

Department of Defense Recovering Warrior Task Force

Non-Voted Draft Annual Report 2013-2014



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



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This is the fourth and final Annual Report of the Department of Defense (DoD) Recovering Warrior Task Force (RWTF), which was established at Congress' behest to examine the effectiveness of military Recovering Warrior (henceforth Recovering Warriors, or RWs) policies and programs and to recommend improvements¹. Congress specified over a dozen RW matters that RWTF was to study each year; although these matters focused primarily on RW needs and resources prior to signing a Certificate of Release or Discharge from Active Duty form (known as the DD214), Congress also charged RWTF to address RWs' transition to the Department of Veterans Affairs (VA) and civilian status. Drawing upon a comprehensive research plan encompassing a wide variety of data sources and collection methods (see Appendix D, Methodology), RWTF produced a total of 77 recommendations in its first three years of effort. These recommendations can be found in Fiscal Year (FY) 2011, FY2012, and FY2013 RWTF Annual Reports available at <http://rwtf.defense.gov/>. The present FY2014 Annual Report makes 13 recommendations, for a total of 90 RWTF recommendations over four years of operation.

Two factors differentiate the tenor and content of this RWTF Annual Report from the three that preceded it: the anticipated sunset of RWTF and the shifting geopolitical landscape. RWTF, a time-limited Federal Advisory Committee (FAC), will sunset September 30, 2014. RWTF is thus mindful that this volume represents a final opportunity to potentially influence the future effectiveness and course of RW care. Secondly, RWTF recognizes that the drawing down of US military operations in Southwest Asia after more than a decade of war poses both risk and opportunity for the enduring RW mission. The decline in combat injuries may jeopardize continued attention and resources for RW matters. At the same time, peacetime affords RW proponents the opportunity—or in RWTF's view, the obligation—to regroup, strategize, formalize, and marshal support for the way forward in RW care and reintegration, for today's generation of RWs and the next.

Chapter 1 presents a short retrospective on what RWTF did and found during its four years of effort, which as noted was DoD-centric by design. This is followed by RWTF's vision for the post-DD214 way ahead, predicated on all it has learned over the past four years about RWs' and Veterans' needs and available services. The centerpiece of Chapter 2 comprises this year's 13 recommendations and the findings that substantiate them. These recommendations, listed below, are grouped under four headers: Integrated Disability Evaluation System, Supporting an Enduring RW Mission, Facilitating RW Recovery and Transition, and Facilitating Access to Healthcare.

(Note: Quantity/titles of recommendations and organizational framework in this Non-Voted Draft are subject to change based on pending July 8-9 voting meeting.)

Integrated Disability Evaluation System (IDES)

- D1. DOD should design a new approach to replace the current DES. The hallmarks of the redesigned approach should include:
 - Simplicity
 - Incentivization of work and wellness
 - Patient and family-centered
 - Standardization across DOD

- D2. Until a new approach is found, DoD needs to continue to improve or address the following issues in the Integrated Disability Evaluation System (IDES) process:
 - Transparency
 - Timeliness
 - Ensuring only those Service members likely to leave the military enter the process
 - Fully informing family members at the outset and at significant decision points throughout the process, including mandatory family member or significant other accompaniment to the initial IDES brief
 - Ensuring productive work opportunities for the Service member in all levels of government as well as in civilian companies
 - Allowing the Service member access to and enrollment in education and training programs through college and certification education programs
 - Emphasizing recovery and rehabilitation
 - Allowing eligibility for “elective” treatments with consideration to recovery time and time remaining in IDES
 - Improving legal services for geographically dislocated RWs, with special consideration for early contact, confidentiality, and involvement of family members
 - Providing all Reserve Component (RC) enrollees with the same access as Active Component (AC) enrollees to compensation & pension (C&P) exams at military treatment facilities (MTFs), in-person briefings and counseling at significant points during the process, and TAP participation prior to discharge.
 - Initiating a default Commander’s Letter from the losing line commander before the Service member transitions to the Warrior Transition Unit.
 - Ensuring scalability of the DES.

Supporting an Enduring RW Mission

- D3. Publish a DODI policy for addressing the needs of RW family members and caregivers and identifying baseline services to be delivered by each Service and Component.
- D4. Establish a uniformed representative from each Service at WCP.

-
- D5. Secure enduring resources for maintaining the capability, infrastructure, and institutional knowledge for supporting RWs that has been developed over the last 10 years.
 - D6. Develop interagency/cross-agency DoD/VA policy that binds and commits both agencies to implement and institutionalize programs that span departments. DOD VA Joint Executive Council (JEC) should establish the capability for the creation of interagency policy.
 - D7. Align COEs under DHA to enable joint effort and direct links to governance processes within the military health system structure and to allow for translation of scientific findings to clinical settings. DHA Chief Medical Officer should work in concert with Medical Director of NIH.

Facilitating Recovering Warrior Recovery and Transition

- D8. To optimize the family and significant other contribution to Warriors' recovery, facilitate their participation and socialization throughout the continuum of care, management, and transition. HIPAA rules that potentially constrain family involvement should be mitigated.
- D9. Pre-DD214, facilitate the transfer of each SM to the VA by automatically enrolling him/her, scheduling an initial appointment, and providing information on how to fully utilize the VA benefit.
- D10. Identify the major DoD and Service-level vocational/employment programs and systematically assess to what extent, as a whole, they satisfy the needs of the RW population and family members.
- D11. Consider existing recruitment standards to ensure quality of future accessions.

Facilitating Access to Healthcare

- D12. Require health insurance as a condition of employment in the RC.
- D13. In order to expand access to care for service members/ Veterans, provide an option to use Medicare/TRICARE/ CHAMPVA.

In addition to recommendations and associated findings, Chapter 2 features six best practices RWTF encountered in FY2014 and presents charts updating the implementation status of RWTF's FY2011, FY2012, and FY2013 recommendations, as of spring 2014. Extensive appendices supply further information regarding RWTF, its methods, and its results. (Appendices are not included in this Non-Voted Draft.)

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The President announced May 27, 2014 that fewer than 10,000 troops would remain in Afghanistan by the end of the year²; the end of the longest war in American history was drawing near. Our military is downsizing.^{3, 4} Approximately one million Service members will leave the military and enter civilian life over the next several years⁵—many of them carrying with them the visible and invisible residual effects of more than a decade of unprecedented deployment tempo^{6, 7, 8}. This is a population, according to DoD casualty statistics from the theater of operations for the period 2001 to 2013, whose new posttraumatic stress disorder (PTSD) diagnoses outnumbered major limb amputations by a factor of 76 (118,828 v. 1,558).⁹ At least as ubiquitous among US Service members is traumatic brain injury (TBI), with over 300,000 new cases diagnosed worldwide over a similar timeframe.¹⁰ As of March 2014, there were 30,478 Service members going through the Integrated Disability Evaluation System (IDES).¹¹ New Veterans may remain in military-centric and urban areas or disperse throughout the heartland to small towns and rural areas^{12, 13}, where medical and allied specialists are often sparse¹⁴.

Overview of RWTF Work

At the behest of Congress, the DoD Recovering Warrior Task Force (RWTF) spent four years examining military policies and programs for the care, management, and transition of wounded, ill, and injured (WII) personnel and making recommendations for improvement.¹⁵ Although as a DoD task force our primary focus was on Recovering Warrior (RW) experience prior to signing a Certificate of Release or Discharge from Active Duty form¹⁶ (referred to hereafter as pre-DD214), we were also charged with examining Service members' DoD/VA transition and interagency coordination.¹⁷ To that end, in addition to comprehensive data gathering from DoD entities, RWTF gathered targeted data from VA Central Office and local VA Medical Centers visited in conjunction with State Joint Forces Headquarters. (See next section for further information about RWTF's data collection approaches and the "Site Visits" appendix of each RWTF Annual Report.) Briefings from proponents from VA Operations Enduring Freedom/Iraqi Freedom/New Dawn (OEF/OIF/OND) Programs, Caregiver Programs, and PTSD/TBI services, and from other VA staff working with transitioning personnel, provided insight into DoD/VA transition issues and informed 22 recommendations¹⁸ over the past four years, including Recommendation D8 in the current report. RWTF remains a staunch advocate for warm and systematic transfers from DoD to VA. At the same time, we are acutely aware that this handoff represents only the beginning of the transitioning Veteran's reintegration journey.¹⁹ The post-DD214 life that looms ahead for new Veterans is fraught with unknowns and challenges, begging the question how we as a military, a Federal Government, and a nation can best meet their needs. In the remainder of this introductory chapter, RWTF addresses both the pre-DD214 world and the post-DD214 world. We start with a short retrospective on what RWTF did and found during its four years of effort, which as noted was DoD-centric by design. We close with a vision, predicated on all we have learned over the past four years about RWs' and Veterans' needs and available services, for the post-DD214 way ahead.

What RWTF did and found between FY2011 and FY2014

As a Congressionally directed DoD federal advisory committee, RWTF partnered with DoD and the Services in assessing and recommending improvements to military programs and policies for the care, management, and transition of Recovering Warriors (RWs). Through numerous site visits each year, we observed how programs and policies are implemented and perceived at ground level. We formulated recommendations based on a comprehensive data gathering effort that drew upon many different sources and methods including 104 focus groups totaling 795 participants at 38 DoD RW sites, 417 briefings at 70 sites (including DoD RW sites, DoD RW headquarters offices, VA medical centers, and VA polytrauma rehabilitation centers²⁰), 171 briefings and panels during 16 business meetings, and ongoing review and synthesis of relevant surveys, reports, academic articles, congressional testimony, etc. Our data gathering included the recommendations made previously by leading commissions (e.g. the President's Commission on Care for America's Returning Wounded Warriors²¹ and the Army-sponsored task force lead by retired General Frederick Franks Jr.²²) and institutions such as Rand²³, the Institute of Medicine²⁴, and the Center for a New American Security²⁵, to name a few, allowing RWTF to build upon earlier work rather than duplicating it. We shined a light on areas needing attention at the Congressional, DoD, or Service levels, and occasionally made suggestions to the VA, for a total of 77 recommendations during the first three years. In accordance with legislative guidance, we also identified best/promising practices each year.

Monitoring outstanding issues after sunset of RWTF

Each RWTF Annual Report, including this one, includes a chart tracking the implementation status of the prior year's recommendations, based on DoD's congressionally mandated evaluation and implementation plan. As of spring 2014, the implementation status of the FY2011-FY2013 recommendations as a whole indicated work remains. That is, RWTF deemed 18 of the 77 recommendations were complete, 55 should continue to be followed, and four should continue to be addressed. The dominant issue areas that remain unresolved, in RWTF's opinion, were the Integrated Disability Evaluation System (IDES) (See current Recommendations D1 and D2), meeting the needs of RC personnel (See Recommendation D11), DoD/VA coordination (See Recommendations D6 and D8), and non-medical case management (NMCM). Thus there remain gaps in the system that Congress asked RWTF to examine, about which Congress will undoubtedly continue to hear from constituents. Going forward, in the absence of RWTF oversight following its September 30, 2014 sunset, and with the corresponding lifting of the legislative requirement that DoD formally respond to RWTF's recommendations, we encourage Congress to use the implementation status of RWTF's 77 recommendations as a checklist of issue areas to monitor and address. When Congress requests testimony from the Service Chiefs regarding RW matters, for instance, this information should guide its questioning.

RWTF specifically urges sustained attention on two pernicious problems for which we have made multiple recommendations in previous years. The interoperable records debate must end and the long awaited Electronic Health Record (EHR) implemented. (See FY2011 Recommendation 20 and FY2012 Recommendation 29.) Fully informed medical care, comprehensive Narrative Summaries (NARSUMs) for disability adjudication, fair disability ratings, and truly seamless transfers between the Military Treatment Facilities (MTFs) and VA medical centers lie in the balance. We therefore add our voice to the chorus of voices and the powerful organizations that are fighting to finally make the EHR a reality. Secondly, all Service members, including the sizable proportion receiving their care

from the TRICARE network, must have access to the best PTSD treatment possible, which today comprises the evidence-based practices²⁶ captured in the DoD/VA Clinical Practice Guideline (CPG) for the Management of Post-Traumatic Stress²⁷ (see nine prior recommendations²⁸). As TRICARE network behavioral health providers' licensing credentials do not ensure the use of CPGs,^{29, 30} this will require a modification in the TRICARE contractors' statements of work. Additionally, DoD might consider undertaking a comparative study of MTF and network PTSD treatment outcomes to better understand how using network providers affects quality of PTSD care. This issue is particularly salient for remotely located Service members, many of them Reservists, who lack the option of MTF care.

RWTF FY2014 draft recommendations

RWTF presents in this fourth and final Annual Report 13 targeted recommendations, many of them strategic in nature. These recommendations are focused on sustaining the capacity of DoD and DoD/VA organizations to continue to support the enduring RW mission more than on improving individual policies and programs. We urge institutionalization of lessons learned, preservation of vital resources, organizational empowerment, out-of-the-box thinking about access to healthcare, and new tacks to tenacious problems. This includes, after three years and 11 prior tactical recommendations related to the current disability evaluation system (DES)³¹, challenging DoD to design a new approach from the ground up (Recommendation D1).

Looking to the Future

Although RWTF was chartered to address pre-DD214 RW programs and policies, the reality is that the large majority of WII Service members will transition out of uniform and spend the rest of their lives in the post-DD214 world, as will all other new Veterans. RWTF would be remiss not to acknowledge the magnitude of the reintegration challenge and scope of response that will be needed to bring America's heroes—abled and disabled—all the way home³².

Transition—a challenge for new Veterans, Recovering Warriors, and American society

Veterans of the OIF/OEF/OND era, including those serving and those who have transitioned to civilian life, are a vulnerable population. While estimates of the prevalence of PTSD and TBI in this population vary³³, RAND calculated in 2008 that roughly one-third of personnel previously deployed to the theater of operations had PTSD, major depression, and/or TBI³⁴. In 2013, there was nine percent joblessness among post 9/11 Veterans, as compared to a nationwide rate of just over seven percent.³⁵ Earlier in this conflict, the Government Accountability Office (GAO) found that even Veterans receiving VA Vocational Rehabilitation and Employment (VR&E) services took an average of four years or more to find suitable employment.³⁶ Veterans are at disproportionate risk of becoming homeless³⁷ and committing suicide^{38, 39, 40}. Rear Admiral (Ret.) Michael S. Baker warned in the journal *Military Medicine* that the legacy of the Global War on Terror (GWOT) is “homelessness, family disruptions, domestic violence, suicide, criminal acts, substance abuse, and risk taking behaviors.”⁴¹ Disability, including co-morbidities⁴² and social impacts^{43, 44} associated with PTSD and TBI, compounds the challenges that transitioning Service members face.

The end of combat operations in Southwest Asia will most assuredly result in fewer wounded; however, Service members and Veterans will continue to need care and healing from their illnesses and accidents, as well as from earlier wounds. This includes late onset, or simply delayed acknowledgement or disclosure, of PTSD/TBI conditions triggered by earlier combat experiences.⁴⁵ In fact, the end of back-to-back deployments—and relief from pressure to stay, or at least appear, deployment ready—may open a floodgate of physical and mental complaints that Service members and Veterans finally feel at liberty to address. Unfortunately, research shows that, among the current generation of Veterans, only about half of those needing treatment for major depression or PTSD seek it.⁴⁶ Veterans with permanent physical disabilities, such as prosthesis wearers and assistive technology users, will require equipment servicing and upgrades, if not also regular medical attention and related nonmedical support.⁴⁷ The most severely wounded, ill, or injured Veterans, including some with PTSD and/or TBI and others with profound mobility and cognitive impairment, may require assistance throughout their lives.^{48, 49} Though very small in number, RWs who choose to return to duty, whether in the same occupational field or a new one, also have ongoing needs that must be addressed.

