (February 28, 2013). NCNG Integrated Behavioral Health System Standard Operating Procedures.

<sup>378</sup> Ibid.

<sup>379</sup> Ibid.

<sup>380</sup> Ibid.

<sup>381</sup> Nissen, S. W., Briefing to the RWTF. North Carolina National Guard State Behavioral Health Programs Director. February 28, 2013.

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<sup>382</sup> North Carolina National Guard Psychological Services Section (February 28, 2013). NCNG Integrated Behavioral Health System Standard Operating Procedures.

<sup>383</sup> Ibid.

<sup>384</sup> Ibid.

<sup>385</sup> Ibid.

<sup>386</sup> Nissen, S. W., Briefing to the RWTF. North Carolina National Guard State Behavioral Health Programs Director. February 28, 2013.

<sup>387</sup> North Carolina National Guard Psychological Services Section (February 28, 2013). NCNG Integrated Behavioral Health System Standard Operating Procedures.

<sup>388</sup> Ibid.

<sup>389</sup> Ibid.

<sup>390</sup> Ibid., page 7.

<sup>391</sup> North Carolina National Guard Psychological Services Section (February 28, 2013). NCNG Integrated Behavioral Health System Standard Operating Procedures.

<sup>392</sup> Ibid.

<sup>393</sup> Ibid.

<sup>394</sup> RWTF RW focus group results, October 2011-March 2012.

<sup>395</sup> RWTF RW focus group results, November 2012-March 2013.

<sup>396</sup> Site briefings to the RWTF, October 2011-March 2012.

<sup>397</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>398</sup> Ibid.

<sup>399</sup> RWTF RW focus group results, November 2012-March 2013.

<sup>400</sup> RWTF Service member focus group results. March/April 2011.

<sup>401</sup> RWTF RW focus group results, October 2011-March 2012.

<sup>402</sup> Site briefings to the RWTF, November 2012-March 2013.

<sup>403</sup> Quist, M.C. Briefing submitted to the RWTF. The Physical Disability Evaluation System (PDES). January 23-24, 2013.

## **ANNEX 1: MEMBER BIOGRAPHIES**



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## **Vice Admiral Matthew L. Nathan, MD**

### **United States Navy**

Vice Admiral Nathan is the 37th Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery.

Nathan received his Bachelor of Science from Georgia Institute of Technology and his Doctor of Medicine from The Medical College of Georgia in 1981. He completed Internal Medicine specialty training in 1984 at the University of South Florida before serving as the Internal Medicine Department Head at Naval Hospital Guantanamo Bay, Cuba. In 1985, Nathan transferred to Naval Hospital, Groton, Connecticut as leader of the Medical Mobilization Amphibious Surgical Support Team. In 1987, Nathan transferred to Naval Medical Center San Diego as Head, Division of Internal Medicine with additional duty to the Marine Corps, 1st Marine Division.

In 1990, he served as a Department Head, Naval Hospital Beaufort, South Carolina before reporting to Naval Clinics Command, London, U.K. where he participated in military-to-military engagements with post-Soviet Eastern European countries. In 1995, he was assigned as Specialist Assignment Officer at the Bureau of Naval Personnel, providing guidance to over 1,500 U.S. Navy Medical Corps officers. In 1998, he accepted a seat at the Joint Industrial College of the Armed Forces located in Washington, D.C., graduating in 1999 with a master's degree in "Resourcing the National Strategy." Nathan went on to serve as the Fleet Surgeon, Forward Deployed Naval Forces, Commander, U.S. 7th Fleet, aboard the flagship USS Blue Ridge (LCC 19), out of Yokosuka, Japan. In 2001, he transferred as Deputy Commander, Navy Medical Center Portsmouth, Va.

In 2004, Nathan assumed command of Naval Hospital Pensacola with additional oversight of 12 clinics in 4 states where he oversaw Navy medical relief efforts following Hurricanes Ivan, Dennis, and Katrina. Despite all facilities receiving crippling blows; his command still garnered the TRICARE/DOD award for "highest patient satisfaction in a medium sized facility". In June 2006, he transferred as the Fleet Surgeon to the Commander, U.S. Fleet Forces Command, instrumental in organizing the Fleet Health Domain integration with the Fleet Readiness Enterprise while providing medical global force management. In 2007, Nathan was assigned as Commander, Naval Medical Center Portsmouth and Navy Medicine Region East with command of over 18,000 personnel and an operating budget exceeding \$1.2 billion.

Nathan also served as Commander, Walter Reed National Military Medical Center and Navy Medicine, National Capital Area where he was the Navy component commander to the largest military medical integration and construction project in Department of Defense history.

Nathan is board certified and holds Fellow status in the American College of Physicians and the American College of Healthcare Executives. He also holds an appointment as Clinical Professor of Medicine at the Uniform Services University of the Health Sciences. He is a recipient of the American Hospital Association "Excellence in Leadership" award for the Federal Sector.

Nathan's personal awards include the Distinguished Service Medal (1); Legion of Merit (5); Meritorious Service Medal (2); Navy Commendation Medal, and Navy Achievement Medal (2).

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## **Mrs. Suzanne Crockett-Jones**

Mrs. Suzanne Crockett-Jones is the wife of Major William Jones (a wounded veteran, retired as of July 2012), and mother of three children. In 2003, while on an unaccompanied tour in Korea, her husband's brigade of the 2nd Division was sent directly to combat operations in Operation Iraqi Freedom. In Iraq, he was severely injured in an ambush not far from Fallujah. During his recovery, her main occupation became "in home nursing care" because his wounds had him restricted to bed rest for weeks, and subsequently confined to a wheelchair for several months.

Although he rejoined his unit as it redeployed to Fort Carson in the fall of 2005 with the intention of returning to company command, his physical recovery had not progressed well enough to allow that. He has been challenged since then to recover from PTSD and physical injuries. Mrs. Crockett-Jones is well versed with the experiences he has had, and also her own perspective on this journey. She has 20 years of experience in customer satisfaction and as a volunteer. Her broad skills in communicating with diverse cultures and age groups has provided her with expertise in solving problems, making independent decisions and adapting quickly to new systems.

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## **Command Sergeant Major Steven D. DeJong**

### **United States Army National Guard**

CSM Steven DeJong is a member of the Indiana National Guard and currently assigned as the Command Sergeant Major of the 2/152 Reconnaissance and Surveillance Squadron located in Columbus, Indiana. On September 9, 2004 he was severely wounded in action during a fire fight in south central Afghanistan and was medically evacuated to the United States for recovery. He recovered from his injuries and returned to Afghanistan in early November that same year.

CSM DeJong was born in Hobart, Indiana in 1975 and joined the Indiana Army National Guard in 1993. His first assignment was as a Stinger Missile gunner with the 1/138th Air Defense Artillery Battalion. He then was assigned by request to the 151st Long Range Surveillance Detachment (LRS-D). During his 13 years assigned to the 151 LRS-D, he attended a wide variety of courses to include: Ranger, Long Range Surveillance Leadership, Pathfinder, basic Airborne and was later the honor graduate of his Jumpmaster class. While assigned to the 151 LRS-D, he was assigned as an assistant recon team leader and later as a recon team leader. In 2004 the LRS-D was deployed to Afghanistan, attached to the 76th Infantry Brigade out of Indianapolis, IN. During this deployment he was assigned as an Embedded Tactical Trainer (ETT) to the Afghanistan National Army in which he and his Afghan company of Soldiers performed combat operations with the 25th Infantry Division and 3rd Special Forces Group.

Upon his return to theatre, (then) SFC DeJong was assigned to the 38th Infantry Division G3 Operations where he was the assistant operations NCO. He was promoted to first sergeant and assigned to C Company, 1/151st Infantry Battalion as the company first sergeant. He and his company deployed in 2007 in support of OIF 07-09, performing convoy security operations in northern Iraq. After returning from Iraq CSM DeJong was assigned as the first sergeant of Headquarters, Headquarters Troop 2/152 Reconnaissance and Surveillance Squadron.

In 2010 CSM DeJong was promoted to sergeant major and was assigned to his current assignment as the Command Sergeant Major of 2/152nd Reconnaissance and Surveillance Squadron. He is a graduate of the United States Army Sergeant Major Academy and is also pursuing a bachelor's degree in fire science and administration. He is a certified firefighter/paramedic in a south suburb of Chicago. CSM DeJong is the recipient of numerous military awards.

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## Mr. Ronald Drach

A Vietnam veteran, Mr. Ronald Drach medically retired from the U.S. Army in 1967, following the amputation of his right leg as a result of combat action. He currently serves on the Board of Directors and is immediate past president of the Wounded Warrior Project, a non-profit organization whose mission is to “honor and empower wounded warriors.”

He was employed by the Department of Labor’s Veterans’ Employment and Training Service (VETS) from April 2002 until his retirement in September 2010. As Director of Government and Legislative Affairs, he was responsible for working with Congressional staff, the Department’s Office of the Solicitor and others within the Department of Labor (DOL) on all veteran’s legislative employment issues that affect the Departments of Labor, Veterans Affairs (VA) and Defense (DoD). Mr. Drach also helped develop and supported the America’s Heroes at Work project, a DOL initiative that addresses the employment needs of veterans with traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD). He served on the Governance Board of the National Resource Directory, a collaborative effort between DoD, VA and DOL which provides access to services and resources at the national, state and local levels that support recovery, rehabilitation and community reintegration.

For 28 years, Mr. Drach worked with the Disabled American Veterans (DAV), 23 of these years as the DAV’s National Employment Director. In this capacity, he was responsible for developing and carrying out DAV’s policies and initiatives (including legislative) relating to employment, vocational rehabilitation, homelessness among veterans, disability issues, and other socio-economic issues affecting veterans. While with DAV his accomplishments included developing DAV’s successful outreach efforts to assist Vietnam veterans experiencing PTSD, homeless veteran initiatives, the Transition Assistance Program to review military medical records for transitioning service members, and a program to provide representation to disabled veterans for disability benefits administered by the Social Security Administration. Mr. Drach is the recipient of numerous military and other awards for his work with disabled veterans.

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## **Technical Sergeant Alex J. Eudy**

### **United States Air Force and Special Operations Command**

Technical Sergeant (TSgt) Alex J. Eudy is the Air Force Special Operations Command (AFSOC) Care Coalition Liaison at Walter Reed National Military Medical Center. His role is to provide Special Operations Forces (SOF) members of all service components with oversight and advocacy through the medical system; from initial point of injury, return to duty, or separation from the armed forces. On January 23, 2009, TSgt Eudy was injured in an IED blast that shattered both of his ankles in Afghanistan. Upon return to the United States, he had multiple extensive surgeries and completed over 8 months of intensive rehabilitation leading to a successful recovery.

TSgt Eudy joined the military right after high school and left for USAF Basic Training in August 2004. An honor graduate of basic training, he then completed the 30 week USAF Weather Forecasting Initial Skills Course at Keesler AFB, Mississippi. His first assignment was Sembach, Germany at the 21st Operational Weather Squadron where he supported operations for USEUCOM, NATO, POTUS and NASA space mission abort landing sites. His main role was to provide resource protection and weather forecasting for military assets throughout the European Theatre. While assigned to Sembach, (then) A1C Eudy was promoted to SrA below the zone and was selected as an Airman of the year nominee for USAFE.

In the summer of 2007, he completed the U.S. Army Basic Static Line Airborne Course at Fort Benning, Georgia followed by the USAF water survival course, helicopter dunker course, and SERE courses (Survival, Evasion, Resistance, and Escape) at Fairchild AFB, Washington. During the fall of 2007, he completed the 10 week Combat Weather Observer Course at Keesler AFB, Mississippi.

In March 2008, (then) SrA Eudy was assigned to the 10th Combat Weather Squadron at Hurlburt Field, Florida. He attended six months of AFSOC's Special Tactics Advance Skills Training. This training was originally reserved for Combat Controllers and Pararescueman but SrA Eudy was one of the first two Special Operations Weather Technicians selected to be immersed in this rigorous training which prepares Battlefield Airman to become SOF operators. Upon completion of training, he joined a pre-deployment train-up and deployed with the 23rd Special Tactics Squadron in the fall of 2008 where he sustained combat-related injuries while working for a Marine Special Operations Team.

After months of recovery, TSgt Eudy returned to Hurlburt Field in July of 2009 to provide administrative and operations support to AFSOC's Special Tactics Units. He was then asked to speak at many military and civic events on special operations and wounded warrior service and recovery.

In March 2010, TSgt Eudy was selected by the AFSOC Command Chief to work as the command's sole liaison for the Special Operations Command Care Coalition. He attended the DOD Recovery Care Coordinator course, numerous non-medical case management courses, and then provided advocacy for SOF members throughout multiple CONUS/OCONUS care facilities. In 2012 TSgt Eudy defied the odds and re-deployed to Afghanistan for six months to manage in-theater US and Coalition Forces SOF warrior care. He considers his current role an honor and is proud to continue to serve the SOF community. TSgt Eudy is the recipient of numerous military awards.

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## **Captain Constance J. Evans, BSN, MHA**

### **United States Navy, Nurse Corps**

Captain (CAPT) Constance J. Evans is the Director, Care, Management, Liaison, Navy Safe Harbor. CAPT Evans completed her undergraduate studies at the University of Southern Mississippi in Hattiesburg. She began her naval career in 1987 and later attained a Masters degree in Healthcare Administration through Central Michigan University.

Following Officer Indoctrination School in Newport, RI, Captain Evans' first assignment was as a Staff Nurse, Medicine-Oncology and Labor and Delivery Units at Naval Medical Center San Diego. Captain Evans transferred to U.S. Naval Hospital Okinawa, Japan and was assigned as a Labor and Delivery Nurse and later as the PM shift Nurse Supervisor. She continued her service at Naval Hospital Jacksonville, FL and was assigned as a Newborn Nursery Nurse, Command Customer Relations Officer, and Division Officer, OB/GYN Clinic.

In a second tour to Okinawa, Japan, she worked as the Community Health Nurse, Risk Manager/Performance Improvement and Patient Education Coordinator. After completion of this tour, she was selected as the Officer in Charge, Naval Aviation Technical Training Center Branch Clinic, Naval Hospital Pensacola. She was recognized for her implementation of Open Access and was later selected as the Senior Nurse for 12 Branch Clinics. During this assignment, she deployed with 3rd Marine Logistics Group to Joint Special Operations Task Force - Philippines where she served as Group Surgeon for 14 Medical Staff. Following Pensacola, she was assigned to U.S. Hospital Naval Rota, Spain, where she served two years as the Deputy Director, Primary Care and one year as the Director, Healthcare Business Operation.

Prior to her current assignment, she served as the Director of the Warrior Family Coordination Cell at Walter Reed National Medical Center and was previously the Director, Hospital Corpsman Knowledge Management, Naval Hospital Corps School, Great Lakes, IL. CAPT Evans is the recipient of numerous military awards.

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## **Lieutenant Colonel Sean P. K. Keane**

### **United State Marine Corps**

Lieutenant Colonel (LtCol) Sean P. K. Keane currently serves as the United States Marine Corps Liaison to Department of Veterans Affairs in Washington, D.C. LtCol Keane graduated from the University of Massachusetts with a degree in Sports Medicine in 1990. He was commissioned a Second Lieutenant in January 1991 aboard the USS Constitution at the Old Boston Navy Yard. Upon completion of The Basic School he attended the Adjutant's course at Camp Johnson, NC and reported to 1st Radio Battalion, at Kaneohe Bay, HI for duty as the Battalion Adjutant. He was promoted to First Lieutenant in January 1993 and transferred to 3d Battalion, 3d Marines in June 1994 where he served as the Battalion Adjutant and Personnel Officer. In June 1995 he was promoted to Captain. He served with Marine Aviation Support Squadron - 6, and attended the Air Support Control Officers' Course in 29 Palms, CA and became a Direct Air Support Control Officer.

LtCol Keane was the last Marine Corps Officer assigned to NAS South Weymouth, while serving as OIC Marine Site Support Element (Rear) during the Base Realignment and Closure of 1996. LtCol Keane also served in Marine Wing Support Squadron - 474 Det B, as the Personnel Officer for the detachment. In December 1999, LtCol Keane transferred to 1st Battalion, 25th Marines to serve as the Battalion Adjutant and Personnel Officer. He was promoted to Major in August 2000. As a Major, he served as the Adjutant to the Deputy Commandant for Plans, Policies and Operations Department, HQMC. In April 2004, he transferred to Intelligence Department, HQMC, Signals Intelligence (SIGINT) Branch, as the assistant Branch Head. In November 2004 he was assigned as the Branch Head for the SIGINT Branch. In September 2005, he was reassigned to the National Security Agency, as the Marine Cryptologic Support Battalion's, Cryptologic Augmentee Program Manager.

LtCol Keane was promoted to his present rank in September 2006, at the Marine Corps War Memorial in Arlington, VA. In 2007, he served as the CJ-1 Director for the Personnel Services Division at CSTC-Afghanistan, at Camp Eggers, Kabul, Afghanistan. In September 2008 LtCol Keane was selected by HQMC to serve on the Chairman of the Joint Chiefs of Staff, Plans and Policy Directorate, J-5 and served as the Chief of the J-5, Director's Action Group. While at the Joint Staff he was directly responsible for the building of both the Chairman's and Vice Chairman's foreign engagement plans. LtCol Keane has been in his present position since December 2010.

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**Colonel Karen T. Malebranche, RN, MSN, CNS**  
**United States Army, Retired**  
**U.S. Department of Veterans Affairs**

COL (Ret.) Karen Malebranche, RN, MSN, CNS, is the Executive Director for Interagency Health Affairs in the Veterans Health Administration at the Department of Veterans Affairs (VA). In this capacity, she is responsible for VHA/DoD collaboration, sharing agreements, OEF/OIF/OND outreach and numerous coordination activities with other national and international agencies on Veteran issues, and policy and services guidance. From September 2007 to January 2009, she was the Executive Director for the Operation Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) Office and served on the Secretary of Veterans Affairs Task Force on the Returning Global War on Terror Heroes. Prior to this, she was the Program Coordinator for Clinical and Case Management in the Office of Seamless Transition and the Chief of the State Home Per Diem Grant Program in the Office of Geriatrics and Extended Care.

COL (Ret.) Malebranche received her civilian undergraduate degree from the University of Portland and her graduate degree from Vanderbilt University in Nashville, TN. She served 31 years in the U.S. Army as an active duty soldier, nurse, senior health systems analyst, program manager, and in various clinical and administrative roles. COL (Ret.) Malebranche is a graduate of the Army Command and General Staff College.

She came to VA after her last active duty assignment in the Office of the Secretary of Defense for Health Affairs, where she was the Director of the Programs and Benefits Directorate at the TRICARE Management Activity. Previous assignments include: Chief, Coordinated Care/TRICARE Division, U.S. Army Medical Command, and Ft. Sam Houston/Office of the Surgeon General; Chief Nurse, Joint Task Force (JTF) Bravo, Honduras; Ft. Campbell; Ft. Rucker; Ft. Ord; Ft. Gordon; Hawaii; and Korea. She has presented at numerous conferences on managed care, resource management, case/care management, and TRICARE. She served as the Chairperson-elect at the National Association of State Veteran Homes and as consultant on the Board of the Armed Forces Veterans Home Foundation. She currently is on the Advisory Board for the first Federal Healthcare facility for the James A. Lovell Federal Health Care Center in North Chicago, co chairs the care and collaboration workgroup for the VA Women Veteran Task Force, and co chairs the governance and policy tiger team on the DoD/VA Wounded Warrior Care and Coordination Task Force. COL (Ret.) Malebranche has worked on numerous VA/DoD initiatives that have greatly enhanced services for Service Members, Veterans, and their families.

COL (Ret.) Malebranche has received numerous military and civilian awards for her service as a soldier and an advanced practice nurse.

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## **Major General Richard P. Mustion**

### **United States Army**

Major General (MG) Richard P. Mustion is the Commander of the U.S. Army Human Resources Command located in Fort Knox, Kentucky. A native of Waynesville, Missouri, MG Mustion was commissioned in the Adjutant General's Corps through the Reserve Officer Training Program (ROTC) at Central Missouri State University in Warrensburg, Missouri in May 1981.

MG Mustion has served in command and staff positions in the continental United States, Germany, Korea and Iraq with the 1st Infantry Division (Mechanized), 2nd Armored Division (Forward), 2nd Armored Division, 4th Infantry Division, III U.S. Corps, 2nd U.S. Army, Eighth U.S. Army, U.S. Army Training and Doctrine Command, U.S. Army Human Resources Command, Department of the Army, Office of the Secretary of Defense and the Multi-National Force-Iraq.

His key assignments include: command of Company D, 498th Support Battalion, the 1st Personnel Services Company, the 502nd Personnel Services Battalion and the 8th Personnel Command; Deputy G1/AG, 2nd Armored Division (Forward) and 1st Infantry Division; Army Chief of Staff, G1/AG, 4th Infantry Division; Reserve Component Advisor, 2nd Army; Combat Service Support and Force Integration Officer, Force XXI Experimental Force Coordination Cell; Recorder, DA Secretariat for Officer Selection Boards; Personnel Policy Staff Officer, and Director, Army G-1 Strategic Initiatives Group; Adjutant General for U.S. Forces Korea and Eighth U.S. Army; Military Assistant to the Under Secretary of Defense for Personnel and Readiness; C1, Director of Personnel, Multi-National Forces-Iraq; Commandant of the Adjutant General School, Chief of the Adjutant General Corps, and Chief, Army Bands; Commanding General, U.S. Army Soldier Support Institute; 64th Adjutant General of the U.S. Army; and, he last served as the Director of Military Personnel Management, Deputy Chief of Staff, G-1. MG Mustion assumed command of the U.S. Army Human Resources Command on August 10, 2012.

MG Mustion is a graduate of the Adjutant General's Corps Officer basic and Advance courses, Combined Arms Staff Services School, Command and General Staff College and the Army War College. He holds a Master of Arts in Public Administration and a Master of National Strategic Studies. MG Mustion is the recipient of numerous military awards.

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**Lieutenant Colonel Steven J. Phillips, MD**  
**United States Army Reserve, Retired**  
**U.S. Department of Health and Human Services**

Steven J. Phillips, M.D. is the Director for Specialized Information Services and Associate Director for the National Library of Medicine (NLM), National Institutes of Health (NIH), U.S. Department of Health & Human Services. He is leading the effort to establish a Disaster Information Management Research Center at the NLM. This Center, totally devoted to disaster informatics, is the first of its kind in the world.

Dr. Phillips is a graduate of Hobart College and Tufts Medical School. He is board certified both in general and thoracic surgery. In 1974, Dr. Phillips demonstrated that emergency intervention during evolving heart attacks saves lives, which is the standard treatment today.

In 1997, Dr. Phillips was interviewed by the White House search committee for the position of Commissioner of the Food and Drug Administration and testified before the Full Committee on Commerce as a witness on the Implementation of the Food and Drug Administration Modernization Act of 1997.

Dr. Phillips served twice in Vietnam and retired from the U.S. Army Reserves as a Lieutenant Colonel in 1993. He is on the Board of the Vietnam Veterans Memorial Reception Center, and serves as a member of a Congressionally-mandated Wounded Warrior Task Force. His security clearance is top secret.

Dr. Phillips is the past president of the American Society for Artificial Internal Organs, Society of Cardiac Surgeons of Spain, and the Polk County Medical Society in Iowa. He has approximately 300 publications with 125 in peer reviewed medical journals, and he has been granted 6 patents.

He is married to Susan Zeff Phillips. They have 5 children and 7 grandchildren.

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## David K. Rehbein, MS

Mr. David K. Rehbein has served a dual career with his professional life being spent in the research field specializing in solid state physics and materials science and his personal life heavily involved in veterans service and issues through The American Legion. Mr. Rehbein is a US Army veteran with service in Germany from 1970-71 with separation at the rank of Sergeant, E-5.

Mr. Rehbein's 36 years of volunteer work in The American Legion resulted in his election to spend a year of service as the National Commander of the 2.7 million member organization. His leadership roles in that organization include service on the National Board of Directors and chairmanship duties on three major commissions including Veterans Affairs and Legislation and several special high-level committees.

In Iowa, Mr. Rehbein received gubernatorial appointments to two terms on the Iowa Commission of Veterans Affairs overseeing the Department of Veterans Affairs and the 650 resident Iowa Veterans Home. He holds a Bachelor of Science in Physics and Master of Science in Metallurgy from Iowa State University and spent 30 years as a research scientist at the Ames Laboratory, US Department of Energy. He is the author of 75 published scientific papers and one patent. His career included work on many unique problems including aging aircraft, nuclear waste storage, space shuttle fuel tanks, high strength bonds for aircraft turbine blades and robotic inspection. Mr. Rehbein brings a unique blend of knowledge of veterans and military health issues and a set of problem-solving and evaluation skills developed through years in a scientific research environment.

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## **Major General Richard A. Stone, MD**

### **United States Army Reserve**

Major General (MG) Richard A. Stone, M.D. is currently serving as the U.S. Army Deputy Surgeon General. Before this selection, MG Stone served as the Deputy Surgeon General for Mobilization, Readiness, and Reserve Affairs from March 2009 to June 2011. From October 2005 to March 2009, he served simultaneously as the Commanding General, Medical Readiness and Training Command in San Antonio, TX, and as Deputy Commander for Administration for the 3rd Medical Command in Forest Park, GA. He also serves as the chairman of the Army Reserve Force Policy Committee.

MG Stone is a graduate of Western Michigan University where he received a Bachelor of Science degree in Biology in 1973. He graduated from the Wayne State University Medical School and earned his degree in Medicine in 1977. He completed his internship in internal medicine and residency in Dermatology at Wayne State University, Detroit, MI, from 1977 to 1981, and is certified by the American Board of Dermatology. His military education includes completion of the AMEDD Officer Basic and Advanced Courses, Command and General Staff College, and the U.S. Army War College.

MG Stone was directly commissioned in the Medical Corps in 1991 and has held assignments in the Army Reserve as a dermatologist, 323d General Hospital, 1991–1994; Commander, Hospital Unit Surgical, 323d General Hospital, 1994–1997; Commander, 948th Forward Surgical Team, 1997–2001; and Commander, 452d Combat Support Hospital 2001–2005. While serving as the 452d Combat Support Hospital Commander, MG Stone deployed to Bagram Airfield, Afghanistan, and subsequently was selected to serve as Commander, Task Force 44 Medical (Forward) in 2003–2004, a multinational medical task force of more than 1,000 medical service members from four nations. During this time, he simultaneously served as the Task Force 180 Command Surgeon. MG Stone is the recipient of numerous military awards.

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**Colonel Russell A. Turner, MD**  
**United States Air Force, Retired**

Dr. Russell A. Turner brings to the Task Force 30 years of leadership at all levels of family practice, flight and occupational medicine, and primary medical care, along with a strong background in medical systems. In 2005, as the commander of a deployed wartime hospital in Iraq he commanded the busiest multi-force, multi-national trauma hospital in Iraq in support of combat operations north of Baghdad. Additional military experience includes delivery of medical care and disability determination as a clinical family practice physician and a primary care clinic manager.

In the civilian sector, Dr. Turner developed and managed San Antonio city-wide outpatient medical and dental care systems coordinating military and civilian care providers for 36,000 patients. With a focus specialty in medical industry and informatics, Dr. Turner's expertise extends to surveying electronic medical records, coding and syndrome surveillance for detection of disease patterns.

Dr. Turner has completed a postgraduate degree at the highest level in the Department of Defense for strategic program acquisition, funding and resource planning. Additionally, he led a 10-year planning and management effort for medical modernization for an Air Force system of 16 hospitals and clinics plus all overseas deployed forces. Dr. Turner is a disabled veteran, and currently owns a small business that provides medical consultant services. Dr. Turner is the recipient of numerous military awards.

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**Justin A. Constantine, JD**  
**(January 2011 to June 2013)**

Justin Constantine graduated from James Madison University in 1992 with a double major in English and Political Science and a minor in German. He graduated from the University of Denver School of Law in 1998, and joined the U.S. Marine Corps after his second year of law school.

As a Marine Reservist, Justin volunteered for deployment to Iraq in 2006, and served in al-Anbar Province as a Team Leader of a group of Marines performing civil affairs work while attached to an infantry battalion. While on a routine combat patrol, Justin was shot in the head by a sniper. Although the original prognosis was that he had been killed in action, Justin survived. Through teamwork and a positive mental attitude, he has had quite a successful recovery. His personal awards from his time in Iraq include the Purple Heart, Combat Action Ribbon, and Navy-Marine Corps Commendation Medal.

In 2009, Justin was the Honor Graduate of his class at the Marine Corps Command and Staff College, and was recently promoted to Lieutenant Colonel in the Marine Corps Reserve. In early 2011, Justin started a job with the Federal Bureau of Investigation working as an attorney on a counterterrorism team. He serves on the Board of Directors of the Wounded Warrior Project, Give An Hour, and SemperMax. In addition, Justin began the Master of Laws (LLM) program at Georgetown University in the Fall of 2012. Based on his remarkable recovery and continued advocacy for veterans, Justin has also received significant recognition from the White House, the Commonwealth of Virginia, the Washington Redskins and James Madison University.

Mr. Constantine recently started his own business as an Inspirational Speaker - over the last several years he has spoken at numerous corporate, military and educational events about the value of a positive attitude, teamwork and community values in overcoming adversity. Justin has also been featured in magazines and programs such as CNN, Fox News, Men's Health, the Huffington Post, the Atlantic, and the Department of Labor's America's Heroes at Work Success Stories.