The 13,873 RWs supported by Army Warrior Transition Units, Marine Corps Wounded Warrior Regiment detachments, and the Air Force Wounded Warrior and Navy Wounded Warrior-Safe Harbor programs as of January 2014^{50, 51, 52, 53} comprise only a small fraction of our military's transitioning WII population. In combination with all other transitioning Service members, who as noted carry risks of their own, and the families that journey with them, this population is so large that some suggest it will significantly strain the economic and social fabric of our society.^{54, 55, 56} Rear Admiral Baker predicted that it will, “crash into our society's structure like a tsunami.”⁵⁷

RWTF's vision for the way ahead

America's cities and communities must be prepared for an expanded Veteran footprint, a bolus of Veterans whose needs will frequently differ from those of the other 99 percent of the citizenry that did not serve, 42 percent of whom do not use VA health services⁵⁸. There will be more TBI and PTSD⁵⁹, and a demand for culturally competent evidence-based treatment that may be lacking in the local private sector.^{60, 61} Equally paramount as access to medical care will be access to nonmedical supports for both Veterans and their families such as social services, education and employment, other transition support, referral and warm handoffs within and across sectors, and case management. Communities that are geographically remote from military installations or VA facilities, and those with fewer job opportunities and healthcare providers, must be prepared for additional challenges from their Veteran constituents.

RWs and Veterans are not just the responsibility of DoD and VA, nor are these Departments equipped to alone address their needs.^{62, 63} From former Chairman of the Joint Chiefs Admiral Mullen's Sea of Goodwill⁶⁴; and the White House's Joining Forces⁶⁵; to RAND⁶⁶; the Center for a New American Security's Military, Veterans, and Society Program⁶⁷; and the Institute of Medicine⁶⁸; recognition of the need for private sector participation is coalescing. We see evidence of the private sector's readiness to embrace this population in the thousands upon thousands of organizations that are registered with the Internal Revenue Service (IRS) as serving Service members, Veterans, RWs, and/or their families⁶⁹ or who advertise online. RWTF is aware that public/private partnerships in support of transitioning Veterans are emerging organically in some areas.^{70, 71, 72} However, a formal

mechanism to strategically harness benevolent support and private sector resources across the country still eludes us.

In anticipation of post-war contraction of federal resources to care for WWII SMs⁷³, the Federal Government must take an active role in ushering in an enlightened era of strategic and proactive partnerships among DoD and VA, other federal entities, academia, and the private sector. These partnerships will be particularly crucial for the transitioning Service members with TBI/PTSD, who as noted are at greater risk for co-morbidities and social impacts.

We highlight several marriages of civic, private, and academic sector entities with DoD and VA in the Best Practices section of this report. The Military Transition Support Project in San Diego, CA, for example, is a consortium initiated through the Chamber of Commerce to prevent the Veteran homelessness that was rampant among separated Sailors and Marines in San Diego during the Viet Nam Era. The University of South Florida (USF) Veterans Reintegration Steering Committee's extensive partnerships—with the James A. Haley Veterans Hospital, Special Operations Command at MacDill Air Force Base, and many private entities—are the brainchild of a passionate retired US Marine Corps flag officer. Some states already have established military-civilian collaborations, for example to address the mental health needs of the Veteran/family community.⁷⁴ We note that it also may be possible to organize inter-sector partnerships regionally, such as by TRICARE regions, VA Veteran Integrated Service Networks (VISNs), or DoD enhanced Multi-Service Markets (eMSMs).⁷⁵ While RWTF applauds all promising examples and ideas for inter-sector partnership, we also recognize that states, cities, and communities work differently and there is no single template.

What is the Federal Government's role in moving the country toward shared responsibility for our Veterans? This is a new mission for DoD and VA.⁷⁶ RWTF suggests that the Departments consider a) creating task forces within states and/or major military impacted areas to facilitate relationships, information-sharing, and coordination among inter-sector stakeholders; b) helping stakeholders navigate the Federal bureaucracy and lending expertise and technical assistance on request; and c) facilitating idea-sharing across states and regions. In a more ambitious role, resources permitting, the Departments might provide proactive leadership in the mobilization of impacted areas and the cultivation of their capacity to indigenously develop comprehensive inter-sector public/private solutions. At minimum, DoD should facilitate the involvement of individual benevolent organizations, which too often lack access to the target population they seek to serve^{77, 78, 79, 80}, by establishing a centralized DoD point of contact or office that can not only channel these resources to where they can be best utilized but also vet them.

Conclusion

The infrastructure that DoD put into place to support the needs of the RW community—much improved but still a work in progress—is at risk of neglect, to the detriment of not only the current generation of RWs and families but also those who come after them. During the steady state that follows the end of OEF/OIF/OND, DoD, VA, and the nation must keep faith with our RWs, and all transitioning Veterans and families, by continuing to enhance, reform, and transform systems of care within both the pre-DD214 and post-DD214 arenas. We must forge a comprehensive, scalable infrastructure grounded in the lessons of the past decade and in the growing awareness of the power and necessity of public/private partnership.

Organization of remainder of report

Chapter 2 of this report presents RWTF’s 13 final recommendations and the corresponding findings that substantiate them. The recommendations are followed by a “Best Practices” section highlighting six particularly promising practices, or best practice areas, that RWTF encountered during FY2014. These pertain broadly to inter-sector collaboration, vocational services, and RC initiatives. Chapter 2 concludes with charts presenting the “Status of FY2013, FY2012, and FY2011 Recommendations,” mentioned earlier. Extensive appendices supply further information regarding RWTF, its methods, and its results. (Appendices are not included in this Non-Voted Draft.)

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This chapter comprises three sections. The first section presents the Recovering Warrior Task Force's (RWTF's) 13 FY2014 recommendations and the findings that support them, the second section presents six noteworthy best practices RWTF encountered in Fiscal Year (FY) 2014, and the third section summarizes the implementation status of RWTF's FY2013, FY2012, and FY2011 recommendations. RWTF's FY2014 recommendations are organized under the following four headers: Integrated Disability Evaluation System (IDES), Supporting an Enduring Recovering Warrior (RW) Mission, Facilitating RW Recovery and Transition, and Facilitating Access to Healthcare. Having made a total of 77 recommendations between FY2011 and FY2013 for improving the sixteen areas Congress directed RWTF to examine, many of RWTF's current recommendations look to securing the future of RW support. A number of the findings draw upon results obtained by RWTF across multiple years and reference recommendations made in prior RWTF Annual Reports, which can be found at <http://rwtf.defense.gov/>.

Integrated Disability Evaluation System (IDES)

In RWTF's founding legislation (Appendix A), Congress directed it to examine two matters pertaining to the disability evaluation system (DES): 1) the effectiveness of measures to improve or enhance the DES and 2) the support provided RWs as they progress through the DES. During its first three years of effort, RWTF's research yielded a total of 18 recommendations aimed at bettering the experience of RWs undergoing disability evaluation, in terms of both process and equitable outcomes.⁸¹ RWTF's final two DES recommendations below are predicated on four years' worth of data, discussion, reflection, and deliberation regarding the adequacy of the current system and ancillary supports.

RECOMMENDATION D1

DOD should design a new approach to replace the current DES. The hallmarks of the redesigned approach should include:

- Simplicity
- Incentivization of work and wellness
- Patient and family-centered
- Standardization across DOD

Requested Agencies to Respond:

Finding: RWTF joins the call of major committees,^{82, 83} position papers,^{84, 85} and RW advocates^{86, 87, 88} for the complete overhaul of the military's DES.

A Vision for the Military's Disability System

A new paradigm for rehabilitation of RWs would move away from a system of compensation for injury, illness, and a lost career to a simple system that incentivizes optimal functioning and capacity through patient-centered, integrative care. Under a simplified, restructured disability system, DoD would provide every RW the means to achieve a productive, working life whether it is a return to Service or the transition to the civilian workforce. Regardless of the circumstances under which an injury or illness was sustained, Service members in both Active and Reserve Components would be provided the resources for recovery, education, and vocational training. Thus, the new disability system would eliminate the Line of Duty (LOD) requirement and, for DoD's purposes, the use of the Veterans Affairs Schedule for Rating Disabilities (VASRD), except for cases of full disability retirement. Upon recovery from injury or illness, an RW would return to his or her military occupational specialty (MOS), a new MOS, or transition to civilian employment.⁸⁹ RWTF's vision for a simplified disability reform process centers on five hallmarks: ability over disability, return to work, patient- and family-centered, integrative care, and standardization across Services and Components.

Ability over Disability and Return to Work

In 2001, the World Health Organization (WHO) adopted a new approach for conceptualizing disability to bring an emphasis on health, functioning, and activity. A key concept of that framework, known as the International Classification of Functioning, Disability, and Health⁹⁰, is that it differentiates capacity and performance. Capacity is the best one can be expected to do in an area of life; performance is what one actually does. Effective programs in rehabilitation, education, or training are seen as those that narrow the capacity-performance gap⁹¹, which could be achieved through accommodations such as prosthetic devices and assistive technologies. In fact, the IDES process as it is currently carried out on the "DoD side" resembles this approach: Citing the growing numbers of Operations Enduring Freedom/Iraqi Freedom/New Dawn (OEF/OIF/OND) RWs with amputations who returned to Service⁹², Daniel M. Gade, MAJ (Ret), USA and a RW, argues DoD already recognizes ability over disability by determinations of fitness for return to duty or "re-assignment to a role better suited to his remaining capacity."⁹³ Under RWTF's vision, resources for education or retraining could be provided through a blanket DoD coverage compensation modeled on workers compensation and short term disability policies and presumably administered by DoD and financially managed by the Defense Finance and Accounting Service (DFAS).

Under RWTF's military disability overhaul, DoD would take on a much greater role in re-training RWs for a new MOS and securing civilian employment. This involvement would stress priority-hiring status for separating RWs to civilian employers and go beyond existing efforts.

Other Approaches to Disability in Military and Non-military Settings

Substantial growth in the U.S. and in many other countries in the number of individuals applying for and being awarded long-term or permanent disability benefits since 1990 has led to research on workers' ability, rehabilitation, and return to work services⁹⁴ which lend some support to a new approach to disability and a reformed model of the US military disability system. In 2002, the largest of these efforts--a six-nation study of the United States, Germany, Denmark, Sweden,

Israel, and the Netherlands--attempted to explore interventions, incentives and disincentives associated with returning civilian beneficiaries to work. One of the most noteworthy findings from the U.S. cases was the poor return to work rates associated with a comprehensive disability determination process that lasts several months, as experienced by the Social Security Administration's (SSA) Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs.⁹⁵

In 2004, SSA implemented several programs to reduce dependency on disability benefits by educating beneficiaries about return to work policies. SSA's Ticket to Work and Work Incentives Planning and Assistance (WIPA)⁹⁶ are federal programs implemented at the state level through public and private partnerships to reduce dependence on SSI and Title II cash benefits. The WIPA program, in particular, has been recommended for expansion to eligible Veterans.⁹⁷ In general, however, the federal civilian sector does not provide an adequate model for an overhaul of the military disability system. For traumatic injuries or occupational disease, the federal system is built on a patchwork of programs under the Federal Employees Compensation Act (FECA) that may start with workers compensation through the Department of Labor, progress through the Disability Retirement Federal Employees Retirement System (FERS) under the Office of Personnel Management, and end with SSDI and SSI. Along the way, elements of the claim process can include periodic medical exams to support continuation of benefits, light and limited duty assignments, and vocational rehabilitation services to assist injured employees return to jobs consistent with their physical, emotional and cognitive abilities.⁹⁸

Military systems outside the U.S. vary in how injuries and illnesses sustained by Service members are compensated. For example, the United Kingdom's Ministry of Defence's Armed Forces Compensation Scheme supports the recovery of wounded, injured and sick armed forces personnel.⁹⁹ Similar to the current US military disability system, personnel recover in Personnel Recovery Centres and follow an Individual Recovery Plan. Compensation for injury is based on severity on 15 levels, organized under four bands to areas affected in "five body zones: (1) head and neck, (2) torso, (3) upper and lower limbs, (4) senses, and (5) mental health."¹⁰⁰ Unlike the U.S., Service members retain the right to sue the UK Ministry for Defence for negligence.

Patient- and Family-centered, Integrative Care

In its landmark 2001 report, *Crossing the Quality Chasm*, the Institute of Medicine (IOM) identified patient-centeredness as one of six aims for the health care system.¹⁰¹ Patient-centric care proactively addresses the patients' needs by bringing together medical and health professionals to deliver comprehensive care in a setting that facilitates partnerships between individual patients, treatment team, and patient's family members/caregivers.¹⁰² The core concepts of patient-and family-centered care are respect, information sharing, participation, and collaboration. These are key concepts to a reformed disability system. Lack of information and lack of visibility of case status during the PEB phase has been a consistent problem that hinders the ability of Service members, families, and case managers (PEBLOs) to plan appropriately. The situation is improving in some Services with greater access to IDES dashboards¹⁰³ but transparency issues remain.¹⁰⁴ Managing the IDES timeline and the consequences of an uncertain timeline on RW well-being has been cited as a challenge that could be improved by greater access to the tools that provide the most up-to-date information on a RW's case, particularly at the Disability Rating Activity Site (DRAS).^{105, 106}

Disability Overhaul in the Context of Ongoing Initiatives in Military Disability and Compensation Reform

RWTF acknowledges both past and ongoing work in the military disability and compensation reform arena. RWTF's recommendation for the overhaul of the military's DES differs in some important respects from recommendations of other committees and entities. For example, the President's Commission on Care for America's Returning Wounded Warriors¹⁰⁷ and RWTF differ not only on the approach to addressing disability (i.e., emphasis on compensation vs. retraining/return to work) but also on the organization responsible for managing this benefit (VA vs. DoD). Secondly, while the President's Commission¹⁰⁸ and RWTF agree that a new disability system should treat all Services equally regardless of Component, only RWTF specifically addresses the shortfalls of the Line of Duty (LOD) system (See also Recommendation D12). RWTF is also aware that recent legislative markups for the FY2015 National Defense Authorization Act (NDAA) legislation would fund a pilot IDES program to co-locate DoD and VA staff at Walter Reed National Military Medical Center and bring greater standardization to technological solutions between the Departments on IDES and E-benefits. These and other considerations are currently being studied by the DoD Office of Warrior Care Policy (WCP) as part of changes to DoD's disability evaluation and temporary disability retirement programs^{109, 110} and input to the Military Compensation and Retirement Modernization Commission¹¹¹. Final reports on these initiatives to Congress are scheduled for August 2014 and February 2015, respectively.

RWTF's vision for recovery, education/vocational training, and employment of RWs is a concept for addressing what currently does not work in the DES. Advancing this concept to a working model and an operational system will require input from disability rehabilitation experts in research, clinical practice, and policy.

RECOMMENDATION D2

Until a new approach is found, continue to improve or address the following issues in the Integrated Disability Evaluation System (IDES) process:

- Transparency
- Timeliness
- Ensuring only those Service members likely to leave the military enter the process
- Fully informing family members at the outset and at significant decision points throughout the process, including mandatory family member or significant other accompaniment to the initial IDES brief
- Ensuring productive work opportunities for the Service member in all levels of government as well as in civilian companies
- Allowing the Service member access to and enrollment in education and training programs through college and certification education programs
- Emphasizing recovery and rehabilitation

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- Allowing eligibility for “elective” treatments with consideration to recovery time and time remaining in IDES
 - Improving legal services for geographically dislocated RWs, with special consideration for early contact, confidentiality, and involvement of family members
 - Providing all Reserve Component (RC) enrollees with the same access as Active Component (AC) enrollees to compensation & pension (C&P) exams at military treatment facilities (MTFs), in-person briefings and counseling at significant points during the process, and TAP participation prior to discharge.
 - Initiating a default Commander’s Letter from the losing line commander before the Service member transitions to the Warrior Transition Unit.
 - Ensuring scalability of the DES.

Requested Agencies to Respond:

Finding: Recommendation D1 calls for the complete overhaul of the DES. However, until the full replacement of the system, and subject to potential changes arising from ongoing^{112, 113} and pending¹¹⁴ studies of IDES, RWTF believes interim improvements must be made. These improvements are both in *system* (i.e., the execution of IDES) and *process* (i.e., the experience and outcome of IDES). These interim steps are to ensure that, consistent with prior RWTF recommendations, IDES (1) as a *system* continues to build on requirements for transparency, timeliness, equitability, scalability, and appropriate referral and, (2) as a *process*, each of these requirements operates within the context of patient-and family centered care, recovery and rehabilitation, and productive employment.^{115, 116, 117}

IDES Successes

RWTF acknowledges that, beginning with full implementation of IDES in 2011, DoD and the Services have made important strides in RW recovery and transition. For example, recent DoD policy updating training standards for MEB providers and PEBLOs¹¹⁸ and standardizing the sizes of the MEB and PEB panels both help to enhance the IDES process. Advanced MEB training for providers and improved staff allocation by the Services may have contributed to recent improvements in timeliness (8%) and reductions in IDES case inventory (7%) since June 2013.¹¹⁹ Quality assurance processes for MEBs, PEBs, and PEBLOS are being implemented across the Services¹²⁰ to address accuracy and consistency of MEB and PEB decisions^{121, 122} and all Services have moved to electronic systems to varying degrees for complete electronic case file transfer^{123, 124}. Other successes include the joint effort by DoD and VA to bring 135 VR&E counselors to military installations for employment assistance^{125, 126} and the key role MEB attorneys continue to play in supporting RWs¹²⁷.

Areas of Continuing Need to Improve the IDES System

Despite these many improvements, the complexity of IDES is such that navigating the system remains a lengthy and mystifying ordeal for RWs. This is borne out in RWTF’s own findings and DoD’s IDES Performance Reports and IDES Satisfaction Survey data. Areas that require continuing efforts to address the execution IDES include better education of RWs and family

members/caregivers about the disability evaluation process, and continued focus on the processes for eligibility screening, elective treatments, non-medical assessments (NMAs), and legal counsel for remotely located RWs.

At VA sites visited by RWTF this year, briefers reported considerable confusion by Service members about the MEB/PEB process.¹²⁸ DoD findings were similar. In WCP's recent IDES Satisfaction Surveys, 41 percent of RWs evaluated their time spent in the PEB phase of IDES as somewhat longer or much longer than expected¹²⁹; the Survey of Wounded, Ill or Injured Service Members Post-Operational Deployment, which was terminated end September 2013, yielded comparable findings about the MEB process, ending with this summary: "Most negative comments about MEBs reflect concerns about the process being slow and time consuming, and insufficient or unclear communication; these comments are common not only in the current quarter [Q3 2013], but also in cumulative results."¹³⁰

Screening procedures for IDES continue to be developed across the Services. For example, since implementing its pre-screening process, the Air Force has found it has greatly reduced the percentage of cases in IPEB that are returned to duty and greatly speeded determinations for return to duty in cases meeting retention standards.¹³¹

Restrictions on eligibility for treatments DoD considers "elective" during IDES create a further barrier to planning for post separation life. One RW focus group participant referenced the uncertainty related to needed medical care post-DD214 that would delay his/her ability to start a job.¹³²

...I need (multiple surgeries) but because I started IDES they said 'no'... (They say) 'Oh, you can do it when you get out.' What am I supposed to do for work then, with a six-month recovery... (Recovering Warrior)

Briefers at one FY2014 Army site suggested several improvements to existing IDES policy to address the challenges associated with elective treatments: The policy for surgery during IDES must be clearly specified and enforced across Services and sites. Additionally, there must be mechanisms in place to notify the WTU Surgeon early in IDES about needed procedures and to educate Service members entering IDES about the types of procedures to which they will and will not be entitled while in IDES. It should be noted that the extent of this problem is unclear to RWTF. At least one breifer at a CBWTU visited in FY2014 described the belief among RWs that they cannot get more surgeries while in IDES as "a common myth."¹³³ The breifer said that if the goal is, for example, to relieve pain or restore function/ability, then surgery is approved even after the medical retention determination point (MRDP). The breifer added that the care may be provided through TRICARE rather than at the MTF.

RWTF notes differing opinions from RWs about whether the non-medical assessment (NMA) should be written by the losing commander or the gaining commander. RWTF believes the assessment should be written by the commander who has fullest visibility of how the RW's condition impacts their duties. Given the importance of the non-medical assessment for fitness determinations and disability benefits¹³⁴, and regular changes in command, there is value in having the NMA updated regularly.

Providing legal counsel to RC RWs residing in remote areas presents additional challenges in the IDES process. Consulting with IDES counsel early in the process ensures that the MEB packet contains all relevant and accurate information needed for the MEB to make fitness determinations¹³⁵ and helps the RW to achieve the IDES outcome he or she desires. As of February 2013, the Army had 24 Medical Evaluation Board Outreach Counsel located at WTU sites. Expanded use of telehealth could improve this situation: RWTF was told this methodology is being used successfully by both VA and MTF behavioral health practitioners working with Service members/Veterans in remote areas at VA centers.¹³⁶ Similar technology could be leveraged to deliver MEB legal services to remotely located RWs.

Areas of Continuing Need to Improve the IDES Process: Employment, Family Involvement, and Scalability

The uncertainty around the IDES timetable can be a distraction to RWs at a time they could be productively seeking or engaging in work, education, and certification programs. RWs participating in FY2014 focus groups stated the uncertain timeline of the recovery and transition process interferes with their ability to seek jobs, as they have no way to know when they will be available to begin work.¹³⁷ The situation is exacerbated when vocational rehabilitation (VR) offices are unable to verify that Service members are in the IDES process, impeding Service members' utilization of the program prior to receiving their DD214 and VA Disability Rating determination.¹³⁸ The extent to which a DoDI and DoDM for VR&E counseling for Service members transitioning through IDES expected to be published in August 2014 (to replace current MOUs) will help is not yet known.

For family members/caregivers, insufficient information about and during the IDES process is an additional obstacle to planning during IDES.¹³⁹ For example, as a CAC-controlled system, the newly implemented Soldier's and Commander's IDES Dashboard provides visibility to commanders, providers, and RWs, but not to the family member/caregiver. DoD's position is that it highly encourages participation by family members and caregivers during IDES, and their presence at briefings and appointments, whenever practical;¹⁴⁰ however, RWTF data suggest a different experience: Across five RWTF family member focus group sessions this year, of those who reported regularly accompanying their SM either to briefings or to medical and non-medical appointments, half felt welcome and half felt unwelcome or disrespected.¹⁴¹ Participants in one session recommended there should be increased emphasis on caregiver participation; participants in another session stated attending appointments with their Service members caused controversy.¹⁴²

The widening use of electronic systems for case file transfer and record integration and the emphasis on training of IDES providers may have the greatest potential for streamlining IDES processes. Yet, RWTF is concerned that even given these advancements and a drawing close to OEF/OIF/OND, no Service has achieved targets for Total Days in IDES.¹⁴³

We are drowning in information and dying of thirst at the same time because we don't have an integrated network, particularly with the VA. (Commanding General, Army Human Resources Command¹⁴⁴)

Unless a new disability system is implemented IDES must demonstrate the scalability to not only to shrink the dedicated infrastructure commensurate with declining numbers in the IDES inventory (35,460 cases in May 2013¹⁴⁵ down to 29,642 cases as of May 2014¹⁴⁶) but also to expand the infrastructure to accommodate surges in demand associated with new wars.

Supporting an Enduring RW Mission

While the drawdown of contingency operations in Southwest Asia will reduce the number of combat casualties, it will not impact the number of ill or injured. Furthermore, the number of combat casualties will surge when our nation next goes to war. RWTF makes five recommendations aimed at ensuring DoD maintains and grows its capacity to meet the enduring RW mission. The first three recommendations target support for proponents responsible for RW care, management, and transition, such as WCP and the Services' RW units and programs. The remaining two recommendations target broader organizational changes that will strengthen the capacity of DoD and VA to effectively care for the RW population.

RECOMMENDATION D3

Publish a DoDI policy for addressing the needs of RW family members and caregivers and identifying baseline services to be delivered by each Service and Component.

Requested Agencies to Respond:

Finding: RWTF differentiates between family members' own needs as they, and perhaps their children, strive to adjust to "a new normal" and family members' needs that are specifically related to their role and responsibilities as caregiver and/or supporter of their RW's recovery process. (The latter is the focus of Recommendation D8). RWTF believes that both areas of need must be formally addressed through policy. To DoD's credit, existing DoD Instructions addressing the nonmedical¹⁴⁷ and medical¹⁴⁸ management of RWs also recognize family members; however, these Instructions focus more on their needs as caregivers, do not delineate roles and responsibilities in meeting family member needs, and do not establish baseline support requirements. WCP informed RWTF in January 2014 that it plans to publish specific DoD guidance regarding support for RW families and caregivers.¹⁴⁹ RWTF believes that, by publishing a DoDI on supporting RW family members/caregivers (hereafter family caregivers or FCGs¹⁵⁰), DoD can officially recognize the enduring commitment of WCP and the Services to addressing the needs of this population.

The following paragraphs summarize content that RWTF believes must be included in the pending DoDI, based on fairly intractable problems RWTF has observed over four years of site visits, through 30 focus groups with 173 family member participants and other encounters. This content echoes 20 recommendations regarding FCGs and information resources that RWTF made during three prior years of effort.¹⁵¹ RWTF presents suggestions grouped under five headers: define the target population, define and establish standards for outreach and engagement, specify and establish standards for information resources, identify baseline services in specific domains, and hold each Service/Component accountable.

Define the target population

To whom should DoD and the Services be providing RW “family support?” RWs rely on diverse relationships for support during the recovery process—with spouses, other relatives, and people to whom they are not related. All who care for and support RWs may be heavily impacted by the practical and emotional strains of this role and an uncertain future, as RWTF documented in prior RWTF Annual Reports and observed again during RWTF’s FY2014 focus groups¹⁵², and as reported by others.^{153, 154} FCGs are dealing with stressful circumstances such as culture shock, marital issues, or other family distress. Regardless of whether or how they are related to their RW, they represent a population in need of targeted services. Yet current official definitions of “eligible family member,” such as those in DoDI 1300.24¹⁵⁵ and the Office of Personnel Management’s (OPM’s) Family Medical Leave Act (FMLA) policy¹⁵⁶, do not include non-married or non-blood-related individuals. This may jeopardize FCGs’ eligibility for invitational travel orders (ITOs) or non-medical attendee (NMA) status¹⁵⁷, unpaid time off work¹⁵⁸, and countless other sources of critical tangible and intangible support. In contrast, the policy for Special Compensation for Assistance with Activities of Daily Living (SCAADL) uses a more inclusive definition of “primary caregiver”: “an individual who renders to an eligible Service member services to support ADL and specific services essential to the safe management of the beneficiary’s condition.”¹⁵⁹

To ensure all caregivers and supporters of RWs receive support, consistently across the enterprise, the DoDI should establish a RW-centered approach to determining who is an FCG. This means continuing to deliver family support services to traditional family systems and simultaneously leaving the aperture open to also providing these services to others whose assistance the RW needs. RWTF considers the proposed RW-centered approach to defining FCG to be consistent in spirit with SCAADL’s broad definition of “primary caregiver.”

I had surgery. . . I had a friend come to drive me around. I told the doctor I would sign something, (my friend) needs to be involved in everything because I have a horrible memory. Tell her everything. The provider wouldn't tell her. He said, 'She's not your wife, we can't tell her.' If she's going to take care of me, she needs to know. (Recovering Warrior)

I'm not a caregiver per se but in that same regard that means I'm more out of the loop. (Family Member)

Define and establish standards for outreach and engagement

Because efforts to actively connect FCGs to resources vary widely across Services and Components, RWTF strongly recommends that the DoDI define and establish standards for outreach and engagement. Several barriers impede successful outreach and engagement toward FCGs, which standards should mitigate. The very definition of outreach varies widely; some RW sites equate mass email to outreach.^{160, 161} (See RWTF FY2013 Recommendation 20.) RW units and programs often do not specify an individual or position responsible for outreach and engagement with FCGs, which may lead to confusion and frustration on the part of FCGs, potentially inhibiting their participation.^{162, 163} Family members participating in RWTF focus groups identified multiple sources of support offered by the RW’s unit, such as the nonmedical

case manager (NMCM), medical care case manager (MCCM), recovery care coordinator (RCC), family readiness support assistant (FRSA), and Army Wounded Warrior (AW2) advocate.¹⁶⁴ (See FY2012 Recommendation 15.) There are unique factors affecting outreach to geographically dislocated FCGs^{165, 166}, whose RWs are frequently in the RC. As RWTF has come to understand, for example, Army Warrior Transition Unit (WTU) cadre frequently do not know their Reservists' FCGs, lack systems for identifying them, and tend to erroneously assume they are receiving support from the home unit. Assuming proponents are familiar with their RWs' FCGs, many remain hesitant to engage with FCGs due to misguided concerns with Health Insurance Portability and Accountability Act (HIPAA) restrictions^{167, 168, 169, 170, 171}, particularly when RWs indicate they do not want their families involved, which RWTF family member focus group participants indicated is not unusual^{172, 173}. Rather than sending even the most benign information directly to FCGs, RW sites often default to sending it through the RW, which is an unreliable means of communicating with FCGs.¹⁷⁴ (See RWTF FY2012 Recommendation 14.)

The recommended DoDI should provide operational definitions of outreach and engagement to ensure common understanding and consistent practices. RWTF's FY2013 Recommendation 20, which defined outreach as positive contact and two-way communication between the Service and the family member, and called for outreach to 100 percent of FCGs, may help to inform this definition. Frequency of contact also should be part of this operational definition. To streamline and standardize the transmission of information and services to FCGs, the DoDI should instruct the Services to provide each FCG a single point of contact and specify both the qualifications and tasks associated with this responsibility. This guidance also should address how this single point of contact relates to the Interagency Care Coordination Committee (IC3) Lead Coordinator role¹⁷⁵ and who is responsible for supporting geographically remote FCGs.

It is essential that the DoDI emphasize that HIPAA does not constrain outreach and engagement with FCGs—by clarifying what information is HIPAA-protected, explaining that outreach and engagement toward FCGs is not contingent on RW approval, and listing examples of programs and services for FCGs that are independent of HIPAA-protected information, such as FCG counseling, access to information resources, programs for employment/vocational support, resources for RW children, and financial counseling. DoD may want to consult the WWR's approach to family engagement, which leverages command emphasis to prevent RWs from unwittingly denying their FCGs access to needed supports.¹⁷⁶ Finally, the DoDI should institutionalize the participation of Active Component (AC) and Reserve Component (RC) FCGs at WTU and WWR in-processing briefings, which is far from the norm.¹⁷⁷ (See FY2013 Recommendation 20.) These events impart critical information and introductions that FCGs need to hear first-hand; furthermore, they present an ideal opportunity for the designated single point of contact to meet and engage FCGs face to face as the RW and FCG begin the journey of recovery and transition.

Most of the support I find is through the Facebook group or typing stuff into Google. There's not an actual person to talk to. (Family Member)

A lot of times I don't have information unless I'm in here picking up my husband. (Family Member)

Specify and establish standards for baseline information resources

There is a plethora of internet-based, digital, telephonic, print, and brick and mortar information resources^{178, 179, 180, 181, 182, 183} available to FCGs from DoD as well as the Services, let alone other entities. Despite the large constellation of available resources, awareness and utilization among FCGs remain inadequate. In RWTF FY2013 and FY2014 mini-surveys, for example, most family member focus group participants reported not having used Military OneSource (MOS); Military OneSource Wounded Warrior Specialty Consultants (MOS WWSC); a Military Family Assistance Center (FAC); the National Resource Directory (NRD); or a Military Hotline.^{184, 185} As long as the NRD remains DoD's primary information resource for the RW community¹⁸⁶, DoD should direct the Services to actively and systematically promote it among FCGs. The DoDI should provide additional guidance regarding information resources in the form of baseline standards for essential information resources that FCGs should be provided or to which they should be directed. RWTF further urges DoD to also develop and address new information resources focused specifically on FCG needs.

Welcome packets can be invaluable but they must be tailored to constituents' circumstances and receipt of these resources by FCGs must be confirmed. To ensure parity across Services and Components, DoD should develop baseline content for four target groups—on-site AC FCGs, on-site RC FCGs, remote AC FCGs, and remote RC FCGs—and direct the Services to distribute these tailored welcome packets systematically to newly identified FCGs. Among the welcome packet materials should be Family Medical Leave Act (FMLA) information. The FMLA now provides 26 weeks of unpaid leave to attend to a RW who was injured while on active duty.¹⁸⁷ If this information is not disseminated early, some FCGs may forgo employment to care for a RW rather than taking their legally-allowed leave time. DoD might consider also developing a series of decision-tree pocket cards for inclusion in the welcome packets, which can guide FCGs from all four target groups through steps and options to be taken as issues arise.

Currently the Services provide no DoD-wide standardized training for RW FCGs. DoD should develop and distribute a program of instruction, leveraging the format and content of the VA Caregiver curriculum. This curriculum, developed by Easter Seals, provides in-person classes, a workbook/DVD, and online training.¹⁸⁸ RWTF recommends that participation in the proposed DoD caregiver training be mandatory for caregivers on NMA orders and for FCGs of RWs who are receiving SCAADL, and strongly encouraged for all other FCGs. Those who complete the training should receive a certificate. The training should include information about the application process for the VA Caregiver Program and benefits thereof, for those FCGs to whom this information pertains. RWTF believes the proposed training, if widely marketed and taken early, has the potential to go a very long way toward fostering a generation of well informed and well engaged FCGs.