## **ANNEX 2: ACRONYM LISTING**



## Acronyms Used in Report

Acronym	Meaning of Acronym
ABHTF	Army Behavioral Health Task Force (ABHTF)
AC	Active Component
AD	Active Duty
AF	Air Force
AFB	Air Force Base
AFI	Air Force Instruction
AFW2	Air Force Wounded Warrior
AHLTA	Armed Forces Health Longitudinal Technology Application
ANG	Air National Guard
AMEDD	Army Medical Department
ARNG	Army National Guard
ASD(HA)	Assistant Secretary of Defense for Health Affairs
AW2	Army Wounded Warrior
CAPT	Captain
CAT	Category
CBWTU	Community-Based Warrior Transition Unit
CDP	Center for Deployment Psychology
CDR	Commander
CFR	Code of Federal Regulations
CISM	Critical Incident Stress Management
COL, Col, Col.	Colonel
CMSgt	Command Master Sergeant
CNS	Clinical Nurse Specialist
CPT	Cognitive Processing Therapy
CSTS	Center for the Study of Traumatic Stress
CTP	Comprehensive Transition Plan
DCoE	Defense Centers of Excellence
DCoE PH & TBI	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DEERS	Defense Eligibility Enrollment Reporting System
DES	Disability Evaluation System
DISCs	District Injured Support Coordinators
DMDC	Defense Manpower Data Center
DoD	Department of Defense
DoDD	DoD Directive
DoDI	DoD Instruction
DPH	Director of Psychological Health

<b>Acronym</b>	<b>Meaning of Acronym</b>
DTM	Directive-Type Memorandum
DWMMC	Deployed Warrior Medical Management Center
E2I	Education and Employment Initiative
EACE	Extremity Injury and Amputation Center of Excellence
EHR	Electronic Health Record
FAC	Family Assistance Center
FPEB	Formal Physical Evaluation Board
FRAGO	Fragmentary Order
FY	Fiscal Year
GAF	Global Assessment of Functioning
GAO	Government Accountability Office
HCE	Hearing Center of Excellence
HIPAA	Health Insurance Portability and Accountability Act
HQDA	Headquarters Department of Army
IBHS	Integrated Behavioral Health System
ICF	ICF International
IDES	Integrated Disability Evaluation System
IEHR	Individual Electronic Health Record
IFAKs	Individual First Aid Kits
IPEB	Informal Physical Evaluation Board
IPO	Interagency Program Office
ITO	Invitational Travel Orders
JBER	Joint Base Elmendorf Richardson
JEC	Joint Executive Council
JFHQ	Joint Forces Headquarters
JFSAP	Joint Family Support Assistance Program
JFTR	Joint Federal Travel Regulation
LDDES	Legacy Disability Evaluation System
LOD	Line of Duty
LRMC	Landstuhl Regional Medical Center
LT	Lieutenant
MC&FP	Military Community and Family Policy
MCCM	Medical Care Case Manager
MCCS	Marine Corps Community Services
M.D.	Medical Doctor
MEB	Medical Evaluation Board
MEDCOM	Medical Command
MEDHOLD	Medical Hold
MFLC	Military Family Life Consultants
MG	Major General

<b>Acronym</b>	<b>Meaning of Acronym</b>
MH	Mental Health
MHS	Military Health System
MOS	Military OneSource
MSC	Military Service Coordinator
MSgt	Master Sergeant
MSN	Master of Science in Nursing
MTF	Military Treatment Facility
NARSUM	Narrative Summary
NCMs	Nurse Case Managers
NCNG	North Carolina National Guard
NGB	National Guard Bureau
NICoE	National Intrepid Center of Excellence
NMA	Non-Medical Attendant
NMCM	Non-Medical Case Manager
NMCSD	Naval Medical Center San Diego
NMFA	National Military Family Association
No.	Number
NOSC	Navy Operational Support Center
NRD	National Resource Directory
NWW-SH	Navy Wounded Warrior-Safe Harbor
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
OASD(R&FM)	Office of the Assistant Secretary of Defense for Readiness and Force Management
OASD(RA)	Office of the Assistant Secretary of Defense for Reserve Affairs
ODASD(WCP)	Deputy Assistant Secretary of Defense for Warrior Care
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OND	Operation New Dawn
OSD	Office of the Secretary of Defense
OUSD(P&R)	Office of the Under Secretary of Defense for Personnel and Readiness
OWF	Operation Warfighter
PDHRA	Post Deployment Health Reassessment
PDRL	Permanent Disability Retirement List
PEB	Physical Evaluation Board
PEBLO	Physical Evaluation Board Liaison Officer
PH	Psychological Health
PhD	Doctor of Philosophy
PHP	Psychological Health Pathways
PTSD	Posttraumatic Stress Disorder
Pub. L.	Public Law

<b>Acronym</b>	<b>Meaning of Acronym</b>
RA	Reserve Affairs
RC	Reserve Component
RCC	Recovery Care Coordinator
REFRAD	Released From Active Duty
Ret.	Retired
RTD	Return to Duty
RWs	Recovering Warriors
RWTF	Recovering Warrior Task Force
SCAADL	Special Compensation for Assistance with the Activities of Daily Living
SecDef	Secretary of Defense
SECNAV	Secretary of the Navy
SGT	Sergeant
Stat.	Statute
TAP	Transition Assistance Program
TAMP	Transitional Assistance Medical Program
TBI	Traumatic Brain Injury
TDRL	Temporary Disabled/Retired List
TSGLI	Service Members' Group Life Insurance Traumatic Injury Protection
USA	United States Army
USAF	United States Air Force
USAR	United States Army Reserve
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USMC	United States Marine Corps
USMCR	United States Marine Corps Reserve
USN	United States Navy
USSOCOM	United States Special Operations Command
VA	Department of Veterans Affairs
VASRD	Veterans Administration Schedule for Rating Disabilities
VBA	Veterans Benefits Administration
VCE	Vision Center of Excellence
VR&E	Vocational Rehabilitation and Employment
VTA	Veterans Tracking Application
VTC	Video Teleconferences
WCP	Office of Warrior Care Policy
WII	Wounded, Ill, and Injured
WRNMMC	Walter Reed National Military Medical Center
WTB	Warrior Transition Battalion
WTC	Warrior Transition Command
WTU	Warrior Transition Unit

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<b>Acronym</b>	<b>Meaning of Acronym</b>
WWCTP	Wounded Warrior Care and Transition Policy
WWR	Wounded Warrior Regiment
WWRC	Wounded Warrior Resource Center



## **APPENDIX A: LEGISLATION**



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**111 P.L. 84, \*; 123 Stat. 2190;  
2009 Enacted H.R. 2647**

**[\*724] Sec. 724. Department of Defense Task Force on the Care,  
Management, and Transition of Recovering Wounded, Ill, and Injured Members  
of the Armed Forces.**

(a) Establishment.--

(1) In general.-- The Secretary of Defense shall establish within the Department of Defense a task force to be known as the “Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces” (in this section referred to as the “Task Force”).

(2) Purpose.-- The purpose of the Task Force shall be to assess the effectiveness of the policies and programs developed and implemented by the Department of Defense, and by each of the military departments, to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces, and to make recommendations for the continuous improvement of such policies and programs.

(3) Relation to senior oversight committee.-- The Secretary shall ensure that the Task Force is independent of the Senior Oversight Committee (as defined in section 726(c) of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110-417; 122 Stat. 4509)).

(b) Composition.--

(1) Members.-- The Task Force shall consist of not more than 14 members, appointed by the Secretary of Defense from among the individuals as described in paragraph (2).

(2) Covered individuals.-- The individuals appointed to the Task Force shall include the following:

(A) At least one member of each of the regular components of the Army, the Navy, the Air Force, and the Marine Corps.

(B) One member of the National Guard.

(C) One member of a reserve component of the Armed Forces other than National Guard.

(D) A number of persons from outside the Department of Defense equal to the total number of personnel from within the Department of Defense (whether members of the Armed Forces or civilian personnel) who are appointed to the Task Force.

(E) Persons who have experience in--

(i) medical care and coordination for wounded, ill, and injured members of the Armed Forces;

(ii) medical case management;

(iii) non-medical case management;

(iv) the disability evaluation process for members of the Armed Forces;

(v) veterans benefits;

(vi) treatment of traumatic brain injury and post-traumatic stress disorder;

- 
- (vii) family support;
  - (viii) medical research;
  - (ix) vocational rehabilitation; or
  - (x) disability benefits.

(F) At least one family member of a wounded, ill, or injured member of the Armed Forces or veteran who has experience working with wounded, ill, and injured members of the Armed Forces or their families.

(3) Individuals appointed from within department of defense.-- At least one of the individuals appointed to the Task Force from within the Department of Defense shall be the surgeon general of an Armed Force.

(4) Individuals appointed from outside department of defense.-- The individuals appointed to the Task Force from outside the Department of Defense--

(A) with the concurrence of the Secretary of Veterans Affairs, shall include an officer or employee of the Department of Veterans Affairs; and

(B) may include individuals from other departments or agencies of the Federal Government, from State and local agencies, or from the private sector.

(5) Deadline for appointments.-- All original appointments to the Task Force shall be made not later than 120 days after the date of the enactment of this Act.

(6) Co-chairs.-- There shall be two co-chairs of the Task Force. One of the co-chairs shall be designated by the Secretary of Defense at the time of appointment from among the individuals appointed to the Task Force from within the Department of Defense. The other co-chair shall be selected from among the individuals appointed from outside the Department of Defense by those individuals.

(c) Annual Report.--

(1) In general.-- Not later than 12 months after the date on which all members of the Task Force have been appointed, and each year thereafter for the life of the Task Force, the Task Force shall submit to the Secretary of Defense a report on the activities of the Task Force and the activities of the Department of Defense and the military departments to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces. The report shall include the following:

(A) The findings and conclusions of the Task Force as a result of its assessment of the effectiveness of the policies and programs developed and implemented by the Department of Defense, and by each of the military departments, to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces.

(B) A description of best practices and various ways in which the Department of Defense and the military departments could more effectively address matters relating to the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces, including members of the regular components, and members of the reserve components, and support for their families.

(C) A plan for the activities of the Task Force in the year following the year covered by the report.

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(D) Such recommendations for other legislative or administrative action as the Task Force considers appropriate for measures to improve the policies and programs described in subparagraph (A).

(2) Methodology.-- For purposes of the reports, the Task Force--

(A) shall conduct site visits and interviews as the Task Force considers appropriate;

(B) may consider the findings and recommendations of previous reviews and evaluations of the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces; and

(C) may use such other means for directly obtaining information relating to the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces as the Task Force considers appropriate.

(3) Matters to be reviewed and assessed.-- For purposes of the reports, the Task Force shall review and assess the following:

(A) Case management, including the numbers and types of medical and non-medical case managers (including Federal Recovery Coordinators, Recovery Care Coordinators, National Guard or Reserve case managers, and other case managers) assigned to recovering wounded, ill, and injured members of the Armed Forces, the training provided such case managers, and the effectiveness of such case managers in providing care and support to recovering wounded, ill, and injured members of the Armed Forces.

(B) Staffing of Army Warrior Transition Units, Marine Corps Wounded Warrior Regiments, Navy and Air Force Medical Hold or Medical Holdover Units, and other service-related programs or units for recovering wounded, ill, and injured members of the Armed Forces, including the use of applicable hiring authorities to ensure the proper staffing of such programs and units.

(C) The establishment and effectiveness of performance and accountability standards for warrior transition units and programs.

(D) The availability of services for traumatic brain injury and post traumatic stress disorder.

(E) The establishment and effectiveness of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, and the centers of excellence for military eye injuries, hearing loss and auditory system injuries, and traumatic extremity injuries and amputations.

(F) The effectiveness of the Interagency Program Office in achieving fully interoperable electronic health records by September 30, 2009, in accordance with section 1635 of the Wounded Warrior Act (title XVI of Public Law 110-181; 122 Stat. 460; 10 U.S.C. 1071 note).

(G) The effectiveness of wounded warrior information resources, including the Wounded Warrior Resource Center, the National Resource Directory, Military OneSource, Family Assistance Centers, and Service hotlines, in providing meaningful information for recovering wounded, ill, and injured members of the Armed Forces.

(H) The support available to family caregivers of recovering wounded, ill, and injured members of the Armed Forces.

(I) The legal support available to recovering wounded, ill, and injured members of the Armed Forces and their families.

(J) The availability of vocational training for recovering wounded, ill, and injured members of the Armed Forces seeking to transition to civilian life.

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(K) The effectiveness of any measures under pilot programs to improve or enhance the military disability evaluation system.

(L) The support and assistance provided to recovering wounded, ill, and injured members of the Armed Forces as they progress through the military disability evaluation system.

(M) The support systems in place to ease the transition of recovering wounded, ill, and injured members of the Armed Forces from the Department of Defense to the Department of Veterans Affairs.

(N) Interagency matters affecting recovering wounded, ill, and injured members of the Armed Forces in their transition to civilian life.

(O) The effectiveness of the Senior Oversight Committee in facilitating and overseeing collaboration between the Department of Defense and the Department of Veterans Affairs on matters relating to the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces.

(P) Overall coordination between the Department of Defense and the Department of Veterans Affairs on the matters specified in this paragraph.

(Q) Such other matters as the Task Force considers appropriate in connection with the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces.

(4) Transmittal.-- Not later than 90 days after receipt of a report required by paragraph (1), the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives the report and the Secretary's evaluation of the report.

(d) Plan Required.--Not later than six months after the receipt of a report under subsection (c), the Secretary of Defense shall, in consultation with the Secretaries of the military departments, submit to the Committees on Armed Services of the Senate and the House of Representatives a plan to implement the recommendations of the Task Force included in the report.

(e) Administrative Matters.--

(1) Compensation.-- Each member of the Task Force who is a member of the Armed Forces or a civilian officer or employee of the United States shall serve on the Task Force without compensation (other than compensation to which entitled as a member of the Armed Forces or an officer or employee of the United States, as the case may be). Other members of the Task Force shall be appointed in accordance with, and subject to, the provisions of section 3161 of title 5, United States Code.

(2) Oversight.-- The Under Secretary of Defense for Personnel and Readiness shall oversee the Task Force. The Washington Headquarters Services of the Department of Defense shall provide the Task Force with personnel, facilities, and other administrative support as necessary for the performance of the duties of the Task Force.

(3) Visits to military facilities.-- Any visit by the Task Force to a military installation or facility shall be undertaken through the Deputy Under Secretary of Defense for Personnel and Readiness, in coordination with the Secretaries of the military departments.

(f) Termination.--The Task Force shall terminate on the date that is five years after the date of the enactment of this Act.

## **APPENDIX B: CHARTER**



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## Charter

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

1. Committee's Official Designation: The Committee shall be known as the Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces (hereafter referred to as "the Task Force").
2. Authority: The Secretary of Defense, under the provisions of section 724 of Public Law 111-84, the Federal Advisory Committee Act of 1972 (5 U.S.C., Appendix 2), and 41 CFR § 102-3.50(a), established the Task Force.

Pursuant to section 724(a)(3), the Secretary of Defense shall ensure that the Task Force's work is independent of the Senior Oversight Committee, as defined by section 726(c) of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110-417; 122 Stat. 4509).

3. Objectives and Scope of Activities: The Task Force shall: (a) assess the effectiveness of the policies and programs developed and implemented by the Department of Defense, and by each of the Military Departments to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces; and (b) make recommendations for the continuous improvements of such policies and programs.
4. Description of Duties: The Task Force, pursuant to section 724(c) of Public Law 111-84, shall no later than 12 months after the date on which all Task Force members have been appointed, and each year thereafter for the life of the Task Force, shall submit a report to the Secretary of Defense.

The Task Force shall submit to the Secretary of Defense a report on the activities of the Task Force, and on the activities of the Department of Defense, to include the Military Departments, to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces. As a minimum, the Task Force's report shall include the following:

- a. The Task Force's findings and conclusions as a result of its assessment of the effectiveness of developed and implemented DoD policies and programs, to include those by the Military Departments, to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces.
- b. A description of best practices and various ways in which the Department of Defense, to include the Military Departments, could more effectively address matters relating to the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces, including members of the Regular and Reserve Components and support for their families.
- c. A plan listing and describing the Task Force's activities for the upcoming year.
- d. Such recommendations for other legislative or administrative action that the Task Force considers appropriate for measures to improve DoD-wide policies and programs that assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces.

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The Task Force, for the purposes of its reports, shall fully comply with sections 724(c)(2) and (3) of Public Law 111-84 in all matters dealing with the report's: (a) methodology; and (b) matters to be reviewed and assessed.

No later than 90 days after receiving the Task Force's report, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives the report and the Secretary's evaluation of the report.

No later than six months after receiving the Task Force's report, the Secretary of Defense, in consultation with the Secretaries of the Military Departments, shall submit to the Committees on Armed Services of the Senate and the House of Representatives a plan to implement the recommendations of the Task Force's annual report.

5. Agency or Official to Whom the Committee Reports: Pursuant to section 724(c) of Public Law 111-84, the Task Force reports its independent findings, advice and recommendations to the Secretary of Defense.
6. Support: The Department of Defense, through the Office of the Under Secretary of Defense for Personnel and Readiness and the Office of the Director of Administration and Management, shall provide support as deemed necessary for the performance of the Task Force's functions, and shall ensure compliance with the requirements of the Federal Advisory Committee Act.

Upon request by the Task Force's co-chairs and in consultation with the Deputy Under Secretary of Defense for Personnel and Readiness, any department or agency of the Federal Government, to include DoD Federally Funded Research and Development Centers, may provide information that the Task Force considers necessary to carry out its duties.

Any Task Force visit to a military installation or facility shall be undertaken through the Deputy Under Secretary of Defense for Personnel and Readiness, in consultation with the appropriate the Secretary of the Military Departments.

7. Estimated Annual Operating Costs and Staff Years: It is estimated that the annual operating costs, to include travel and contract support is approximately \$5,000,000.00. The estimated annual DoD personnel costs are 25.0 full-time equivalents (FTE).
8. Designated Federal Officer: The Designated Federal Officer, pursuant to DoD policy, shall be a full-time or permanent part-time DoD employee, and shall be appointed in accordance with established DoD policies and procedures.

In addition, the Designated Federal Officer is required to be in attendance at all Task Force and subcommittee meetings; however, in the absence of the Designated Federal Officer, the Alternate Designated Federal Officer shall attend the meeting.

9. Estimated Number and Frequency of Meetings: The Task Force shall meet at the call of the Task Force's Designated Federal Officer, in consultation with the co-chairs. The estimated number of Panel meetings is five (5) per year.
10. Duration: The need for this advisory function, unless extended by Act of Congress, is for five years; however this Charter is subject to renewal every two years.

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11. **Termination:** Unless otherwise extended by Act of Congress, the Task Force, pursuant to section 724(f) of Public Law 111-84, terminates no later than October 27, 2014.

12. **Membership and Designation:** The Task Force, pursuant to section 724(b) of Public Law 111-84, shall be comprised of not more than 14 members appointed by the Secretary of Defense.

Pursuant to 724(b)(2) of Public Law 111-84, the Secretary of Defense shall appoint:

- a. At least one member of each of the Regular Components of the Army, the Navy, the Air Force and the Marine Corps;
- b. One member of the National Guard;
- c. One member of a Reserve Component of the Armed Forces other than the National Guard;
- d. At least one family member of a wounded, ill, or injured member of the Armed Forces or veteran who has experience working with wounded, ill, and injured members of the Armed Forces or their families; and
- e. A number of person from outside the Department o Defense equal to the total number of personnel from within the Department of Defense (whether members of the Armed Forces or civilian personnel) who are appointed to the Task Force.

Sections 724(b)(2) through (4) of Public Law 111-84, further stipulate the following Task Force appointment requirements:

- a. At least one individual appointed to the Task Force from within the Department of Defense shall be the Surgeon General of an Armed Force.
- b. The individuals appointed to the Task Force from outside the Department of Defense –
  - i. With the concurrence of the Secretary of Veterans Affairs, shall include an officer or employee of the Department of Veterans Affairs; and
  - ii. May include individuals from other departments or agencies of the Federal Government, from State and local agencies, or from the private sector.
- c. Persons appointed to the Task Force shall have experience in –
  - i. Medical care and coordination for wounded, ill, and injured members of the Armed Forces;
  - ii. Medical case management;
  - iii. Non-medical case management;
  - iv. The disability evaluation process for members of the Armed Forces;
  - v. Veterans benefits;
  - vi. Treatment of traumatic brain injury and post-traumatic stress disorder;
  - vii. Family support;
  - viii. Medical research;
  - ix. Vocational rehabilitation; or
  - x. Disability benefits.

There shall be two co-chairs of the Task Force. One of the co-chairs shall be designated by the Secretary of Defense at the time of appointment from among the individuals appointed to the Task Force from within the Department of Defense. The other co-chair shall be selected from among the individuals appointed from outside the Department of Defense by those individuals.

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Pursuant to sections 724(e)(1) of Public Law 111-84, Task Force members who are members of the Armed Forces or a civilian officer or employee of the United States shall serve on the Task Force without compensation (other than compensation to which entitled as a member of the Armed Forces or an officer or employee of the United States, as the case may be).

Other Task Force members shall be appointed in accordance with, and subject to, the provisions of 5 U.S.C. § 3161 and shall be compensated. These individuals shall serve as special government employees, and they shall not be considered full-time or permanent part-time officers or employees of the Federal Government for the purpose of determining the applicability of the Federal Advisory Committee Act of 1972.

All Task Force members shall be appointed for the duration of the Task Force. In the event of a vacancy on the Task Force the individual appointed to fill that vacancy shall be appointed by the same officer (or the officer's successor) who made the appointment to the seat when the Task Force was first established.

All Task Force members shall receive travel and per diem for official Task Force travel.

13. Subcommittees: With DoD approval, the Task Force is authorized to establish subcommittees, as necessary and consistent with its mission. These subcommittees or working groups shall operate under the provisions of the Federal Advisory Committee Act of 1972, the Government in the Sunshine Act of 1976 (5 U.S.C. § 552b), and other governing Federal regulations.

Such subcommittees or workgroups shall not work independently of the chartered Task Force, and shall report all their recommendations and advice to the Task Force for full deliberation and discussion. Subcommittees or workgroups have no authority to make decisions on behalf of the chartered Task Force; nor can they report directly to the Department of Defense or any Federal officers or employees who are not Task Force members.

Subcommittee members, who are not Task Force members, shall be appointed in the same manner as Task Force members.

14. Recordkeeping: The records of the Task Force and its subcommittees shall be handled according to section 2, General Record Schedule 26 and governing Department of Defense policies and procedures. These records shall be available for public inspection and copying, subject to the Freedom of Information Act of 1966 (5 U.S.C. § 552, as amended).
15. Filing Date: 18 November 2010

## **APPENDIX C: REFERENCE HANDBOOK**



*DEPARTMENT OF DEFENSE TASK FORCE ON THE CARE,  
MANAGEMENT, AND TRANSITION OF RECOVERING WOUNDED, ILL,  
AND INJURED MEMBERS OF THE ARMED FORCES*



**Reference Handbook of Key Topics and Terms**

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**Updated January 2013**

Including updates from NDAA 2013

Recovering Warrior Task Force  
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*DEPARTMENT OF DEFENSE TASK FORCE  
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This Reference Handbook was prepared for Members of the Recovering Warrior Task Force (RWTF) as a primer on specific matters that Congress charged the RWTF to address. Consisting of 15 separate information papers and an acronym glossary, the handbook is intended to provide a baseline familiarity across a wide array of initiatives undertaken on behalf of Recovering Warriors (RWs). The handbook also is intended to promote the RWTF Members' fluency with terms and acronyms associated with these initiatives. (For purposes of this handbook, the term "recovering warrior" is synonymous with "wounded warrior," "recovering wounded, ill, and injured Service member;" "recovering Service member;" and "wounded, ill, and injured Service (WII) member.")

As directed by Section 724 of the 2010 National Defense Authorization Act (NDAA), the RWTF will assess the effectiveness of the policies and programs developed and implemented by the Office of the Secretary of Defense (OSD) and each of the military departments (hereafter referred to collectively in this handbook as the "Department") to assist and support the care, management, and transition of recovering WII members of the Armed Forces, and to make recommendations for the continuous improvement of corresponding policies and programs. The RWTF provides an invaluable service to the Department and, as an independent body of advisors, was formed to evaluate, provide expert advice, and give recommendations on the policies and programs within the Department that affect wounded warriors. The RWTF's objective is to provide a report with legislative and administrative recommendations to the Department at the end of each year of its four-year duration.

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**Reference Handbook of Key Topics and Terms  
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*\*Pub. L. 111-84, 123 Stat. 2190, §724 Subsection c (Annual Report), paragraph 3 (Matters to be Reviewed and Assessed, subparagraphs A-Q). (The information paper on topic 3O: Senior Oversight Committee has been removed following consolidation of the Senior Oversight Committee into the Joint Executive Council (topic 3P). No information paper was prepared on topic 3N: Interagency Matters Affecting Transition to Civilian Life).*



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**Topic:** Non-medical case management (performed by recovery care coordinators or federal recovery coordinators and non-medical case managers) (see also information papers on *medical care case management* and *wounded warrior programs*)

**Background:**

Case management is “a process intended to assist returning Service members with management of their care from initial injury through recovery” and “is especially important for returning Service members who must often visit numerous therapists, providers, and specialists,” which can result in multiple, uncoordinated treatment plans.<sup>1</sup> Congress prioritized case management for Recovering Warriors (RWs) through the creation of the Recovery Coordination Program (RCP); DoD published DoD Instruction (DoDI) 1300.24 with RCP implementation guidance in 2009.<sup>2, 3</sup>

According to DoDI 1300.24, the RCP includes: 1) a comprehensive recovery plan (CRP) developed and implemented for each Recovering Warrior (RW), encompassing medical/non-medical needs and short-/long-term goals, to include transition to the Department of Veterans Affairs (VA) or civilian care and medical separation or retirement, or return to duty; 2) a recovery care coordinator (RCC) with “primary responsibility for development of the CRP” and oversight and coordination of identified medical and non-medical services and resources throughout the continuum of care; and 3) a recovery team (RT) of multidisciplinary medical/non-medical providers collaborating with the RCC to develop the CRP, deliver or facilitate services, and provide resources. The RT includes a non-medical case manager (NMCM) working closely with the RW and family to ensure they “get needed non-medical support” and assistance “resolving non-medical issues.”<sup>4</sup>

DoD policy recognizes three care categories (CAT) to identify an RW:

- CAT I: An RW labeled with a mild injury or illness, likely to return to duty in less than 180 days;
- CAT II: An RW labeled with a serious injury or illness, unlikely to return to duty in less than 180 days. and,
- CAT III: An RW labeled with a severe/catastrophic injury or illness, likely to be medically separated from the military.<sup>5</sup>

At a minimum, DoD policy requires RCCs be assigned to a RW whose medical condition(s) are expected to last at least 180 days (CAT II or CAT III).<sup>6</sup> In addition, FRCs are made available to an RW likely to separate from service because of their medical condition(s) (CAT III).<sup>7</sup>

RCCs are hired and trained jointly by DoD and the Services’ wounded warrior programs. Currently, more than 180 RCCs (49 Marine Corps<sup>8</sup>; 32 Air Force; 37 Army; 19 Army Reserve; 25 Special Operations Command; and 21 Navy<sup>9</sup>) are assigned to more than 40 locations.<sup>10</sup> DoD guidance requires the Services’ wounded warrior programs to assign RCCs and NMCMs



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caseloads of 40 RWs or fewer, based upon on condition acuity and complexity of non-medical needs. Waivers are required for exceptions,<sup>11</sup> and training for RCCs is provided by the Office of Warrior Care Policy (WCP).

The Services' wounded warrior programs differ in their use of—and nomenclature for—RCCs and NMCMs. Army Warrior Transition Units (WTUs) assign RWs a Squad Leader who functions as the primary NCMC (actual caseload 1:11<sup>12</sup>); more severely injured RWs are assigned an AW2 Advocate (actual caseload 1:25<sup>13</sup>). Warrior Transition Command (WTC) has indicated all WTC AW2 Advocates will receive DoD RCC training.<sup>14</sup> The Marine Corps uses RCCs (49 located at 14 separate sites,<sup>15</sup> actual caseload 1:25<sup>16</sup>) and Wounded Warrior Battalion (WWBn) section leaders as the primary NMCMs (actual caseload 1:11).<sup>17</sup> The Navy uses 21 RCCs, called Safe Harbor non-medical care managers (actual caseload 1:37).<sup>18</sup> The Air Force uses 32 RCCs<sup>19</sup> (actual caseload 1:31<sup>20</sup>), as well as 23 Air Force Wounded Warrior (AFW2) NMCMs for those meeting the AFW2 criteria (actual caseload 1:60<sup>21</sup>). The Special Operations Command Care Coalition includes 22 Wounded Warrior Advocates (caseload 1:300) and 27 Liaison Officers (LNOs) (caseload 1:10).<sup>22</sup> Care Coalition caseloads are based on contact frequency, so although an Advocate may have up to 300 lifetime members of Care Coalition, the actual caseload is one staff to 32 special operators needing weekly, monthly, or quarterly contacts.<sup>23</sup>



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**Topic:** Medical care case management (see also information paper on *non-medical case management*)

**Background:**

A medical care case manager (MCCM) is a licensed registered nurse or degreed social worker who provides coordination of medical care and treatment (also known as clinical case management).<sup>24</sup> The MCCM works as a part of the recovery team with the Recovering Warrior (RW), the RW's commander, a recovery care coordinator (RCC), a nonmedical case manager (NMCM)<sup>25</sup>, and/or federal recovery coordinator (FRC).<sup>26</sup>

In Section 1611 of the 2008 National Defense Authorization Act, Congress specified the duties of the MCCM, which include:

1. Assisting the Service member or family member/designee to understand medical status during care, recovery, and transition;
2. Assisting the Service member in receiving prescribed medical treatment during care, recovery, and transition; and
3. Conducting periodic reviews of the Service member's medical status with the Service member or, with a manager's approval, a designated family member, if the Service member cannot participate.<sup>27</sup>

NDAA 2008 also mandated uniform standards for the training and skills of MCCMs—and others who work with wounded, ill, and injured (WII) Service members—to detect and report signs of posttraumatic stress disorder (PTSD), suicidal or homicidal thoughts, and other behavioral health concerns. DoD policy guidance also requires MCCMs to communicate directly with the accepting physician or facility as an RW transitions to veteran status.<sup>28</sup> Congress tasked DoD and the Department of Veterans Affairs (VA) to develop policies for MCCMs on caseloads and training requirements, as well as rank and occupation specifications for supervisors of MCCMs. In addition, NDAA 2008 specified MCCMs must be fully trained before assuming the duties of the job, and that DoD and VA must provide the necessary resources to operate a medical care case management program.<sup>29</sup>

DoD Instruction (DoDI) 1300.24, "Recovery Coordination Program," tasks the Assistant Secretary of Defense for Health Affairs (ASD(HA)) and the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) with ensuring the development and consistent implementation of policies and procedures for MCCMs across the Services, including training, qualifications, and caseloads.<sup>30</sup>

Directive-Type Memorandum (DTM) 08-033, "DoD Health Affairs' Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Service Member in the Military Health System (MHS)," delineates requirements for the implementation of clinical case



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management and establishes the MHS medical and clinical policies and procedures for WII care. DTM 08-033 was reauthorized on August 16, 2011, and again on July 25, 2012, and was to expire January 11, 2013.<sup>31, 32</sup> In accordance with DTM 08-033 to support MCCM training, the ASD(HA) developed basic and advanced medical management trainings available through the MHS Learn Portal.<sup>33</sup> To further unify MCCM efforts across DoD, ASD(HA) identified required clinical case management training modules utilizing a patient-centered approach to clinical case management, common combat-related injuries, and transition care coordination.<sup>34</sup> DTM 08-033 also states, “[T]he standard number of cases to be managed by each case manager shall be no more than 30.”<sup>35</sup> As of December 2011 (Navy) and January 2012 (Army and Air Force), the Services’ MCCM caseloads were well within that standard.<sup>36, 37, 38</sup>



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**Topic:** Wounded warrior units and programs (see also information paper on *non-medical case management*)

**Background:**

The wounded warrior units and programs are the vehicles through which the Services execute the Recovery Coordination Program (RCP) and manage the transition of Recovering Warriors (RWs), as directed by the 2008 National Defense Authorization Act (NDAA) and DoD Instruction (DoDI) 1300.24.<sup>39</sup>

Section 738 of NDAA 2013 required the Secretary of Defense (SecDef) to establish policy for uniform measurement of effectiveness of the Army, Navy, Air Force, and United States Special Operations Command (USSOCOM) programs for warrior in transition.<sup>40</sup> The SecDef is to collect metrics on each of the programs and report to Congress annually until 2018. Congress specifically requested that the reports address access to medical and rehabilitation services, effectiveness of vocational and employment services, differences in outcomes, and numbers of providers/numbers of Service members in need of providers' services.