I thought that this place (SFAC) is only for when my husband tells me I can come, then that's when I come. I didn't know it's open to dependents... (Family Member)

I didn't know this (SFAC) was here until today. (Family Member)

Identify baseline services in specific domains, such as family member education and employment, transfer to VA, and emotional support

In an effort to target specific areas of unmet needs for the FCG population, the DoDI should identify baseline services in specific domains such as family member education/employment, the transfer from DoD to VA care, and emotional support.

The FCG population is often hit hard by the strains of maintaining or finding employment while caring for a RW. A RAND report showed that almost half (47%) of post-9/11 caregivers must make work adjustments due to caregiving.¹⁸⁹ Some FCGs become the family's primary breadwinner—a role for which they may be unprepared.¹⁹⁰ RWTF site briefings nevertheless suggested that vocational and employment services are under-utilized by FCGs.^{191, 192} The DoDI should establish the requirement to systematically assess FCG vocational/employment needs and to link FCGs with services as appropriate. This guidance should also identify the primary vocational/employment services available to FCGs, including services for both RWs and FCGs and services that specifically target FCGs. To adequately meet this requirement, those charged with carrying it out will require dedicated training.

Only families of post 9/11 combat-injured RWs receiving SCAADL are eligible for VA services, through the VA Caregiver Program.¹⁹³ For those eligible, the handoff is neither smooth nor transparent.^{194, 195} (See FY2012 Recommendation 16.) The DoDI should instruct nonmedical case managers or designated FCG points of contact to proactively engage the VA Caregiver Program on FCGs' behalf in order to ensure a seamless transfer and avoid discontinuity of support upon RW discharge. It should be noted that, while only a subset of FCGs are themselves eligible for VA services, many FCGs will experience VA services indirectly through their RW. Thus the DoDI should also address the importance of empowering FCGs to help their RWs navigate the VA system, possibly through the DoD FCG training curriculum mentioned earlier in regard to information resources.

The DoDI must address the delivery of emotional support to FCGs, including children of RWs.¹⁹⁶ RAND found that 38 percent of post-9/11 military caregivers have probable major depressive disorder, yet two-thirds of them had not sought mental health care in the past year.¹⁹⁷ RWTF urges that the DoDI promote Military Family Life Consultants (MFLCs) as a resource the Services and Components can capitalize on to meet the emotional needs of FCGs.¹⁹⁸ The US Special Operations Command (SOCOM) Care Coalition makes good use of this program at 19 locations, where MFLCs address areas such as marital/relationship issues, communication, job stress, family dynamics, and stress.¹⁹⁹ However, it appears that this valuable resource is not as well-utilized by the Service-specific RW units and programs.²⁰⁰ Children may face unique stressors and strains, and FCGs are having difficulty locating services for them.^{201, 202}

With little ones it's getting support for them to help them ease their minds. It would make our work more manageable, having psychological support for him... (Family Member)

We're still living in a trauma state environment. (My husband has gone through) multiple things, multiple surgeries. Every time surgery hits, treatment hits, what are the side effects? Then we get

brought back into a trauma state. Now I worry about him and them (the children) teetering on depression. I have (a young child) that is reacting, saying, 'when will this end?' (Family Member)

Hold each Service/Component accountable

Accountability requires metrics. The DoDI should provide guidance for the gathering and reporting of standard metrics—by Service, Component, and overall—on an established basis. The metrics must be sufficiently comprehensive to assess compliance with requirements and they must be comparable across echelons, Services, and Components. For optimal usefulness, DoD should prioritize metrics that are focused on outputs (e.g., utilization) and outcomes (e.g., satisfaction or behavior).

RWTF is aware that the Services and Components address RW FCG needs differently within their respective organizational structures. For example, Army Warrior Transition Units (WTUs) have Family Readiness Support Assistants (FRSAs)^{203, 204} and Marine Corps Wounded Warrior Regiment (WWR) detachments have Family Readiness Officers (FROs)²⁰⁵; there are military family assistance centers such as the Army Soldier and Family Assistance Centers (SFACs)^{206, 207} that are dedicated to the RW community and Navy Fleet and Family Support Centers²⁰⁸ and others like it that are more generic; and individual Nonmedical Case Managers (NMCMs), Recovery Care Coordinators (RCCs), Medical Care Case Managers (MCCMs), and even chaplains may offer varying levels of assistance to FCGs.²⁰⁹ In the National Guard, there are Family Programs offices within the Joint Forces Headquarters (JFHQ) and Army and Air National Guard units/wings.²¹⁰ However, when asked who is expressly responsible for supporting FCGs, too often the response is “everyone”^{211, 212} or “no one.”^{213, 214, 215} The DoDI should require each Service and Component to identify at Headquarters level and in the field the dedicated office, or at least the dedicated position within a specific office, that is responsible for implementing the requirements of the pending DoDI, including the gathering and reporting of metrics.

There's just so much change (within the unit), and for a lack of a better term, red tape. (Family Member)

RECOMMENDATION D4

Establish a uniformed representative from each Service at WCP.

Requested Agencies to Respond:

Finding: WCP not only fulfills a vital mission but is DoD's steward of institutional knowledge gained over more than a decade of war. However, RWTF is deeply concerned about the longevity of WCP going forward. RWTF recommends DoD take a step toward strengthening the viability of this organization by establishing permanent Service representative positions at WCP. Integrating a Soldier, Airman, Sailor, and Marine into WCP's battle rhythm will promote needed communication, coordination, and alignment between DoD as policy maker and the Services as policy implementers as these entities navigate the way ahead. Furthermore, it will

better equip DoD to provide central oversight of the Services' recovering warrior units and programs, as the General Accountability Office recommended in 2012.²¹⁶

WCP was originally established in November 2008 as the Office of Transition Policy and Care Coordination (TPCC) under the Secretary of Defense (Personnel and Readiness),²¹⁷ with the mission to “ensure equitable, consistent, high-quality care coordination and transition support for members of the Armed Forces, including wounded warriors (WW) and their families through appropriate interagency collaboration, responsive policy and effective program oversight.”²¹⁸ The office was tasked with four lines of action – the DES, care management reform, compensation and benefits, and the Transition Assistance Program (TAP).²¹⁹ The name was changed to the Office of Wounded Warrior Care and Transition Policy (WWCTP) in October 2009 when the agency became a permanent organization.²²⁰ In October 2012, the name was again changed to the current Office of Warrior Care Policy (WCP), in conjunction with the realignment to its current location under the Office of Assistant Secretary of Defense (Health Affairs) (ASD(HA)), and TAP moved under the Office of Readiness and Force Management.²²¹ Between WCP's inception in 2008 and 2014, six individuals served at the helm of this organization.^{222, 223, 224, 225, 226}

In Annual Reports over the past three years, RWTF has repeatedly challenged WCP to do more.²²⁷ At the same time, RWTF looks to WCP as DoD's “center of excellence,” standard-bearer, integrator, and advocate for carrying forward the mission of RW care, management, and transition. Turbulence in the young life of this organization, however—including name changes, realignments, and turnover at the top—portends vulnerability. In 2012, RWTF recommended DoD take steps to institutionalize WCP by enacting legislation to permanently establish the office under the Secretary of Defense for Personnel and Readiness at a level no less than the Deputy Assistant Secretary of Defense. DoD non-concurred, finding that legislation was not called for and the location of WCP (at the time within the Office of the Under Secretary of Defense for Personnel and Readiness) was acceptable.²²⁸ (DoD also noted the position of the Director of WCP was already a Deputy Assistant Secretary of Defense.²²⁹) In light of DoD's decision against solidifying WCP's permanence as recommended, we urge DoD to strengthen the viability of the office in a different way—by facilitating its relationships with the Services.

During a February 2014 site visit to WCP, briefers told RWTF that it has had uniformed representatives on its premises in the past, but their presence was sporadic.²³⁰ WCP indicated further that it would embrace permanent on-site Service representative positions.²³¹ As the Nation moves to a drawn-down peacetime environment, the needs of recovering wounded, ill, and injured Service members will continue and it is important that WCP be sustained. Placing uniformed representatives at WCP is an opportunity for DoD to recognize and support this enduring mission.

RECOMMENDATION D5

Secure enduring resources for maintaining the capability, infrastructure, and institutional knowledge for supporting RWs that has been developed over the last 10 years.

Requested Agencies to Respond:

Finding: Since the start of the Global War on Terror (GWOT), the US has devoted increasing resources, and amassed extensive lessons learned, in the care, management, and transition of RWs and their families.²³² RWTF is concerned that this investment will fall victim to shifting budget priorities as operations in Southwest Asia draw to a close, Overseas Contingency Operations (OCO) funding dries up, and the nation’s interest in RWs wanes.^{233, 234} Our nation must take steps to preserve the robust support infrastructure we have built over the last decade so it will continue to be available for the current—and the next—generations of wounded, ill, and injured Service members and their families.

At the core of this support infrastructure are the dedicated units and programs that each Service has developed in accordance with DoDI 1300.24, Recovery Coordination Program (RCP)²³⁵ to provide case management and facilitate RWs’ recovery and transition back to duty or civilian status.²³⁶

It is really nice that there is nothing extra for us to do here (in the Patient Squadron), just heal. And I think back to what I was like before I got here. It was bad for me and bad for my family. But they understand my experience here. (Recovering Airman)

I would like to say that in general the whole WTU program is a very good tool for all. Back in the day when they sent us for treatment, you didn’t have all this. You stayed home and popped pills and that’s it. (Recovering Soldier)

It’s a lot more than what guys got when they got back from Viet Nam. We’re grateful for that. (Recovering Marine)

The Services have shaped these units and programs over time, learning from internal feedback such as Service-level surveys and staff assistance visits, and external feedback such as DoD-level surveys, Government Accountability Office (GAO) reports, legislative guidance, and RWTF recommendations. For example, the Army Warrior Care and Transition Program (WCTP) was created in 2007²³⁷, while Army Warrior Transition Command (WTC), a partnership of Army Medical Command (MEDCOM) and Army Human Resources Command²³⁸ that oversees and implements the WCTP²³⁹, was stood up two years later²⁴⁰. During this time, the WCTP has gone through three iterations of solutions for managing remote care—the Medical Holdover (MHO) system^{241, 242}, the Community-Based Warrior Transition Unit (CBWTU)²⁴³, and the Community Care Unit (CCU), which was formally introduced in Fiscal Year 2014^{244, 245}. The Marine Corps Wounded Warrior Regiment (WWR), which also has been in existence since 2007^{246, 247}, established a Liaison Officer (LNO) position at Marine Forces Reserve (MARFORRES) in spring 2013²⁴⁸, funding it out of hide to increase the WWR’s capacity to track and support geographically dispersed RWs. (Also see Best Practices.) Navy Wounded Warrior-Safe Harbor (NWW-SH)—whose mission in 2008 expanded to include nonmedical case management and tracking/oversight of seriously wounded, ill, and injured²⁴⁹—until 2013 was assigning to each eligible Sailor a single individual to fulfill both the Nonmedical Case Manager (NMCM) role and the Recovery Care Coordinator (RCC) role²⁵⁰. The Air Force Wounded Warrior (AFW2) Program, a 2007 rebranding of Air Force PALACE HART (Helping Airmen Recover Together)²⁵¹ and a component of Air Force Wounded Warrior and Survivor Care²⁵², did not begin servicing non-combat injured/ill personnel until November 2012²⁵³. All four Services have independently seen

fit to add a “sustainment” element to facilitate the RW’s transition out of uniform^{254, 255, 256, 257} — further evidence that these units and programs are dynamic learning organizations.

The support infrastructure for the RW community extends well beyond the Service’s dedicated units and programs. The Federal Government has responded to the needs of the RW community by weaving and re-weaving a multi-faceted tapestry of supports provided by DoD, the Services, and VA. WCP, established in 2008²⁵⁸, defines its mission as ensuring “...recovering wounded, ill, injured, and transitioning members of the Armed Forces receive equitable, consistent, and high-quality support and services...”²⁵⁹ (See also Recommendation D4.) Also integral are 258 RCCs^{260, 261, 262, 263, 264}, who fall under the DoD RCP²⁶⁵ and, as of FY2013, 24 Federal Recovery Coordinators (FRCs)²⁶⁶ who are part of the DoD/VA Federal Recovery Coordination Program (FRCP) for the most severely impacted Warriors²⁶⁷. Numerous supports now accompany the disability evaluation process—such as approximately 1500 Physical Evaluation Board Liaison Officers (PEBLOs)^{268, 269}, Medical Evaluation Board (MEB) legal counsel including 91 attorneys and 65 paralegals^{270, 271, 272, 273}, and VA Liaisons for Healthcare at 19 military treatment facilities (MTFs)²⁷⁴. VA OEF/OIF/OND Program Offices now exist in all VA Medical Centers to facilitate the successful transfer and acclimation of the current generation of Veterans.²⁷⁵ Additionally, as of spring 2014, the DoD/VA IC3 was primed to broadly implement the Lead Coordinator role²⁷⁶ to mitigate gaps in care management across the stages of an RW’s recovery and transition²⁷⁷. The tapestry encompasses a plethora of internet-based, digital, telephonic, print, and brick and mortar information resources^{278, 279, 280, 281, 282, 283}; vocational/employment services OWI²⁸⁴ and VR&E²⁸⁵; and FCG-focused resources such DoD’s Special Compensation for Assistance with Activities of Daily Living (SCAADL)²⁸⁶ and VA’s Caregiver Program²⁸⁷. It includes initiatives targeting Reservists as well, such as the National Guard’s 78 Psychological Health Program Directors distributed across the 54 states and territories²⁸⁸, and the Army National Guard’s Reserve Component Managed Care (RCMC) implemented in 20 states as of second quarter 2013²⁸⁹. All these elements and more, many of them addressed elsewhere in this report and in previous RWTF reports, together form the support infrastructure our Federal Government has forged over the past decade plus for the RW community.

The Army made a sizable investment in brick and mortar SFACs that support WTUs at medical treatment facilities (MTFs) in and outside the continental US (CONUS).²⁹⁰ Twenty of these facilities were new military construction projects.²⁹¹ As of April 2013, there were 32 SFACs²⁹²; roughly one year later there were 30²⁹³. As of February 2014, five CONUS WTUs were slated for closure by the end of FY2014, and with them their SFACs. The Army indicated further closures of WTUs and SFACs are expected through FY2017.²⁹⁴ As of February 2014, SFACs Army-wide had 264 validated requirements, 208 authorizations, and a 67 percent fill rate.²⁹⁵ During site visits, RWTF saw evidence of this fill rate firsthand in some SFACs that were clearly short-staffed. RWTF is concerned about how the Army intends to maintain SFAC services and preserve SFAC facilities and subject matter expertise going forward.

The ongoing demand for the described RW resources going forward is unquestionable. WCP and each of the Service-level units and programs have stated their missions will endure.^{296, 297, 298, 299, 300} As of January 2014, the units and programs served a combined census of 13,873 RWs.^{301, 302, 303, 304} While the number of wounded will decline post-war, the number of ill and injured will not. Furthermore, the units and programs serve only a fraction of the Service members in need of support. As of May 2014, there were 29,642 Service members going through the IDES

process.³⁰⁵ Two hundred fifty thousand Service members are expected to leave the military each year over the next four to five years,³⁰⁶ many of whom will have physical or mental conditions requiring support. Regrettably, the demand for these resources will burgeon whenever our nation again goes to war.