**Army.** The Army Warrior Transition Command (WTC) oversees two programs: the Warrior Transition Unit (WTU); and, the Army Wounded Warrior (AW2) Program. WTUs are brigade-, battalion-, or company-level units to which RWs are assigned while preparing to transition back to duty or to civilian status. WTUs are located at major medical treatment facilities (MTFs) and provide "command and control, administrative support, and clinical and non-clinical case management to wounded, ill, and injured (WII) Soldiers (and their families) who are expected to require six months or more of rehabilitative care or who require complex medical management."<sup>41</sup> As of April 2012, approximately 9,718 Soldiers were assigned to 38 WTUs, including nine community-based WTUs (CBWTUs) for Reservists requiring only outpatient care.<sup>42, 43</sup> More than 1,200 Soldiers with severe disabilities were participating in the AW2 Program, which assigns RWs and their families an AW2 Advocate to assist with needs related to career and education, benefits, transition, information, and more.<sup>44, 45, 46</sup>

**U.S. Marine Corps (USMC).** The USMC Wounded Warrior Regiment (WWR) provides non-medical case management throughout the recovery period to post 9/11 WII Marines and Sailors assigned to or directly supporting Marine units. WWR supports Active and Reserve Component Marines, including those who have separated or retired.<sup>47</sup> The WWR is comprised of a battalion at Camp Lejeune (WWBn-East) and at Camp Pendleton (WWBn-West), which have detachments at 12 principal MTFs and four Department of Veterans Affairs (VA) polytrauma rehabilitation centers. There are 15 to 20 RWs assigned to each detachment.<sup>48</sup> The USMC program emphasizes outreach and reintegration through resources, such as the Battalion Contact Centers, the Sergeant Merlin German Call Center, 29 District Injured Support Coordinators (DISCs) located in 22 defined Veterans Integrated Service Network (VISN) regions,<sup>49</sup> and the Marine for Life (M4L) Program.<sup>50</sup> As of February 2012, 794 WII Marines and Sailors were assigned to the WWR.<sup>51</sup>



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**Navy.** The Navy Safe Harbor Program provides non-medical case management for severely injured—and high-risk, non-severely injured—WII Sailors, Coast Guardsmen, and their families.<sup>52</sup> Safe Harbor is available to those with injuries, whether combat-related or due to a shipboard or liberty accident, and to those with serious physical or psychological illnesses; enrollees remain assigned to their parent unit.<sup>53</sup> The Safe Harbor Operations Department consists of 1) non-medical care managers (NMCs) geographically dispersed at major MTFs and VA Polytrauma hospitals, and 2) a Strategic Support Department of subject matter experts who assist the NMCs.<sup>54, 55</sup> As of February 2012, 789 Sailors were in the Safe Harbor program.<sup>56</sup> Safe Harbor partners with voluntary and community organizations to offer the Anchor Program to provide mentorship to Reserve and separating/retiring members during their transition to civilian life. The Anchor Program extends RWs' contact with Safe Harbor.<sup>57</sup> The Navy Medical Hold Program (MEDHOLD) allows Reservists to stay on medical continuation orders and receive medical treatment beyond the expiration of their Service orders.<sup>58</sup>

**Air Force.** Air Force (AF) Warrior and Survivor Care includes the Air Force Wounded Warrior (AFW2) Program, the Recovery Coordination Program (RCP), and other non-medical support to RWs.<sup>59</sup> The AFW2 Program is for Airmen who have a combat-related injury or illness, necessitating long-term care that will require a Medical Evaluation Board (MEB) or Physical Evaluation Board (PEB) to determine fitness for duty.<sup>60</sup> AFW2 leverages existing resources, such as AFSAP and installation Airman and Family Readiness Centers (A&FRCs), to provide services, including expanded transition assistance, extended case management, follow-up, and advocacy.<sup>61</sup> As part of AFSAP, AFW2 RWs and their families are assigned a Family Liaison Officer to facilitate the logistics of medical treatment away from home.<sup>62, 63</sup> As of January 2012, 1384 Airmen were enrolled in the AFW2 Program.<sup>64</sup> In 2012, the Air Force consolidated all wounded warrior, casualty, mortuary, Airmen and Family, IDES, and medical continuation (MEDCON) functions under the command of the Air Force Personnel Center (AFPC). Initial Operating Capacity (IOC) for this organizational realignment was expected by July 2012.<sup>65</sup>

**U.S. Special Operations Command (USSOCOM).** The USSOCOM Care Coalition provides mentorship, advocacy, non-medical case management, and support through return to duty or transition to civilian life.<sup>66</sup> As of February 2012, Care Coalition was assisting 4,857 WII currently-serving and retired special operators and families.<sup>67</sup> Care Coalition partners with governmental and non-governmental agencies to optimize RWs' access to services—particularly cutting-edge care—and works closely with unit leadership to facilitate swift return of SOF members to duty, as appropriate, and improve SOF readiness.<sup>68</sup> It also serves as a liaison with, and complements, the Services' wounded warrior programs by advocating that standards be met or exceeded and by promoting equality of benefits across the Services.<sup>69</sup>



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**Topic:** Services for posttraumatic stress disorder and traumatic brain injury

**Background:**

Posttraumatic stress disorder (PTSD) is “a psychological condition that affects those who have experienced a traumatizing or life-threatening event such as combat, natural disasters, serious accidents, or violent personal assaults.”<sup>70</sup> The prevalence rates of PTSD among Service members and Veterans vary widely. The Institute of Medicine’s (IOM) “Committee on the Assessment of Ongoing Efforts in the Treatment of Posttraumatic Stress Disorder” estimated the prevalence of PTSD to be between 13 and 20 percent.<sup>71</sup> The average prevalence rate among infantry, post-deployment, is approximately 15 percent.<sup>72</sup> Between 2000 and the spring of 2012, there were 104,703 new diagnoses of PTSD among deployed and non-deployed Service members.<sup>73</sup>

DoD defines traumatic brain injury (TBI) as the “traumatically induced structural injury or physiological disruption of brain function as a result of external force to the head.”<sup>74</sup> According to the Defense and Veterans Brain Injury Center (DVBIC), there were more than 253,330 diagnosed cases of TBI at all severity levels across the Services from Fiscal Year (FY) 2000 through the second quarter of FY2012.<sup>75</sup> PTSD and TBI frequently co-occur and affect moods, thoughts, and behavior, “yet these wounds often go unrecognized and unacknowledged.”<sup>76</sup> Mild TBI (mTBI), or concussion, is particularly difficult to diagnose because symptoms are not typically obvious.

DoD’s National Intrepid Center of Excellence (NICoE), which opened June 2010 on the Walter Reed National Military Medical Center (WRNMMC) campus in Bethesda, Maryland, offers cutting-edge diagnosis, treatment, rehabilitation, and follow-up for warriors with PTSD, TBI, and related conditions.<sup>77</sup> Effective August 10, 2011, the NICoE was transferred from the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) to the Department of the Navy (DON) for further alignment under WRNMMC.<sup>78</sup>

Several provisions of the 2013 National Defense Authorization Act (NDAA) addressed psychological health and TBI. Section 706 of NDAA 2013 authorized the Secretary of Defense (SecDef) to conduct a pilot to improve research, treatment, education, and outreach on mental health (MH) and substance abuse.<sup>79</sup> Section 724 instructed the SecDef and the Secretary of the Department of Veterans Affairs (VA) to enter into a memorandum of understanding (MOU) to allow Service members returning from combat operations to participate in VA peer support counseling programs.<sup>80</sup> Section 725 instructed the SecDef to “provide for the translation of research on the diagnosis and treatment of mental health conditions into policy on medical practices,” and it required a July 2013 report to Congress on translation of research to practice.<sup>81</sup> Section 726 of NDAA 2013 tasked the VA with developing and implementing measures to assess the timeliness, quality, capacity, availability, and provision of evidence based treatments, and patient satisfaction of VA mental health care.<sup>82</sup> This section also required the VA to develop staffing guidelines for providers of mental health care and to contract the National Academy of Sciences to study VA mental health care. Section 739 required the SecDef to



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submit a plan to improve coordination and integration of DoD programs for psychological health and TBI to Congress by July 2013.<sup>83</sup> The report shall include identification of gaps in services, identification of unnecessary redundancies, a plan to mitigate the identified gaps and redundancies, and identification of the DoD official responsible for leading the plan.

**Prevention and early intervention of PTSD.** A wide variety of DoD- and Service-level resources and initiatives exist to facilitate PTSD prevention and early intervention. DoD offers free, confidential counseling through Military OneSource and the Military Family Life Consultants (MFLC) Program. The Army's Comprehensive Fitness Program (CFP) trains Soldiers to improve resilience, decrease stress, and promote success.<sup>84</sup> Battlemind is a training curriculum that facilitates transition from combat zone to "home zone" through expectations management.<sup>85</sup> The Army also has begun to embed behavioral health teams within its Brigade Combat Teams.<sup>86</sup> The Marine Corps and Navy Reserves have established Psychological Health Outreach Program (PHOP) teams that provide access to psychological health services to increase resilience and facilitate recovery.<sup>87, 88</sup> Cognitive Behavioral Therapy (CBT), combat exposure-based therapies, and psychological first aid are treatment methodologies found to be effective for early intervention and prevention of PTSD.<sup>89</sup> There is a push across DoD toward providing early intervention and care for PTSD in integrated mental health and primary care settings.<sup>90, 91, 92</sup>

**Screening for PTSD.** According to legislation and DoD policy, Service members are required to receive medical examinations including mental health assessments before deployment, as deployment concludes, and during post-deployment.<sup>93, 94, 95</sup> NDAA 2012 added to requirements for screening and diagnosis, specifying a timetable in Section 705,<sup>96</sup> and requiring feedback on research into the efficacy of neuroimaging as a diagnostic tool in section 723.<sup>97</sup>

**Treatment of PTSD.** Service members can access PTSD treatment and information through several mental health services, including the National Center for PTSD (NCPTSD), NICoE, DCoE for Psychological Health and Traumatic Brain Injury, as well as other sources. NCPTSD's mission is to advance the clinical care and social welfare of America's Veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders.<sup>98</sup> Treatment options include psychotherapy, medication, and/or complementary and alternative approaches, such as acupuncture, yoga, and herbal/dietary supplements. The most empirically supported treatment modalities for PTSD include cognitive therapies, specifically Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), and Stress Inoculation Training (SIT). Eye Movement Desensitization Reprocessing (EMDR) has also been shown to be an effective treatment modality.<sup>99</sup> A number of installations offer Intensive Outpatient Therapy (IOP) programs for PTSD (e.g., Fort Campbell and the Naval Medical Center-San Diego).<sup>100</sup> In regards to pharmacological treatments, the evidence base is strongest for selective serotonin reuptake inhibitors (SSRIs)<sup>101</sup> and serotonin norepinephrine reuptake inhibitors (SNRI).<sup>102</sup>

Access to mental health care for Reservists in training—not on Active Duty—is addressed by Section 703 of NDAA 2012. This section of the law provides for access to mental health care at



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no cost to the Reservist, including PTSD care and training on suicide prevention and response.<sup>103</sup>

**Screening and treatment of TBI.** Section 722 of Public Law 111-383, NDAA 2011, required the SecDef to develop and implement a comprehensive policy on consistent neurological cognitive assessments of Service members before and after deployment no later than January 31, 2011.<sup>104</sup> TBI screening occurs in theatre, at Landstuhl Regional Medical Center (LRMC), during PDHA and PDHRA, and VA Medical Centers.<sup>105</sup>

The Military Acute Concussion Evaluation (MACE) tool helps to systematize the diagnosis of TBI.<sup>106</sup> DoD TBI treatment programs have been established throughout the continental United States (CONUS) and overseas.<sup>107</sup> Evidence-based treatment protocols have been tailored to treatment location (e.g., in-theatre, CONUS), acuity of condition (e.g., acute, sub-acute, chronic), and severity of condition (e.g., mild, moderate, severe, penetrating).<sup>108</sup> Directive-Type Memorandum (DTM) 09-033, “Policy Guidance for Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting,” established guidance for the management of concussions in deployed settings. Signed into policy on June 21, 2011, DTM 09-033 establishes mandatory protocols for exposure, medical evaluation, rest requirements, and resumption of activities that involve a concussion risk.<sup>109</sup> DoDI 6490.11, “DoD Policy Guidance for Management of Mild TBI/Concussion in the Deployed Setting,” signed September 18, 2012, incorporated and cancelled DTM 09-033.<sup>110</sup>

A comprehensive brain injury rehabilitation program may include: visual, vestibular, vocational, physical, and cognitive rehabilitation; specialty services; and psychological counseling.<sup>111</sup> The focus of cognitive rehabilitation is on specific cognitive deficits and the effects of these deficits on social, communication, behavioral, and vocational/academic performance.<sup>112</sup>

Section 724 of NDAA 2012 required the SecDef to report on how to identify, refer, and treat Operations Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Service members who served before the 50-meter from explosion criterion was established. Additionally, it required SecDef to report on the effectiveness of several newer policies, including managing concussion and mTBI in deployed settings, identifying and treating blast injuries (including the 50-meter criterion), and operational effectiveness in theatre.<sup>113</sup>



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**Topic:** Centers of Excellence for Psychological Health and Traumatic Brain Injury, for Vision, for Hearing, and for Traumatic Extremity Injuries and Amputation

**Background:**

The Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury was established November 2007 under DoD’s Military Health System (MHS).<sup>114</sup> In an effort to address concerns about management and oversight raised by the Government Accountability Office (GAO)<sup>115</sup> and consistent with the 2011 recommendation of the RWTF, the Secretary of the Army was named executive agent for the DCoE in DoD Directive 6000.17E, dated January 2, 2013<sup>116</sup>; complete transition is expected by October 2013.<sup>117</sup> DCoE serves as DoD’s “open front door” for needs associated with psychological health (PH) and traumatic brain injury (TBI) experienced by our Service members. The DCoE currently comprises five directorates and three component centers: Defense and Veterans Brain Injury Center (DVBIC), Deployment Health Clinical Center (DHCC), and National Center for Telehealth and Technology (T2).<sup>118</sup>

Established by Congressional mandate, the mission of the DCoE is to “improve the lives of our Service Members, families, and Veterans by advancing excellence in PH and TBI prevention and care.”<sup>119</sup> DCoE compiles and coordinates the work of scientific researchers, clinicians, and other health professionals—from DoD, the Department of Veterans Affairs (VA), and other federal agencies, academic institutions, state and local agencies, and the non-profit and private sectors—to expand the state of knowledge about PH and TBI. The DCoE endeavors to drive the translation of research to practice in the areas of PH, TBI, and suicide prevention; and ensures best practices and quality standards are continuously and consistently implemented throughout the continuum of care, regardless of a Service member’s branch, component, or location. The DCoE Director is Captain Paul S. Hammer, MC, USN.

Among its many activities, DCoE and its component centers develop and train providers in new techniques and technologies in PH and TBI treatment; sponsor and conduct research studies on posttraumatic stress disorder (PTSD), TBI, and promising treatments; create and disseminate guidelines to military and civilian practitioners; develop outreach programs for military and veteran communities and the public; and establish mechanisms to coordinate local, state, and federal resources to eliminate gaps in care for patients in transition between DoD and VA.<sup>120</sup>

Section 716 of Public Law 111-383, the 2011 National Defense Authorization Act (NDAA), mandated several actions relevant to the DCoE. Specifically, it required the Secretary of Defense (SecDef) to develop and implement training on the use of pharmaceuticals in rehabilitation programs for seriously ill or injured Service members. NDAA 2011 also specified that training shall be provided to several groups, including: patients in, or transitioning to, a wounded warrior unit, with special accommodations in the trainings for patients with cognitive disabilities; non-medical case managers; military leaders; and family members. In addition,



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NDA 2011 required the SecDef to review DoD policies and procedures regarding the use of pharmaceuticals in rehabilitation programs for seriously ill or injured Service members.<sup>121</sup>

In addition to the DCoE, Congress directed the establishment of three other centers: 1) the Vision Center of Excellence (VCE) mandated by NDA 2008<sup>122</sup>; 2) the Hearing Center of Excellence (HCE) mandated by NDA 2009; and 3) the Extremity Trauma and Amputation Center of Excellence (EACE), also mandated by NDA 2009.<sup>123</sup> Like the DCoE, these Centers of Excellence share a common purpose of addressing blast injuries, described as the signature wounds of the wars in Afghanistan and Iraq.<sup>124</sup> All four Centers of Excellence currently receive guidance and direction from the recently established Military Health System Center of Excellence Oversight Board.<sup>125</sup>

**Vision Center of Excellence (VCE).** The mission of the VCE, headed by COL Donald A. Gagliano, MD, USA, is to “lead and advocate for programs and initiatives to improve vision health, optimize readiness, and enhance quality of life for Service members and Veterans.”<sup>126</sup> The concept of operations was approved January 10, 2012, and the VCE is continuing to evolve initial operational capability.<sup>127</sup> The VCE has two locations: clinical headquarters at Walter Reed National Military Medical Center (WRNMMC) in Bethesda, Maryland; and administrative personnel in Crystal City, Virginia.<sup>128, 129</sup> The VCE has made it a priority to coordinate and collaborate with other Centers of Excellence, including HCE, DCoE, and National Intrepid Center of Excellence (NICoE), on the Joint Theatre Trauma Registry (JTTR) and VA Eye Injury Data Store.<sup>130</sup>

**Hearing Center of Excellence (HCE).** Headquartered at Joint Base San Antonio, Texas, and headed by interim Director Col(s) Mark D. Packer, MD, USAF, the HCE began initial operating capability in May 2011 by drafting its concept of operations. Today, the HCE is organized in five directorates: Prevention & Surveillance; Clinical Care, Rehabilitation & Restoration; Research; Global Outreach; and Informatics.<sup>131</sup> As of December 2011, five directorate chiefs were appointed, and “hub” support personnel were partnering with VCE to develop a registry able to capture clinical audiogram data. The HCE was continuing to implement a communications/prevention campaign, prioritize ongoing research, and produce clinical practice guidelines. Full operating capability, defined as a functional DoD/VA hearing data registry, was expected by December 2013, and plans called for a staff of 37 to be hired incrementally over five years.<sup>132</sup>

Section 704 of Public Law 111-383, NDA 2011, mandated several actions relevant to the HCE. Under this mandate, the SecDef was to identify the best tests currently available to screen Service members for tinnitus, develop a plan to ensure all Service members are screened prior to and after deployment to a combat zone. NDA 2011 also required the SecDef to examine methods to improve the aural protection for Service members in combat.<sup>133</sup>

**Extremity Trauma and Amputation Center of Excellence (EACE).** The mission of the EACE is to “Serve as the joint DoD/VA lead organization for policy direction and oversight of



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the multidisciplinary network for continuous care and study of amputations and extremity injuries resulting from trauma, point of injury through definitive care and rehabilitation, into lifelong surveillance in order to reduce the disability and optimize the quality of life for Service Members and Veterans.”<sup>134</sup> The EACE is in the early stages of establishment.<sup>135, 136</sup> As of February 2012, the EACE was directed by Mr. John Shero and the hiring of staff was ongoing.<sup>137</sup> The concept of operations and decision to headquarter the EACE in San Antonio, Texas, was approved by the Centers of Excellence Oversight Board in January 2012.<sup>138</sup>



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**Topic:** Interagency Program Office

**Background:**

The Interagency Program Office (IPO) was established by Congress in Section 1635 of Public Law 110-181, the 2008 National Defense Authorization Act (NDAA).<sup>139</sup> Congress mandated DoD and the Department of Veterans Affairs (VA) to work together to:

1. Increase the speed of health information exchange;
2. Develop capabilities to share health information in a usable way (interoperability) by September 30, 2009; and
3. Establish the IPO as the office accountable for developing and implementing the health information sharing capabilities for DoD and VA.

The IPO was formed by DoD and VA April 17, 2008, and chartered by January 2009.<sup>140</sup> At that time, the permanent staffing structure included seven government service (GS) civilian positions from DoD and seven GS positions from VA, led by a DoD Director and a VA Deputy Director, both Senior Executive Service (SES) positions.<sup>141</sup> In April 2009, at the direction of the Senior Oversight Committee (SOC), the IPO charter was changed to include coordinating and overseeing the development of the Virtual Lifetime Electronic Record (VLER), which provides Veterans, Service members, their families, care-givers, and their service providers with a single source of information for health and benefits in a way that is secure, and is authorized by the Service member or Veteran.<sup>142,143</sup>

Since 2008, the IPO has received substantial scrutiny from Congress and the Government Accountability Office (GAO), which has issued a number of reports on the interoperability of DoD and VA health information systems and the IPO.<sup>144, 145, 146, 147, 148</sup> NDAA 2011 required the Secretary of Defense to assess and report on existing health information technology systems and future plans for legacy systems and new electronic health record initiatives, including IPO's role.<sup>149</sup>

Although significant data sharing has existed between DoD and VA for years, the Departments had been taking separate paths to replace their existing legacy Electronic Health Record (EHR) systems: DoD's AHLTA (Armed Forces Health Longitudinal Technology Application) and VA's VISTA (Veterans Health Information Systems and Technology Architecture).<sup>150</sup> Starting March 2011, the Department Secretaries committed to jointly developing and implementing the next generation of EHR capabilities. The IPO has organized teams comprised of clinicians from both departments to define individual EHR (iEHR) capabilities and processes, and is communicating with private health care providers pioneering the exchange of information through VLER. In October 2011, the Department Deputy Secretaries signed a new IPO charter giving more authority to the joint program office and making the IPO the single point of accountability for the iEHR.<sup>151</sup>



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The iEHR will enable DoD and VA to align resources and investments with business needs and programs to implement a common EHR platform. This single system will enable sharing of health care information to allow both departments to track medical care from the time an individual joins the military until they become a Veteran and through the rest of their lives.<sup>152</sup>

The common platform will be developed using the following sequentially ordered business rules:<sup>153</sup>

1. Purchase commercially available components for joint use whenever possible and cost effective;
2. Adopt applications developed by VA, DoD, or other federal agencies if a modular commercial solution is not available and currently exists inside the government;
3. Approve joint application development on a case by case basis, and only if a modular commercial or federally-developed solution is not available; and
4. Use applications developed by the other Department unless justification and approval to develop a separate application is sought by the IPO Advisory Board.

In addition, the Department Secretaries agreed to implement a high-level governance structure that includes the IPO, whose Director serves as the Program Executive, and an IPO Advisory Board.<sup>154</sup> In essence, the IPO serves as the single point of accountability for the Departments in the development and implementation of the iEHR, and coordinates with the existing DoD/VA Joint Executive Council to integrate capability, functional requirements, and business process re-engineering (BPR). Mr. Barclay Butler assumed the position of Director of the IPO February 27, 2012. As of that date, a staff of approximately 100 personnel was anticipated, with half from DoD and half from VA.<sup>155</sup>

In February 2012, the IPO indicated that, while it aggressively pursues the development and phased implementation of the iEHR, other initiatives of the IPO would continue uninterrupted. This includes the demonstration project underway at the North Chicago DoD/VA medical facility—an interagency collaboration leveraging interoperable legacy electronic DoD and VA health records that “speak to one another.”<sup>156</sup> Section 1098 of NDAA 2011 required ongoing review of the North Chicago pilot by the Comptroller General in July of 2011, 2013, and 2015.<sup>157</sup>



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**Topic:** Wounded warrior information resources

**Background:**

**National Resource Directory ([www.nationalresourcedirectory.gov](http://www.nationalresourcedirectory.gov)).** One of four cornerstones of the Recovery Coordination Program (RCP) established through the Senior Oversight Committee (SOC),<sup>158</sup> the National Resource Directory is a joint venture of DoD, the Department of Labor (DOL), and the Department of Veterans Affairs (VA). It is an online partnership “connecting Wounded Warriors, Service Members, Veterans, their families and caregivers with those who support them.”<sup>159</sup> The directory provides access to national, state, and local governmental and non-governmental services and resources for recovery, rehabilitation, and reintegration.<sup>160</sup> Major topic areas include benefits and compensation, education and training, employment, family and caregiver support, health, homeless assistance, housing, transportation and travel, volunteer opportunities, and other services and resources.<sup>161</sup> In November 2011, the National Resource Directory added a tab with access to the new Veterans Job Bank, an online tool that allows veterans to search for jobs by their military skills and zip code.<sup>162</sup> The National Resource Directory web page also provides the phone number to access Military OneSource Wounded Warrior Specialty Consultations the Wounded Warrior Resource Center/Military OneSource.<sup>163</sup>

**Military OneSource Wounded Warrior Specialty Consultations (800-342-9647 or [wwrc@militaryonesource.mil](mailto:wwrc@militaryonesource.mil)).** A companion to the National Resource Directory, this initiative (previously known as the Wounded Warrior Resource Center<sup>164</sup>) provides “wounded warriors, their families, and their primary caregivers with a single point of contact for assistance with reporting deficiencies in covered military facilities, obtaining healthcare services, receiving benefits information, and any other difficulties encountered while supporting wounded warriors.”<sup>165</sup> It is staffed 24/7 by Wounded Warrior specialty consultants who are Master’s level professionals with specialties in the social sciences.<sup>166</sup> It is accessible at 800-342-9647 or via email at [wwrc@militaryonesource.mil](mailto:wwrc@militaryonesource.mil).<sup>167</sup> (Previously, there was also a Wounded Warrior Resource Center website<sup>168</sup>, but this has been replaced by the National Resource Directory website<sup>169</sup>.) Specialty consultants work with the Services’ wounded warrior programs and the VA in order to make referrals to help address callers’ needs.<sup>170</sup> Individuals can learn about this resource through Military OneSource staff, briefings, or webinars.<sup>171</sup> Within 24 hours following each call, a consultant must reach out to the Services and/or VA, and within 96 hours, the Services and/or VA must release a plan of action.<sup>172</sup>

**Military OneSource ([www.militaryonesource.mil](http://www.militaryonesource.mil) or 800-342-9647).** Military OneSource is an all-purpose portal for Active and Reserve Component Service members, spouses, families, and service providers, through which DoD’s Office of Military Community and Family Policy (MC&FP) disseminates information to the military community.<sup>173</sup> Military OneSource is staffed 24/7 by Master’s level professionals.<sup>174</sup> The Military OneSource Wounded Warrior tab provides a link to the National Resource Directory and the phone number for the Military OneSource Wounded Warrior Specialty Consultations.<sup>175</sup>



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The “Keeping It All Together” binder from Military OneSource consolidates information across a range of websites, hotlines, and programs.<sup>176, 177</sup> It is a valuable tool for family members, filling an identified need for a “one-stop” information resource.<sup>178, 179</sup> The Marine Corps Wounded Warrior Regiment (WWR) has had particular success customizing and distributing the binder to families.<sup>180, 181</sup>

**Family Assistance Centers.** The Army has established Soldier and Family Assistance Centers (SFACs) at all medical treatment facilities (MTFs) with Warrior Transition Units (WTUs) to facilitate family and Soldier access to information and resources.<sup>182</sup> Army SFACs offer a wide variety of services, including information and referral; human resources/military benefits; education counseling; financial counseling/Army Emergency Relief; social services; outreach services; transition support; child, youth, and school services; and computer rooms.<sup>183, 184</sup> As of February 2011, the Army had 32 SFACs (29 locations within the continental U.S. (CONUS) and three major locations outside of CONUS).<sup>185</sup> As of July 2011, six of 18 CONUS SFAC construction locations were open and operating in centrally located, campus-like RW settings.<sup>186, 187</sup> , and 12 more new construction projects were underway or in the planning stages.<sup>188, 189</sup> Also as of July 2011, SFACs employed an Army-wide staff of over 200.<sup>190</sup> Sister Services and Army Reserve Component sites provide information to RWs and their families but do not have dedicated site-level facilities for them.<sup>191</sup>

**Service hotlines.** Three Service-specific hotlines operate 24/7:

- Army Wounded Soldier and Family Hotline (800-984-8523) is designed to allow Soldiers and their families to seek information and share concerns about medical care. Concerns can also be shared anonymously through the website: <http://www.armymedicine.army.mil/wsfh/index.html><sup>192</sup>
- Marine Corps Sergeant Merlin German Wounded Warrior Call Center (877-487-6299) is for wounded Marines, their families, and eligible Sailors, and is also used for outreach.<sup>193</sup>
- Navy Safe Harbor established the Navy Wounded Warrior Call Center (NWCC) as of October 2012. Safe Harbor staff indicated the NWCC was established because most calls received through Military OneSource required Service-specific consultation and follow up.<sup>194</sup>

The Air Force wounded warrior website provides key links and telephone numbers.<sup>195</sup> However, Air Force Warrior and Survivor Care does not operate a hotline for RWs.<sup>196</sup>



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**Topic:** Support for family caregivers

**Background:**

The financial burden experienced by caregivers and families has been well documented.<sup>197,198, 199</sup> Several pieces of legislation have been written to address this burden and to support caregivers as they, in turn, support their Recovering Warriors (RWs).