Maintaining and preserving this infrastructure and the considerable capabilities and institutional knowledge that undergirds it will require a committed effort. Standards, programs, and processes must be codified in legislation; DoD, Service-level, and VA guidance; and even joint DoD/VA policy (see Recommendation D6), as RWTF has strongly advocated in each prior Annual Report (and again in Recommendation D3 of the current report, urging the issuance of a DoD Instruction to standardize support for RW FCGs.) At the same time, RWTF acknowledges that inroads have been made. Among key policies published since FY2011, when RWTF began its operations, are: Special Compensation for Assistance with Activities of Daily Living (SCAADL) (DoDI 1342.12)³⁰⁷, Access to VA Vocational Rehabilitation and Employment (MOU)³⁰⁸, Mandatory Transition Assistance (DTM 12-007)³⁰⁹, Medical Management (DoDI 6025.20)³¹⁰, Education and Employment Initiative (E2I) and Operation WARFIGHTER (OWF) (DoDI 1300.25)³¹¹, and Job training, employment skills training, apprenticeships, and internships (DoDI 1322.29)³¹². The Services published guidance during this period as well. This must continue, with emphasis on institutionalizing the lessons learned from more than a decade of war regarding RW unit and program operations. Equally importantly, DoD must anticipate the waning of available Defense dollars for RW matters and ensure the continued financial viability of the units and programs, WCP, and other key RW resources through the Program Objective Memorandum (POM) process.

RECOMMENDATION D6

Develop interagency/cross-agency DoD/VA policy that binds and commits both agencies to implement and institutionalize programs that span departments. DOD VA Joint Executive Council (JEC) should establish the capability for the creation of interagency policy.

Requested Agencies to Respond:

Finding: RWTF believes that the care, management, and transition of Recovering Warriors (RWs) by DoD and VA requires that there be lasting interagency policy of joint activities and initiatives. Interagency policy should establish and implement enduring solutions for: (1) continuity of medical and non-medical care for transitioning service members and their families, (2) reintegration of RWs to education, training, and employment, and (3) special mechanisms (e.g., interdepartmental communication protocols) for managing the transition of service members with behavioral health diagnoses.

Interagency policies must be created by a higher authority than the agencies themselves. This can be achieved through Presidential Decision Directives, federal statutory laws, or Congressional directives under appropriations (e.g., in the NDAA). RWTF believes that DoD and VA would benefit from the creation of interagency policies, specifically in areas such as:

- SCAADL and VA Caregiver Program: RWTF has been made aware of disparities between these two programs, specifically, in definitions, activities of daily living, application forms,

and caregiver training. RWTF believes that these two programs could be made more uniform through the creation of interagency policy and this would ease the transition of service members from DoD to VA. RWTF also feels that there could be associated cost savings (e.g., by rectifying a service member who was getting SCAADL and then became eligible for the VA Caregiver Program).

- Centers of Excellence: RWTF sees benefit to the creation of interagency policy regarding how often CoEs collaborate and how they are accountable for disseminating their products.
- IC3: RWTF believes the creation of interagency policy would solidify and sustain IC3 and Lead Coordinators as the role of Lead Coordinators is fully implemented across all MTFs.

Within the Federal government, there have been myriad examples of successful interagency policy. For example, the IRS-SSA-CMS Data Match was a law enacted by Congress (Section 6202 of the Omnibus Budget Reconciliation Act of 1989) to provide the Centers for Medicare & Medicaid Services (CMS) with better information about Medicare beneficiaries' group health plan (GHP) coverage. The law requires the Internal Revenue Service (IRS), the Social Security Administration (SSA), and CMS to share information that each agency has about whether Medicare beneficiaries or their spouses are working. Since its creation, the Data Match project has saved the Medicare Trust funds more than \$3.5 billion.³¹³ In addition, the Information Sharing and Access Interagency Policy Committee was established by the White House in 2009 and subsumed the role of a predecessor body, the Information Sharing Council, which was established by Executive Order 13356: Strengthening the Sharing of Terrorism Information to Protect Americans in 2004. This committee is comprised of Department of Homeland Security, Department of Justice, Federal Bureau of Investigation, National Counterterrorism Center, National Archives and Records Administration, Office of the Director of National Intelligence.³¹⁴ Furthermore, the Interagency Security Committee, established on October 19, 1995 by President Clinton's Executive Order 12977, was created to address continuing government-wide security for Federal facilities. The ISC's membership is comprised of chief security officers and other senior executives from 53 Federal agencies and departments. The Interagency Security Committee sets standards and best practices for Federal security professionals to implement at their nonmilitary Federal facilities; like other interagency efforts that are not bound by law, the enforcement of these standards is up to each individual agency.³¹⁵ The Federal Interagency Committee on Emergency Medical Services was established in 2005 by Congress to ensure coordination among Federal agencies involved with State, local, tribal, and regional emergency medical services and 9-1-1 systems. This Committee's strategic plan is developed through a collaborative process and funded by three different federal departments.³¹⁶

According to its charter, the JEC "serves as the primary VA/DOD coordination body for overseeing and supporting joint activities, initiatives and wounded, ill and injured issues. The JEC institutionalizes VA and DOD sharing and collaboration to ensure the efficient use of services and resources for the delivery of health care and other authorized benefits to Service members and Veterans."³¹⁷ Included in its scope of responsibilities, the JEC "identifies, approves and implements changes in policies procedures and practices that promote mutually beneficial coordination or sharing of services and resources between the two Departments."³¹⁸ There are limitations, however, in what the JEC has the authority to do. Established under 38 U.S.C. Section 320, the JEC is required to submit an annual report to Congress that includes recommendations for joint coordination and sharing efforts. The JEC also must submit a strategic plan to the Secretaries of each department.³¹⁹ While its strategic plan is submitted to the

two Department Secretaries, there is neither additional oversight nor a requirement for collaboration or interagency policy between the two Departments. As it stands, the JEC can identify, approve, and implement policy but it cannot develop policy by itself. To that end, the JEC has historically relied on Memoranda of Understanding (MOUs) and Memoranda of Agreement (MOAs) to facilitate the coordination of their efforts.³²⁰

RWTF believes that the establishment of interagency policy by the higher authorities between DoD and VA will provide a lasting foundation for the continuity of care, management, and transition of RWs that is currently lacking in current MOAs, DoDIs, and VA Directives.

RECOMMENDATION D7

Align CoEs under DHA to enable joint effort and direct links to governance processes within the military health system structure and to allow for translation of scientific findings to clinical settings. DHA Chief Medical Officer should work in concert with Medical Director of NIH.

Requested Agencies to Respond:

Finding: The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), Hearing Center of Excellence (HCE), Vision Center of Excellence (VCE), and Extremity Trauma and Amputation Center of Excellence (EACE) should be aligned under the Defense Health Agency (DHA) to better accomplish their mission and intent and ensure maximum impact upon the Military Health System (MHS). The DHA Chief Medical Officer will be well positioned to act as an advocate for the CoEs and to work in concert with the Medical Director of NIH/HHS as well as other agencies.

RWTF recognizes the contributions of the Centers of Excellence (CoEs) and their efforts to disseminate best practices throughout the MHS, including through partnerships with various agencies and groups^{321, 322, 323, 324}. However, the CoEs continue to confront obstacles that limit their effectiveness. Several of the CoEs have cited challenges in reaching full operating capabilities and promulgating best practices across the enterprise. Specific challenges cited by the CoEs include hiring freezes, delays in hiring actions, the need for better alignment to provide stability of operations, and inability to influence policy across both MHS and the VA healthcare system.^{325, 326} GAO corroborated CoEs shortfalls in a 2011 report, citing lengthy hiring processes and a weak strategic plan.³²⁷ Furthermore, in a 2012 report, GAO cited additional challenges faced by DCoE related to reporting use of resources to Congress. GAO recommended increased visibility over both DCoE's spending and its role as a coordinating authority for issues concerning psychological health (PH) and traumatic brain injury (TBI).³²⁸

There continues to be concern about the CoEs' connection with the MHS as a whole, and the transparency and accountability of the CoEs, under the current governance structure and alignment under the Services.³²⁹ In April 2013, the CoEs Oversight Board reported to RWTF it has the authority to facilitate policy development to implement findings from the CoEs, but the briefer said the Services impede this process.³³⁰ An annual review of the CoEs by the CoE Oversight Board was to examine cost effectiveness,³³¹ RWTF is unaware whether this review materialized. It is RWTF's understanding that the CoE Oversight Board, scheduled to hold bimonthly meetings, has not met since September 2013.³³²

In past years, RWTF made recommendations to empower the CoEs through policy and alignment under an executive agent.^{333, 334} These recommendations predated the stand-up of the DHA, whose mission includes managing “the execution of policy as issued by the Assistant Secretary of Defense for Health Affairs...”³³⁵ Based on FY2014 CoEs briefings, RWTF believes alignment under the DHA would both improve oversight of the CoEs and enable the CoEs to more effectively and efficiently realize their mission and intent.^{336, 337} In particular, by aligning DCoE, VCE, HCE, and EACE under the DHA, DHA’s policy execution role can now be leveraged to support CoEs efforts to translate clinical research into policy and promote consistent use of best clinical practices across the Services.³³⁸

Facilitating Recovering Warrior Recovery and Transition

In this section, RWTF hones in on several aspects of how DoD supports the RW community. Three recommendations address, respectively, empowering FCGs and others to optimally support RWs, systematizing the transfer of Service members from DoD to VA, and comprehensively assessing the effectiveness of available vocational/employment services. A fourth recommendation addresses recruitment standards, which in theory influence how RWs fare during recovery and transition.

RECOMMENDATION D8

To optimize the family and significant other contribution to Warriors’ recovery, facilitate their participation and socialization throughout the continuum of care, management, and transition. HIPAA rules that potentially constrain family involvement should be mitigated.

Requested Agencies to Respond:

Finding: RWTF believes that FCGs are an important part of the RW recovery process, “recovery multipliers” who enhance the recovery and healing of their wounded, ill, or injured Service members. FCGs fill a number of roles during the recovery and rehabilitation process, such as medical aide, chauffeur, spokesperson, personal manager, counselor, advocate, etc.^{339, 340,}
³⁴¹ DoD must equip FCGs with the information and support needed to fulfill these roles and to optimally support their RWs. This may include RW medical/mental health information, as appropriate and legally permissible. It is important to note that the focus of this recommendation is on the FCG’s role as caregiver. RWTF recognizes that RW FCGs also have their own needs related to adjusting to the changes in their lives, which are addressed in Recommendation D3 of this report.

RWTF believes that FCG involvement, including two-way communication with provider, is particularly essential in assessment and treatment for PTSD and/or TBI. RWs with these diagnoses may be unable (due to memory deficiencies, for example) or unwilling to accurately report their symptoms to their providers.^{342, 343} By relying only on the self-report of RWs, providers may miss critical aspects of the patient’s conditions. The FCG perspective can give the provider supplementary data, enabling a better treatment plan. Additionally, absent contact with an FCG, providers lack a channel for informing them of potential risk factors present for their RWs, diminishing FCGs’ ability to fully support their RWs. This can have potentially devastating

consequences, including suicide.³⁴⁴ RWTF also notes there is evidence suggesting that inclusion of FCGs in treatment is associated with improved patient outcomes^{345, 346, 347, 348}

With my husband, we met with the psychologist. (My husband) said ‘Talk to my wife. She knows how I react.’ (The psychologist) asks me all these questions. (My husband) said, ‘She is the better one to tell you.’ (Family Member)

For me, I would make husband and wife do the appointments at therapy, education, support, all the junk, together because my husband can tell (the therapist) one thing and I can tell the therapist another. (Family Member)

The Health Insurance Portability and Accountability Act (HIPAA) is often identified as a barrier that prevents medical and nonmedical providers from readily communicating with patients’ FCGs.^{349, 350, 351, 352, 353} RWTF strongly believes that, for communicating with RW FCGs about *their personal needs*, HIPAA is irrelevant. (See FY2012 Recommendation 14 and Recommendation D3 of the current report.) Conversely, for communicating with RW FCGs about their *at-risk RW’s needs*, HIPAA is an unintended obstacle that must be mitigated. A solution must be found to enable providers to share medical and/or mental health information with designated FCGs when necessary for the well-being of the patient. RWTF proposes the introduction of an opt-out default system allowing providers to communicate with designated FCGs when deemed clinically advisable. The opportunity for Service members to opt-out and/or update the name of the designated FCG could be integrated into personnel processing at key career junctures such as pre-deployment, annually, changes of station, and transition out of the military. If the Service member does not sign this opt-out form, a provider who is concerned about the RW’s well-being or mental health is permitted to contact the designated FCG.

To further mitigate unintended HIPAA constraints, FCGs of deploying Service members and of Service members already diagnosed with PTSD or TBI must be better educated, or socialized, about HIPAA (see Recommendation D3). Specifically, it must be clear to FCGs that, even without a specific authorization or the proposed opt-out system, their RW’s medical providers can still take in information, such as concerns FCGs may have about their RW’s well-being or symptoms, as this direction of information flow from FCGs to providers is not limited by HIPAA.

More generally, despite the importance and value to RWs of FCG involvement in the recovery process, too often it has been difficult for the DoD to empower FCGs and to provide them the tools they need to actively support their RW’s recovery. FCGs are often not recognized as a part of the RW’s recovery team despite the requirement in DoDI 1300.24³⁵⁴ to do so; they are not proactively reached out to by the RW’s nonmedical case manager, nor do they receive needed information about resources, processes, or how to cope with their RW’s condition as they themselves also try to adjust.^{355, 356, 357, 358} Recent Congressional testimony from both Military and Veteran Service Organizations (MSOs and VSOs) highlight this ongoing need by encouraging increased inclusion of FCGs in the recovery process, advocating for increased awareness and education for FCGs in identifying signs of stress³⁵⁹ and arguing that RW FCGs are a part of the rehabilitation and recovery team who need to be included and educated about medical care and treatment.³⁶⁰ RWTF has drawn DoD’s attention to these shortfalls in each prior Annual Report,

through a total of 13 recommendations.³⁶¹ For example, at the conclusion of RWTF's first year of effort, the RWTF urged DoD to empower FCGs with the resources they need to fulfill their roles in the successful recovery of RWs (FY2011 Recommendation 14.) In the FY2012 report, RWTF recommended that the Services seek every opportunity to unify family members/caregivers and RWs (FY2012 Recommendation 18), in part due to the impact of on-site family support on the RW's recovery process, which has been found to be associated with improved recovery,^{362,363} reduced medication use,³⁶⁴ and return to work³⁶⁵.

RWTF has been gratified to observe modest signs of progress in RW FCG over its four years of operation. DoDI 1300.2, Recovery Care Program³⁶⁶, and DoDI 6025.20, Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas³⁶⁷ both acknowledge that families require assistance/support as part of the recovery process. DoDI 1341.12: Special Compensation for Assistance with Activities of Daily Living was published in 2011 and revised in 2012³⁶⁸ to extend eligibility to RWs who are not homebound. The VA launched caregiver training classes and caregiver stipend payments in 2011.³⁶⁹ RWTF was pleased to see that WCP published a caregiver resource directory in 2013.³⁷⁰ RWTF also celebrated as a best practice in its FY2012 report the Marine Corps practice of involving the FCG early in the process with the help of the WWR RCP Family Contact Authorization Form and procedure.³⁷¹ However, RWTF believes that much work remains to be done in the area of empowering FCGs to actively participate in, and support, their RW's recovery and transition process. This work must include systematically socializing FCGs to the content areas and milieus they will need to master and navigate on their RW's behalf throughout the continuum of care. Examples include the hospital (during the acute phase of care and with each change in facility); the military environment and culture (for those who may be relatively new to it, such as parents, new spouses, or reserve spouses); FCG rights and benefits; HIPAA constraints; the recovery team; the RW's condition, care needs, prognosis, and treatment plan (including updates as warranted); the concept of the "new normal;" military and non-military resources available for the RW and the family/caregiver (initially and as circumstances and locations change); the continuum of care including transition to VA; Service-specific units and programs, IDES, and so forth. (Recommendation D3 addresses some of these areas.)

RECOMMENDATION D9

Pre-DD214, facilitate the transfer of each SM to the VA by automatically enrolling him/her, scheduling an initial appointment, and providing information on how to fully utilize the VA benefit.

Requested Agencies to Respond:

Finding: RWTF believes that the transfer from DoD to VA systems is foundational to successful transition to civilian life but not yet institutionalized in a way that meets the needs of transitioning Service members, and particularly transitioning RWs (and eligible families³⁷²). It appears existing systems designed to facilitate successful transfer, such as the VA Liaison for Healthcare and the VA OEF/OIF/OND Program within each VA Medical Center are not widely used.³⁷³ Only about 55 percent of OEF/OIF/OND Veterans utilize VA services.³⁷⁴ DoDIs addressing the nonmedical³⁷⁵ and medical³⁷⁶ management of RWs do not detail how recovery teams should work together with the OEF/OIF/OND case manager or other forms of collaboration to optimize the transfer process. Congressional testimony echoes the need for

additional efforts to realize the goal of “seamless transition”³⁷⁷ and advocates for improvements in accountability between DoD and VA to better support transitioning RWs and caregivers³⁷⁸.