**Special compensation for members of the uniformed Services with catastrophic injuries or illnesses requiring assistance in everyday living.** Catastrophic injury or illness is defined as “a permanent, severely disabling injury, disorder, or illness that the Secretary [of the military Service] ... determines compromises the ability of the afflicted person to carry out the activities of daily living to such a degree that the person requires personal or mechanical assistance to leave home or bed, or constant supervision to avoid physical harm to self or others.”<sup>200</sup> Section 603 of Public Law 111-84, the 2010 National Defense Authorization Act (NDAA),<sup>201</sup> amends federal law<sup>202</sup> to authorize monthly compensation to RWs to pay for aid and attendance care without which they would require hospitalization, nursing home care, or other residential institutional care. Eligibility expires on the earliest of the following dates: after a 90-day period following the date of separation or retirement; when a Service member dies or is determined to no longer be afflicted with the catastrophic injury or illness; or when the Service member begins receiving comparable veteran’s compensation under Title 38.<sup>203</sup> Section 634 of Public Law 111-383, NDAA 2011, changed the basis for determining the amount of special compensation paid to Service members from the Department of Veterans Affairs (VA), Veterans Administration Schedule for Rating Disabilities (VASRD) to personal caregiver stipends established under 38 United States Code (U.S.C.) Section 1720G.<sup>204</sup>

On August 31, 2011, this law was promulgated through the publication of DoD Instruction (DoDI) 1341.12 “Special Compensation for Assistance with Activities of Daily Living (SCAADL).” SCAADL pays Service members for the time and assistance their caregivers provide them at home.<sup>205</sup> In order to be eligible for this stipend, a Service member must have a catastrophic illness or injury incurred in the line of duty and must be certified by a licensed physician as 1) requiring assistance from another person in order to perform activities of daily living and 2) requiring some form of institutional care if such assistance was not available.<sup>206</sup> As of January 31, 2012, the Army had received 258 applications and 231 individuals were receiving the stipend,<sup>207</sup> the Air Force had received 11 applications and 10 individuals were receiving the stipend,<sup>208</sup> the Navy had received 24 applications and 20 individuals were receiving the stipend,<sup>209</sup> and the Marine Corps had processed 194 applications and 178 were rated for benefits.<sup>210</sup> DoDI 1341.12 was updated May 24, 2012, to remove the requirement that the Service member be homebound.<sup>211</sup>

**Expanded authority for family member travel.** Section 632 of NDAA 2010 expanded the authorized coverage for families of a seriously ill or injured Service member who has been hospitalized to roundtrip travel and per diem once every 60 days and extended the benefit to



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individuals other than family members chosen by the Service member.<sup>212</sup> Eligible Service members may be hospitalized due to combat injury or other serious illness or injury.<sup>213</sup> This requirement is implemented in the current Joint Federal Travel Regulation (JFTR).<sup>214</sup>

**Authorized travel and transportation allowances for non-medical attendants for very seriously and seriously wounded, ill, or injured members.** A qualified non-medical attendant (NMA) is defined as a person whose presence, in the judgment of the attending physician or surgeon and commander or head of the military medical facility, “may contribute to the health and welfare of the [Service] member” while hospitalized for treatment of the wound, illness, or injury or during continuing outpatient treatment.<sup>215</sup> Section 633 of NDAA 2010 amended federal law by authorizing round-trip transportation for NMAs between their home and the location at which the member is receiving treatment, as well as additional transportation while accompanying the member for further treatment.<sup>216</sup> NMAs are also authorized a per diem allowance or reimbursement for actual and necessary travel expenses.<sup>217</sup> This requirement is implemented in the current JFTR.<sup>218</sup>

**Respite care for seriously ill or injured active duty members.** Respite care is defined as “short-term care for a patient to provide rest and change for the primary caregivers who have been caring for the patient at home,” to include assisting the Service member with activities of daily living (e.g., dressing, feeding, hygiene)<sup>219</sup> and respite care for seriously ill or injured active duty members is currently available through DoD.<sup>220</sup> Respite care is available if the Service member’s care includes more than two “interventions during the eight-hour period per day that the primary caregiver would normally be sleeping.”<sup>221</sup> Respite care is limited to eight hours per day, five days per week, and must be provided by a TRICARE-authorized home health agency.<sup>222</sup> Federal law authorizing respite for TRICARE ECHO participants—family members of Service members—was amended to allow this benefit for Service members.<sup>223</sup>

**VA support for caregivers of RWs.** On May 5, 2010, the President signed Public Law No. 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010.<sup>224</sup> The law expanded VA support for family caregivers of active duty (i.e., still serving) RWs.<sup>225</sup> Sections 101 through 104 provided for a program of comprehensive assistance, including: 1) instruction, preparation, and training in providing personal care services; 2) ongoing technical support; 3) counseling; 4) lodging and subsistence; 5) mental health services; 6) respite care of not less than 30 days annually, including 24-hours per day; 7) medical care; and 8) a monthly stipend.<sup>226</sup> The VA launched this comprehensive caregiver program in May 2011 and began the first care-giving training in June 2011.<sup>227</sup>

When the program began, it was projected that caregivers would receive an average of \$1,600 per month.<sup>228</sup> The total amount of the stipend is calculated based on the Veteran’s condition, the amount of care the Veteran requires, and where the Veteran lives.<sup>229</sup> Under the program of comprehensive assistance, caregivers must complete caregiver training developed by Easter Seals in collaboration with the VA.<sup>230</sup> As of January 10, 2012, 4,575 applications had been filed with 2,671 approved, 692 disapproved, 449 withdrawn, and 763 still in process.<sup>231</sup>



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**Inclusion in pre-separation counseling.** Section 529 of Public Law 112-81, NDAA 2012, authorizes the inclusion of a spouse in portions of pre-separation counseling and added more content areas to that counseling.<sup>232</sup> Pre-separation counseling is required for transitioning Service members (see also information paper on the *Transition Assistance Program*).<sup>233</sup>



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**Topic:** Legal support

**Background:**

Directive-Type Memorandum (DTM) 11-015, “Integrated Disability Evaluation System (IDES),” issued guidance for providing legal support during the IDES process.<sup>234</sup> Each Service branch is required to provide uniformed or civilian legal counsel at no cost to the Service member.<sup>235</sup> In addition, each Service branch was required to establish procedures to inform Service members—upon referral to the IDES—of available government legal counsel and the alternative options of retaining private counsel at their own expense or using the services of a representative of a service organization recognized by the Department of Veterans Affairs (VA).<sup>236</sup>

The Services historically assign attorneys to Physical Evaluation Board (PEB) locations where they offer legal counsel and representation to Service members undergoing formal PEB (FPEB) hearings. The Army has more than 15 Soldiers’ Counsel—mostly mobilized Reservists on one-year tours—assigned to support three PEB sites in the continental United States (CONUS), and, to provide legal support for overseas FPEBs via video teleconference.<sup>237</sup> The Navy provides legal support for the FPEB process at the Navy Yard in Washington, DC, which is the sole PEB site for Sailors and Marines.<sup>238</sup> The Air Force provides legal support for the FPEB process at Lackland Air Force Base, which is the sole PEB site for Airmen.<sup>239</sup> Apart from their consistent support for FPEB hearings, the Services vary in their legal support to WWII Service members in the disability evaluation system, including the legal resources the Services have allocated and where these resources are housed organizationally. In addition, the Services vary in how early in the process they seek to engage Service members.

**Army.** In 2008, the Army initiated the Soldiers’ MEB Counsel (SMEBC) program to introduce legal support earlier in the disability evaluation process.<sup>240</sup> SMEBC teams also assist severely injured Soldiers receiving care at VA polytrauma centers.<sup>241</sup> In late 2011, the Army authorized the hiring of additional SMEBC attorney/paralegal teams, in order to increase the total number of SMEBC teams Army-wide.<sup>242</sup> As of November 2012, the Army had more than 40 SMEBC teams—mostly permanent civilian employees—at Army locations worldwide.<sup>243</sup>

The SMEBC teams are available to educate and advise WWII Soldiers one-on-one before and during the MEB process, and to help them formulate—and optimize the likelihood of attaining—their goals.<sup>244</sup> SMEBC teams also prepare MEB appeals, requests for impartial provider reviews, requests for reconsideration, requests for formal hearings, and requests for rating reconsiderations.<sup>245</sup> In addition, SMEBC teams conduct regular outreach briefings at Warrior Transition Units (WTUs), Soldier and Family Assistance Centers (SFACs), MEB in-processing briefings, and town hall meetings, and they coordinate with PEB Liaison Officers (PEBLOs).<sup>246</sup> WWII Soldiers should be referred to the servicing SMEBC office for an informational briefing on the DES and their rights in the process within 14 days of initiation of the MEB process.<sup>247</sup>



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**Navy.** The Navy has designed a program specifically to address the legal needs of WII shipmates.<sup>248</sup> As of February 2012, the Navy DES Outreach Attorney Program was staffed with 12 civilian attorneys, including a Program Manager, who provide legal counsel to Sailors and Marines as they navigate the DES process.<sup>249</sup> The Program is expanding an outreach campaign that will ensure that those Sailors and Marines pending review by the PEB are made aware of, and have access to, Navy DES Outreach Attorney Program services at the earliest opportunity, including the limited duty and referral phases.<sup>250</sup> The early use of Outreach Attorney services will help ensure that the most complete and accurate medical information is submitted to the PEB, assisting in expediting Sailors and Marines through the DES process.<sup>251</sup> The Program also seeks to bridge the transition between the informal and formal PEB phases (IPEB and FPEB, respectively) of the DES process, allowing for an efficient overall evolution that instills confidence in Service members and their families.<sup>252</sup> Navy DES Outreach Attorneys are located at the major medical treatment facilities (MTFs) that process Navy and Marine Corps DES cases.<sup>253</sup> In November 2012, the Navy reported a total of 19 Navy Informal PEB (IPEB) disability attorneys, including six Marine Corps assets, were assigned to provide legal advice and assistance to Service members at Navy medical treatment facilities (MTFs).<sup>254</sup>

**Marine Corps.** The Marine Corps provides legal counsel to assist and advise Marines and Sailors as soon as they are referred to the MEB.<sup>255</sup> As of January 2012, the Marine Corps had mobilized six Reserve judge advocates within the Wounded Warrior Regiment and Judge Advocate Division who provide legal support on the East and West coasts, as well as at Quantico, Virginia, and Bethesda, Maryland.<sup>256</sup> The Program Manager, one of the six mobilized Reservists, is located at Marine Corps Headquarters.<sup>257</sup> In addition, two Reserve judge advocates were mobilized to provide legal support for the FPEB process at the Navy Yard in Washington, DC.<sup>258</sup> The Judge Advocate Division was evaluating future use of active duty judge advocates.<sup>259</sup> As of November 2012, the Marine Corps' IPEB counsel staffing continued to consist of six Reserve judge advocates.<sup>260</sup>

**Air Force.** The Air Force provides disability evaluation legal support through the Office of Airmen's Counsel (OAC), at Lackland AFB, Texas.<sup>261</sup> Formerly under the Air Force Personnel Center, this program was moved to the Air Force Trial Defense Division in April 2011 to best serve the interests of Recovering Airmen.<sup>262</sup>

In August 2011, the Air Force began supplementing its staffing with Reserve support of three attorneys and two paralegals.<sup>263</sup> As of December 2011, the Air Force had six attorneys and three paralegals providing Airmen legal support after the IPEB decision and, on a space available basis, during the IPEB and MEB stages.<sup>264</sup> In January 2012, the Air Force planned to increase OAC staffing, with the help of newly authorized active duty positions, to 13 attorneys and 10 paralegals.<sup>265</sup> The expanded staff will enable OAC to provide legal support at the MEB, IPEB, FPEB, and appellate stages of the DES conduct outreach briefings, and provide educational support to affiliated service providers, such as PEBLOs, Military Service Coordinators (MSCs), and Transition Assistance Program (TAP) and family support personnel.<sup>266</sup>



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**Topic:** Vocational Services

**Background:**

DoD and the Services collaborate with the Department of Veterans Affairs (VA) and the Department of Labor (DOL) to provide job training, counseling, referral, placement, and other assistance.

**The VA Vocational Rehabilitation and Employment (VR&E) Program.** The VR&E program can include free tuition at any institution of higher learning or vocational training where the Veteran is accepted, academic counseling, special tutoring if needed, dental care, job referrals, job placement, and other benefits.<sup>267</sup> VR&E is available to Veterans with a combined disability rating of 20 percent or more and to some Service members awaiting discharge.<sup>268, 269</sup> Access to VR&E for active duty Service members was mandated by NDAA 2011 which had a sunset provision ending their access by December 31, 2012.<sup>270</sup> The VOW to Hire Heroes Act of 2011 extended this sunset provision by an additional two years, until December 31, 2014.<sup>271</sup> In Fiscal Year (FY) 2012, VR&E began placing its counselors at all Integrated Disability Evaluation System (IDES) sites; at these sites, Service members referred to the Physical Evaluation Board (PEB) were mandated to meet with a VR&E counselor for information, evaluation, and to begin VR&E services where appropriate.<sup>272</sup>

**DoD Operation Warfighter (OWF) Program.** OWF is a federal internship program for RWs that strives to place RWs in work experiences that support recuperation.<sup>273</sup> The program provides RWs an opportunity to build their resumes, explore federal employment, develop job skills, and gain valuable federal government work experience.<sup>274</sup> While there is no promise of permanent employment with a federal agency upon completion of the OWF assignment, the program helps federal agencies experience the talent and skills of transitioning Service members. Many employers participating in the OWF program hire transitioning Service members; of the more than 2,000 RWs placed in OWF internships, 350 transitioned into federal employment.<sup>275</sup>

**Additional Initiatives.** Vocational services are often included in the annual National Defense Authorization Acts (NDAA), to pilot new services, or expand availability of existing services.<sup>276, 277</sup> Many of these provisions target the needs of all Service members rather than RWs specifically. For example, Section 551 of NDAA 2012 allows the Secretaries of the Services to offer job skills training programs, including apprenticeships, for Service members preparing to transition to civilian employment and civilian life.<sup>278</sup> For RWs, this means internship opportunities beyond the federal sector. Section 555 of NDAA 2012 allowed the Secretary of the Air Force to permit certain post-9/11 RWs to enroll in degree programs of the Community College of the Air Force.<sup>279</sup>



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**Topic:** Disability Evaluation System

**Background:**

Under the Legacy Disability Evaluation System (LDES), Service members are separately evaluated by DoD to determine fitness for duty and compensation for injury or disease incurred in the line of duty that inhibits a Service member's ability to perform the duties of her or his office, grade, rank, or rating.<sup>280, 281</sup> In LDES, the Department of Veterans Affairs (VA) evaluates the Service member separately to determine VA benefits, factoring in "all disabilities incurred or aggravated during military service" warranting a disability rating of 10 percent or higher.<sup>282, 283, 284</sup> This difference in what was considered by DoD and VA evaluations accounted for differences in ratings that transitioning Service members received from DoD and VA. Implementation of a new process has been underway since at least 2002 to address these discrepancies and other shortcomings in the Disability Evaluation System (DES).<sup>285, 286</sup>

The Senior Oversight Committee (SOC) called for pilot testing of an Integrated Disability Evaluation System (IDES) in 2007 as an alternative to the LDES; pilots began November 2007<sup>287</sup> at three military installations, and Congress included the pilots in the 2008 National Defense Authorization Act (NDAA).<sup>288</sup> The pilots were intended to provide a singular evaluation—using VA protocols and rating—in lieu of the separate DoD and VA evaluations. Specifically, the SOC called for increased consistency in ratings for Service members and veterans, protecting appellate procedures, ensuring direct hand-off from DoD case managers to VA case managers when a Service member transitions, and a reduction in the time from referral to DES to receipt of VA benefits.<sup>289</sup> At the direction of the SOC co-chairs, IDES was expanded worldwide.<sup>290</sup> Full DoD-wide implementation—replacing LDES—was achieved by the end of September 2011.<sup>291</sup> In December 2011, DoD published the first comprehensive Directive-Type Memorandum (DTM) 11-015, "Integrated Disability Evaluation System."<sup>292</sup> This DTM compiled numerous previous letters and guidelines published by the SOC and established in work groups.<sup>293</sup> This is the first comprehensive policy document on the DES since DoD Directive 1332.18, "Separation or Retirement for Physical Disability," in 1996.<sup>294</sup> DTM 1332.18 was reauthorized May 3, 2012, with an expiration date of January 1, 2013.<sup>295</sup>

The IDES features a single set of disability medical examinations designed for determining both fitness and ability to return to duty, and disability. Evaluation of a Service members' fitness for duty by DoD runs concurrently with VA determination of a disability rating, and has led to a streamlined process that reduces the amount of time it takes for Recovering Warriors (RWs) to receive benefits.<sup>296</sup> While the Physical Evaluation Board Liaison Officer (PEBLO) is assigned to assist the Service member through the process in both LDES and IDES, the assistance of a Military Service Coordinator (MSC) is a new support available in IDES.<sup>297</sup> Legal support related to DES is also available (see also information paper on *legal support*).

The IDES monthly report tracks IDES performance based on data from the VA Veterans Tracking Application (VTA) IDES module and customer satisfaction surveys administered by



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the Defense Manpower Data Center. The IDES population continues to grow and, as of October 2012, the average number of days to completion was 375 as compared to the goal of 295 and the average of 355 days for the previous month.<sup>298</sup>

Several sections of Public Law 111-383, NDAA 2011, addressed disability benefits and the disability process, including Sections 533, 534, 631, 632, and 633. Section 533 introduced a modification of the PEB process, expanding the rights of Service members by broadening the criteria for those eligible to request a review of their retirement or separation without pay for physical disability—this eligibility was formerly restricted to officers.<sup>299</sup> In an additional step, Section 534 prohibited a Service branch from authorizing an involuntary administrative separation of a Service member because of that member's unsuitability for deployment or worldwide assignment, when the unsuitability is because of a medical condition already assessed by a PEB.<sup>300</sup> Sections 631, 632, and 633 modified the criteria for calculating disability retirement pay. Section 631 allowed benefits to exceed the 75 percent cap on disability retirement for members who served on active duty for more than 30 years while retaining the retired pay multiplier based on years of service.<sup>301</sup> Section 632 specified that disability pay will be paid on the first day of each month, beginning after the month in which the right to such pay accrues.<sup>302</sup> Section 633 amended the method by which eligibility for receiving retired pay is calculated for Reserve Component (RC) Service members; the new method awards credit for time receiving medical care to be counted toward years of service.<sup>303</sup>

NDAA 2012 introduced additional provisions regarding disability evaluations. Section 527 prohibited Services from administratively separating a Service member based on medical conditions for which s/he was found fit for duty by a PEB.<sup>304</sup> Section 596 required the Secretary of Defense (SecDef) to report on the feasibility and advisability of an expedited disability determination process for RWs with certain specific diseases or conditions.<sup>305</sup> According to WCP, an expedited DES process is available for the most severely wounded, ill, or injured, but very few take advantage of it.<sup>306</sup>

NDAA 2013 also contained provisions related to IDES. Section 518 expands authority to conduct pre-separation medical exams for PTSD to licensed clinical social workers and psychiatric advanced practice registered nurses.<sup>307</sup> Section 524 instructs the Secretary of Defense to standardize, assess, and monitor the Services' quality assurance programs for MEBs, PEBs, and PEBLOs to ensure accuracy, consistency, and regular monitoring.<sup>308</sup>



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**Topic:** Support systems to ease transition from DoD to the Department of Veterans Affairs: Transition Assistance Program

**Background:**

Section 502 of Public Law 101-510, the 1991 National Defense Authorization Act (NDAA), as codified in 10 USC §1141-1143 and 1144-1150, authorized comprehensive transition assistance benefits and services for military personnel and their spouses separating or retiring from the Armed Forces within the last 180 days of service and beginning no fewer than 90 days prior to separation.<sup>309, 310, 311</sup> The transition assistance program (TAP) is a mutual responsibility of DoD, the Department of Labor (DOL), the Department of Veterans Affairs (VA), and the Department of Homeland Security (DHS), representing the Coast Guard.<sup>312, 313</sup>

The Veterans Opportunity to Work (VOW) to Hire Heroes Act, enacted November 21, 2011, made TAP mandatory for all eligible Service members, exempting only those the Secretaries of DoD and DHS, in consultation with DOL and VA, determined would not benefit because they “are unlikely to face major readjustment, health care, employment, or other challenges associated with the transition to civilian life” and those whose specialized skills are needed to support a deploying unit.<sup>314</sup>

Directive-Type Memorandum (DTM) 12-007, issued on November 21, 2012, implements the redesigned TAP in accordance with Section 221 of Public Law 112-56, the VOW to Hire Heroes Act of 2011.<sup>315</sup> According to the DTM, TAP consists of mandatory pre-separation counseling and the newly created Transition Goals, Plans, and Success (GPS).<sup>316</sup> The redesign of TAP was led by an interagency team with representatives from DoD, DHS, DOL, VA, and the Department of Education (ED), with the Office of Personnel and Management (OPM) and the Small Business Administration (SBA).<sup>317</sup> Transition GPS consists of a core curriculum, tracks (additional curriculum components designed to prepare Service members to transition into education, technical training, or entrepreneurship), and a mandatory capstone.<sup>318</sup> The DOL employment workshop and VA benefits briefing that were part of the legacy TAP are now mandatory components of the Transition GPS core curriculum, though the DTM does allow some exemptions to participation in the DOL workshop.<sup>319</sup> Other components of the core curriculum (transition overview, military occupation code crosswalk, resilient transitions, financial planning, and individual transition plan review) are not mandatory.<sup>320</sup> Rollout of Transition GPS to all military installations is expected to be complete by the end of 2013.<sup>321, 322</sup>

The scope of Transition GPS encompasses all Active Component (AC) separations and retirements and all Reserve Component (RC) deactivations.<sup>323</sup> DTM 12-007 indicates eligible Service members may begin the transition process up to 12 months prior to separation for those who are not retiring and, in the case of Service members anticipating retirement, 24 months prior to retirement.<sup>324</sup> Specifically, the DTM indicates pre-separation counseling should begin “as soon as possible during the 12-month period before separation,” and that the capstone should be completed no later than 90 days before separation.<sup>325</sup> Prior to release from active



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duty, demobilizing Reserve Component (RC) Service members are encouraged to “begin pre-separation counseling as soon as possible within their remaining period of service.”<sup>326</sup>

For those without easy access to an installation’s Transition Assistance Office, DoD established a TAP web portal—[www.TurboTAP.org](http://www.TurboTAP.org)—that provides a series of resources.<sup>327</sup> These resources include guidebooks and checklists, materials for transitioning personnel to help prepare for mandatory counseling, resources for TAP counselors and state transition assistance providers, links to partner websites, and other tools and information to help facilitate successful transition. The “Pre-separation Guide – Active Component” and “Transition Guide – Reserve Component” are available through TurboTAP.<sup>328</sup> Changes to TurboTAP will take place as part of the rollout of Transition GPS.<sup>329</sup>



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**Topic:** Overall coordination between DoD and the Department of Veterans Affairs: Joint Executive Council

**Background:**

As early as 2002, Congress recognized the need for health care collaboration between DoD and the Department of Veterans Affairs (VA). To foster such collaboration, Congress established the Joint Executive Council (JEC), which “provides senior leadership for collaboration and resource sharing between VA and DoD.”<sup>330</sup> Federal law describes the purpose of the JEC as follows:

“The Secretary of Veterans Affairs and the Secretary of Defense shall enter into agreements and contracts for the mutually beneficial coordination, use, or exchange of use of the health care resources of the Department of Veterans Affairs and the Department of Defense with the goal of improving the access to, and quality and cost effectiveness of, the health care provided by the Veterans Health Administration and the Military Health System to the beneficiaries of both Departments.”<sup>331</sup>

The JEC’s charter encompasses four areas: 1) overseeing development and implementation of the VA/DoD Joint Strategic Plan (JSP); 2) overseeing the Health Executive Council (HEC), the Benefits Executive Council (BEC), and Interagency Program Office (IPO); 3) identifying opportunities to enhance mutually beneficial services and resources; and 4) submitting an annual report to Department Secretaries and Congress, including progress on the JSP.<sup>332, 333</sup> The JEC laid a foundation of interagency collaboration which was furthered through the creation of the Senior Oversight Committee (SOC) for the Wounded, Ill, and Injured (WII) by Congress as part of the 2008 National Defense Authorization Act (NDAA). The SOC consisted of a team of senior DoD and VA officials co-chaired by the respective Deputy Secretaries. In early 2012, and consistent with the 2011 recommendation by the Recovering Warrior Task Force (RWTF), the SOC was folded into the JEC becoming the Wounded, Ill, and Injured Committee (WIIC) (see RWTF Reference Handbooks from Fiscal Years 2011 and 2012 for more information on the SOC). Subsequent JEC meetings have included review of the VA/DoD Warrior Care and Coordination Task Force and other Recovering Warrior (RW) matters.<sup>334</sup>

JEC’s Fiscal Year (FY) 2011 Annual Report summarizes JEC accomplishments under three goal areas.<sup>335</sup> Below is a sampling of accomplishments related to RWs, many of which are also under the purview of federal entities other than the JEC.

- Goal 1: Benefits and Services
  1. The TurboTap website was expanded and some of its material was redesigned in order to increase access and participation in pre-discharge programs and benefit briefings.



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2. A Wounded Warrior Care Coordination Summit was held on March 28-31, 2011, “to determine high priority wounded warrior issues and best practices to identify actionable recommendations to be worked by four chartered working groups.”
  3. A total of 75 Recovery Care Coordinators were trained across the services (including Special Operations Command); as well as nine Non-Medical Case Managers and 20 other participants from various Service Wounded Warrior Programs.
  4. National Resource Directory (NRD) unique visitors increased from less than 50,000 per month in August 2010 to more than 150,000 per month in September 2011. By the end of FY 2011, the NRD averaged more than 4,900 hits per day. Additionally, the number of resources on the NRD grew from 12,000 to nearly 14,000.
  5. The Federal Recovery Coordination Program (FRCP) successfully ensured that all referrals to the program were evaluated and assigned appropriately. In cases where it was not appropriate for an individual to be enrolled in FRCP, the evaluation process identified and facilitated access to that service or benefit. The FRCP program also met its goal of 100 percent participation in targeted educational activities for the FRCs.
  6. VA worked with DoD at all levels to ensure program integration between their complementary care coordination programs. Twice DoD and VA jointly participated in hearings with the United States House of Representatives, Veterans Affairs Committee in order to discuss the importance of the FRCP and the Recovery Coordination Program and how the programs complement each other.
- Goal 2: Health Care
    1. VA and DoD continued ongoing work to develop consistent standards for training in Evidence- Based Psychotherapy (EBP) for psychological health (PH) conditions. The Departments are working to consistently increase the availability of effective treatments for posttraumatic stress disorder (PTSD), major depression, and other PH conditions.
  - Goal 3: Efficiency of Operations
    1. Building upon the success of the Disability Evaluation System (DES) Pilot, particularly the ability to rapidly and effectively assist a larger number of Service members and their families, VA and DoD achieved their goal of extending the Integrated Disability Evaluation System (IDES) to 100 percent of Service members.
    2. Registered user accounts of the eBenefits portal increased by 500 percent from FY 2010 to FY 2011. The increase in registered eBenefits users suggests that VA/DoD outreach efforts were successful.



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3. The Departments launched the first survey mechanism to specifically gather input regarding the VA portion of the Transition Assistance Program (TAP). The surveys will be used for recording attendance and for the continued improvement of TAP.
4. The Departments worked cooperatively to develop a common Integrated Electronic Health Record (iEHR), including designing a governance structure consisting of a Program Executive and an Interagency Program Office (IPO) Advisory Board.
5. The Departments continued to demonstrate their shared commitment to the Virtual Lifetime Electronic Record (VLER) Initiative, enabling access to individuals' information in databases produced by VA, DoD, other federal and state agencies, and private sector partners.

These listed accomplishments also represent topics that Congress directed RWTF to assess. As such these topics are also addressed in other sections of the Research Handbook.



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**Topic:** Other matters: Resources for Reserve Component

**Background:**

The Reserve Components (RC) of each Service branch—Army Reserve (USAR), Air Force Reserve, Navy Reserve, Marine Corps Reserve, Coast Guard Reserve, Army National Guard (ARNG), and Air National Guard (ANG)—total nearly 1.1 million Service members.<sup>336</sup> Members of the Ready Reserve comprise 29 percent of the military force.<sup>337</sup> The ARNG and USAR have deployed more than 475,000 Soldiers—many Soldiers have been deployed more than once—in support of Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND).<sup>338</sup> The Services are required to “ensure their Recovery Coordination Programs (RCPs) are extended to include Recovering Service members (RSMs) in their RCs and incorporate all program services, to include identifying RSMs, assigning RSMs to Recovery Care Coordinators (RCCs), and preparing recovery plans.”<sup>339</sup> The Services’ wounded warrior programs do not differentiate between Active Component (AC) members and activated Reservists (see also information paper on *wounded warrior units and programs*).<sup>340</sup> However, certain resources are unique to the RC as a whole and to specific RCs.

**Army Community-Based Warrior Transition Units (CBWTUs).** CBWTUs allow qualified ARNG and USAR Reservists to recover in their home communities. As of March 2012, 56 percent of the 9,718 Soldiers assigned to WTUs/CBWTUs were ARNG or USAR Soldiers, and 23 percent of the 9,718 were managed by a CBWTU.<sup>341</sup>

**USAR RCCs.** As of February 2012, 19 RCCs, trained by DoD, are located in high-density areas throughout the USAR. The USAR RCC program does not support ARNG Soldiers.<sup>342, 343</sup>

**National Guard Bureau (NGB) Transition Assistance Advisor (TAA) Program.** NGB TAA serves all redeploying or separating RC members, injured or not. TAAs are in each of the 50 states and four territories, co-located with the state Adjutants General and working with the Department of Veterans Affairs (VA) sectors and the CBWTUs.<sup>344</sup> TAAs assist RC members and families with reintegration into the unit or transition to civilian life by establishing one-on-one contact and educating them on federal, state, local, and community benefits and entitlements. TAAs partner extensively with entities such as the Joint Family Support Assistance Program (JFSAP), Employer Support of the Guard and Reserve (ESGR), Psychological Health (PH), Yellow Ribbon Reintegration Program (YRRP), CBWTUs, job assistance programs, veterans service organizations (VSOs), and others.<sup>345</sup> As of December 2012, there were 65 contracted TAAs and a handful of TAAs working as state employees or in Active Duty for Operational Support (ADOS) status. TAAs carry caseloads of approximately 1:64 for wounded, ill, or injured (WII) members and 1:6020 for all separating/returning members.<sup>346</sup> While TAAs serve all RC members, and even some AC members, ARNG members comprise their largest clientele.<sup>347</sup>



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**ARNG.** The ARNG has taken several steps to address gaps in RC medical care, and the management of Soldiers who are not medically ready for deployment. One such step was creating a process for Soldiers with low risk-low acuity conditions, who were injured or became ill during mobilization or training, to return to active duty on short-term orders to resolve those duty-related limiting conditions. The Reserve Component Managed Care (RCMC) Pilot Program included 14 states (12 actively involved) from the ARNG with a formal application process for putting eligible Soldiers on active duty orders for up to 179 days. Soldiers participating in this program were managed through the Medical Management Processing System (MMPS). MMPS systematically monitors, manages, and facilitates authorized medical care for Soldiers who are medically non-available for deployment and focuses on facilitating a final disposition of their medical condition. MMPS utilizes many of the full-time medical staff that the ARNG has brought on board over the past 10 years to assist in building and maintaining medical readiness. Overseen by the Deputy State Surgeon, the staff that support the MMPS include case managers, care coordinators and medical readiness non-commissioned officers (NCOs). The RCMC pilot expired August 2012; as of December 2012, the National Guard Bureau was awaiting Army Headquarters approval for full implementation of the RCMC Program across the ARNG.<sup>348</sup>

Another recent initiative was the implementation of the RC Soldier Medical Support Center (SMSC). Established in Pinellas Park, Florida, in January 2011 and staffed by USAR and ARNG Soldiers, it was conceived as a short-term solution to facilitate the screening of the backlog of RC Medical Evaluation Board (MEB) packets, and a gateway for RC Integrated Disability Evaluation System (IDES) medical processing support. The RC SMSC screens RC MEB packets for accuracy/completeness; validates and submits RC MEB packets to Medical Command; and provides administrative /medical subject matter expertise regarding IDES RC medical processing.<sup>349</sup> Aligned in 2012 under the U.S. Army Physical Disability Agency (USAPDA),<sup>350</sup> SMSC indicated in December 2012 that it was moving toward expanding its mission beyond the screening, validation, and submission of MEB packets, and will begin to work directly with states and Regional Support Commands (RSCs) to help them identify cases that warrant disability evaluation.<sup>351</sup>

**Marine Corps Reserve.** The Marine Corps Reserve established its PH Outreach Program in 2009 to provide activated Reserve Marine forces access to appropriate PH care services, to increase resilience, and to facilitate recovery. Much like the Navy Psychological Health Outreach Program (PHOP), six teams of five licensed clinicians work throughout the country in Washington, California, Missouri, Georgia, Louisiana, and Massachusetts. They provide Marines and family members initial screenings, referrals, and telephone/email follow-up services to ensure clients have received needed information and services, whether through military, VA, or civilian community resources. In addition, PHOP provides psycho-educational briefs and consultation to command, and interfaces with civilian resources to ensure they have the background necessary to effectively serve the Marine Corps population.<sup>352</sup>



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**Navy Reserve.** The Navy Region Mid-Atlantic (NRMA) RC Command Medical Hold Department (MEDHOLD) East, located in Norfolk, Virginia, provides case management services for RC members who are authorized a medical hold status.<sup>353</sup> Eligible Sailors must be unfit for duty and have “conditions incurred or aggravated after completion of continuous active duty orders for more than 30 days.”<sup>354</sup> MEDHOLD case management is provided by RN case managers, with an emphasis on medical matters, although non-medical case management is provided as warranted.<sup>355</sup>

The Navy Reserve established a PHOP in 2008 aimed at maintaining psychological health and promoting resilience and recovery of Reserve Service members and their families.<sup>356</sup> PHOP staff, including clinically licensed outreach coordinators and outreach support team members, are co-located with RC Command staff in five regions—Mid-Atlantic, Southeast, Southwest, Northwest, and Midwest. They conduct a thorough behavioral health screening to holistically assess an individual’s psychological, physical, and social functioning, and family well-being. Based on this screening, PHOP staff link individuals with appropriate military or community-based providers and provide follow-up. PHOP also conducts outreach calls with recently demobilized Sailors and provides psycho-educational briefings on a variety of topics of interest to the Navy Bureau of Medicine and Surgery (BUMED).<sup>357</sup>

**YRRP.** The 2008 National Defense Authorization Act (NDAA) called for the establishment of the YRRP to provide information, services, referral, and proactive outreach programs to RC members and families throughout the deployment cycle.<sup>358</sup> DoD Instruction 1342.28, “DoD Yellow Ribbon Reintegration Program (YRRP)” provides comprehensive guidance regarding YRRP policy, responsibilities, and implementation, replacing earlier departmental guidance.<sup>359</sup> For reintegration purposes, the YRRP is organized on a 30-60-90-day post-deployment model.<sup>360</sup> Official health screening in the form of the post-deployment health reassessment (PDHRA) is to be incorporated into 90-day YRRP activities (see also information paper on *services for posttraumatic stress disorder and traumatic brain injury*).<sup>361</sup>

NDAA 2011 introduced YRRP several enhancements, including 1) expansion of partnerships with the VA and Service and state-based programs, 2) a mechanism for the Center for Excellence in Reintegration to evaluate the effectiveness of YRRP, 3) authorization of resiliency training, and 4) authorization of transportation and per diem allowances for YRRP participants.<sup>362</sup> Section 590 of NDAA 2012 restated the function of the Center for Excellence in Reintegration to focus on lessons learned from states’ Guard/Reserve, training for state representatives, and identifying best practices in information dissemination and outreach.<sup>363</sup> Section 703 of NDAA 2012 provides for mental health care and training on suicide prevention and response for un-activated Reservists during training, at no cost to the Reservists.<sup>364</sup>



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**References for non-medical case management:**

<sup>1</sup> Government Accountability Office (September 26, 2007). DoD and VA: Preliminary observations on efforts to improve health care and disability evaluations for returning service members. Washington, DC: Author. GAO 07-1256T.

<sup>2</sup> National Defense Authorization Act of 2008, Pub. L. No. 110-181, §1611 (2008).

<sup>3</sup> Office of the Under Secretary of Defense for Personnel & Readiness (December 1, 2009). Department of Defense Instruction 1300.24: Recovery coordination program.

<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

<sup>7</sup> Department of Defense (October 2011). Wounded, ill, and injured (WII) compensation and benefits handbook. Retrieved January 17, 2012, from <http://warriorcare.dodlive.mil/files/2011/11/2011-DoD-Compensation-and-Benefits-Handbook1.pdf>

<sup>8</sup> Col Mayer, J.L., and Williamson, P.D. Marine Corps Wounded Warrior Regiment briefing to the RWTF. February 23, 2012. While WWCTP indicated 50 RCCs for the USMC, USMC WWR indicated 49 RCCs with caseloads. WWCTP reported a total of 181 RCCs as of February 2012.

<sup>9</sup> CAPT Carter, B., and Paganelli, V.M. Navy Safe Harbor and BUMED briefing to the RWTF. February 22, 2012. Navy Safe Harbor indicated having 21 as of February 2012, while WWCTP indicated Navy had 18 RCCs.

<sup>10</sup> Burdette, P. Briefing to the RWTF. Wounded Warrior Care and Transition Policy. February 21, 2012.

<sup>11</sup> Mencl, P., Roberts, S., and Stevens, B. (June 10, 2010). Wounded Warrior Care and Transition Policy programs overview. Presentation to DoD Inspector General Office.

<sup>12</sup> Army Warrior Care and Transition Policy response to the RWTF data call. April 16, 2012.

<sup>13</sup> Army Warrior Care and Transition Policy response to the RWTF data call. April 16, 2012.

<sup>14</sup> BG Williams, D. Army Warrior Transition Command briefing to the RWTF. February 21, 2012.

<sup>15</sup> Wounded Warrior Regiment. Briefing to the RWTF. Recovery Care Coordinators. January 11, 2012.

<sup>16</sup> Col Mayer, J.L., and Williamson, P.D. Marine Corps Wounded Warrior Regiment briefing to the RWTF. February 23, 2012.

<sup>17</sup> Ibid.



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<sup>18</sup> CAPT Carter, B., and Paganelli, V.M. Navy Safe Harbor and BUMED briefing to the RWTF. February 22, 2012.

<sup>19</sup> Burdette, P. Briefing to the RWTF. Wounded Warrior Care and Transition Policy. February 21, 2012.

<sup>20</sup> Air Force Warrior and Survivor Care response to the RWTF data call. March 8, 2012.

<sup>21</sup> Lt Col Black, S. Briefing to the RWTF. Air Force Wounded Warrior program: Non-medical care management and support. December 6, 2011.

<sup>22</sup> McDonnell, K. USSOCOM Care Coalition briefing to the RWTF. February 22, 2012.

<sup>23</sup> Ibid.

**References for medical care case management:**

<sup>24</sup> Department of Defense (August 26, 2009; Rev. August 16, 2011). Department of Defense Directive-Type Memorandum 08-033: Interim guidance for clinical case management for the wounded, ill, and injured service member in the military health system.

<sup>25</sup> Department of Defense (December 1, 2009). Department of Defense Instruction 1300.24: Recovery coordination program.

<sup>26</sup> Weese, C. Briefing to the RWTF. Federal Recovery Care Program. February 21, 2012; slide 2. Federal recovery coordinators are masters-prepared nurses and clinical social workers who provide care coordination for severely wounded, ill, and injured Service members, Veterans, and their families.

<sup>27</sup> National Defense Authorization Act of 2008, Pub. L. No. 110-181, §1611 (2008).

<sup>28</sup> Department of Defense (December 1, 2009). Department of Defense Instruction 1300.24: Recovery coordination program.

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**Appendix:**

**Acronyms Used in Handbook**

A&FRC	Airman and Family Readiness Centers
AC	Active Component
ADOS	Active Duty for Operational Support
AF	Air Force
AFPC	Air Force Personnel Center
AFSAP	Air Force Survivor Assistance Program
AFW2	Air Force Wounded Warrior
AHLTA	Armed Forces Health Longitudinal Technology Application
ANG	Air National Guard
ARNG	Army National Guard
ASD(HA)	Assistant Secretary of Defense for Health Affairs
AW2	Army Wounded Warrior
BEC	Benefits Executive Council
BPR	Business Process Re-engineering
BUMED	Navy Bureau of Medicine and Surgery
CAT	Category
CBT	Cognitive Behavioral Therapy
CBWTU	Community-Based Warrior Transition Unit
CONUS	Continental United States
CPT	Cognitive Processing Therapy
CRP	Comprehensive Recovery Plan
DCoE	Defense Centers of Excellence
DES	Disability Evaluation System
DHCC	Deployment Health Clinical Center
DHS	Department of Homeland Security



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DISC	District Injured Support Coordinators
DoD	Department of Defense
DoDI	Department of Defense Instruction
DOL	Department of Labor
DTM	Directive-Type Memorandum
DVBIC	Defense and Veterans Brain Injury Center
EACE	Extremity Trauma and Amputation Center of Excellence
EBP	Evidence- Based Psychotherapy
EHR	Electronic Health Record
EMDR	Eye Movement Desensitization and Reprocessing
ESGR	Employer Support of the Guard and Reserve
FPEB	Formal Physical Evaluation Board
FRC	Federal Recovery Coordinator
FRCP	Federal Recovery Coordination Program
FY	Fiscal Year
GAO	Government Accountability Office
GS	Government Service
HCE	Hearing Center of Excellence
HEC	Health Executive Council
IDES	Integrated Disability Evaluation System
iEHR	Individual Electronic Health Record
IOC	Initial Operating Capacity
IOM	Institute of Medicine
IOP	Intensive Outpatient Therapy
IPEB	Informal Physical Evaluation Board
IPO	Interagency Program Office
JEC	Joint Executive Council
JFSAP	Joint Family Support Assistance Program
JFTR	Joint Federal Travel Regulation



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JSP	Joint Strategic Plan
JTTR	Joint Theatre Trauma Registry
LDES	Legacy Disability Evaluation System
LNO	Liaison Officer
LRMC	Landstuhl Regional Medical Center
M4L	Marine for Life Program
MACE	Military Acute Concussion Evaluation
MCCM	Medical Care Case Manager
MCFP	Military Community and Family Policy
MEB	Medical Evaluation Board
MEDCON	Medical Continuation
MEDHOLD	Medical Hold Department
MFLC	Military Family Life Consultant
MH	Mental Health
MHS	Military Health System
MMPS	Medical Management Processing System
MOS	Military Occupational Specialty
MOU	Memorandum of Understanding
MSC	Military Service Coordinator
mTBI	Mild Traumatic Brain Injury
MTF	Medical Treatment Facility
NCO	Non-Commissioned Officer
NCPTSD	National Center for Posttraumatic Stress Disorder
NDAA	National Defense Authorization Act
NGB	National Guard Bureau
NICoE	National Intrepid Center of Excellence
NMA	Non-Medical Attendant
NMCM	Non Medical Case Manager
NRMA	Navy Region Mid-Atlantic



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OAC	Office of Airmen’s Counsel
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OND	Operation New Dawn
OPM	Office of Personnel and Management
OSD	Office of the Secretary of Defense
OWF	Operation Warfighter
PDHRA	Post-Deployment Health Reassessment
PE	Prolonged Exposure
PEB	Physical Evaluation Board
PEBLO	Physical Evaluation Board Liaison Officer
PH	Psychological Health
PHOP	Psychological Health Outreach Program
PTSD	Posttraumatic Stress Disorder
RC	Reserve Component(s)
RCC	Recovery Care Coordinator
RCMC	Reserve Component Managed Care
RCP	Recovery Coordination Program
RSM	Recovering Service Member
RT	Recovery Team
RW	Recovering Warrior
RWTF	Recovering Warrior Task Force
SBA	Small Business Administration
SCAADL	Special Compensation for Assistance with Activities of Daily Living
SMSC	Soldier Medical Support Center
SecDef	Secretary of Defense
SES	Senior Executive Service
SFAC	Soldier and Family Assistance Center
SMEBC	Soldiers’ Medical Evaluation Board Counsel



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SNRI	Serotonin Norepinephrine Reuptake Inhibitors
SOC	Senior Oversight Committee
SOF	Special Operations Forces
SSRI	Selective Serotonin Reuptake Inhibitors
T2	National Center for Telehealth and Technology
TAA	Transition Assistance Advisor
TAP	Transition Assistance Program
TBI	Traumatic Brain Injury
TMA	TRICARE Management Activity
USAR	U.S. Army Reserve
USAPDA	U.S. Army Physical Disability Agency
USC	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USMC	U.S. Marine Corps
USSOCOM	U.S. Special Operations Command
VA	Department of Veterans Affairs
VASRD	Veterans Administration Schedule for Rating Disabilities
VCE	Vision Center of Excellence
VISN	Veterans Integrated Service Networks
VISTA	Veterans Health Information Systems and Technology Architecture
VLER	Virtual Lifetime Electronic Record
VOW	Veterans Opportunity to Work
VR&E	Vocational Rehabilitation and Employment
VSO	Veterans Service Organizations
VTA	Veterans Tracking Application
WCP	Office of Warrior Care Policy
WII	Wounded, Ill, and Injured
WIIC	Wounded, Ill, and Injured Committee
WRNMMC	Walter Reed National Military Medical Center



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WRNMMC	Walter Reed National Military Medical Center
WTC	Warrior Transition Command
WTU	Warrior Transition Unit
PWWBn	Wounded Warrior Battalion
WWBn-East	Wounded Warrior Battalion-East (Camp Lejeune)
WWBn-West	Wounded Warrior Battalion-West (Camp Pendleton)
WWCTF	Wounded Warrior Care and Transition Policy
WWR	Wounded Warrior Regiment
YRRP	Yellow Ribbon Reintegration Program



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## **APPENDIX D: METHODOLOGY**



## RWTF 2012/2013 Methodology

This appendix provides an overview of the RWTF’s research methodology during its third year of operations. The overview is organized in five parts:

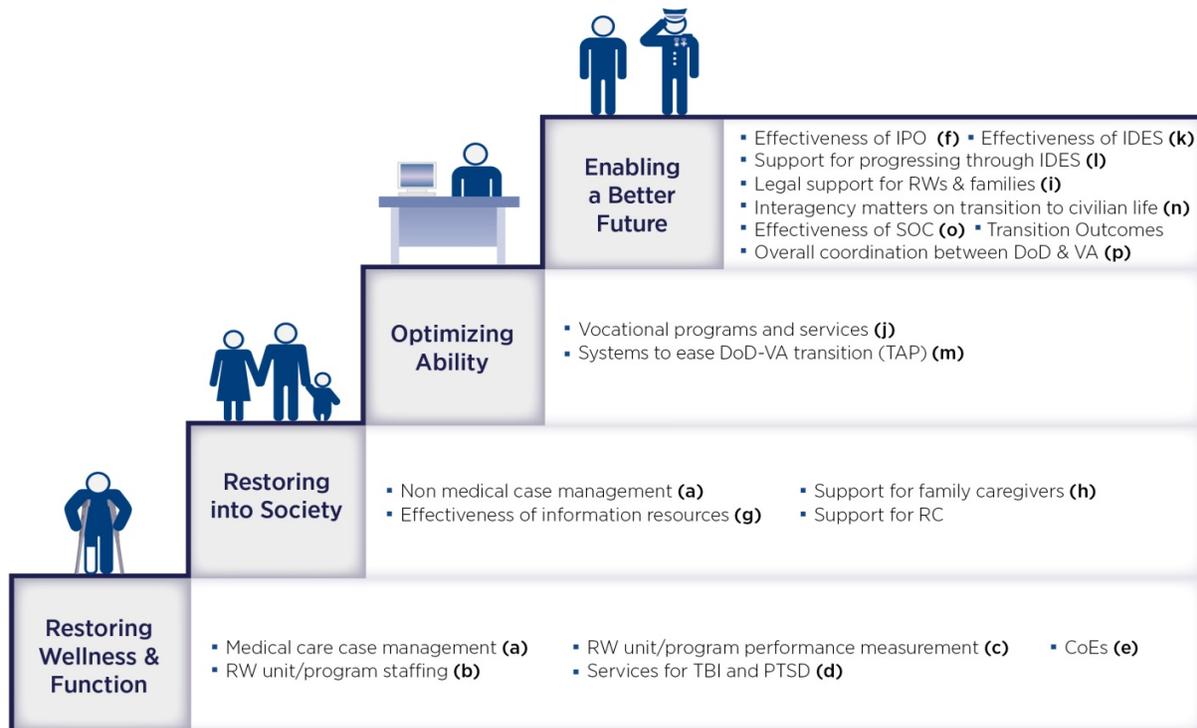
- Research topics.
- Approach.
- Focus groups.
- Transition outcomes.
- Strategy for assessing effectiveness.

Additional detail regarding aspects of the RWTF’s methodology is contained in separate appendices and referenced below.

### Research Topics

Congress specified over a dozen diverse matters that the RWTF is to review and assess each year. Historically, the RWTF has conceptualized these topics into four domains reflecting a holistic, progressive, and RW-centered approach for recovery, rehabilitation, and reintegration: Restoring Wellness & Function, Restoring into Society, Optimizing Ability, and Enabling a Better Future. These domains and topics are depicted graphically in the exhibit following.

**Exhibit 1: Topics Organized by Domain**



The letters following many of the above topics (a through p) reference the legislation establishing the RWTF within the NDAA 2010. These topics are listed in the legislation under Annual Report, Matters to be reviewed and assessed (Para (C)(3)). The topics added by the RWTF, Support for Reserve Component (RC) and Transition Outcomes, are also included in this exhibit.

## Approach

The RWTF engaged in a broad range of data collection activities between November 2012 and April 2013 to inform its third annual assessment and recommendations. These activities were guided by an adapted version of the comprehensive data collection framework that structured the first two years of effort. The RWTF's FY 2013 approach mirrored the previous two years; in addition, focus groups were held, and survey data collected, from RWs at Joint Force Headquarters sites and from family members at a CBWTU. The main sources from which the RWTF gathered information were: Headquarters-level proponents, site-level proponents, Recovering Warriors and family members, and pre-existing information sources such as reports, other literature and documents, and administrative or survey databases. The main methods the RWTF used to gather information from these sources included briefing presentations and panel discussions during bimonthly RWTF business meetings, briefing presentations and focus groups during site visits, and analysis of existing databases, reports, or literature. Exhibit 1 identifies the types of methods used to gather various categories of information.

**Exhibit 1:** Information Gathering Methods by Information Source

Source of Information	Methods of Gathering Information	Example
Headquarters-level program proponents	<ul style="list-style-type: none"> <li>▶ Briefings during business meetings</li> <li>▶ Panel discussions during business meetings</li> </ul>	DoD and Service-level Wounded Warrior programs
Site-level program proponents	<ul style="list-style-type: none"> <li>▶ Briefings during site visits</li> </ul>	Wounded Warrior program/unit leadership and cadre
Recovering Warriors and family members	<ul style="list-style-type: none"> <li>▶ Focus groups</li> </ul>	RW assigned to RW units or line units, and RWs at JFHQs; spouses and/or parents of RWs at WTUs and CBWTU, and WWR battalions/detachments
Existing reports, literature, and documents	<ul style="list-style-type: none"> <li>▶ Search and review</li> </ul>	GAO reports, peer reviewed literature, news articles
Administrative or survey databases	<ul style="list-style-type: none"> <li>▶ Data calls</li> </ul>	Personnel rosters, survey results

Highlights of the RWTF's 2012/2013 data collection activities are summarized below:

- Six business meetings totaling approximately 168 RWTF person-days.<sup>1</sup>
- Forty Headquarters-level (or other national-level) briefings, involving 60 personnel.
- Nine Headquarters-level (or other national-level) panel discussions, involving 26 personnel.
- Fourteen site visits totaling 95 RWTF person-days.<sup>1</sup>
- One hundred twenty site-level briefings,<sup>2</sup> involving over 150 site-level personnel.
- Thirty site-level focus groups involving 263 participants (including 23 Recovering Warrior (RW) sessions and seven Family Member (FM) sessions).
- Review of more than 175 reports, articles, and policy documents.

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A more detailed accounting of the RWTF's data collection activities is in Appendices E and F, including the business meeting and site visit schedules and in Appendix G, a crosswalk of sources by topic. Further detail regarding the RWTF's focus groups follows.

## Focus Groups

On-site focus groups form a centerpiece of the RWTF's data collection activities, capturing a real-time customer perspective. This year, teams of 3 to 5 members visited 13 Army, Air Force, Navy, Marine Corps, joint, and National Guard sites, where they held separate focus groups with RWs (assigned to transition units or line units) and family caregivers. In addition, the RWTF visited the James A. Lovell Federal Health Care Center. The RWTF conducted 23 RW focus groups and seven caregiver focus groups at these locations, employing a methodology and instruments approved in advance by the ICF International Institutional Review Board. The RWTF also conducted.

Focus group participants also completed anonymous mini-surveys, which gathered both demographic and substantive information. The mini-surveys were completed by 205 Recovering Warriors, of whom 84 percent were male. One-half were Active Component and Army National Guard Soldiers. Most were junior enlisted personnel and junior noncommissioned officers (88%). Almost two-thirds (64%) indicated that they have more than one condition. The most prevalent of these conditions was an orthopedic injury, followed by psychological diagnosis and traumatic brain injury (TBI). Seventy-two family members completed mini-surveys, of whom three-quarters (75%) were spouses. Over four-fifths (82%) of the family members indicated their Service member had more than one condition, and the most prevalent of these conditions was an orthopedic injury, followed by psychological diagnosis and TBI. See Appendix I for further detail regarding the characteristics of the mini-survey respondents.

## Transition Outcomes

In FY2013, the RWTF continued to explore “transition outcomes” and strategies to improve transition by gathering information from select DoD proponents, VA proponents, and private organizations providing lifetime and/or post-transition support.

Four specific Transition Outcome questions were posed:

- What are the gaps and snags that interfere with transitioning wounded, ill, and injured to local VA programs, including VHA and VBA (warm handoff)?
- What can DoD do to improve the transition of wounded, ill, and injured to local VA programs (warm handoff)?
- What are the gaps and snags that interfere with transition wounded, ill, and injured to civilian life (long term outcomes)?
- What can DoD do to improve the transition of wounded, ill, and injured to civilian life (long term outcomes)?

A total of 23 briefings or panels during business meetings and site visits, involving approximately 50 proponents, responded to these transition outcome questions. Among the briefers/panelists were Navy Wounded Warrior - Safe Harbor non-medical care managers and Anchor Program mentors, Army Wounded Warrior (AW2) Advocates, Wounded Warrior Regiment District Injured Support

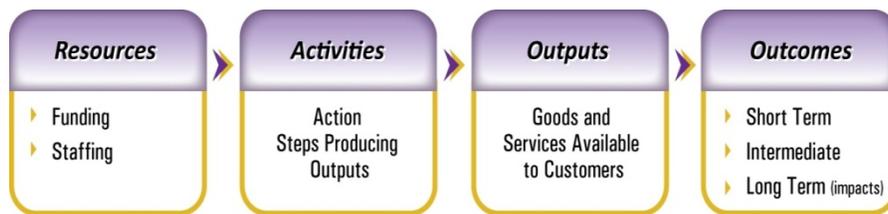
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Coordinators (DISCs), Air Force Wounded Warrior (AFW2) non-medical case managers (NMCs), VA OEF/OIF Program Managers, other VA providers, Hope for the Warriors, Wounded Warrior Project, and Yellow Ribbon Fund, and other entities.

### Strategy for Assessing Effectiveness

“Effectiveness” may be defined as the extent to which a policy or program accomplishes its stated goals and objectives or meets the needs it was established to address. Assessing effectiveness tells what positive difference a policy or program makes. It is not a straightforward task, however, and there are myriad ways to approach it—some more formal and rigorous than others. The RWTF’s approach to assessing effectiveness is a practical one that takes into account the maturity of existing RW programs and policies as well as the metrics that these initiatives are currently gathering. The RWTF approach capitalizes on the logic model—a tool that helps program developers and evaluators explicate how the elements of a program are supposed to work together to achieve intended outcomes. This model is particularly useful for illustrating the range of opportunities and various types of metrics—in addition to outcomes—that can contribute to an assessment of effectiveness. A pared-down sample logic model is presented in Exhibit 2.

**Exhibit 2:** Basic Logic Model



Although outcome data provide the strongest evidence of an initiative’s effectiveness, younger initiatives are more likely to be gathering resource data, activity data, and/or output data. Accordingly, the RWTF sought and used the best available metrics to inform its assessments of program and policy effectiveness.

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<sup>1</sup>Total includes RWTF Members only.

<sup>2</sup>Although most briefings were presented directly to the RWTF Members, some briefing content was imparted less formally, and other briefings and related collateral were provided to the Members as take-away materials.

**APPENDIX E: BUSINESS MEETINGS  
AND PRESENTATIONS/PANELS**



## Business Meetings and Presentations/Panels

Dates	Presentations/Panels
December 4–5, 2012	<p><b>Presentations</b></p> <ul style="list-style-type: none"> <li>▶ Assessment of Ongoing Efforts in the Treatment of PTSD (COL (Ret) E.C. Ritchie)</li> <li>▶ Transition Assistance Advisor Program (M.J. Conner Sr.)</li> <li>▶ Update from Army National Guard on Medical Initiatives to Build Overall Personnel Readiness (COL J.K. Faris &amp; R. Holdeman)</li> <li>▶ U.S. Physical Disability Agency (USAPDA) &amp; Reserve Components Soldier Medical Support Center (RC SMSC) (COL K.E. Knowlton)</li> <li>▶ Physical Disability Board of Review (PDBR) (M. LoGrande)</li> </ul> <p><b>Panel: Special Compensation for Assistance With Activities of Daily Living (SCAADL)</b></p> <ul style="list-style-type: none"> <li>▶ Army (L. Lock &amp; L.A. Perry)</li> <li>▶ Navy (CDR D. Shapiro &amp; L.B.P. Weatherford)</li> <li>▶ Marine Corps (P. Williamson)</li> <li>▶ Air Force (M Sgt C. Noel)</li> </ul> <p><b>Panel: Recovering Warriors</b></p> <ul style="list-style-type: none"> <li>▶ J. Allen, C. Essex, C. Frost, and M. Ramsey</li> </ul>
January 14-15, 2013	<p><b>Presentations</b></p> <ul style="list-style-type: none"> <li>▶ Hearing Center of Excellence (Lt Col M.D. Packer)</li> <li>▶ Vision Center of Excellence (COL D.A. Gagliano &amp; M.G. Lawrence)</li> <li>▶ Extremity Trauma and Amputation Center of Excellence (B J. Randolph)</li> <li>▶ DoD/VA Interagency Program Office (B.P. Butler)</li> <li>▶ National Intrepid Center of Excellence (CAPT S.M. Kass, J.P. Kelly, &amp; CAPT R.L. Koffman)</li> <li>▶ Rehabilitation in Traumatic Brain Injury (K.C. Curley)</li> <li>▶ Veteran Affairs VR&amp;E Service (M. Devlin)</li> <li>▶ Federal Recovery Coordination Program (C.A. Weese)</li> <li>▶ Clinical Case Management Services (G. Quisenberry &amp; D.F. Lovelace)</li> <li>▶ Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Update (CAPT P.S. Hammer, A. Cernich, C.C. Engel, &amp; COL J.B. Grimes).</li> </ul>
February 27-28, 2013	<p><b>Presentations</b></p> <ul style="list-style-type: none"> <li>▶ Army WTC Survey Program (Dr. M. Gliner)</li> <li>▶ Army Response to RWTF FY12 Recommendations (BG D. Bishop, LTC E. Brusher, Mr. R. Coffey, COL J. Jones, LTC J. Baker, Ms. M. Tuddenham, LTC D. Dudek, and Ms. N. Adams)</li> <li>▶ Additional Questions for Army WTC - Family/Caregiver Support, PTSD Services, and Vocational Services (COL J. Jones, LTC E. Brusher, and Ms. N. Adams)</li> <li>▶ Air Force Response to RWTF FY12 Recommendations (Col N. DeMarco and Col T. Poindexter)</li> <li>▶ USAF Wounded Warriors Survey (2011): Key Findings, Follow-up, and Next Steps (Dr. C. Sims and Dr. C. Vaughan)</li> <li>▶ Navy Wounded Warrior, Safe Harbor (N95) – Department of the Navy Response to RWTF FY12 Recommendations (CAPT S. Hall, CAPT C. Evans, R. Powers, and CDR D.E. Webster)</li> <li>▶ Navy Safe Harbor Enrollee Survey (G. Patrissi)</li> <li>▶ Navy Safe Harbor Family Caregiver Survey (G. Patrissi)</li> <li>▶ Marine Corps WWR Response to RWTF FY12 Recommendations (Col W. Buhl)</li> <li>▶ Marine Corps WWR Survey Program (E. Flores)</li> <li>▶ Army Back-up Slides (Briefing submitted to the RWTF)</li> <li>▶ Navy Back-up Slides (Briefing submitted to the RWTF)</li> <li>▶ Marine Corps Back-up Slides (Briefing submitted to the RWTF)</li> <li>▶ Air Force Back-up Slides (Briefing submitted to the RWTF)</li> </ul>

Dates	Presentations/Panels
April 2-3, 2013	<b>Presentations</b>
	<ul style="list-style-type: none"> <li>▶ Military Health System (MHS) Centers of Excellence (CoE) Oversight Board (W. Lockette)</li> <li>▶ Military Health System (MHS) Patient Centered Medical Home (PCMH) (R. Julian)</li> <li>▶ Continuous Process Improvements: Navy Medical Evaluation Board, Navy Physical Evaluation Board, and Comprehensive Combat and Complex Casualty Care (C5) (T. Ward)</li> <li>▶ Transition Assistance Program Re-Design (S. Kelly)</li> <li>▶ Military Health System (MHS) Governance Reorganization (Maj Gen D. Robb)</li> <li>▶ VA-DoD Warrior Care Coordination (K. Guice and J.D. Riojas)</li> <li>▶ Job Training, Employment Skills Training, Apprenticeships and Internships (F.C. DiGiovanni)</li> <li>▶ Telephone Survey of Ill or Injured Service Members Post-Operational Deployment: Survey Results through 65th Month-FY12 Q4 (R. Bannick)</li> <li>▶ DoD Response to the Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces (D. Seymour)</li> <li>▶ Center for Deployment Psychology (W. Brim)</li> <li>▶ Yellow Ribbon Reintegration Program: Overview Brief (M. Balocki and CAPT J. Mason)</li> </ul>
	<b>Panel: Genitourinary Injuries Update</b>
	<ul style="list-style-type: none"> <li>▶ Defense Health Program Research &amp; Development Overview: Focus on Clinical &amp; Rehabilitative Medicine &amp; Genitourinary/Lower Abdomen Reconstruction (T. Rauch)</li> <li>▶ Army Medicine Urogenital Injury Update (COL Crunkhorn)</li> </ul>
	<b>Panel: Nonprofits Supporting RWs</b>
June 10–11, 2013	<b>Task Force Recommendation Development</b>
	July 25–26, 2013

## **APPENDIX F: SITE VISITS**



## Site Visits

Dates	Installation/ Location/Service	Presentations
November 13-15, 2012	Walter Reed National Military Medical Center (Army, Navy, and Marine Corps)	<ul style="list-style-type: none"> <li>▶ Wounded Warrior Coordinated Medical Case Management - Navy</li> <li>▶ Wounded Warrior Coordinated WTB Nurse Case Management</li> <li>▶ The Medical Boards Division (Mario F. Golle, Jr., MD. and LT Brenna S. Kelly)</li> <li>▶ Office of Soldiers' Counsel (Army) (Lakandula Duke Dorotheo and Jennifer Hays) (HQ-level briefing)</li> <li>▶ Navy Disability Attorney Program (Karen Morrisroe, Del Grissom, and Liz Moores) (HQ-level briefing)</li> <li>▶ USMC DES Counsel Brief (Major W.J. Collins, Jr.) (HQ-level briefing)</li> <li>▶ Marine Corps Recovery Care Coordinators</li> <li>▶ TBI Services at WRNMMC (Louis M. French, Psy.D.)</li> <li>▶ PTSD Services for RWs (CDR James West)</li> <li>▶ Transition Outcomes:               <ul style="list-style-type: none"> <li>- AW2</li> <li>- FRC</li> <li>- USSOCOM Care Coalition (Mark Boyett)</li> <li>- WWR</li> </ul> </li> <li>▶ Vocational and Employment Services:               <ul style="list-style-type: none"> <li>- SOCOM</li> <li>- USMC</li> <li>- WTB</li> </ul> </li> <li>▶ Army-Specific Questions for Army WTB Leaders - 2nd Battalion Command Brief</li> <li>▶ Marine Corps Recovery Care Coordinators</li> <li>▶ USMC-Specific Questions for WWR Detachment</li> <li>▶ Marine Corps Section Leaders</li> <li>▶ USSOCOM Care Coalition Transition Initiative (Mimi Miller)</li> </ul>
December 6-7, 2012	Navy Wounded Warrior Safe Harbor (Navy HQ)	<ul style="list-style-type: none"> <li>▶ Navy Wounded Warrior – Safe Harbor Program (CAPT Stephen Hall)</li> <li>▶ Operations Officer and Assistant Operations Officer East (LT Noriega)</li> <li>▶ Navy Wounded Warrior – Safe Harbor Recovery Care Program (LT David Noriega and Kendall Hillier)</li> <li>▶ Non Medical Care Manager Panel (LT Kiernan Carroll, Master Chief Doug Staszak, and Master Chief Anthony Edwards)</li> <li>▶ Navy Safe Harbor – Family Support (Dario Santana)</li> <li>▶ Navy Safe Harbor – Transition Support (David Pennington)</li> <li>▶ Navy Wounded Warrior Adaptive Sports (LT Megan Haydel)</li> <li>▶ Navy Wounded Warrior – Safe Harbor NPS Millington Liaison (Ralph Gallauger)</li> <li>▶ Secretary of the Navy Physical Evaluation Board (PEB) (Robert Powers)</li> <li>▶ BUMED IDES Program (CDR Webster)</li> </ul>
January 9-10, 2013	Fort Carson (Army)	<ul style="list-style-type: none"> <li>▶ Transition Unit Leadership</li> <li>▶ Lifetime Support Resources</li> <li>▶ Squad Leaders</li> <li>▶ Medical Case Management</li> <li>▶ IDES</li> <li>▶ Legal Support in IDES</li> <li>▶ Caregiver Support and Information Resources</li> <li>▶ TBI Services for RWs</li> <li>▶ PTSD Services for RWs</li> <li>▶ Vocational and Employment Services</li> </ul>
January 17, 2013	James A. Lovell Federal Health Care Center (all Services)	<ul style="list-style-type: none"> <li>▶ Overview of VA/DoD Patient Caregiver Support Center</li> <li>▶ Federal Health Care Center (FHCC) Brief (Patrick L. Sullivan and CAPT Jose Acosta)</li> <li>▶ OEF/OIF/OND Program and DoD Case Management Team (Mr. Michael Konkoly)</li> </ul>