Numerous gaps exist in the transfer process from DoD to VA that can prevent Service members from establishing care at the VA or accessing resources/benefits for which they are eligible.^{379, 380} Service members and FCGs lack information about VA resources and benefits prior to coming to the VA. Service members are often overwhelmed by information at discharge, misinformed or not informed about particular benefits, and/or confused about the difference between VHA and VBA.^{381, 382, 383} There is also a lack of a consistent warm handoff between DoD and the VA to ensure transitioning Service members have an appointment at the VA or have met a point of contact for assistance within the VA system.³⁸⁴ Distance from facilities and the belief that the VA focuses on the needs of older, chronically ill patients can also reduce OEF/OIF/OND Veterans’ comfort level in pursuing services at the VA.³⁸⁵

In RWTF focus groups, participants were more likely to express lack of confidence than confidence about how their transition to VA would work out.³⁸⁶ Those lacking confidence explained they had a previous bad experience with the VA, the process had not been explained well, or they feared their information or records would not be transferred correctly.³⁸⁷

I think I’m a little worried, just because it’s overwhelming, and it’s a little painful to get set up over there. It’s so big you don’t know where to start. (Recovering Warrior)

I have some concerns. But I don’t know if it’s just, again—when changing from one to another, there’s always the possibility of getting lost in the shuffle. (Recovering Warrior)

Inconsistent handoffs are particularly concerning among RWs with behavioral health concerns, as continuity of care is essential to their well-being yet potential barriers can prevent them from connecting to a new mental health provider. For example, Service members experiencing PTSD and/or TBI symptoms, who are also prone to co-morbid disorders³⁸⁸, may have difficulty remembering important information about their care and/or advocating for themselves.^{389, 390} They may not be provided a sufficient quantity of psychotropic medication by DoD to last until their first appointment at the VA, and then they may discover unexpected differences in VA and DoD formularies.^{391, 392} Stigma that seeking behavioral health care is a sign of weakness can present another barrier to continuity of care³⁹³, as can inadequate access to mental health services.³⁹⁴ Circumstances such as these heighten the importance of the warm handoff for this sub-population.

RWTF has had an abiding interest since FY2011 in the successful transfer to VA for RWs and all Service members, and has made many recommendations over the past three years related to improving the transition process³⁹⁵ and the coordination between DoD and the VA.³⁹⁶ For example, in FY2012, RWTF recommended that DoD widely market VA services and benefits to DoD leadership and encourage Service members to register in the VA e-benefits program (Recommendation 35). In FY2013, in order to facilitate the referral of National Guard Veterans and other eligible members of the National Guard, RWTF recommended that the National Guard Bureau (NGB) direct 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 Program offices in their areas (Recommendation 8). RWTF stands by both these recommendations. In addition, based on data gathered over the past four years, RWTF now proposes a three-part approach to institutionalizing the DoD-VA handoff process: automatic registration/enrollment, scheduling the first appointment by a designated DoD entity, and proactive education/outreach to inform Service members about VA services.

- **Automatic registration/enrollment:** An IT solution should be developed to provide an automatic enrollment process in the VA system for 100 percent of transitioning Service members. This system should pull data from existing DoD administrative databases, thus reducing the burden on Service members.
- **First appointment scheduled by a designated DoD entity: DoD should designate the DoD position that is responsible for scheduling all transitioning personnel’s first appointment at VA.** RWTF recommends that, for RWs, this individual be a designated member of the recovery team who coordinates with the OEF/OIF/OND Program office in order to introduce RWs to the VA healthcare system, orient them to their particular VAMC and OEF/OIF/OND program office, schedule a PTSD/TBI screening, engage them in the referral process for any needed care, and evaluate any service-connected conditions that were not identified prior to discharge. The designated entity should proactively schedule this appointment before the DD214 is processed.
- **Proactive education/outreach to inform Service members about VA services:** The purpose of this component is to instill within transitioning Service members the know-how and desire to pursue their VA benefit (similar to FY2012 Recommendation 35). This requires education and marketing efforts, some of which are already in progress. The current Transition GPS (formerly TAP) curriculum provides six hours of orientation to VA benefits and processes—including a four-hour informational briefing on VA Benefits such as education, health care, compensation, life insurance, home loans, and the Vocational Rehabilitation and Employment program (VR&E); and a two-hour orientation to benefits registration.³⁹⁷ We urge Transition GPS designers to continue to assess and refine this curriculum to ensure it remains responsive to Service members’ needs. In addition, RWTF is heartened by plans to launch, with VA support, the progressive Military Life Cycle concept within DoD, which will institute career-long mindfulness of an eventual transition out of DoD.^{398, 399, 400} Over time, this concept should contribute to a culture change in how Service members view the VA and a greater permeability in the boundaries between the two institutions. In the meantime, a marketing campaign is essential to persuade the current generation of Veterans, who have not had the benefit of career-long VA training, that “this is not your father’s VA.”

The VA’s Office of Public and Intergovernmental Affairs (OPIA) stood up the National Veterans’ Outreach Office⁴⁰¹ to lead and coordinate outreach programs to increase Veteran awareness of VA healthcare, benefits, and services available to them and their FCGs.⁴⁰² While the development of the VA Outreach Office is a good start, RWTF believes a more formalized approach capturing each of the three components outlined above is needed in order to institutionalize the successful transfers of Service members from DoD to VA. RWTF believes such successful handoffs are in many instances key to subsequent transition success, particularly for Service members with behavioral health needs.

RECOMMENDATION D10

Identify the major DoD and Service-level vocational/employment programs and systematically assess to what extent, as a whole, they satisfy the needs of the RW population and family members.

Requested Agencies to Respond:

Finding: According to the Bureau of Labor Statistics (BLS), in 2013, nine percent of all Gulf-War II Veterans, and 21 percent of Gulf-War II Veterans 18 to 24 years old, were unemployed.⁴⁰³ Given estimates that over a million additional Service members are expected to transition to civilian life in the next four or five years,⁴⁰⁴ it is critical to prepare these Veterans for successful employment. RWTF is concerned that DoD and the Services do not adequately evaluate their own vocational/employment (V/E) programs, that DoD does not systematically assess other V/E programs, and thus DoD does not know whether V/E programs meet the needs of RWs and their families. The Institute of Medicine (IOM) expressed similar concerns in a 2013 report, stating, “the literature assessing the effectiveness of DOD’s and VA’s transition-assistance programs is relatively thin, even though reentry into the labor force is one of the most important readjustment challenges.”⁴⁰⁵

Administered by WCP, E2I and OWF are DoD’s two RW vocational/transition assistance programs. In each of its four years, RWTF has collected data on E2I and OWF, including from site briefers, RW mini-surveys, and RW focus groups. In a FY2014 briefing to RWTF, WCP staff shared currently collected E2I and OWF metrics.⁴⁰⁶ These metrics include (among others) participation (“percent of Service members who are eligible for (E2I and OWF) and who are referred to the programs by their Services”), career readiness (“percent of all recipients of OWF services who are career ready when they complete their OWF internship” and “percent of all recipients of E2I services who are career ready/prepared when referred to Department of Labor American Job Centers”) and employment or internship outcomes (“percent of eligible Service members participating in (E2I and OWF) programs, who are accepted into employment opportunities or internships”).

RWTF recognizes that WCP places significant importance on developing the career readiness of RWs.⁴⁰⁷ However, RWTF believes evaluating whether or not RWs are career ready does not go far enough. WCP must evaluate outcomes in order to know whether programs are effective. RWTF notes metrics for E2I outcomes, but believes WCP should also collect outcome data concerning OWF, since the ultimate goal of this internship program is to make RWs more employable. RWTF believes DoD will not know how well this program meets the needs of RWs without assessing to what extent participation is associated with employment.

In addition to DoD-level programs, the Services’ RW units and programs have vocational programs for RWs. In FY2013 and FY2014 RWTF asked the Services how their units and programs measure vocational/employment program effectiveness. RWTF was disappointed to learn that only USAF Wounded Warrior Program tracks program outcomes, including whether RWs are employed, and if so the sector in which they are employed (Active Duty, Civilian, Federal, or Self-Employed).^{408, 409} USN Wounded Warrior-Safe Harbor conducts interviews with a sample of RWs to ensure they have received appropriate support and reaches out through their call center to transitioned Veterans to ensure information has been distributed, but did not explicitly state they track outcomes.⁴¹⁰ USMC WWR administers satisfaction surveys concerning

their vocational/employment programs, and is considering adding post-separation contact with transitioned Marines concerning employment outcomes.^{411, 412} USA WTC collects participation data but admitted they lack post-transition feedback mechanisms necessary to track outcomes.^{413, 414} RWTF believes that inconsistent tracking of V/E program users by the Services' compromises effective, equitable V/E program delivery across the Services. More robust assessment using common metrics, which go beyond mere participation and/or career readiness to outcomes, is needed in order to ensure RWs of all Services receive the best possible vocational support.

Overlaying RWTF's concern about insufficient DoD and Service-level assessment of their respective V/E programs is RWTF's belief that the effectiveness of the collective whole of the programs across both DoD and the Services is not well understood. Do RWs from all Services have adequate access to all DoD and Service programs for which they are eligible? Are available programs between DoD and the Services duplicative or complementary? To what extent do DoD and Service programs as a whole meet the needs of RWs? Are there areas of need that are simply not being met by any V/E program?

I'm scared -- I'm not going to lie. I don't have a degree and I'm scared to death to get out, just because I don't know what's going to happen. (Recovering Warrior)

RWTF's data suggest areas of unmet need do exist. Over four years of installation visit briefings, proponents of vocational programs identified persistent challenges: limitations on the kinds of opportunities RWs could pursue (such as federal vs. private sector); limited opportunities due to location/geographic distance; insufficient staffing; and mismatch between available opportunities and RW capabilities.^{415, 416, 417, 418} RW mini-survey respondents had little first-hand experience with vocational resources when queried (for example, over various years, about E2I, OWF, VA Vocational Rehabilitation and Employment (VR&E), Department of Labor (DOL) programs, and the Transition Assistance Program (TAP)).^{419, 420, 421, 422} RWs who participated in RWTF focus groups in both FY2012⁴²³ and FY2013⁴²⁴ were as likely to say that available vocational opportunities met their needs as not, underscoring that even the opportunities that were available to them were insufficient. While a majority of FY2014 RW focus group participants indicated vocational opportunities met their needs, a sizable minority stated vocational opportunities did not meet their needs.⁴²⁵ Additionally, members of an RW panel convened during a business meeting described significant difficulties finding jobs.⁴²⁶ DoD must undertake a systematic assessment of all DoD and Service-level programs in order to conclusively determine to what extent RW needs are being met.

Specifically concerning E2I and OWF, WCP described the programs as relatively immature.⁴²⁷ RWTF site briefings across multiple years corroborate this, while also indicating that OWF has been more robustly implemented than E2I.^{428, 429, 430, 431} Still, RWTF's assessment data suggest low utilization of both programs. RWTF FY2012 through FY2014 mini-surveys asked RWs whether they had first-hand experience with E2I and OWF. Across the three years, only ten percent of respondents indicated having first-hand experience with OWF, and only 13 percent indicated having first-hand experience with E2I.^{432, 433, 434} In FY2014, RWTF asked the Services how many of their RW unit and program enrollees were participating in E2I and OWF. USA⁴³⁵, USAF⁴³⁶, USN⁴³⁷, and USMC⁴³⁸ reported seven percent, two percent, 63 percent, and nine percent,

respectively, were participating in E2I and 12 percent, seven percent, 23 percent, and three percent, respectively, were participating in OWF.

I don't know how to get into that (OWF). Nothing has come out in some time. (Recovering Warrior)

They (internships) are available, but they are hard to get into. They make it hard. (Recovering Warrior)

A more extensive assessment of E2I and OWF program utilization as part of a larger systematic assessment of DoD, Service-level, and other V/E programs would give DoD a more rigorous understanding of E2I and OWF utilization (including whether or not RW needs were being met through other means).

Systematic assessment must also take into account other vocational programs used by RWs, which DoD must first identify. For example, RWs may take advantage of private sector job training, employment skills training, apprenticeships, and internships (JTEST-AI) as outlined in DoDI 1322.29 (published in January 2014).⁴³⁹ DoDI 1322.29 defines outcomes metrics, including how many participating Service members receive a job offer. RWTF believes the proposed systematic assessment of V/E services must encompass rather than silo programs such as JTEST-AI, and their accompanying metrics. RWTF further notes that a systematic assessment of major DoD and Service-level vocational programs resembles other recent efforts to drive parity and integration within DoD, including standing up the Defense Health Agency.

Beyond the needs of RWs, DoD must also identify and systematically assess the vocational/employment programs that support FCGs. As with RWs, RWTF recognizes vocational support is an area of unmet needs for many FCGs. As described in the 2014 RAND report, *Hidden Heroes: America's Military Caregivers*, 76 percent of FCGs of post-9/11 Service members work compared to 55 percent of FCGs of pre-9/11 Service members.⁴⁴⁰ Several reports on FCGs describe major hardships that result from balancing working and caregiving: FCGs frequently have to miss work, and some have to stop working altogether for a time, and caregivers and RWs experience significant financial strain due to the increased cost of care and the reduced income from employment.^{441, 442, 443} RWTF family member focus group participants from FY2013 and FY2014 echoed these unmet needs associated with caregiving.^{444, 445} While some vocational support activities allow and encourage family members/caregivers to attend, data presented during FY2013⁴⁴⁶ and FY2014⁴⁴⁷ site briefings, as well as in FY2014 Congressional Testimony⁴⁴⁸, indicated few take advantage of these opportunities.

RECOMMENDATION D11

Consider existing recruitment standards to ensure quality of future accessions.

Requested Agencies to Respond:

Finding: Among the many topics that Congress directed RWTF to examine each year are services for Posttraumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). In the

course of studying these areas, RWTF has become sensitized to the high rate of PTSD among the Veterans of Operations Enduring Freedom, Iraqi Freedom, and New Dawn.⁴⁴⁹ While current rates of PTSD apparently are not a historical anomaly,⁴⁵⁰ RWTF believes they may be linked to accession standards. Going forward, RWTF encourages DoD to closely consider the impact of recruitment standards—in multiple domains, not just behavioral health—on the resilience, capabilities, overall quality, and mission readiness of the all-volunteer force.

Current DoD recruitment standards instruct each Service to limit accessions to individuals with certain aptitudes and forbids accession of individuals with particular psychiatric conditions/history. Aptitude is measured by a battery of tests known as the Armed Forces Qualifications Test (AFQT), which measures performance on four subtests—arithmetic reasoning, mathematics knowledge, paragraph comprehension, and word knowledge; the AFQT is designed to measure developed abilities and helps predict future academic and occupational success in the military.⁴⁵¹ The AFQT score determines whether a candidate meets the minimal criterion for accession into a Service (each of which sets its own standard) as well as the career fields for which a candidate may be eligible. Based on their scores, candidates are classified as Category I through IV (with Cat IV defined as “below average” trainability and on-the-job performance). Medical standards preclude the access of individuals with particular medical, psychiatric, and behavioral conditions and histories.⁴⁵²

The current recruitment standards, according to DODI 1145.01, allow four percent of each year's recruits to be Category IV applicants⁴⁵³. It is also the understanding of the RWTF that each service can set the number of waivers it issues for accession.⁴⁵⁴

As one would expect, research suggests that a force made up of personnel with high AFQT scores contributes to more effective and accurate team performance.⁴⁵⁵ Specifically, one study examined the relationship between AFQT and the performance of three-person teams on communications tasks, including making a system operational and troubleshooting the system to identify faults. There was a significant correlation between the group's average AFQT score and its performance on both activities; if the average group AFQT score is lowered from the midpoint of category IIIA to the midpoint of category IIIB, the probability that the group will successfully operate the system falls from 63 percent to 47 percent.⁴⁵⁶ RWTF believes DoD should recruit candidates with the intellectual ability and skill sets to be successful and resilient and accomplish the mission.