Dates	Installation/ Location/Service	Presentations
January 23-24, 2013	Fort Bragg (Army)	<ul style="list-style-type: none"> <li>▶ Transition Unit Leadership</li> <li>▶ Lifetime Support Resources</li> <li>▶ Squad Leaders</li> <li>▶ Medical Case Management</li> <li>▶ IDES</li> <li>▶ Legal Support in IDES</li> <li>▶ Caregiver Support and Information Resources</li> <li>▶ TBI Services for RWs</li> <li>▶ PTSD Services for RWs</li> <li>▶ Vocational &amp; Employment Services</li> <li>▶ Physical Disability Evaluation System (Marcelle C. Quist)</li> <li>▶ WTB Demographics and Career Map</li> </ul>
February 5-6, 2013	CBWTU Arkansas (Army RC)	<ul style="list-style-type: none"> <li>▶ Transition Unit Leadership (MAJ Steve Lunsford and 1SG James Easter)</li> <li>▶ Platoon Sergeants</li> <li>▶ Medical Case Management (MAJ Ward, LTC Herndon, CPT Long, and LTC Jessen)</li> <li>▶ Vocational, Employment, and Transition Assistance Services (CPT Hill, SGT McDowell, and Ms. Pearly)</li> <li>▶ IDES (MSG Patterson and SFC Brooks)</li> </ul>
February 20-21, 2013	Joint Base San Antonio (Air Force)	<ul style="list-style-type: none"> <li>▶ Air Force Personnel Center (Randy Tillery)</li> <li>▶ Air Force Medical Operations Agency: AF Medical Home (Col Michael Kindt)</li> <li>▶ Air Force Medical Operations Agency: AF Medical Continuation (Col Michael Kindt)</li> <li>▶ Air Reserve Component Case Management Division (COL Kim Greene)</li> <li>▶ Airman &amp; Family Readiness Centers (Theresa Marvin)</li> <li>▶ Warrior &amp; Survivor Care (Lt Col Susan Black)</li> <li>▶ Pre-IDES Screening (Dr. L. Trout)</li> <li>▶ Air Force PEB (Col Deb Aspling)</li> <li>▶ Office of Airmen's Counsel (Maj Tara Villena)</li> </ul>
February 28- March 1, 2013	JFHQ North Carolina and VA (Army and Air Guard)	<ul style="list-style-type: none"> <li>▶ State ARNG Leadership (COL Simpson, COL Johnson, MSgt Smith, MSgt Scott, MAJ Kirk)</li> <li>▶ State Family Readiness Program Manager (ARNG)</li> <li>▶ Surgeon, DPH (ARNG)</li> <li>▶ Lead TAA (ARNG)</li> <li>▶ North Carolina Air National Guard Leadership</li> <li>▶ State Family Readiness Program Manager (ANG)</li> <li>▶ 145TH Airlift Wing DPH</li> <li>▶ Durham VA Medical Center</li> </ul>
March 5-6, 2013	JFHQ Iowa and VA (Army and Air Guard)	<ul style="list-style-type: none"> <li>▶ Iowa National Guard Leadership Brief</li> <li>▶ ARNG Family Assistance</li> <li>▶ Surgeon/DPH</li> <li>▶ TAA Brief</li> <li>▶ 132nd Fighter Wing and Medical Group Staff</li> <li>▶ ANG Family Readiness</li> <li>▶ Air Guard Surgeon Wing Director of Psychological Health</li> <li>▶ Iowa VA Visit</li> </ul>

Dates	Installation/ Location/Service	Presentations
March 12-13, 2013	JFHQ Arkansas and VA (Army and Air Guard)	<ul style="list-style-type: none"> <li>▶ State ARNG Leadership (COL Shillcutt, LTC Erica Ingram, COL Robert Smothers, and LTC Shannon Saucy)</li> <li>▶ State Family Readiness Program (LTC Shannon Saucy)</li> <li>▶ Director of Psychological Health and State Surgeon (LTC Erica Ingram and Ms. Joyce Wesley)</li> <li>▶ Lead TAA (Ms. Barbara Lee)</li> <li>▶ Briefing of AR Best Practices and/or Lessons Learned (LTC Damon Cluck and Chaplain Golaway)</li> <li>▶ State ANG Leadership</li> <li>▶ State Family Readiness Program</li> <li>▶ Surgeon, DPH of each Wing</li> <li>▶ Arkansas VA Visit</li> </ul>
March 19-20, 2013	Camp Pendleton (Marine Corps)	<ul style="list-style-type: none"> <li>▶ Transition Unit Leadership</li> <li>▶ RCCs (Vernon Ollison, Damon Brummett, Carissa Tourtelot, and FRC Kathleen White)</li> <li>▶ Lifetime Support Resources (MSgt Marino)</li> <li>▶ Section Leaders/Unit Staff (GySgt Acosta, SSgt Corral, GySgt Higuera, and SSgt Stokes)</li> <li>▶ Medical Case Management</li> <li>▶ TBI Services for RWs</li> <li>▶ PTSD Services for RWs</li> <li>▶ Caregiver Support and Information Resources (FRO Melinda Willett 1st Sgt Dempsey, and SSgt Kerr)</li> <li>▶ Vocational &amp; Employment Services (Lt Col Zegley, C&amp;E staff, and VR&amp;E staff)</li> <li>▶ IDES</li> <li>▶ Legal Support in IDES</li> </ul>
March 21-22, 2013	NOSC San Diego and MEDHOLD West (Navy Reserve)	<ul style="list-style-type: none"> <li>▶ NOSC Leadership</li> <li>▶ MEDHOLD</li> <li>▶ Preparing for Transition – Vocational Services &amp; IDES</li> </ul>
March 25-26, 2013	Joint Base Lewis McChord (Army)	<ul style="list-style-type: none"> <li>▶ Transition Unit Leadership (MAJ Antonio Flores, CPT Kristina Carney, SSG Robbins, SSG Antill, SSG Phillips, and SSG Groenier)</li> <li>▶ Lifetime Support Resources (William Janssen, CPT Jonathan Entrekin, and Mr. Boyd)</li> <li>▶ Transition Unit Leadership (Clayton Metternich)</li> <li>▶ Medical Case Management (MAJ (P) Jackie King and MAJ Lorry Kelley)</li> <li>▶ Legal Support in IDES (Mr. Joshua Kellcy and Mr. Steven Engle)</li> <li>▶ IDES (Dirk Hosie)</li> <li>▶ Caregiver Support and Information Resources (Jacqueline Seabrook)</li> <li>▶ TBI Services for RWs (James Brassard and Frederick Flynn)</li> <li>▶ PTSD Services for RWs (Ellen Bloom LCSW)</li> <li>▶ Career &amp; Education Readiness/Vocational &amp; Employment Services (Cherie Westphal)</li> <li>▶ SFAC tour</li> <li>▶ IDES/PEB tour</li> </ul>

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Dates	Installation/ Location/Service	Presentations
March 28-29, 2013	Joint Base Elmendorf- Richardson and Fort Wainwright (Army)	<ul style="list-style-type: none"> <li>▶ Transition Unit Leadership (LTC Benefield)</li> <li>▶ Lifetime Support Resources (Mr. Usman)</li> <li>▶ Unit Staff</li> <li>▶ Medical Case Management (COL Chun, LTC Warner, CPT Nichols, and MAJ Goodin)</li> <li>▶ IDES (LTC Warner, Jeremy Peal, &amp; Patrick Scott)</li> <li>▶ Legal Support (Wendy Marshall)</li> <li>▶ Caregiver Support and Information Resources (SFAC) (Mr. Black)</li> <li>▶ TBI Services for RWs (COL Thompson, LTC Warner, and CPT Wilson)</li> <li>▶ PTSD Services for RWs (COL Thompson, LTC Warner, and CPT Wilson)</li> <li>▶ Vocational &amp; Employment Services (Mr. Avery, Ms. Achterhoff, Ms. Hanson, Mr. Matier, and Mr. Hutto)</li> </ul>

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## **APPENDIX G: INFORMATION SOURCES BY TOPIC**



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## Information Sources by Topic

### MCCM References

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**APPENDIX H-1: RECOVERING WARRIOR FOCUS GROUP PROTOCOL**



**V RWTF, YEAR 3**  
**RECOVERING WARRIOR FOCUS GROUP PROTOCOL**

**SESSION INFORMATION**

Location:

Date:

Time:

Facilitator:

Recorder:

# of Participants present for entire session:

# of Participants excused/reasons:

**Scribe Note:** be sure you note what group/program these participants were recruited from (e.g., Army WTU or CBWTU, joined to Marine Corps WWR, supported by Marine Corps WWR, enrolled in Navy Safe Harbor, in Air Force Wounded Warrior (AFW2)).

**FOCUS GROUP KICK-OFF: KEY POINTS TO COVER**

**(As participants start to arrive, scribe distributes name tents and markers)**

- **Welcome attendees**
  - Thank you for taking the time to join our discussion today.
  - I am \_\_\_ (insert name) and I am a member of the DoD Recovering Warrior Task Force (RWTF), and this is \_\_\_ (introduce partner), also a member of this Task Force.
  - Our scribe, \_\_\_, is part of the RWTF research staff.
- **Introduce RWTF and its purpose**
  - The 2010 National Defense Authorization Act directs the Recovering Warrior Task Force (RWTF) to assess the effectiveness of the policies and programs developed and implemented by the DoD and the military departments, and make recommendations for improvements.
  - The RWTF is comprised of 14 members including 7 DoD and 7 non-DoD members.
  - The RWTF is chartered for four years and will generate an Annual Report at the end of each year of effort. We are now in our third year.
- **Describe how focus group session will work**
  - This session is intended for recovering Service members.
  - We have scripted questions formulated to address specific topics.
  - The session will last approximately 90 minutes, and we will not take a formal break. (Restrooms are located xxxxxx)
  - Before we begin our voluntary discussion, we will pass around a short questionnaire to gather some basic background information from you. The questionnaire is voluntary and should be completed anonymously—no names please. If you need assistance filling out the questionnaire, please let us know so one of us can offer our assistance.
  - Try not to mention individuals by name in your comments to protect their confidentiality.
  - Each of us has a role to play here.
    - I serve as an impartial data gatherer and discussion regulator.
    - Our scribe serves as recorder—note s/he is taking no names and we are not audio- or video-taping the session.
    - You serve as subject matter experts.

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- My other colleagues are here to observe.
- **Emphasize that participation is voluntary**
  - Your participation in this session is voluntary.
  - While we would like to hear from everyone; feel free to answer as many or as few questions as you prefer.
  - If you would prefer to excuse yourself from the focus group at this time, or at any point after we get started, you are free to do so. If you do leave, you are welcome to return.
  - Also, let us know if you would prefer to talk with a Task Force member one-on-one.
- **Address confidentiality**
  - We treat the information you share as confidential. That means we will protect your confidentiality to the extent allowable by law. We will not reveal the names of study participants and no information will be reported that can identify you or your family.
  - Your name will never be linked to your answers or to any comments you make during the discussion. Your answers to our questions will not affect your promotions, rights, or benefits.
  - However, there are some behaviors that we are required to report. If we learn that you are being hurt or planning on hurting yourself or others, or others are being hurt or planning on hurting themselves or others, the law requires that we share this information with someone who can help and to the appropriate authority.
  - Also, because this is a group meeting, it is important that each of you keep any information you hear today in the strictest of confidence and not discuss it with anyone outside of this group.
  - Please be aware, however, that we cannot guarantee that other participants will honor this expectation. If this concerns you, you should limit your participation.
  - We will distribute an informed consent form for you to read and sign. If you have any questions or need assistance with the form, please let us know so one of us can offer our assistance.
- **Ask scribe to distribute the informed consent forms and mini-surveys.**

Scribe will collect the informed consent forms immediately after they are signed but will not collect the surveys until the focus group is over.

  - Informed consent form is to be read and signed.
  - Short mini-survey is to be completed anonymously.
- **Explain ground rules**
  - Speak one at a time so that your statement can be heard by all.
  - There are no right or wrong answers.
  - We want to hear the good and the bad.
  - We respect and value differences of opinion.
  - Please avoid sidebar conversations.
  - Please note that we use the terms recovering Service member; recovering warrior; and wounded, ill, or injured Service member interchangeably.

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**RECOVERING WARRIOR FOCUS GROUP PROTOCOL**

**WARM-UP/INTRODUCTIONS**

To begin, I'd like to go around the room and ask each of you to introduce yourselves and to share some brief background. Specifically please tell us:

1. Your AC/RC status
2. When you became wounded, ill, or injured
3. Are you married or single?
4. Do you live on or off the installation?
5. Are you a part of [*fill in Army WTB or CBWTU, Navy Safe Harbor, Marine WWR, or Air Force WW Program*]

**DISCUSSION QUESTIONS**

We are here to learn about your experiences and perspectives regarding the policies and programs that have been established to support the care, management, and transition of recovering Service members and their families. We are particularly interested in hearing how effectively these resources meet your needs.

We will be talking about a number of topics. Some of these topics include: medical case management, non-medical case management, the transition process, the disability evaluation process, and services for traumatic brain injury (TBI) and post traumatic stress (PTS).

**INITIAL QUESTIONS**

- A. Who is part of your team helping you through the recovery process?
- B. Which of these "team members" is most valuable to you as you recover?
- C. During this recovery process, what needs do you have that are not being met, if any?

FOR RC RWs ONLY:

- D. What RC-specific programs or services are you aware of?
- E. Which of these have you used?
- F. To what extent do they meet your needs? (Please speak to each individual program/service separately)

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**RECOVERING WARRIOR FOCUS GROUP PROTOCOL**

**FOLLOW-ON QUESTIONS**

**I. Medical Care Case Management**

INTRO: Medical care case management is sometimes called clinical case management. The medical care case manager is typically a registered nurse (RN).

- a. What kinds of support does your medical care case manager provide you?
- b. To what extent does s/he meet your needs?
- c. How does your MCCM contribute to the CRP/CTP process?

**II. Non-Medical Case Management**

INTRO: We are interested in the non-medical case management you are receiving. Non-medical case management refers to coordination and advocacy efforts to ensure RWs receive needed support and assistance in resolving non-medical issues.

*Note to Moderator: many NMCM questions below are Service-branch specific*

**Army focus groups:**

- a. What kinds of support does your **Squad Leader** provide you?
- b. To what extent does your **Squad Leader** meet your needs?
- c. How does your **Squad Leader** contribute to the CTP process?

**Navy focus groups:**

- a. What kinds of support does your **Safe Harbor NMCM** provide you?
- b. To what extent does your **Safe Harbor NMCM** meet your needs?
- c. How does your **Safe Harbor NMCM** contribute to the CRP process?

**Marine Corps and Air Force focus groups:**

- a. What kinds of support does your **RCC** provide you?
- b. To what extent does your **RCC** meet your needs?
- c. How does your **RCC** contribute to the CRP process?

**Only Army and Marine Corps focus groups:** Your *transition unit chain of command* may also provide non-medical case management.

- a. Who within the transition unit chain of command provides you non-medical case management?
- b. What kinds of support does s/he provide you?
- c. To what extent does s/he meet your needs?
- d. How does s/he or others in the transition unit chain of command contribute to the CTP/CRP process?

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**All focus groups (all Service branches).** Your *line or operational unit chain of command* may also provide non-medical case management.

- a. Who within the line or operational unit chain of command provides you non-medical case management?
- b. What kinds of support does s/he provide you?
- c. To what extent does s/he meet your needs?
- d. How does s/he or others in the line or operational unit chain of command contribute to the CRP/CTP process?

**All focus groups (all Service branches).** *Other entities* inside or outside the line or operational unit may also provide non-medical case management.

- a. What other entity inside or outside the line or operational unit, if any, provides you non-medical case management?
- b. What kinds of support does s/he provide you?
- c. To what extent does s/he meet your needs?
- d. How does s/he contribute to the CRP/CTP process?

**All focus groups (all Service branches):**

- a. How well does the CRP/CTP work for you?

### **III. Services for TBI & PTSD**

INTRO: Many combat veterans experience traumatic brain injuries (TBI) or post-traumatic stress disorder (PTSD). Some Service members experience PTS symptoms that could become more severe if untreated.

*Note to Moderator: no show of hands necessary; participants' personal experience with PTSD/TBI is captured in mini-survey*

- a. What treatment options are available for PTSD at this location?
- b. To what extent do available treatment options meet the needs of Service members diagnosed with PTSD?
- c. What treatment options are available for TBI at this location?
- d. To what extent do available treatment options meet the needs of Service members diagnosed with TBI?

### **IV. Transition**

INTRO: We'd like to talk with you now about your transition experience, regardless of whether you are returning to duty or transitioning to civilian life. We realize you may be at different points along this journey and you may still be uncertain of your plans. First, please take a look at

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Question #1 of your survey, which asks where you are in this process. Notice whether you checked “early,” “middle,” “returning to duty,” or “in Disability Evaluation System.”

*Note to Moderator: to get a sense for the group, ask for **show of hands** for who checked early, middle, returning to duty, or DES*

INTRO continued: The following questions are for those of you who are further along in the transition process, i.e., raised your hand for “middle,” “returning to duty,” or “in Disability Evaluation System.”

- a. How well informed are you about transition options?
- b. How satisfied are you so far with the process leading to your transition decision?
- c. If you are in the process of transitioning to civilian life, how confident are you about how the transition from DoD to VA care and services will work?

## **V. Disability Evaluation System (DES)**

INTRO: We’d like to hear about your experiences with the Disability Evaluation System (DES).

- a. Who has heard the term Disability Evaluation System, or DES? You may know this as the Medical Evaluation Board, also known as MEB or Med Board, which is part of the DES process. (**show of hands**)
- b. Who is in the DES? (**show of hands**) For those of you in the DES:
  - a. What types of support and assistance are available to you, and from whom? (This may include a PEBLO, a military service coordinator (MSC) from the VA, or anyone else helping you through the DES.)
  - b. Which of these supports have you used?
  - c. To what extent have they met your needs as you progress through this process?
  - d. If you are in the process of preparing your MEB packet, or have already submitted your MEB packet, have you been informed of your right to have an independent physician review it prior to submission? (This may have been called an independent medical review.) (**show of hands**)

## **VI. Legal Support**

INTRO: Military personnel, including recovering Service members and others, have access to legal assistance services. We are interested in the *additional* legal support that is available to you as you prepare to transition either to civilian status or back to duty.

- a. Have you been briefed on the legal supports available to you during the MEB phase of IDES (**show of hands**)?
- b. What legal support has been provided to you during the MEB phase of IDES? (e.g., meeting with lawyer, paralegal, Veterans Service Organization (VSO) representative, etc)

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- c. To what extent has it met your needs?

## **VII. Vocational Support**

INTRO: For RWs who are transitioning out of uniform, we are interested in the resources available to help you find employment. To start, we would like to know which employment preparation, job readiness, and internship programs you have heard of.

- a. Who has heard of each of the following programs (**show of hands**):
- Operation Warfighter (OWF)
  - E2I
  - Other internship programs (specify)
  - DVOPS at REALifelines
  - VA VR&E
  - TAP
  - DTAP
  - Other employment preparation or job readiness programs (specify).
- b. If you have used any of these programs, to what extent does it meet your needs? (specify program)

## **Wrap Up**

As we draw to a close, we have one final question.

- a. If you were “king/queen for a day” and in charge of all RW programs and policies, what would your first action be?
- b. (If time permits) What else would you like to tell us?

*This concludes our discussion. **PLEASE LEAVE YOUR SURVEYS ON THE TABLE FACE DOWN AND WE WILL COLLECT THEM.** Please remember not to repeat what you heard in this room. Thank you for taking the time to share your opinions and experiences with us. Your thoughts are invaluable to our efforts to inform the Secretary of Defense and Congress on these matters. Once again, thank you very much, and our sincere best wishes for your continued recovery.*



**APPENDIX H-2: FAMILY MEMBER FOCUS GROUP PROTOCOL**



**RWTF, YEAR 3**  
**FAMILY MEMBER FOCUS GROUP PROTOCOL**

**SESSION INFORMATION**

Location:  
Date:  
Time:  
Facilitator:  
Recorder:  
# of Participants present for entire session:  
# of Participants excused/reasons:

**FOCUS GROUP KICK-OFF: KEY POINTS TO COVER**

**(As participants start to arrive, scribe distributes name tents and markers)**

- **Welcome attendees**
  - Thank you for taking the time to join our discussion today.
  - I am \_\_\_ (insert name) and I am a member of the DoD Recovering Warrior Task Force (RWTF), and this is \_\_\_ (introduce partner), also a member of this Task Force.
  - Our scribe, \_\_\_, is part of the RWTF research staff.
  
- **Introduce RWTF and its purpose**
  - The 2010 National Defense Authorization Act directs the Recovering Warrior Task Force (RWTF) to assess the effectiveness of the policies and programs developed and implemented by the DoD and the military departments, and make recommendations for improvements.
  - The RWTF is comprised of 14 members including 7 DoD members and 7 non-DoD members. The RWTF is chartered for four years and will generate an Annual Report at the end of each year of effort. This is our third year.
  
- **Describe how focus group session will work**
  - This session is intended for participants who are family members of recovering Service members.
  - We have scripted questions formulated to address specific topics.
  - The session will last approximately 90 minutes, and we will not take a formal break. (Restrooms are located xxxxxx)
  - Before we begin our voluntary discussion, we will pass around a short questionnaire to gather some basic background information from you. The questionnaire is voluntary and should be completed anonymously—no names please. If you need assistance filling out the questionnaire, please let us know so one of us can offer our assistance.
  - Try not to mention individuals by name in your comments to protect their confidentiality.
  - Each of us has a role to play here.
    - I serve as an impartial data gatherer and discussion regulator.
    - Our scribe serves as recorder—note s/he is taking no names and we are not audio- or video-taping the session.
    - You serve as subject matter experts.
    - My other colleagues are here to observe.

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**FAMILY MEMBER FOCUS GROUP PROTOCOL**

- **Emphasize that participation is voluntary**
  - Your participation in this session is voluntary.
  - While we would like to hear from everyone, feel free to answer as many or as few questions as you prefer.
  - If you would prefer to excuse yourself from the focus group at this time, or at any point after we get started, you are free to do so. If you do leave, you are welcome to return.
  - Also, if you would prefer to talk with a Task Force member one-on-one, we can do that.
  
- **Address confidentiality**
  - We treat the information you share as confidential. That means we will protect your confidentiality to the extent allowable by law. We will not reveal the names of study participants and no information will be reported that can identify you or your family.
  - Your name will never be linked to your answers or to any comments you make during the discussion. Your answers to our questions will not affect your or your Service member's promotions, rights, or benefits.
  - However, there are some behaviors that we are required to report. If we learn that you are being hurt or planning on hurting yourself or others, or others are being hurt or planning on hurting themselves or others, the law requires that we share this information with someone who can help and to the appropriate authority.
  - Also, because this is a group meeting, it is important that each of you keep any information you hear today in the strictest of confidence and not discuss it with anyone outside of this group.
  - Please be aware, however, that we cannot guarantee that other participants will honor this expectation. If this concerns you, you should limit your participation.
  - We will shortly distribute an informed consent form for you to read and sign. If you have any questions or need assistance with the form, please let us know so one of us can offer our assistance.
  
- **Ask scribe to distribute/collect the informed consent forms and then the mini-surveys. (After collecting the completed mini-surveys, the scribe will place the completed informed consent forms and mini-surveys in two separate folders.)**
  - Informed consent form to be read and signed.
  - Short mini-survey to be completed anonymously.
  
- **Explain ground rules**
  - Speak one at a time so that your statement can be heard by all.
  - There are no right or wrong answers.
  - We want to hear the good and the bad.
  - We respect and value differences of opinion.
  - Please avoid sidebar conversations.
  - Please note that we use the terms recovering Service member; recovering warrior; and wounded, ill, or injured Service member interchangeably.

**RWTF, YEAR 3**  
**FAMILY MEMBER FOCUS GROUP PROTOCOL**

**WARM-UP/INTRODUCTIONS**

To begin I'd like to go around the room and ask each of you to introduce yourselves (your first name is sufficient) and to share some brief background on your Service member and his/her injury. Specifically please tell us:

1. What is your relationship to your Service member (e.g., spouse? parent?)
2. When did he or she become wounded, ill, or injured?
3. At this point in time, is your Service member hoping to return to duty or leave the military, or is s/he undecided?
4. Is your Service member in the Active Component or Reserve Component?
5. Does your Service member live on or off the installation?
6. Is your Service member a part of [*fill in Army WTB or CBWTU, Navy Safe Harbor, Marine WWR, or Air Force WW Program*]

**DISCUSSION QUESTIONS**

We are here to learn about your experiences and perspectives regarding the policies and programs that have been established to support the care, management, and transition of recovering Service members and their families. We are particularly interested in hearing how effectively these resources meet **your** needs as family members and caregivers. We are collecting data on support to Recovering Warriors during the Service Member focus group.

We will be talking about several topics, among them: 1) Support for family caregivers, 2) information sources, and 3) services for traumatic brain injury (TBI) and post traumatic stress disorder (PTSD).

**INITIAL QUESTIONS**

- A. Who is part of your Service member's team helping him or her through the recovery process?
- B. Which of these "team members" is most valuable **to you** as your Service member recovers?
- C. What needs do **you** have that are not being met, if any?

For family caregivers of RC RWs ONLY:

- D. What RC-specific programs or services are you aware of?
- E. Which of these have **you** used?
- F. To what extent do they meet **your** needs? (Please speak to each individual program/service separately)

**RWTF, YEAR 3**  
**FAMILY MEMBER FOCUS GROUP PROTOCOL**

**FOLLOW-ON QUESTIONS**

**I. Support for Family Caregivers**

INTRO: We know that the families of recovering warriors, and particularly those in the caregiver role, are profoundly impacted by their Service member's condition and the recovery process.

- a. What supports have **you** been using? (*Note to moderator: start with top of mind*) These may be financial, travel/lodging, respite care, caregiver training, vocational training, counseling, family readiness groups, etc.
- b. How did you learn about these supports?
- c. To what extent have these supports met **your** needs as the family member/caregiver of a RW?
- d. What has prevented **you** from taking fuller advantage of available supports?

INTRO: Your Service member may have one or more non-medical case managers and/or care coordinators supporting him/her. These may include an RCC, FRC, AW2 Advocate, Squad Leader, Section Leader, Navy Safe Harbor NMCM, etc. Some of these NMCMs/ Care Coordinators may also be supporting you. (**Note to moderators:** please capture the position of the case manager/care coordinator named if the participant does not.)

- a. Which of these non-medical case managers/ care coordinators have supported **you**?
- b. What types of support have they provided to **you**?
- c. To what extent have they met **your** needs?

INTRO: Let's take a moment to focus specifically on the Comprehensive Recovery Plan/ Comprehensive Transition Plan.

- a. In what ways are **you** included in the CRP/CTP process?

**II. Recovering Warrior Information Resources**

INTRO: We'd like to talk with you about information resources for recovering warriors and their families. Please note these questions about information resources are about **your experiences** with these information resources, rather than your Service member's.

When your Service member was seriously wounded, ill, or injured, they and you began a treatment, recovery, and rehabilitation journey together.

- a. Throughout this journey with your Service member, how have you gotten the information that you needed?
- b. To what extent has the information available to you met **your** needs?
- c. What prevents **you** from taking fuller advantage of these and other information resources?

**RWTF, YEAR 3**  
**FAMILY MEMBER FOCUS GROUP PROTOCOL**

Now let us ask you some questions about specific information sources. (*Note to moderator: ask for show of hands*)

- a. Have **you** consulted the *National Resource Directory*? This is an online directory of national, state, and local governmental and non-governmental services and resources that assist with recovery, rehabilitation, and reintegration.
  - How helpful was it?
  
- b. Have **you** consulted *Military OneSource*? This is an all-purpose portal for the military community, accessible online or by phone, and provides dedicated support for recovering warriors and their families.
  - How helpful was it?
  
- c. Have **you** visited or used a military *Family Assistance Center* to get help with RW related concerns? This is an office or agency that facilitates recovering Service member and family access to information and resources (e.g. Army SFAC, Army Community Service, Navy Fleet and Family Support Center, Airman and Family Readiness Center, and Marine Corps Community Services)?
  - If so, which one?
  - How helpful was it?

**III. Services for TBI & PTSD**

INTRO: Many combat veterans experience traumatic brain injuries (TBI) or post-traumatic stress disorder (PTSD). Some Service members experience PTS symptoms that could become more severe if untreated.

- a. What treatment options are available for PTSD at this location?
- b. To what extent do available treatment options meet the needs of Service members diagnosed with PTSD?
- c. What kinds of support services, including support groups, are available to family members of RWs with PTSD?
- d. What treatment options are available for TBI at this location?
- e. To what extent do available treatment options meet the needs of Service members diagnosed with TBI?
- f. What kinds of support services, including support groups, are available to family members of RWs with TBI?

**RWTF, YEAR 3**  
**FAMILY MEMBER FOCUS GROUP PROTOCOL**

**IV. Wrap Up**

As we draw to a close, we have one final question.

- a. If you were “king/queen for a day” and in charge of all RW programs and policies, what would your first action be?

*This concludes our discussion. Please remember not to repeat what you heard in this room. Thank you for taking the time to share your opinions and experiences with us. Your thoughts are invaluable to our efforts to inform the Secretary of Defense and Congress on these matters. Once again, thank you very much, and our sincere best wishes for your Service member’s continued recovery.*

## **APPENDIX H-3: RECOVERING WARRIOR MINI-SURVEY**



# RWTF Focus Groups: Mini Survey for Recovering Warriors

## ABOUT YOU

### 1. Where are you in the recovery, rehabilitation, and transition process? (Mark only one)

- Early: I am receiving regular medical care and am unsure if I will return to duty or transition out of the military  
⇒ Skip to Question #3
- Middle: I am nearing the medical decision point, when I have reached maximum medical benefit according to my medical care providers and it is time to decide whether I will return to duty or transition out of the military.  
⇒ Skip to Question #3
- Returning to Duty: I have begun the process to return to duty  
⇒ Skip to Question #3
- In Disability Evaluation System (DES): I have begun the disability evaluation process.  
⇒ Proceed to the next question

### 2. If you are in the Disability Evaluation System (DES), please answer the two questions below.

#### Are you in Legacy DES or Integrated DES? (Mark only one):

- Legacy DES (starts with a DoD exam)
- Integrated DES (starts with a VA exam)
- Not sure

#### Which steps have been completed? (Mark all that apply):

- Compensation & pension (C&P) exam
- Medical evaluation board
- Briefing by VA MSC
- Physical evaluation board
- Does not apply; I have not completed any of these steps.