Facilitating Access To Healthcare

Congress did not expressly charge RWTF with examining access to healthcare, apart from services for post-traumatic stress disorder/traumatic brain injury (PTSD/TBI). However, RWTF has grown increasingly aware of systemic disparities in this arena that, in turn, impact the opportunity of RWs to recover and transition to the next phase of their life, whether that is returning to duty or Citizen-Soldier status, or taking off the uniform. Accordingly, RWTF recommends two systemic changes to increase RW access to healthcare. The first recommendation urges eliminating the line of duty (LOD) determination as the gateway to healthcare for Reservists; the second proposes expanding the healthcare options available to RWs and Veterans to encompass not only TRICARE and Civilian

Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), but also Medicare.

RECOMMENDATION D12

Require health insurance as a condition of employment in the RC

Requested Agencies to Respond:

Finding: In each year of its existence, RWTF encountered concern about the LOD process for Reserve Component (RC) RWs. Between its FY2012 and FY2013 reports, RWTF made a total of six recommendations related to improving the LOD process.⁴⁵⁷ While addressing these recommendations will improve outcomes for RWs, they only target select aspects of the LOD process and do not address the larger system. This year, RWTF recommends alleviating the LOD problem altogether by a) eliminating the Service-connection criterion and b) requiring some form of health insurance as a condition of employment in the RC. While the net cost/benefit of this recommendation is not yet clear, what is clear is that this change is the right one to make on behalf of a standby reserve that has served as an operational force since 9/11 and will be experiencing the residual effects for decades to come. RWTF notes that, for many young Americans, access to health insurance may prove to be a boon to recruitment into the RC, just as tuition assistance was in the past.

RWTF's understanding of LOD issues stems largely from visiting 21 RC locations over four years (four in FY2011, five in FY2012, six in FY2013, and six in FY2014). Across these site visits, RWTF has repeatedly heard about and witnessed the LOD process tending to obstruct—rather than facilitate—access to care and benefits for eligible Reservists.^{458, 459, 460, 461} In contrast, Reservists' Active Component (AC) counterparts can use TRICARE for any condition regardless whether Service-connected. Furthermore, a November 2012 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.⁴⁶²

The LOD process can become untracked at every stage. The event is supposed to be documented in theater, but frequently is not.^{463, 464} If the LOD documentation is completed in theater, there is not a mechanism to systematically transmit it back to the home unit.^{465, 466} Documentation shortfalls contribute to inadequate medical screening at the demobilization site, failure to identify or confirm service-connected conditions, and premature deactivation before LOD conditions are identified or addressed by the military.^{467, 468, 469, 470} Once deactivated, Reservists with LOD conditions lose their Active Duty benefits, including TRICARE^{471, 472, 473}, and it is difficult to reinstate their Title 10 orders if necessary.^{474, 475, 476, 477} Furthermore, as attested to by briefers at numerous RC sites, the process is cumbersome and lengthy.^{478, 479} Factors contributing to the time lag include the need to assemble medical records from the VA and civilian physicians, as well as the fact that LOD paperwork approval, like many other administrative functions in the RC, is the responsibility of drilling Reservists who are only at the Reserve site on a part-time basis. Several National Guard sites told RWTF that, in addition, there is a backlog of LOD cases waiting for processing at NGB Headquarters.⁴⁸⁰

In particular, the LOD process is problematic for personnel with PTSD.⁴⁸¹ It may be many months post-deployment before symptoms arise, which adds further length to the process. Additionally, unlike many service-connected conditions, it is difficult to trace psychological symptoms to a specific incident/date in theater, making an LOD determination very complex.

Requiring Reservists to have health insurance ensures RC RWs have access to the care they need under any circumstances. Having health insurance grants RC RWs comparable access to healthcare as AC RWs. Health insurance eliminates the access gap RC RWs currently experience while awaiting LOD orders. Furthermore, health insurance covers RC RWs for conditions that would not be deemed service-connected. Health insurance from any source, such as a civilian employer, spouse, or parent, would meet this requirement. Since AC personnel also have dental insurance, RWTF recommends that Reservists be required to have it as well.⁴⁸² Individuals who do not have health insurance should be required to purchase TRICARE Reserve Select (TRS) and TRICARE Dental Program as a condition of employment in the RC. RWTF is aware that younger personnel, in particular, may resist purchasing insurance—a briefer with the USMC Wounded Warrior Regiment (WWR) noted that young RC Marines often choose not to purchase TRS, to their detriment.⁴⁸³

RWTF recognizes this recommendation not only calls for a paradigm shift but has cost implications, as well as implications for existing programs and benefits. TRS, which DoD partially subsidizes, is currently only offered to eligible members of the Selected Reserve (and their families).⁴⁸⁴ It is possible eligibility for TRS will need to be extended to the other components of the Ready Reserve.⁴⁸⁵ Costs to DoD could go up, for example, as more Reservists enroll in TRS. At the same time, costs to DoD could go down as more Reservists with service-connected conditions use private insurance and fewer are retained on active duty. Additionally, RC RWs are currently eligible for additional pay and benefits (such as SCAADL and TSGLI) through the LOD process.⁴⁸⁶ DoD will need to devise alternate ways to ensure eligible RC RWs continue to receive the supports to which they are entitled. The Transitional Assistance Medical Program (TAMP) currently provides a bridge between the termination of AD care and benefits and initiation of other healthcare/health insurance⁴⁸⁷ and the Transitional Care for Service-Related Conditions (TCSRC) Program extends coverage beyond TAMP⁴⁸⁸. DoD will need to determine how the elimination of LOD impacts both these programs. Finally, civilian health insurance plans will be impacted. Should the cost to civilian health insurance plans rise significantly, DoD may need to consider subsidizing the plans for RC RWs, as suggested by The Military Coalition in April 2014 testimony to Congress.⁴⁸⁹

Over its four years of operation, RWTF has come to see the LOD process as complicated, bureaucratic, and not patient-centered. RWTF believes the LOD process fails to meet the needs of the RC RWs it is intended to serve, and must be replaced. As the first step toward implementing this recommendation, RWTF urges DoD to conduct a business case analysis (BCA) of how a) eliminating the Service-connection criterion and b) requiring some form of health insurance will impact both DoD, RC RWs, and the civilian sector.

RECOMMENDATION D13

In order to expand access to care for service members/ Veterans, provide an option to use Medicare/TRICARE/CHAMPVA.

Requested Agencies to Respond:

Finding: The RWTF believes that several specific populations would benefit from increased access to a choice of medical care; these include disability retirees and length of service retirees who also have a disability,⁴⁹⁰ as well as Service members and Veterans residing in rural/remote areas.

Currently, active duty Service members and Veterans have several options for obtaining health insurance.⁴⁹¹ All active duty military personnel and activated members of the National Guard and Reserves are eligible for TRICARE; active duty personnel are automatically enrolled in TRICARE Prime at no cost. Non-active duty participants may opt for TRICARE Standard—a fee-for-service option benefiting the one-third of non-active duty participants who live in areas without access to the TRICARE Prime network. Veterans are eligible for the Veterans Health Administration (VHA) program which, in contrast to TRICARE, generally functions as a health care delivery system rather than an insurance plan. Additionally, CHAMPVA is a small insurance program for survivors and certain groups of Veterans. Because of limited resources, VHA currently uses a priority system to establish which Veterans can actually receive care. OEF/OIF/OND Veterans accounted for just 4 percent of VHA spending. Military retirees over age 65 who have Medicare coverage are also covered by TRICARE for Life, a wraparound plan. Close to half of VHA users have Medicare.

Despite the existence of these health insurance options, RWTF has observed that insufficient access to care is a persistent problem for RWs and Veterans. During FY2013 and FY2014 focus groups RWTF heard that AC RWs were frustrated with a lack of access to adequate medical care, including long waits for appointments.^{492, 493}

I needed surgery... I can't walk without a cane. It took so long to get an appointment that my (body part) healed and it healed incorrectly. (Recovering Warrior)

It took me 11 months to get an appointment at the pain clinic. (Recovering Warrior)

Service members and Veterans experience disparate access to care, and access to care for rural or remote service members is particularly problematic. During its site visits, RWTF learned about specific challenges for remotely located service members⁴⁹⁴ including providers dropping coverage when there is a transition to a new TRICARE contractor, difficulty with medication management, and a perceived de-escalation in service members' care plans once the decision is reached that they will be transitioned to remote care. In addition, briefers at several sites described a lack of access to adequate behavioral health care; specifically, that the access to care standard is difficult to meet for behavioral health due to lack of providers in and around certain geographic areas.⁴⁹⁵

By increasing the number of choices Service members and Veterans have for insurance coverage, RWTF postulates that competition among payers and providers will increase. This competition may lead to improved quality of care; RWTF feels that various Federal and civilian systems should compete for what is best for Veteran's needs. The San Antonio Military Health System, for example is working to recapture some of its patient population who receive

medication through civilian pharmacies;⁴⁹⁶ their approach is to coordinate with the VA to standardize their formularies which would lead to a more seamless experience for beneficiaries as well as cost savings for the System overall.

While increasing the insurance options for service members and Veterans may improve access and result in increased competition and therefore higher quality of care, increasing the number of military personnel accessing care through civilian sector may present several challenges. First, increasing the percentage of DOD health services that are furnished in the private sector at a time that occupancy rates in military facilities have declined could reduce the standard of care within military treatment facilities.⁴⁹⁷ Second, the transfer of health record information, which is already a challenge for service members and Veterans,^{498, 499, 500} could become increasingly difficult for a larger number of individuals who would be receiving care at DOD, VA, and civilian treatment centers. Difficulties in record transfer could disrupt continuity of care and could actually impede access. Third, the lack of access to mental health care described above is tied to a national shortage of behavioral health providers and reimbursement rates.⁵⁰¹ In 1991 Congress instructed DoD to lower TRICARE reimbursement rates to mirror Medicare rates. As of 2011, reimbursement rates for TRICARE have been brought to match Medicare's with the exception of a handful of procedures. In addition, a 2011 GAO report⁵⁰² describes how increasing insurance options for service members and Veterans may not actually make behavioral health care more attainable for this population given the low reimbursement rates and lack of providers overall. Finally, the Affordable Care Act⁵⁰³ has largely addressed the lack of alternatives available for service members and Veterans through the establishment of health insurance exchanges through which States provide affordable insurance options.⁵⁰⁴ Despite these challenges, RWTF believes the Federal health systems should be simplified and the barriers of bureaucracy should be removed.

Best Practices

This section highlights six promising practices RWTF encountered during FY2014. The first, Public-Private Partnership Models, elaborates on four comprehensive inter-sector partnerships, including several mentioned in Chapter 1. The second practice, the National Ability Center, is an example of a successful partnership of a single private entity with an Army Community-Based Warrior Transition Unit (CBWTU). This is followed by three encouraging vocational/employment initiatives, including US Special Operations Command (USSOCOM) Care Coalition SOF X-Roads, Joint Base Lewis-McChord's Pre-Apprenticeship and Career Skills Programs, and Veterans Administration Pacific Islands Health Care System (VAPIHCS)/Warrior Transition Unit (WTU) Internship Pilot. The sixth practice comprises a set of Marine Corps Wounded Warrior Regiment (WWR) initiatives aimed at tracking and supporting RC RWs.

Public-Private Partnership Models

RWTF believes the federal sector is neither equipped nor solely responsible for supporting America's transitioning heroes. As military operations in Southwest Asia draw to a close, federal resources for taking care of RWs are expected to contract^{505, 506}, which may challenge the military's capacity to care for this deserving population. What is more, transitioning RWs make up only a small fraction of the larger exodus of transitioning personnel who will be taking off the uniform and

entering civilian life over the next several years^{507, 508, 509, 510, 511}, yet a reliable system for facilitating Service members' successful transfer from DoD to VA, and navigation of the initial military-to-civilian transition, continues to elude the Departments⁵¹². And transition is just the beginning of the new Veteran's journey, yet no DoD or VA office is charged with the mission of supporting the longer-term challenge of Veteran reintegration.⁵¹³ Perhaps in part to fill this void, at least for RWs, each of the Services has allocated resources to some sort of post-DD214 contact/outreach.^{514, 515, 516, 517} At the same time, within the private sector, there is a groundswell of interest and activity in supporting Service members, Veterans, and their families.⁵¹⁸ RWTF's vision for the way ahead in caring for transitioning Service members and Veterans, public-private partnerships, is driven by this scenario.

No government entity adequately stewards the transition from military service, none is concerned with the long-term prospect of Veteran reintegration with civilian society and none provides consistent guidance to the thousands of nongovernmental entities that inevitably shoulder the attendant public health and social welfare burdens. (Nancy Berglass and Margaret C. Harrell, Center for a New American Security⁵¹⁹)

The level of DoD involvement needed to empower public-private partnerships on behalf of transitioning Veterans is an open question; RWTF believes DoD could provide invaluable leadership through outreach to prospective partners, coordinating and synchronizing efforts, facilitating access, and sharing technical expertise. Following are several public-private partnership models that RWTF learned about during FY2014. RWTF was impressed by their vision and approach, which demonstrated strong synergy with DoD and VA. Other common characteristics of these organizations included their proximity to areas having a high density of Veterans and a solid understanding about how to support transitioning RWs. In many cases, these partnering organizations provided unique services that complemented those of DoD and VA.

- **Military Transition Support Project (MTSP), San Diego, CA.** The MTSP is a successful collaboration among San Diego's military, government agencies, elected officials, nonprofits, businesses, and philanthropic institutions.⁵²⁰ Its mission is to develop a comprehensive plan to better coordinate community resources for Veterans and to connect Service members to those resources to as early in the transition process as possible. An integral component of MTSP's community plan is a web-based portal that will aggregate employment, education and vetted social service information, and highly-trained Veteran navigators to provide personal assistance to those needing additional support. The MTSP Veteran Wellness Model, which guides their mission, includes education and jobs, basic needs, mental and physical health, and social and personal connections as its foundation. The MTSP is funded primarily by Blue Shield of California Foundation, with additional support from WebMD Health Foundation, and Rancho Santa Fe Foundation. One of the Project's key goals is to share the process with other communities by documenting their framework and plan development.
- **The University of South Florida (USF) Veterans Reintegration Steering Committee.** USF's Veterans Reintegration Steering Committee is focused on the adjustment and integration of Veterans back into their communities.⁵²¹ The Committee is composed of individuals employed by the university, including deans and administrators, professors of such disciplines as neurosurgery, psychology, and engineering, and leaders of the Student Veterans Association; and

individuals employed by university partners, such as VA doctors, USSOCOM Care Coalition administrators, and private sector executives. Housed within USF, it is proximate to both MacDill Air Force Base, home of U.S. Central Command (USCENTCOM) and USSOCOM Care Coalition, and the James A. Haley VA Hospital. The Committee collaborates closely with both SOCOM (e.g., through programs that provide assistance to Service members transitioning into the University, and a job training program for student Veterans) and the VA (through collaborative research on Veteran rehabilitation), as well as with numerous private entities (e.g., a mentoring program for student Veterans with Jacobs Technologies, and job training and employment programs with Tampa Bay Technology Forum, Edward Jones, Mortenson Engineering and Vistra Communications), formalizing these partnerships through extensive memoranda of understanding (MOUs).⁵²² Part of the Committee's work is the development of the USF Rehabilitation Research Project, whose goal is "to foster research collaborations, identify funding opportunities, build the research infrastructure, and conduct state-of-the-art research aimed at the rehabilitation of military veterans and their adjustment and reintegration into civilian life."⁵²³ The USF's planned Center for Rehabilitation Science, Engineering and Medicine will enhance this work by serving as a collaborative entity to coordinate and improve knowledge intended to improve the lives of RWs. This facility will be located next to USF's health colleges as well as the James A. Haley VA Hospital. Furthermore, it will be affiliated with the Bay Pines VA Hospital in St. Petersburg, FL.⁵²⁴ USF is uniquely located as a nexus of RW/Veteran support, with about 25 percent of Florida's Veterans living in counties served by USF.⁵²⁵

- **Augusta Warrior Project (AWP) in Augusta, GA.** The mission of the AWP is to improve the quality of life for warriors and their FCGs in the central Savannah River area.⁵²⁶ Through intensive outreach, AWP provides navigational services to link warriors to local services that meet their needs. AWP recognizes the challenges associated with the inherently complicated system facing newly transitioning RWs, and therefore provides tools to teach warriors about available local services and ensure their access. According to AWP, the most difficult barrier is linking warriors with the benevolent organizations that are willing and able to assist them in their transition. Since February of 2012, AWP has assisted hundreds of warriors in their communities by linking them with permanent housing, college or training programs, employment, and the VA. AWP has also partnered with the Wounded Warrior Project to replicate the AWP model in 10 communities throughout the U.S.
- **San Antonio Military Health System (SAMHS) and San Antonio Military Medical Center (SAMMC) eMSM (enhanced Multi-Service Market).** In 2013, SAMHS was selected by MHS as one of six enhanced Multi-Service Markets in the United States. Comprised of nine MTFs serving 240,000 beneficiaries with approximately 12,000 staff, SAMHS has forged extensive community partnerships to achieve its goal of leveraging civilian and federal resources to support military and Veteran patients as well as taxpayers⁵²⁷. Current SAMHS partnerships include Federal (VA, Centers for Disease Control, National Institutes of Health), state and local government (South Texas Regional Advisory Council, San Antonio Mayor's Council on Fitness, Greater San Antonio Chamber of Commerce Health and Bioscience Committee), academic (University of Michigan, University of Texas Health Science Center), and non-profits (Henry M. Jackson Foundation, BioMed San Antonio, Geneva Foundation, Southwest Research Institute).⁵²⁸ SAMHS meets monthly with VA to review opportunities for partnering and to discuss resource sharing such as training and equipment and ways to reduce duplicative services.⁵²⁹ Such partnerships enable SAMHS to provide quality, cost-effective health care by directing workload and workforce among San Antonio military treatment facilities. As an

integrated health system, the SAMHS continues to optimize the direct care system while strengthening the collaboration with VA and other community partners across the San Antonio metropolitan area.