### 3. What is your gender?

- Male
- Female

### 4. Please tell us about your condition. (Mark all that apply)

- Traumatic Brain Injury
- Amputation
- Spinal Cord injury
- Burn injury
- Vision loss
- Psychological diagnosis
- Intra-abdominal injury
- Orthopedic injury
- Chest injury
- Hearing loss
- Inhalation injury
- Medical diagnosis

### 5. What is your marital status?

- Married
- Single, never married
- Legally separated or filing for divorce
- Divorced or widowed

### 6. Do you have dependent children living in the home?

- Yes
- No

### 7. What is your branch of Service?

- Army
- Navy
- Air Force
- Marine Corps
- Coast Guard
- Army Reserve
- Navy Reserve
- Marine Corps Reserve
- Air Force Reserve
- Coast Guard Reserve
- Army National Guard
- Air National Guard

### 8. What is your pay grade?

- E1
- E2
- E3
- E4
- E5
- E6
- E7
- E8
- E9
- WO1
- CW2
- CW3
- CW4
- CW5
- O1
- O2
- O3
- O4
- O5
- O6

**CASE MANAGEMENT SUPPORT FOR YOU**

9. Please indicate whether you are working with each of the following types of case managers by marking NOT SURE, NO, or YES. For each type of case manager, if you indicate YES, please rate how helpful they are to you.

	Have you used any of these case managers or care coordinators? If YES, rate the helpfulness of each.			If YES, how helpful have these case managers or care coordinators been to you?				
	Not sure	No	Yes	Not at all helpful	A little helpful	Moderately helpful	Very helpful	Extremely helpful
a. Nurse Case Manager/ Medical Care Case Manager (MCCM)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Recovery Care Coordinator (RCC)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Army Squad Leader?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Army Wounded Warrior Program (AW2) Advocate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. USMC Section Leader?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Navy Safe Harbor Nonmedical Case Manager (NMCM)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Air Force Wounded Warrior Program (AFW2) NMCM?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. SOCOM Care Coalition Liaison?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. SOCOM Care Coalition Advocate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Federal Recovery Coordinator (FRC)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Other case manager? Specify (Title of program/position rather than name of person): <hr/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**INFORMATION RESOURCES FOR YOU**

10. Please indicate whether you have used each of the following information resources by marking NOT SURE, NO, or YES. For each information resource, if you indicate YES, please rate how helpful it has been to you.

	Have you used any of these information resources? If YES, rate the helpfulness of each.			If YES, how helpful have these information resources been to you?				
	Not sure	No	Yes	Not at all helpful	A little helpful	Moderately helpful	Very helpful	Extremely helpful
a. Wounded Warrior Resource Center?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. National Resource Directory?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Military OneSource?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Military Hotline?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Military Family Assistance Center?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**SUPPORT FOR YOU DURING THE DES PROCESS**

11. Have you met with your Physical Evaluation Board Liaison Officer (PEBLO)?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

12. How helpful is your PEBLO to you?

- Does not apply—I do not have a PEBLO
- Extremely helpful
- Very helpful
- Moderately helpful
- A little bit helpful
- Not at all helpful

**VOCATIONAL RESOURCES FOR YOU**

**13. Please indicate whether you have had first-hand experience with any of the following vocational programs by marking NOT SURE, NO, or YES. For each of the programs, if you indicate YES you have had first-hand experience, please rate how helpful it has been to you.**

	Have you used any of these vocational resources? If YES, rate the helpfulness of each.			If YES, how helpful have these vocational resources been to you?				
	Not sure	No	Yes	Not at all helpful	A little helpful	Moderately helpful	Very helpful	Extremely helpful
a. Operation Warfighter?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Education and Employment Initiative (E2I, from DoD)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Other internship opportunities? Specify: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. DVOPS at REALifelines?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. VA VR&E?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Army Career and Education Readiness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Transition Assistance Program (TAP)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Disabled Transition Assistance Program (DTAP)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Other employment preparation or job readiness programs? Specify: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**OTHER DOD PROGRAMS AND SERVICES FOR YOU**

**14. Please indicate whether you have had first-hand experience with any of the following programs and services by marking NOT SURE, NO, or YES. For each of the programs, if you indicate YES you have had first-hand experience, please rate how helpful it has been to you.**

	Have you used any of these RW resources? If YES, rate helpfulness.			If YES, How helpful have these RW resources been to you?				
	Not sure	No	Yes	Not at all helpful	A little helpful	Moderately helpful	Very helpful	Extremely helpful
a. Services for TBI?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Services for PTSD?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Support for family caregivers?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Integrated Disability Evaluation System (IDES)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Legal support for RWs and families during the MEB phase of IDES?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*Thank you for providing this information.*



## **APPENDIX H-4: FAMILY MEMBER MINI-SURVEY**



## RWTF Focus Groups: Mini Survey for Family Members

### ABOUT YOU

**1. What is your relationship to the recovering Service member?**

- Parent of recovering Service member
- Spouse of recovering Service member
- Other (Please specify): \_\_\_\_\_

**2. What is your gender?**

- Male
- Female

### ABOUT YOUR SERVICE MEMBER

**3. Where is your Service member in the process of recovery, rehabilitation, and transition? (Mark only one)**

- Early: Receiving regular medical care and is unsure if he/she will return to duty or transition out of the military
- Middle: Nearing the medical decision point, when he/she has reached maximum medical benefit according to the medical care providers and it is time to decide whether he/she will return to duty or transition out of the military.
- Returning to Duty: Has begun the process to return to duty
- In Disability Evaluation System (DES)

**4. What is your Service member's marital status?**

- Married
- Single, never married
- Legally separated or filing for divorce
- Divorced or widowed

**5. Does your Service member have dependent children living in the home?**

- Yes
- No

**6. Please tell us about your Service member's condition. (Mark all that apply)**

- Traumatic Brain Injury
- Amputation
- Spinal Cord injury
- Burn injury
- Vision loss
- Psychological diagnosis
- Intra-abdominal injury
- Orthopedic injury
- Chest injury
- Hearing loss
- Inhalation injury
- Medical diagnosis

**7. What is your Service member's branch of Service?**

- Army
- Navy
- Air Force
- Marine Corps
- Coast Guard
- Air National Guard
- Army Reserve
- Navy Reserve
- Marine Corps Reserve
- Air Force Reserve
- Coast Guard Reserve
- Army National Guard

**8. What is your Service member's pay grade?**

- E1
- E2
- E3
- E4
- E5
- E6
- E7
- E8
- E9
- WO1
- CW2
- CW3
- CW4
- CW5
- O1
- O2
- O3
- O4
- O5
- O6

**ABOUT SUPPORT YOU HAVE RECEIVED**

9. Please indicate whether your Service member is working with each of the following types of case managers by marking NOT SURE, NO, or YES. For each type of case manager, if you indicate YES, please rate how helpful they are to you.

	Have <u>you</u> used any of these case managers or care coordinators? If YES, rate the helpfulness of each.			If YES, how helpful have these case managers or care coordinators been to you?				
	Not sure	No	Yes	Not at all helpful	A little helpful	Moderately helpful	Very helpful	Extremely helpful
a. Nurse Case Manager/ Medical Care Case Manager (MCCM)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Recovery Care Coordinator (RCC)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Army Squad Leader?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Army Wounded Warrior Program (AW2) Advocate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. USMC Section Leader?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Navy Safe Harbor Non Medical Case Manager (NMCM)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Air Force Wounded Warrior Program (AFW2) NMCM?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. SOCOM Care Coalition Liaison?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. SOCOM Care Coalition Advocate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Federal Recovery Coordinator (FRC)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Other case manager? Specify (Title of program/position rather than name of person): <hr/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> → <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**ABOUT INFORMATION RESOURCES FOR YOU**

**10. Please indicate whether you have used each of the following information resources by marking NOT SURE, NO, or YES. For each information resource, if you indicate YES, please rate how helpful it has been to you.**

Have <u>you</u> used any of these information resources? If YES, rate the helpfulness of each.	If YES, how helpful have these information resources been to you?							
	Not sure	No	Yes	Not at all helpful	A little helpful	Moderately helpful	Very helpful	Extremely helpful
a. Wounded Warrior Resource Center?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>				
b. National Resource Directory?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>				
c. Military OneSource?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>				
d. Military Hotline?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>				
e. Military Family Assistance Center	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>				

**SUPPORT FOR YOUR FAMILY**

**11. For each stage of your Service member’s treatment and recovery, please indicate your overall level of satisfaction or dissatisfaction with the military’s support for your family.**

<b>Stages of Treatment/Recovery Process</b>	<b>Very dissatisfied</b>	<b>Dissatisfied</b>	<b>Neither satisfied nor dissatisfied</b>	<b>Satisfied</b>	<b>Very satisfied</b>	<b>Does not apply</b>
a. Support getting you to the member’s bedside after you were notified	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Support while member undergoes inpatient care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Support during outpatient care or partial hospitalization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Support during follow up care (home, rehabilitation)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**12. Please indicate your level of satisfaction or dissatisfaction with the military’s support of your family in each of the following areas:**

<b>Areas of Support</b>	<b>Very dissatisfied</b>	<b>Dissatisfied</b>	<b>Neither satisfied nor dissatisfied</b>	<b>Satisfied</b>	<b>Very satisfied</b>	<b>Does not apply</b>
a. Overall support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Finances (e.g., advances, reimbursements)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Logistics (e.g., movement to and between treatment facilities)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Condition of facilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Information/education to help you care for your Service member	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Information/education about available benefits and services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Emotions (e.g., stress management, coping with depression /grief)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Assistance/advocacy (e.g., reducing red-tape, case management, respite care)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Support helping children cope with a Service member’s injuries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**OTHER DOD PROGRAMS AND SERVICES FOR YOU**

**13. Please indicate whether you have first-hand experience with any of the following programs and services by marking NOT SURE, NO, or YES. For each of the programs, if you indicate YES you have had first-hand experience, please rate how helpful it has been to you.**

<b>Have <u>you</u> used any of these RW resources? If YES, rate the helpfulness of each.</b>	<b>If YES, how helpful have these RW resources been <u>to you</u>?</b>							
	Not sure	No	Yes	Not at all helpful	A little helpful	Moderately helpful	Very helpful	Extremely helpful
a. Services for TBI?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>				
b. Services for PTSD?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>				
c. Integrated Disability Evaluation System (IDES)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>				
d. Legal support for RWs and families during the MEB phase of IDES?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	<input type="radio"/>				

*Thank you for providing this information.*



## **APPENDIX I-1: RECOVERING WARRIOR MINI-SURVEY RESULTS**



<b>Demographic Profile (N = 205)</b>		
<b>Variable/Response</b>	<b>N*</b>	<b>Percent**</b>
<b>Gender:</b>		
Male	172	84%
Female	32	16%
Total	204	100%
<b>Branch of Service:</b>		
Army	60	29%
Navy	20	10%
Air Force	0	0%
Marine Corps	34	17%
Coast Guard	0	0%
Army Reserve	14	7%
Army National Guard	58	28%
Air Force Reserve	0	0%
Air National Guard	2	1%
Naval Reserve	16	8%
Marine Corps Reserve	0	0%
Coast Guard Reserve	0	0%
Total	204	100%
<b>Pay Grade:</b>		
E1 – E3	15	7%
E4 – E6	136	66%
E7 – E9	31	15%
WO	3	2%
O1 – O3	13	6%
O4 – O6	7	3%
Total	205	99%
<b>Marital Status:</b>		
Married	115	57%
Single, never married	46	23%
Legally separated or filing for divorce	17	8%
Divorced or widowed	25	12%
Total	203	100%
<b>Dependent Children Living in the Home:</b>		
Yes	102	50%
No	102	50%
Total	204	100%

\*Not every participant answered each question.

\*\*Percentages may not sum to 100% due to rounding.

\*\*\*Survey results with a very small sample size are in gray font.

<b>Care Profile (N = 200)</b>		
<b>Variable/Response</b>	<b>N*</b>	<b>Percent**</b>
<b>Where are you in the process of recovery, rehabilitation, and transition?</b>		
Early	59	30%
Middle	29	15%
Returning to Duty	9	5%
In Disability Evaluation System	103	52%
Total	200	102%
<b>If in DES, are you in the Legacy DES or Integrated DES?</b>		
Legacy DES (starts with a DoD exam)	6	6%
Integrated DES (starts with a VA exam)	69	68%
Not sure	26	26%
Total	101	100%

Care Profile (N = 200)		
Variable/Response	N*	Percent**
<b>If in DES, what steps have been completed? (Mark all that apply)</b>		
Compensation & pension (C&P) exam	51	51%
Medical Evaluation Board	63	63%
Briefing by VA MSC completed	51	51%
Physical Evaluation Board	51	51%
Does not apply; I have not completed any of these steps	15	15%
Total number of respondents	100	
<b>Number of Service members who endorsed each of the following conditions:</b>		
Traumatic Brain Injury	72	36%
Amputation	13	7%
Spinal Cord Injury	50	25%
Burn Injury	6	3%
Vision Loss	14	7%
Psychological Diagnosis	89	45%
Intra-abdominal Injury	9	5%
Orthopedic Injury	104	52%
Chest Injury	3	2%
Hearing Loss	58	29%
Inhalation Injury	7	4%
Medical Diagnosis	60	30%
Total number of respondents	200	
<b>Total Number of conditions endorsed:</b>		
One	71	36%
Two	48	24%
Three	36	18%
Four	25	13%
Five	14	7%
Six	3	2%
Seven	2	1%
Eight	1	1%
Total number of respondents	200	102%

\*Not every participant answered each question.

\*\*Percentages may not sum to 100% due to rounding.

\*\*\*Survey results with a very small sample size are in gray font.

Case Management Support (N = 202)		
Variable/Response	N*	Percent**
<b>Please indicate whether you are working with each of the following types of case managers:</b>		
<b>Nurse Case Manager/Medical Care Case Manager (MCCM)</b>		
No	12	6%
Yes	187	93%
Not Sure	3	1%
Total	202	100%
<b>Recovery Care Coordinator (RCC)</b>		
No	94	48%
Yes	65	33%
Not Sure	37	19%
Total	196	100%
<b>Army Squad Leader</b>		
No	79	40%
Yes	116	59%
Not Sure	1	1%
Total	196	100%

Case Management Support (N = 202)		
Variable/Response	N*	Percent**
<b>Please indicate whether you are working with each of the following types of case managers:</b>		
<b>Army Wounded Warrior Program (AW2) Advocate</b>		
No	127	65%
Yes	47	24%
Not Sure	21	11%
Total	195	100%
<b>USMC Section Leader</b>		
No	146	75%
Yes	36	18%
Not Sure	14	7%
Total	196	100%
<b>Navy Safe Harbor Nonmedical Case Manager (NMCM)</b>		
No	163	83%
Yes	20	10%
Not Sure	14	7%
Total	197	100%
<b>Air Force Wounded Warrior Program (AFW2) NMCM</b>		
No	186	94%
Yes	2	1%
Not Sure	9	5%
Total	197	100%
<b>SOCOM Care Coalition Liaison</b>		
No	172	87%
Yes	8	4%
Not Sure	18	9%
Total	198	100%
<b>SOCOM Care Coalition Advocate</b>		
No	172	87%
Yes	6	3%
Not Sure	19	10%
Total	197	100%
<b>Federal Recovery Coordinator</b>		
No	166	84%
Yes	4	2%
Not Sure	27	14%
Total	197	100%
<b>Other case manager</b>		
No	139	74%
Yes	25	13%
Not Sure	23	12%
Total	187	99%

\*Not every participant answered each question.

\*\*Percentages may not sum to 100% due to rounding.

\*\*\*Survey results with a very small sample size are in gray font.

Variable/Response	N*	Percent**
<b>Please rate how helpful the following are to you:</b>		
<b>Nurse Case Manager/Medical Care Case Manager (MCCM)</b>		
Extremely helpful	67	36%
Very helpful	56	30%
Moderately helpful	39	21%
A little helpful	20	11%
Not at all helpful	4	2%
Total	186	100%
<b>Recovery Care Coordinator (RCC)</b>		
Extremely helpful	25	40%
Very helpful	23	37%
Moderately helpful	10	16%
A little helpful	4	6%
Not at all helpful	1	2%
Total	63	101%
<b>Army Squad Leader</b>		
Extremely helpful	42	37%
Very helpful	43	38%
Moderately helpful	15	13%
A little helpful	11	10%
Not at all helpful	3	3%
Total	114	101%
<b>Army Wounded Warrior Program (AW2) Advocate</b>		
Extremely helpful	14	31%
Very helpful	17	38%
Moderately helpful	11	24%
A little helpful	2	4%
Not at all helpful	1	2%
Total	45	99%
<b>USMC Section Leader</b>		
Extremely helpful	10	28%
Very helpful	19	53%
Moderately helpful	4	11%
A little helpful	2	6%
Not at all helpful	1	3%
Total	36	101%
<b>Navy Safe Harbor Nonmedical Case Manager (NMCM)</b>		
Extremely helpful	12	60%
Very helpful	6	30%
Moderately helpful	2	10%
A little helpful	0	0%
Not at all helpful	0	0%
Total	20	100%

\*Not every participant answered each question.

\*\*Percentages may not sum to 100% due to rounding.

\*\*\*Survey results with a very small sample size are in gray font.

Variable/Response	N*	Percent**
<b>Please rate how helpful the following are to you:</b>		
<b>Air Force Wounded Warrior Program (AFW2) NMCM</b>		
Extremely helpful	1	50%
Very helpful	1	50%
Moderately helpful	0	0%
A little helpful	0	0%
Not at all helpful	0	0%
Total	2	100%
<b>SOCOM Care Coalition Liaison</b>		
Extremely helpful	5	63%
Very helpful	1	13%
Moderately helpful	0	0%
A little helpful	1	13%
Not at all helpful	1	13%
Total	8	102%
<b>SOCOM Care Coalition Advocate</b>		
Extremely helpful	4	67%
Very helpful	1	17%
Moderately helpful	0	0%
A little helpful	0	0%
Not at all helpful	1	17%
Total	6	101%
<b>Federal Recovery Coordinator</b>		
Extremely helpful	0	0%
Very helpful	1	25%
Moderately helpful	3	75%
A little helpful	0	0%
Not at all helpful	0	0%
Total	4	100%
<b>Other case manager</b>		
Extremely helpful	11	52%
Very helpful	6	29%
Moderately helpful	3	14%
A little helpful	0	0%
Not at all helpful	1	5%
Total	21	100%

\*Not every participant answered each question.

\*\*Percentages may not sum to 100% due to rounding.

\*\*\*Survey results with a very small sample size are in gray font.

Information Resources (N = 204)		
Variable/Response	N*	Percent**
<b>Please indicate whether you have used each of the following information resources:</b>		
<b>Wounded Warrior Resource Center</b>		
No	102	50%
Yes	81	40%
Not Sure	21	10%
Total	204	100%
<b>National Resource Directory</b>		
No	171	84%
Yes	10	5%
Not Sure	22	11%
Total	203	100%
<b>Military OneSource</b>		
No	104	52%
Yes	84	42%
Not Sure	14	7%
Total	202	101%
<b>Military Hotline</b>		
No	179	88%
Yes	9	4%
Not Sure	15	7%
Total	203	99%
<b>Military Family Assistance Center</b>		
No	136	67%
Yes	56	28%
Not Sure	11	5%
Total	203	100%

\*Not every participant answered each question.

\*\*Percentages may not sum to 100% due to rounding.

\*\*\*Survey results with a very small sample size are in gray font.

Information Resources (N = 80)		
Variable/Response	N*	Percent**
<b>How helpful have these information resources been to you?</b>		
<b>Wounded Warrior Resource Center</b>		
Extremely helpful	24	30%
Very helpful	33	42%
Moderately helpful	16	20%
A little helpful	5	6%
Not at all helpful	1	1%
Total	79	99%
<b>National Resource Directory</b>		
Extremely helpful	1	10%
Very helpful	4	40%
Moderately helpful	5	50%
A little helpful	0	0%
Not at all helpful	0	0%
Total	10	100%
<b>Military OneSource</b>		
Extremely helpful	16	20%
Very helpful	23	29%
Moderately helpful	22	28%
A little helpful	17	21%
Not at all helpful	2	3%
Total	80	101%

Variable/Response	N*	Percent**
<b>How helpful have these information resources been to you?</b>		
<b>Military Hotline</b>		
Extremely helpful	1	13%
Very helpful	2	25%
Moderately helpful	2	25%
A little helpful	3	38%
Not at all helpful	0	0
Total	8	101%
<b>Military Family Assistance Center</b>		
Extremely helpful	12	22%
Very helpful	22	40%
Moderately helpful	13	24%
A little helpful	5	9%
Not at all helpful	3	6%
Total	55	101%

\*Not every participant answered each question.

\*\*Percentages may not sum to 100% due to rounding.

\*\*\*Survey results with a very small sample size are in gray font.

<b>Support During the DES Process (N = 194)</b>		
Variable/Response	N*	Percent**
<b>Have you met with your Physical Evaluation Board Liaison Officer (PEBLO)?</b>		
Yes	114	59%
No	80	41%
Total	194	100%
<b>How helpful is your PEBLO to you?</b>		
Extremely helpful	24	21%
Very helpful	42	37%
Moderately helpful	22	20%
A little bit helpful	19	17%
Not at all helpful	6	5%
Total	113	100%

\*Not every participant answered each question.

\*\*Percentages may not sum to 100% due to rounding.

\*\*\*Survey results with a very small sample size are in gray font.

Vocational Resources (N = 203)		
Variable/Response	N*	Percent**
<b>Please indicate whether you have first-hand experience with any of the following vocational programs:</b>		
<b>Operation Warfighter</b>		
No	159	79%
Yes	26	13%
Not Sure	17	8%
Total	202	100%
<b>Education and Employment Initiative (E2I, from DoD)</b>		
No	154	76%
Yes	28	14%
Not Sure	21	10%
Total	203	100%
<b>Other internship opportunities</b>		
No	160	83%
Yes	22	11%
Not Sure	11	6%
Total	193	100%
<b>DVOPs at REALifelines</b>		
No	183	91%
Yes	2	1%
Not Sure	17	8%
Total	202	100%
<b>VA VR&amp;E</b>		
No	138	70%
Yes	36	18%
Not Sure	23	12%
Total	197	100%
<b>Army Career and Education Readiness</b>		
No	149	74%
Yes	35	17%
Not Sure	17	9%
Total	201	100%
<b>Transition Assistance Program (TAP)</b>		
No	113	56%
Yes	78	39%
Not Sure	10	5%
Total	201	100%
<b>Disabled Transition Assistance Program (DTAP)</b>		
No	132	65%
Yes	56	28%
Not Sure	14	7%
Total	202	100%
<b>Other employment preparation or job readiness programs</b>		
No	151	80%
Yes	29	15%
Not Sure	10	5%
Total	190	100%

\*Not every participant answered each question.

\*\*Percentages may not sum to 100% due to rounding.

\*\*\*Survey results with a very small sample size are in gray font.

Variable/Response	N*	Percent**
<b>How helpful have these vocational programs been to you?:</b>		
<b>Operation Warfighter</b>		
Extremely helpful	8	31%
Very helpful	6	23%
Moderately helpful	4	15%
A little helpful	5	19%
Not at all helpful	3	12%
Total	26	100%
<b>Education and Employment Initiative (E2I, from DoD)</b>		
Extremely helpful	4	16%
Very helpful	8	32%
Moderately helpful	11	44%
A little helpful	1	4%
Not at all helpful	1	4%
Total	25	100%
<b>Other internship opportunities</b>		
Extremely helpful	8	40%
Very helpful	8	40%
Moderately helpful	2	10%
A little helpful	2	10%
Not at all helpful	0	0%
Total	20	100%
<b>DVOPs at REALifelines</b>		
Extremely helpful	0	0%
Very helpful	0	0%
Moderately helpful	2	100%
A little helpful	0	0%
Not at all helpful	0	0%
Total	2	100%
<b>VA VR&amp;E</b>		
Extremely helpful	4	11%
Very helpful	10	29%
Moderately helpful	15	43%
A little helpful	5	14%
Not at all helpful	1	3%
Total	35	100%
<b>Army Career and Education Readiness</b>		
Extremely helpful	6	18%
Very helpful	16	47%
Moderately helpful	8	24%
A little helpful	4	12%
Not at all helpful	0	0%
Total	34	101%
<b>Transition Assistance Program (TAP)</b>		
Extremely helpful	6	8%
Very helpful	30	40%
Moderately helpful	28	37%
A little helpful	10	13%
Not at all helpful	2	3%
Total	76	101%

Variable/Response	N*	Percent**
<b>How helpful have these vocational programs been to you?:</b>		
<b>Disabled Transition Assistance Program (DTAP)</b>		
Extremely helpful	8	15%
Very helpful	19	35%
Moderately helpful	19	35%
A little helpful	7	13%
Not at all helpful	2	4%
Total	55	102%
<b>Other employment preparation or job readiness programs</b>		
Extremely helpful	7	28%
Very helpful	9	36%
Moderately helpful	9	36%
A little helpful	0	0%
Not at all helpful	0	0%
Total	25	100%

\*Not every participant answered each question.

\*\*Percentages may not sum to 100% due to rounding.

\*\*\*Survey results with a very small sample size are in gray font.

<b>Experience Across Resources (N = 203)</b>		
Variable/Response	N*	Percent**
<b>Please indicate whether you have first-hand experience with any of the following programs:</b>		
<b>Services for TBI</b>		
No	134	67%
Yes	61	30%
Not Sure	6	3%
Total	201	100%
<b>Services for PTSD</b>		
No	100	49%
Yes	96	47%
Not Sure	7	3%
Total	203	99%
<b>Support for family caregivers</b>		
No	165	82%
Yes	26	13%
Not Sure	11	5%
Total	202	100%
<b>Integrated Disability Evaluation System (IDES)</b>		
No	99	49%
Yes	82	41%
Not Sure	21	10%
Total	202	100%
<b>Legal support for RWs and families during the MEB phase of IDES</b>		
No	131	65%
Yes	53	26%
Not Sure	17	9%
Total	201	100%

\*Not every participant answered each question.

\*\*Percentages may not sum to 100% due to rounding.

\*\*\*Survey results with a very small sample size are in gray font.

<b>How helpful have these programs and services been to you?</b>		
<b>Variable/Response</b>	<b>N*</b>	<b>Percent**</b>
<b>Services for TBI</b>		
Extremely helpful	8	13%
Very helpful	21	35%
Moderately helpful	13	22%
A little helpful	17	28%
Not at all helpful	1	2%
Total	60	100%
<b>Services for PTSD</b>		
Extremely helpful	13	14%
Very helpful	34	38%
Moderately helpful	26	29%
A little helpful	13	14%
Not at all helpful	4	4%
Total	90	99%
<b>Support for family caregivers</b>		
Extremely helpful	3	12%
Very helpful	10	39%
Moderately helpful	9	35%
A little helpful	3	12%
Not at all helpful	1	4%
Total	26	102%
<b>Integrated Disability Evaluation System (IDES)</b>		
Extremely helpful	14	18%
Very helpful	16	20%
Moderately helpful	26	33%
A little helpful	13	17%
Not at all helpful	10	13%
Total	79	101%
<b>Legal support for RWs and families during the MEB phase of IDES</b>		
Extremely helpful	15	29%
Very helpful	20	39%
Moderately helpful	9	17%
A little helpful	6	12%
Not at all helpful	2	4%
Total	52	101%

\*Not every participant answered each question.

\*\*Percentages may not sum to 100% due to rounding.

\*\*\*Survey results with a very small sample size are in gray font.



## **APPENDIX I-2: FAMILY MEMBER MINI-SURVEY RESULTS**



<b>Demographic Profile (N = 72)</b>	
<b>Variable/Response</b>	<b>N*</b>
<b>Gender of Family Member:</b>	
Male	4
Female	68
Total	72
<b>Family Member relationship to the recovering Service member:</b>	
Parent of recovering Service member	17
Spouse of recovering Service member	54
Other	1
Total	72
<b>Branch of Service:</b>	
Army	36
Navy	0
Air Force	0
Marine Corps	18
Coast Guard	0
Army Reserve	3
Army National Guard	13
Air Force Reserve	0
Air National Guard	0
Naval Reserve	0
Marine Corps Reserve	0
Coast Guard Reserve	0
Total	70
<b>Service Member Pay Grade:</b>	
E1 – E3	2
E4 – E6	51
E7 – E9	10
WO	2
O1 – O3	2
O4 – O6	2
Total	69
<b>What is your Service member's marital status?</b>	
Married	55
Single, never married	11
Legally separated or filing for divorce	1
Divorced or widowed	4
Total	71
<b>Does your Service member have dependent children living in the home?</b>	
No	24
Yes	47
Total	71

\*Not every participant answered each question.

\*\*Percentages are not provided due to small sample size.

<b>Care Profile (N = 71)</b>	
<b>Variable/Response</b>	<b>N*</b>
<b>Where is your Service member in the process of recovery, rehabilitation, and transition?</b>	
Early	15
Middle	22
Returning to Duty	3
In Disability Evaluation System (DES)	27
Total	67
<b>Number of Service members with each of the following conditions:</b>	
Traumatic Brain Injury	35
Amputation	14
Spinal Cord Injury	14
Burn Injury	2
Vision Loss	10
Psychological Diagnosis	35
Intra-abdominal Injury	3
Orthopedic Injury	38
Chest Injury	3
Hearing Loss	27
Inhalation Injury	2
Medical Diagnosis	26
<b>Total Number of conditions endorsed:</b>	
One	13
Two	20
Three	19
Four	7
Five	5
Six	5
Seven	1
Eight	0
Nine	1
Total	71

\*Not every participant answered each question.

\*\*Percentages are not provided due to small sample size.

<b>Case Managers (N = 71)</b>	
<b>Variable/Response</b>	<b>N*</b>
<b>Please indicate whether your Service member is working with each of the following types of case managers:</b>	
<b>Nurse Case Manager/Medical Care Case Manager (MCCM)</b>	
No	4
Yes	65
Not Sure	2
Total	71
<b>Recovery Care Coordinator (RCC)</b>	
No	28
Yes	22
Not Sure	21
Total	71
<b>Army Squad Leader</b>	
No	18
Yes	43
Not Sure	4
Total	65
<b>Army Wounded Warrior Program (AW2) Advocate</b>	
No	25
Yes	22
Not Sure	15
Total	62
<b>USMC Section Leader</b>	
No	42
Yes	17
Not Sure	6
Total	65
<b>Navy Safe Harbor Non Medical Case Manager (NMCM)</b>	
No	58
Yes	0
Not Sure	5
Total	63
<b>Air Force Wounded Warrior Program (AFW2) NMCM</b>	
No	59
Yes	0
Not Sure	4
Total	63
<b>SOCOM Care Coalition Liaison</b>	
No	46
Yes	4
Not Sure	13
Total	63
<b>SOCOM Care Coalition Advocate</b>	
No	45
Yes	4
Not Sure	16
Total	65
<b>Federal Recovery Coordinator (FRC)</b>	
No	41
Yes	6
Not Sure	18
Total	65

Variable/Response	N*
<b>Please indicate whether your Service member is working with each of the following types of case managers:</b>	
<b>Other case manager</b>	
No	33
Yes	11
Not Sure	13
Total	57

\*Not every participant answered each question.

\*\*Percentages are not provided due to small sample size.

Variable/Response	N*
<b>Please rate how helpful the following are to you:</b>	
<b>Nurse Case Manager/Medical Care Case Manager (MCCM)</b>	
Extremely helpful	23
Very helpful	20
Moderately helpful	9
A little helpful	9
Not at all helpful	3
Total	64
<b>Recovery Care Coordinator (RCC)</b>	
Extremely helpful	6
Very helpful	8
Moderately helpful	2
A little helpful	3
Not at all helpful	1
Total	20
<b>Army Squad Leader</b>	
Extremely helpful	18
Very helpful	8
Moderately helpful	6
A little helpful	8
Not at all helpful	2
Total	42
<b>Army Wounded Warrior Program (AW2) Advocate</b>	
Extremely helpful	6
Very helpful	5
Moderately helpful	5
A little helpful	2
Not at all helpful	1
Total	19
<b>USMC Section Leader</b>	
Extremely helpful	2
Very helpful	4
Moderately helpful	3
A little helpful	4
Not at all helpful	4
Total	17
<b>Navy Safe Harbor Non Medical Case Manager (NMCM)***</b>	
Extremely helpful	0
Very helpful	0
Moderately helpful	0
A little helpful	0
Not at all helpful	0
Total	0

<b>Variable/Response</b>	
<b>Please rate how helpful the following are to you:</b>	
<b>Air Force Wounded Warrior Program (AFW2) NMCM***</b>	
Extremely helpful	0
Very helpful	0
Moderately helpful	0
A little helpful	0
Not at all helpful	0
Total	0
<b>SOCOM Care Coalition Liaison</b>	
Extremely helpful	2
Very helpful	2
Moderately helpful	0
A little helpful	0
Not at all helpful	0
Total	4
<b>SOCOM Care Coalition Advocate</b>	
Extremely helpful	3
Very helpful	1
Moderately helpful	0
A little helpful	0
Not at all helpful	0
Total	4
<b>Federal Recovery Coordinator (FRC)</b>	
Extremely helpful	0
Very helpful	1
Moderately helpful	1
A little helpful	0
Not at all helpful	2
Total	4
<b>Other case manager</b>	
Extremely helpful	5
Very helpful	3
Moderately helpful	2
A little helpful	0
Not at all helpful	0
Total	10

\*Not every participant answered each question.

\*\*Percentages are not provided due to small sample size.

\*\*\*None of the respondents indicated their Service member is working with this type of case manager

Information Resources (N = 70)	
Variable/Response	N*
<b>Please indicate whether you have used each of the following information resources:</b>	
<b>Wounded Warrior Resource Center</b>	
No	40
Yes	22
Not Sure	8
Total	70
<b>National Resource Directory</b>	
No	58
Yes	4
Not Sure	8
Total	70
<b>Military OneSource</b>	
No	36
Yes	30
Not Sure	4
Total	70
<b>Military Hotline</b>	
No	61
Yes	7
Not Sure	2
Total	70
<b>Military Family Assistance Center</b>	
No	32
Yes	31
Not Sure	7
Total	70
<b>How helpful have these information resources been to you?</b>	
<b>Wounded Warrior Resource Center</b>	
Extremely helpful	8
Very helpful	5
Moderately helpful	4
A little helpful	3
Not at all helpful	0
Total	20
<b>National Resource Directory</b>	
Extremely helpful	0
Very helpful	1
Moderately helpful	0
A little helpful	1
Not at all helpful	0
Total	2
<b>Military OneSource</b>	
Extremely helpful	4
Very helpful	3
Moderately helpful	9
A little helpful	7
Not at all helpful	4
Total	27

\*Not every participant answered each question.

\*\*Percentages are not provided due to small sample size.

Variable/Response	N*
<b>How helpful have these information resources been to you?</b>	
<b>Military Hotline</b>	
Extremely helpful	1
Very helpful	0
Moderately helpful	3
A little helpful	0
Not at all helpful	2
Total	6
<b>Military Family Assistance Center</b>	
Extremely helpful	9
Very helpful	7
Moderately helpful	7
A little helpful	4
Not at all helpful	1
Total	28

\*Not every participant answered each question.

\*\*Percentages are not provided due to small sample size.

<b>Family Support (N = 70)</b>	
Variable/Response	N*
<b>Please indicate your overall level of satisfaction or dissatisfaction with the military's support for your family:</b>	
<b>Support getting you to the member's bedside after you were notified</b>	
Very satisfied	16
Satisfied	13
Neither satisfied or dissatisfied	7
Dissatisfied	3
Very dissatisfied	10
Does not apply	21
Total	70
<b>Support while member undergoes inpatient care</b>	
Very satisfied	23
Satisfied	9
Neither satisfied or dissatisfied	11
Dissatisfied	3
Very dissatisfied	7
Does not apply	16
Total	69
<b>Support during outpatient care or partial hospitalization</b>	
Very satisfied	17
Satisfied	16
Neither satisfied or dissatisfied	11
Dissatisfied	8
Very dissatisfied	8
Does not apply	9
Total	69
<b>Support during follow-up care (home, rehabilitation)</b>	
Very satisfied	16
Satisfied	11
Neither satisfied or dissatisfied	7
Dissatisfied	5
Very dissatisfied	7
Does not apply	24
Total	70

\*Not every participant answered each question.

\*\*Percentages are not provided due to small sample size.

<b>Family Support (N = 70)</b>	
<b>Variable/Response</b>	<b>N*</b>
<b>Please indicate your level of satisfaction or dissatisfaction with the military's support of your family in each of the following areas:</b>	
<b>Overall support</b>	
Very satisfied	24
Satisfied	17
Neither satisfied or dissatisfied	12
Dissatisfied	7
Very dissatisfied	5
Does not apply	1
Total	66
<b>Finances (e.g., advances, reimbursements)</b>	
Very satisfied	13
Satisfied	21
Neither satisfied or dissatisfied	14
Dissatisfied	7
Very dissatisfied	5
Does not apply	7
Total	67
<b>Logistics (e.g., movement to and between treatment facilities)</b>	
Very satisfied	18
Satisfied	14
Neither satisfied or dissatisfied	16
Dissatisfied	7
Very dissatisfied	2
Does not apply	12
Total	69
<b>Condition of facilities</b>	
Very satisfied	22
Satisfied	32
Neither satisfied or dissatisfied	9
Dissatisfied	1
Very dissatisfied	1
Does not apply	4
Total	69
<b>Information/education to help you care for your Service member</b>	
Very satisfied	14
Satisfied	19
Neither satisfied or dissatisfied	13
Dissatisfied	12
Very dissatisfied	9
Does not apply	2
Total	69
<b>Information/education about available benefits and services</b>	
Very satisfied	12
Satisfied	23
Neither satisfied or dissatisfied	13
Dissatisfied	10
Very dissatisfied	10
Does not apply	1
Total	69

Variable/Response	N*
<b>Please indicate your level of satisfaction or dissatisfaction with the military's support of your family in each of the following areas:</b>	
<b>Emotions (e.g., stress management, coping with depression/grief)</b>	
Very satisfied	13
Satisfied	17
Neither satisfied or dissatisfied	11
Dissatisfied	14
Very dissatisfied	10
Does not apply	4
Total	69
<b>Assistance/advocacy (e.g., reducing red-tape, case management, respite care)</b>	
Very satisfied	11
Satisfied	15
Neither satisfied or dissatisfied	18
Dissatisfied	8
Very dissatisfied	10
Does not apply	8
Total	70
<b>Support helping children cope with a Service member's injuries</b>	
Very satisfied	8
Satisfied	7
Neither satisfied or dissatisfied	14
Dissatisfied	5
Very dissatisfied	13
Does not apply	20
Total	67

\*Not every participant answered each question.

\*\*Percentages are not provided due to small sample size.

<b>Experience Across Resources (N = 71)</b>	
<b>Variable/Response</b>	<b>N*</b>
<b>Please indicate whether you have first-hand experience with any of the following programs:</b>	
<b>Services for TBI</b>	
No	40
Yes	26
Not Sure	5
Total	71
<b>Services for PTSD</b>	
No	37
Yes	27
Not Sure	5
Total	69
<b>Integrated Disability Evaluation System (IDES)</b>	
No	40
Yes	17
Not Sure	11
Total	68
<b>Legal support for RWs and families during the MEB phase of IDES</b>	
No	45
Yes	16
Not Sure	9
Total	70

\*Not every participant answered each question.

\*\*Percentages are not provided due to small sample size.

Variable/Response	N*
<b>How helpful have these resources been to you?</b>	
<b>Services for TBI</b>	
Extremely helpful	7
Very helpful	6
Moderately helpful	6
A little helpful	1
Not at all helpful	5
Total	25
<b>Services for PTSD</b>	
Extremely helpful	4
Very helpful	6
Moderately helpful	4
A little helpful	9
Not at all helpful	2
Total	25
<b>Integrated Disability Evaluation System (IDES)</b>	
Extremely helpful	3
Very helpful	6
Moderately helpful	2
A little helpful	4
Not at all helpful	2
Total	17
<b>Legal support for RWs and families during the MEB phase of IDES</b>	
Extremely helpful	5
Very helpful	4
Moderately helpful	2
A little helpful	3
Not at all helpful	1
Total	15

\*Not every participant answered each question.

\*\*Percentages are not provided due to small sample size.



**APPENDIX J: DATA CALL RESULTS – POPULATION AND  
STAFFING OF PROGRAMS**



## Recovering Warrior Medical Care Case Management (MCCM) Staffing

Each organization listed below responded to data calls from the RWTF. Additional details provided by those who responded are captured verbatim.

### Air Force Medical Service (As of January 31, 2013)

<b>Number of Wounded, Ill, or Injured Currently Receiving Medical Case Management:</b>			<b>~1,000</b>
<b>Percent that are combat injured within that population:</b>			<b>--</b>
	Number of MCCMs:		
Status	RNs	MSW/LCSWs	Total
Uniformed			
AC	4		4
Mobilized reservist			
Government civilian	20	2 LMSW	22
Contractor	108	2 LCSW	110
<b>Total</b>	<b>132</b>	<b>4</b>	<b>136</b>
<b>Current ratio of MCCMs to eligible Recovering Warriors: 1:7<sup>a</sup></b>			

<sup>a</sup> AF RWs are not assigned to transition units. Instead, the majority remain assigned to their base unit and get follow-on care at the base MTF. As of this data call, only 17 of 75 MTFs had MCCMs dedicated for RWs; baseline MCCMs have mixed caseloads (RWs and other active duty personnel). Air Force MCCMs have a 1:29 average caseload, and the average caseload for MCCMs caring primarily for RWs is 1:14.

### US Army Warrior Care & Transition Program (As of January 31, 2013)

<b>Number of Wounded, Ill, or Injured Currently Receiving Medical Case Management:</b>			<b>9,967</b>
<b>Percent that are combat injured within that population:</b>			<b>--</b>
	Number of MCCMs:		
Status	NCMs <sup>b</sup>	MSW/LCSWs <sup>c</sup>	Total
Uniformed			
AC	262		262
Mobilized reservist			
Government civilian	71		71
Contractor	191		191
Government civilian	342		342
Contractor	9		9
<b>Total</b>	<b>613</b>		<b>613</b>
<b>Current ratio of NCMs to eligible Recovering Warriors: 1:16</b>			
<b>Current ratio of LCSWs to eligible Recovering Warriors: NA</b>			

<sup>b</sup> Medical Care Case Managers (MCCMs) are Nurse Case Managers (NCMs).

**BUMED Case Management<sup>c</sup>**  
**(As of April 26, 2013)**

<b>Number of Wounded, Ill, or Injured Currently Receiving Medical Case Management:</b>			<b>1,687<sup>c</sup></b>
<b>Percent that are combat injured within that population:</b>			--
	Number of MCCMs:		
Status	RNs	MSW/LCSWs	Total
Uniformed	11	4	15
AC	9	4 LCSW	13
Mobilized reservist	2		2
Government civilian	107	9 LCSW	116
Contractor	93	9 LCSW	102
<b>Total</b>	<b>211</b>	<b>22</b>	<b>233</b>

**Current ratio of MCCMs to eligible Recovering Warriors: 85:1687 or 1:20**

<sup>c</sup> The BUMED case management program serves all populations. Not all wounded service members elect to live in barracks but remain with fellow comrades not eligible to reside in the barracks. Although not all WW units/barracks have an embedded case manager, each is assigned to a case manager. BUMED indicates there are 1687 AD combat and non-combat related (RWs), who are served by 85 of their 233 MCCMs. BUMED indicates target ratio for wounded warrior program sites is 1:20 (except in low acuity settings like Twentynine Palms), but general MCCM target ratio is 1:30. Acuity is factored into caseloads.

## Recovering Warrior Non-Medical Care Case Management (NMCM) Staffing

Each organization listed below responded to data calls from the RWTF. Additional details provided by those who responded are captured verbatim.

### Air Force Warrior and Survivor Care (As of January 31, 2013)

<b>Number of Wounded, Ill, or Injured Currently Assigned to Wounded Warrior Unit or Program:</b>							<b>1,035</b>
<b>Percent that are combat injured within that population:</b>							<b>22%</b>
	Number of NMCMs: <sup>e</sup>						
	Transition Unit Staff					Other NMCMs	
Status	RCCs	Platoon Sergeants	Squad Leaders	Section Leaders	AW2 Advocates	AFW2 NMCMs	Navy Safe Harbor
Uniformed							
AC							
Mobilized reservist							
Government civilian						11	
Contractor	41					16	
<b>Total</b>	<b>41</b>					<b>27</b>	
<b>Staffing ratio: RCCs to eligible Recovering Warriors: 25:1</b>							
<b>Staffing ratio: AFW2 NMCMs to Recovering Warriors assigned to unit/program: 38:1</b>							

<sup>e</sup> NMCMs consist of trained GS and Contractor employees per DoDI 1300.24. Training consists of DoD RCC and in-house training. 23 of 27 NMCMs have received DoD RCC training.

### US Army Warrior Care & Transition Program (As of January 31, 2013)

<b>Number of Wounded, Ill, or Injured Currently Assigned to WTC (WTUs and CBWTUs):</b>							<b>9,967</b>
<b>Percent that are combat injured within that population:</b>							<b>10%</b>
	Number of NMCMs:						
	Transition Unit Staff					Other NMCMs	
Status	RCCs	Platoon Sergeants	Squad Leaders	Section Leaders	AW2 Advocates <sup>9</sup>	AFW2 NMCMs	Navy Safe Harbor
Uniformed		261	969				
AC		163	802				
Mobilized reservist		98	167				
Government civilian					16		
Contractor					37		
<b>Total</b>		<b>261</b>	<b>969</b>		<b>53</b>		
<b>Staffing ratio: AW2 Advocates to eligible Recovering Warriors: 1:27 (1,262 eligible)</b>							
<b>Staffing ratio: Platoon SGTs to eligible Recovering Warriors: 1:38</b>							
<b>Staffing ratio: Squad Leaders to eligible Recovering Warriors: 1:10</b>							

<sup>9</sup>Army Wounded Warrior (AW2) Advocates are Recovery Care Coordinators (RCC).

**Marine Corps Wounded Warrior Regiment  
(As of January 31, 2013)**

<b>Number of Wounded, Ill, or Injured Currently Assigned to Wounded Warrior Unit or Program:</b>							<b>759</b>
<b>Percent that are combat injured within that population:</b>							<b>56%</b>
	Number of NMCMS:						
	Transition Unit Staff				Other NMCMS		
Status	RCCs	Platoon Sergeants	Squad Leaders	Section Leaders	AW2 Advocates	AFW2 NMCMS	Navy Safe Harbor
Uniformed				73			
AC				29			
Mobilized reservist				44			
Government civilian							
Contractor	51						
<b>Total</b>	<b>51</b>			<b>73</b>			
<b>Staffing ratio: RCCs to eligible Recovering Warriors: 1:21<sup>h</sup></b>							
<b>Staffing ratio: Section Leaders to eligible Recovering Warriors: 1:10</b>							

<sup>h</sup> Due to the acuity of cases and in-depth support provided to family members, the WWR encourages caseloads to not exceed 25 per RCC. Locations that exceed this ratio are Camp LeJeune and Camp Pendleton where there are a large number of Marines resident at the Hope and Care Centers or recovering with their parent units.

**Navy Safe Harbor  
(As of February 6, 2013)**

<b>Number of Wounded, Ill, or Injured Currently Assigned to Wounded Warrior Unit or Program:</b>							<b>270</b>
<b>Percent that are combat injured within that population:</b>							<b>15%</b>
	Number of NMCMS:						
	Transition Unit Staff				Other NMCMS		
Status	RCCs	Platoon Sergeants	Squad Leaders	Section Leaders	AW2 Advocates	AFW2 NMCMS	Navy Safe Harbor NMCMS (equivalent to RCCs)
Uniformed							17
AC							16
Mobilized reservist							1
Government civilian							5
Contractor							1
<b>Total</b>							<b>23</b>
<b>Staffing ratio: Navy Safe Harbor NMCMS to eligible Recovering Warriors: 1:12</b>							

## **APPENDIX K: OTHER RESULTS**



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## Other FY13 Results

This appendix presents additional findings in support of Recommendations 10 and 19. These findings augment those presented in the body of the report.

### Additional Findings for:

Recommendation 10: DoD must establish policy to ensure the accuracy, timeliness, accessibility, and relevancy of information sources. Specifically:

- Define roles and responsibilities of online resources and call centers established by DoD and the Services for the RW community; include common measures of effectiveness across all resources.
- Promote and improve marketing for the Wounded Warrior Resource Center 800 number (1-800-342-9647) as the single primary telephone resource for all RWs and their families.
- Maximize the availability of this information to include mobile platforms.
- Ensure the National Resource Directory's (NRD's) capacity to serve as a one-stop website source. At minimum, this should include executing a comprehensive marketing strategy targeting RWs and family members across the country and a mechanism to track its success in engaging RWs and family members.

Congress specifically instructed the RWTF to explore the effectiveness of Military OneSource (MOS), Wounded Warrior Resource Center (now called Military OneSource Wounded Warrior Specialty Consultations<sup>1</sup>), Family Assistance Centers (FACs), Service hotlines, and the National Resource Directory (NRD). The following data summarize the utilization and assessment of these information resources by RWs and family members.

**Military OneSource.** According to DoD Office of Military Community and Family Policy, 347,065 Service members and 305,523 family members utilized MOS during FY2012 (i.e., received in-person counseling, assistance by phone or email, or online registration).<sup>2</sup> Among RWTF RW mini-survey respondents, 42 percent (84/202) indicated they had used this information resource, and of these, 49 percent (39/80) found it very or extremely helpful.<sup>3</sup> Thirty out of 72 family members reported that they had used MOS, but of those who used MOS, only seven (out of 30) reported that they found it very or extremely helpful.<sup>4</sup> Awareness of MOS was tended to be somewhat lower at the RC sites than at the AC sites.<sup>5</sup>

**Military OneSource Wounded Warrior Specialty Consultations.** MOS Wounded Warrior Specialty Consultations, which provides resources specifically to RWs and their family members, processed 2,938 of the calls received by MOS in FY2012.<sup>6</sup> Concerning MOS Wounded Warrior Specialty Consultations, 40 percent (81/204) of RW mini-survey respondents indicated they had used this information resource, and of these, 72 percent (57/81) found it very or extremely helpful.<sup>7</sup> Family members were less likely than RWs to have used this resource (22/70), and of those who used this resource, 13/30 reported that they found it very or extremely helpful.<sup>8</sup>

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**Family Assistance Centers.** Twenty-eight percent (56/203) of RW mini-survey respondents indicated they had used this information resource, and of these, 61 percent (34/56) found it very or extremely helpful.<sup>9</sup> Family members tended to be more likely than RWs to have used this resource (31/70), and of those who used this resource, 16/31 reported they found it very or extremely helpful.<sup>10</sup> However, in focus group discussions, family members assessments of FACs tended to be more positive; they stated that they appreciated having access to all of the resources available at the FACs, including Army SFACs and Marine Corps Community Services, and that the people who work there were helpful.<sup>11</sup>

**Service hotlines.** The Marine Corps, Army, and Navy Safe Harbor have hotlines that operate 24/7, including the Marine Corps Sergeant Merlin German Wounded Warrior Call Center which is also used for outreach,<sup>12</sup> the Army Wounded Soldier and Family Hotline (WSFH) which is used for concerns about medical care,<sup>13</sup> and the recently established Navy Wounded Warrior Call Center.<sup>14</sup> The Air Force Wounded Warrior website provides key links and telephone numbers, but does not operate a Service-specific Wounded Warrior hotline.<sup>15</sup> The Marine Corps Sergeant Merlin German Wounded Warrior Call Center staff conduct an average of 7,000 outreach calls each month and receive an average of 1,100 incoming calls.<sup>16</sup> The Army WSFH received 54,398 inbound calls and made 12,689 outbound calls with over 75% of the inbound calls resolved within the first call.<sup>17</sup> As of December 6, 2012, the Navy Wounded Warrior Safe Harbor call center staff had answered 100 calls since it began in October 2012.<sup>18</sup> Almost none of the RW mini-survey respondents indicated having used a military hotline (4%, or 9/203), and of these only three individuals found it very or extremely helpful.<sup>19</sup> Only seven out of 70 family member mini-survey respondents indicated they have used a Service hotline, and only one individual reported finding it very or extremely helpful.<sup>20</sup> No written policy exists addressing the relationship of the DoD WWRC to the existing Army, Marine Corps, and Navy call centers or clarifying DoD expectations regarding the establishment of an Air Force call center.

**National Resource Directory.** RWTF mini-survey respondents reported low utilization of the NRD. Only five percent (10/203) of RWs indicated using it, and of these 50 percent (5/10) found it very or extremely helpful<sup>21</sup>, only four out of 70 family members indicated using it<sup>22</sup>. While DoD WCP reported to the RWTF that the NRD receives approximately 100,000 visits per month,<sup>23</sup> WCP was not able to further characterize these hits or indicate how many unique users they represent. Based on RWTF focus group and mini-survey data, and limited WCP utilization metrics, the RWTF does not believe the NRD is adequately meeting the needs of the RW community.

### **Additional Findings for:**

Recommendation 19: There is a disparity in the ambient knowledge of the RC as compared to the AC as to non-medical case management. The Services will establish a protocol that ensures non-medical information is resident, current, and accessible in RC organizations.

The RWTF is concerned that the RC RW community may not be as connected to RW resources as they could be, or as their Active Component 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. Exhibit 1 compares the percentage of RC personnel in the respective Service-specific RW programs against

two proxies for how many RC might be eligible (percent of Service branch and percent of wounded in action). In some Service branches the percentage of RC in the RW programs is considerably lower than expected.

**Exhibit 1: Reserve representation within Service branch, among Service branch wounded in action, and in Service-specific RW units/programs, by component**

Reserve Components	% of Service branch <sup>24</sup> (Selected Reserve/ Total Service branch)	% of Service branch WIA <sup>25</sup> (RC WIA/Total Service branch WIA)	% of those in Service-specific program (RC in program/Total Service branch in program)
ARNG	29.8%	16.2%	32.0% <sup>26</sup>
USAR	16.9%	6.0%	21.3% <sup>27</sup>
ANG	19.5%	11.5%	10.0% <sup>28</sup>
AFR	13.2%	4.4%	11.3% <sup>29</sup>
USNR	15.3%	12.2%	7.8% <sup>30</sup>
USMCR	13.2%	9.8%	2.6% joined <sup>31</sup> (2.8% supported <sup>32</sup> )

Similarly, the RWTF is uncertain whether in all Services the number of RC personnel receiving SCAADL payments is commensurate with the number who qualify. Exhibit 2 shows for each Service branch the percentage of RC SCAADL recipients and, for comparison purposes, the percentage of RC within the Service-specific RW unit or program.

**Exhibit 2: Reserve representation among SCAADL recipients and in Service-specific RW units/programs, by component**

Services	% RC among SCAADL recipients	% RC within Service-specific unit/program
Army	28% <sup>33</sup>	53.3% <sup>34</sup>
Air Force	8% <sup>35</sup>	21.3% <sup>36</sup>
Navy	6% <sup>37</sup>	7.8% <sup>38</sup>
Marine Corps	5% <sup>39</sup>	2.6% joined <sup>40</sup> (2.8% supported <sup>41</sup> )

**Notes**

<sup>1</sup> Clouse, N. Office of the Secretary of Defense, Military Community and Family Policy, personal communication with the RWTF, July 29, 2013.

<sup>2</sup> Clouse, N. Office of the Secretary of Defense, Military Community and Family Policy, personal communication with the RWTF, January 23, 2013.

<sup>3</sup> RWTF RW mini-survey results, November 2012-March 2013.

<sup>4</sup> RWTF family member mini-survey results, November 2012-March 2013.

<sup>5</sup> Ibid.

<sup>6</sup> Clouse, N. Office of the Secretary of Defense, Military Community and Family Policy, personal communication with the RWTF, January 23, 2013.

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- <sup>7</sup> RWTF RW mini-survey results, November 2012-March 2013. The RWTF RW mini-survey referred to the Wounded Warrior Resource Center rather than MOS Wounded Warrior Specialty Consultations, the more current title, which may have confounded these results.
- <sup>8</sup> RWTF family member mini-survey results, November 2012-March 2013. The RWTF family member mini-survey referred to the Wounded Warrior Resource Center rather than MOS Wounded Warrior Specialty Consultations, the more current title, which may have confounded these results.
- <sup>9</sup> RWTF RW mini-survey results, November 2012-March 2013.
- <sup>10</sup> RWTF family member mini-survey results, November 2012-March 2013.
- <sup>11</sup> RWTF family member focus group results, November 2012-March 2013.
- <sup>12</sup> Sergeant Merlin German Wounded Warrior Call Center (2012). U.S Marine Corps Wounded Warrior Regiment. Retrieved February 7, 2012, from <http://www.woundedwarriorregiment.org/callcenter/callcenter.cfm>
- <sup>13</sup> Wounded Soldier and Family Hotline (2012). U.S. Army Medical Department. Retrieved February 7, 2012, from <http://www.armymedicine.army.mil/wsfh/index.html>
- <sup>14</sup> CAPT Hall, S. Briefing to the RWTF. Navy Wounded Warrior – Safe Harbor. December 6, 2012.
- <sup>15</sup> Air Force Wounded Warrior (2012). U.S. Air Force. Retrieved February 7, 2012, from <http://www.woundedwarrior.af.mil/>
- <sup>16</sup> Briefing submitted to the RWTF. Marine Corps Back-up Slides. February 27, 2013.
- <sup>17</sup> Briefing submitted to the RWTF. Army Back-up Slides. February 26, 2013.
- <sup>18</sup> CAPT Hall, S. Briefing to the RWTF. Navy Wounded Warrior – Safe Harbor. December 6, 2012.
- <sup>19</sup> RWTF RW mini-survey results, November 2012-March 2013.
- <sup>20</sup> RWTF family member mini-survey results, November 2012-March 2013.
- <sup>21</sup> RWTF RW mini-survey results, November 2012-March 2013.
- <sup>22</sup> RWTF family member mini-survey results, November 2012-March 2013.
- <sup>23</sup> Seymour, D. Briefing to the RWTF. DoD Response to the Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces. April 3, 2013.
- <sup>24</sup> Defense Manpower Data Center (2011). 2011 Demographics: profile of the military community. Retrieved May 29, 2013, from [http://www.militaryonesource.mil/12038/MOS/Reports/2011\\_Demographics\\_Report.pdf](http://www.militaryonesource.mil/12038/MOS/Reports/2011_Demographics_Report.pdf). Raw numbers for Selected Reserve/Total Service branch: ARNG 361,561/1,215,299, USAR 204,803/1,215,299, ANG 105,685/541,320, AFR 71,321/541,320, USNR 64,792/423,156, USMCR 39,772/301,479.
- <sup>25</sup> Defense Casualty Analysis System (May 29, 2013). U.S. military casualties: GWOT casualty summary by service component. Retrieved May 29, 2013, from [https://www.dmdc.osd.mil/dcas/pages/report\\_sum\\_comp.xhtml](https://www.dmdc.osd.mil/dcas/pages/report_sum_comp.xhtml)
- <sup>26</sup> Briefing submitted to the RWTF. Army Back-up Slides. February 26, 2013.
- <sup>27</sup> Ibid.

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- <sup>28</sup> Briefing submitted to the RWTF. Air Force Back-up Slides. February 26, 2013.
- <sup>29</sup> Ibid.
- <sup>30</sup> LT Noriega, D. Navy Wounded Warrior-Safe Harbor Operations Officer, personal communication with the RWTF, December 6, 2012.
- <sup>31</sup> Briefing submitted to the RWTF. Marine Corps Back-up Slides. February 27, 2013.
- <sup>32</sup> Ibid.
- <sup>33</sup> Lock, L. and Perry, L.A. Panel presentation to the RWTF. Army Special Compensation for Assistance with Activities of Daily Living. December 5, 2012.
- <sup>34</sup> Briefing submitted to the RWTF. Army Back-up Slides. February 26, 2013.
- <sup>35</sup> MSgt Noel, C. Panel presentation to the RWTF. Air Force Special Compensation for Assistance with Activities of Daily Living. December 5, 2012.
- <sup>36</sup> Briefing submitted to the RWTF. Air Force Back-up Slides. February 26, 2013.
- <sup>37</sup> CDR Shapiro, D. and Weatherford, L.B. Panel presentation to the RWTF. Navy Special Compensation for Assistance with Activities of Daily Living. December 5, 2012.
- <sup>38</sup> LT Noriega, D. Navy Wounded Warrior-Safe Harbor Operations Officer, personal communication with the RWTF, December 6, 2012.
- <sup>39</sup> Williamson, P. Panel presentation to the RWTF. Marine Corps Special Compensation for Assistance with Activities of Daily Living. December 5, 2012.
- <sup>40</sup> Briefing submitted to the RWTF. Marine Corps Back-up Slides. February 27, 2013.
- <sup>41</sup> Ibid.



**APPENDIX L: RECOMMENDATIONS  
FOR CONGRESSIONALLY MANDATED TOPICS**



## Recommendations for Congressionally Mandated Topics

Topics Listed in 111 Pub. L. 111-84, 123 Stat 2190, Section 724, subsection c, paragraph 3:	Recommendation	Page
	2	10
	5	15
	7	17
	8	19
	11	24
a. Case management	15	28
	16	29
	17	31
	19	32
	20	33
	21	36
b. Staffing of units and programs	9	20
	18	31
c. Performance and accountability standards for units and programs	2	10
	5	15
	20	33
	3	11
	4	13
d. Services for TBI and PTSD	7	17
	8	19
	9	20
e. Centers of Excellence	1	9
f. Interagency Program Office	-	
g. Wounded warrior information resources	10	22
	10	22
	15	28
h. Support to family caregivers	16	29
	20	33
i. Legal support	11	24
j. Vocational training	21	36
	6	16
	12	25
k. Enhancements to the DES (IDES)	13	26
	21	36
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**Topics Listed in 111 Pub. L. 111-84, 123 Stat 2190,  
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