National Ability Center

The private non-profit, National Ability Center (NAC) in Park City, Utah is an example of a private organization that has formed an innovative partnership with a RW unit, Community-Based Warrior Transition Unit (CBWTU) Utah. CBWTU Utah “provides remote command and control, medical case management, and administrative services for 200 soldiers in 15 states.”⁵³⁰ The CBWTU Utah and NAC partnership provides the opportunity for RWs to connect, learn about available resources, and participate in activities to enhance their resilience and fitness⁵³¹ through wide-ranging sports and wellness activities, education, and training. RWTF believes that public-private partnerships for comprehensive health and wellness are a best practice for all military units serving RWs.

Under the CBWTU Utah/NAC partnership, RWs attend CBWTU musters at NAC. The Army provides orders for travel, meals, and lodging for CBWTU Utah members to attend the week-long muster at NAC while NAC provides facilities, and staff for transition training and adaptive reconditioning activities (e.g. archery, snowboarding, rope courses)⁵³², resilience training and wellness (e.g., Comprehensive Soldier Fitness-Performance and Resilience Enhancement Program, equine-facilitated learning, yoga, and nutrition)⁵³³, and program coordination for Heroes for Hire and the Education and Employment Initiative (E2I).⁵³⁴ As of December 2013, NAC had hosted 35 musters, which otherwise would be cumbersome for the CBWTU to coordinate and less attractive and rewarding for the participants.⁵³⁵

NAC partners with other military entities as well. It was established in 1985 with the mission to serve “individuals of all abilities by building self-esteem, confidence and lifetime skills through sport, recreation and educational programs.” Service to the military and Veteran community has been rooted in NAC’s mission since inception, and the organization has grown its military programs significantly in recent years. In 2013, almost 50 military groups and over 900 U.S. service-related individuals participated in NAC activities, including a CBWTU-Utah muster with the U.S. Paralympics organization.^{536, 537}

I have been deployed in Iraq twice – in 2004/2005 and 2010/2011. After everything I have been through, the National Ability Center has been one of the more positive points in my healing and recovery process. Keep an open mind, don't be afraid or ashamed to ask for help, and don't wait any longer to start the rest of your life. (Recovering Warrior)

They come here and find other spouses and family members going through the same thing they are. A lot of Soldiers aren't asking the questions they should, but gosh darn it their significant other will. (Gail Loveland, Executive Director for the NAC [2011])

US Special Operations Command (USSOCOM) Care Coalition SOF X-Roads

The SOCOM Care Coalition SOF X-Roads is a web-based tool that uses analytics to align transitioning Recovering Warriors (RWs) with relevant job opportunities.^{538, 539} Both USSOCOM and

RWTF are aware of the challenges that all RWs—not just special operators—face when transitioning from the military to civilian employment. RWs are often uncertain about their career path after separation or which civilian jobs match their military skills and experience.^{540, 541, 542, 543}

I was recommended Not Fit for Duty. Transitioning is hard. You have to accept your limits, and get past what you could once do. Now I guess I have to decide what I want to be when I grow up (laughs). (Recovering Warrior)

Despite DoD and Service-provided vocational assistance programs some RWs have difficulty finding meaningful jobs^{544, 545}, or finding jobs at all⁵⁴⁶. Additionally, there are a great many open job opportunities in the private sector, which many RWs reasonably find overwhelming to search through^{547, 548}.

SOCOM Care Coalition combats these challenges by encouraging their RWs to seek employment that will fulfill their need for “purpose and relevance.”^{549, 550} Care Coalition advocates first assist RWs to define what kind of work holds “purpose and relevance” for them. Advocates and RWs then enter this definition into the SOF X-Roads database, which uses language algorithms to match RW interests with potential opportunities. More sophisticated than key word searches, the SOF X-Roads’ engine combs through millions of job listings identifies relevant possibilities, and describes with accuracy and fidelity how closely different opportunities align with RW interests. SOF X-Road’s algorithms are able to produce job matches missed by traditional job search engines such as Monster or USAJobs. With further development of the tool, employers will be able to directly load job opportunities. As of January 2014, SOF X-Roads was only available to members of the SOCOM community.⁵⁵¹ However, SOCOM Care Coalition believes the tool would have utility for all RWs and intended for it to be made available in time. The system is designed to refine the algorithms over time, and will become “smarter” as more people use it. SOCOM Care Coalition briefers further noted that the Department of Labor (DOL), VA, and Office of the Secretary of Defense (OSD) have been involved in the development of SOF X-Roads, and the American International Group (AIG) as well as the Wounded Warrior Project (WWP) have seen demonstrations of SOF X-Roads and expressed enthusiasm about its potential. RWTF supports the expanded use of SOF X-Roads.

Joint Base Lewis-McChord Pre-Apprenticeship and Career Skills Programs

On January 24, 2014, DoD published DoDI 1322.29: Job Training, Employment Skills Training, Apprenticeships, and Internships (JTEST-AI) for Eligible Service Members authorizing expanded vocational opportunities beyond the federal sector.⁵⁵² The Pre-apprenticeship and Career Skills Programs pilot at Joint Base Lewis-McChord (JBLM) has successfully implemented the authority granted by this DoD Instruction, addressing a longstanding unmet need.

Over the last three years (FY2012 through FY2014), RWTF has consistently heard that vocational opportunities limited to the federal sector—through vocational assistance programs such as Operation Warfighter (OWF)—are insufficient. Very few of the hundreds of RWs with whom RWTF spoke indicated having first-hand experience with these resources.^{553, 554, 555} For example, across the three years, only ten percent of respondents (45/463) indicated having first-hand experience with OWF. In RWTF focus groups in both FY2012⁵⁵⁶ and FY2013⁵⁵⁷, RWs were as likely to say that available vocational opportunities met their needs as not, underscoring that even the

opportunities that were available to them were inadequate. Most recently, in FY2014, a majority of RW focus group participants indicated vocational opportunities met their needs, although a sizable minority disagreed.⁵⁵⁸ Site briefings to RWTF during each year have further corroborated that federal sector vocational support was too limited.^{559, 560, 561} To address these unmet needs, RWTF recommended in both FY2012⁵⁶² and FY2013⁵⁶³ that DoD publish policy empowering the Services to expand non-federal vocational opportunities.

The David L. Stone Education Center at JBLM has implemented DoDI 1322.29 through a pilot called the Pre-apprenticeship and Career Skills Programs.⁵⁶⁴ The Programs include apprenticeship for RWs in four areas:

- Welding;
- Heating, ventilation, air conditioning and refrigeration;
- Software and IT systems; and
- Painting and allied trades.^{565, 566, 567}

Apprenticeships in construction electric and trucking are also available for Veterans.⁵⁶⁸ In each area, JBLM partners with a private sector union or corporation, such as United Association pipefitters union, Microsoft, and the International Union Painters. The goal of the Programs is to provide accelerated training in high demand career fields which are known to align with transitioning Service member skills and interests. In order to be eligible, Service members must have completed at least 180 continuous days on active duty, and must be expected to be discharged or released from active duty within 180 days of starting a Program.⁵⁶⁹ Participation is competitive, but pre-apprenticeship training is paid entirely by the private sector entity and is free to the selected transitioning Service members.⁵⁷⁰ Upon successful completion of a Pre-apprenticeship Program, Service members are guaranteed direct entry into careers or formal apprenticeship training following their transition from active duty. Additionally, participating Service members can also earn college credit toward an Associate's Degree during training courses. Pre-apprenticeship Program sessions run for 18 weeks, allowing for 2 or 3 sessions a year in each of the four areas.⁵⁷¹ From its beginning in January of 2013 through May of 2014, the Programs have graduated 114 Service members, with more currently enrolled scheduled to graduate, and more classes scheduled to begin, through the end of 2014. The JBLM Pre-apprenticeship and Career Skills Programs have been expanded to Fort Carson, CO; and, Fort Hood, TX; with plans to continue expansion to other military installations.⁵⁷²

Given estimates that over a million military Service members are expected to transition to civilian life in the next four or five years,⁵⁷³ the publication of DoDI 1322.29 was critical. The next critical step is its implementation across DoD. RWTF lauds the achievements to date by the JBLM pilot Programs and enthusiastically supports further expansion of the JBLM model.

Veterans Administration Pacific Islands Health Care System (VAPIHCS) / Warrior Transition Unit (WTU) Internship Pilot

The VAPIHCS/WTU Internship Pilot is an initiative of the Hawaii VA Medical Center (VAMC) to help Recovering Warriors (RWs) transition to civilian employment within the VA.⁵⁷⁴ Launched February 2014 as a nine-month pilot modeled after a similar program at the VAMC in Louisville, KY, this pilot aims not only to help RWs acquire vocational skills but also to help the VA identify

quality job candidates. RWTF was introduced to this initiative during a site visit to VAPIHCS only days after it was officially launched, precluding performance metrics; nevertheless, RWTF is impressed by the concept and the collaborative effort between the VA and its Army partner, Warrior Transition Battalion (WTB) Hawaii.

Twenty-seven internship positions were initially identified across a wide variety of VA services such as engineering (7 positions), mental health (3 positions), primary care (2 positions), utilization management (2 positions), human resources (2 positions), homeless program (2 positions), and others. As of February 2014, 13 WTU Soldiers had been identified and referred for placement. The VA and the WTB coordinate closely on candidate selection and choice of placement, taking into consideration the Soldier's medical status and military skills. Specific skill sets are not required for placement; rather, the focus of these internships is on exposure to civilian occupations and the civilian work environment. To promote the transition from a military to a civilian mindset, interns wear civilian clothing. As active-duty Soldiers, they are not paid.

VAPIHCS briefers expressed the expectation that, based on the Louisville VA's experience, interns will be fairly well qualified by the conclusion of the program and, in many cases, the VA services with which they are interning will be eager to hire them. Additionally, the VA can appoint them non-competitively.⁵⁷⁵ Should the intern not plan to stay in the local area upon separation from the military, the internship still offers a valuable learning and networking opportunity, plus the VA can provide a letter of endorsement for employment at a mainland VA.

Post-pilot, this VAPIHCS initiative may be expanded to encompass VA internship opportunities beyond the VAMC, e.g., at Oahu Community-based Outpatient Clinics and on other Pacific Islands served by VAPIHCS. Additionally, eligibility may be extended to recovering Airmen, Sailors, and Marines. VAPIHCS briefers indicated they have not yet engaged Operation Warfighter, DoD's federal internship program, but will do so once they evaluate and refine the pilot, and demonstrate its potential.

Marine Corps Wounded Warrior Regiment Initiatives to Track and Support RC RWs

The Wounded Warrior Regiment (WWR) is the Marine Corps' "centralized point for coordination and care of Marine wounded, ill, and injured, regardless of component."⁵⁷⁶ To best track and support Reserve RWs spread across more than 170 sites in 48 states and territories,⁵⁷⁷ the WWR has established several key initiatives, including the Reserve Medical Entitlements Determination (RMED) cell at WWR Headquarters in Quantico, VA, and two dedicated full-time positions, both created out of hide, at Marine Forces Reserve (MARFORRES) Headquarters in New Orleans, LA.

The **RMED** cell at Quantico, "oversees all cases of WII Reservists who require medical care or referral into the disability evaluation system for service-incurred ailments."⁵⁷⁸ This includes Reservists who are extended on active duty and placed in the Medical Hold (MedHold) Program (and possibly joined to or supported by the WWR) as well as those who return to civilian life and address their medical needs through Line of Duty (LOD) benefits. RMED is staffed with Reservists, which provides WWR invaluable familiarity and expertise regarding Reserve issues. The RMED Senior Medical Officer conducts medical case management from a records review standpoint. An RMED nurse case manager (NCM) on the RMED staff ensures the rare LOD Marine who returns to the community but needs conventional medical case management receives it

through a Military Treatment Facility (MTF). RMED also screens every case for the need for a Recovery Care Coordinator (RCC). RMED briefers believe they have full visibility on all Marine Reservists in MedHold or LOD status, or potentially needing it, thanks to a monthly updating process and daily contact with MARFORRES. RMED tracks Marine Reservists until they are returned to full duty or referred to IDES and receive their final PEB results.

The **WWR Liaison Officer (LNO) to MARFORRES**⁵⁷⁹ was established spring 2013 in response to growing WWR awareness of the challenges associated with supporting geographically dispersed wounded, ill, and injured (WII) Marines. These Marines are typically attached to MARFORRES units and outside WWR command and control, and the MARFORRES units to which they are assigned lack the requisite subject matter expertise in WII policies and programs necessary to properly support them. Over the last several years, RWTF has documented such challenges—across DoD—including RC organizations’ lack of ambient knowledge about available nonmedical resources for RWs.^{580, 581, 582}

The LNO provides “liaison between the Commanding Officer, WWR and the MARFORRES staff in matters related to the care and support of WII Marine and their families assigned to MARFORRES units through tracking and maintaining accountability in order to ensure proper/continuous care is coordinated; and provide education to provide subject expertise to MARFORRES units.”⁵⁸³ In this capacity, the LNO is able to keep the WWR apprised of issues impacting the care of WII Marines assigned to Reserve units. At the same time, the LNO serves as the major conduit through which critical information is pushed to Reserve commands. The LNO assists these Reserve commands in understanding their administrative and support responsibilities to WII Marines, including proper procedures for LOD and MedHold benefits, as well as limited duty and medical board processes. Additionally, the LNO informs Reserve units of WWR resources—many of which are accessible to geographically dispersed personnel outside the WWR detachments. The LNO’s reach into Reserve commands is extended through the instruction he provides at MARFORRES training conferences for Inspectors & Instructors (I&I), Administrators at MARFORRES sites, Corpsmen and Limited Duty Coordinators (LDCs) assigned to MARFORRES sites, and Family Readiness Officers (FROs). Through the LNO, MARFORRES and WWR collaborate daily. The LNO position is currently funded through FY2015.⁵⁸⁴

The **Force Limited Duty Coordinator (LDC)** position at MARFORRES trains and assists the LDCs located at each MARFORRES site and oversees their LOD caseloads,⁵⁸⁵ raising the level of consistency and quality control in the management of these cases. Unit-level LDCs are responsible for identifying and tracking all personnel within the command undergoing processing through IDES; ensuring those not in a full duty status in excess of 60 days are placed on temporary limited duty (TLD) and have proper medical documentation; ensuring proper administrative action is taken on personnel on light duty, TLD, permanent limited duty (PLD), and undergoing IDES; monitoring the status of Marines on the Convenience of the Government MEDHOLD; monitoring the status of Marines sent home awaiting final disposition by the PEB; and monitoring and tracking LODs.⁵⁸⁶ The Force LDC was to deliver the first annual MARFORRES LDC Course in April 2014.⁵⁸⁷

Other US Marine Corps Reserve elements further aid in tracking and supporting wounded, ill, and injured Reservists. For example, I&I stations responsible for specific geographic regions can deal with administrative issues and will work with WWR as well as District Injured Support Coordinators (DISCs) as necessary.⁵⁸⁸ Also, since 2010, Marine Corps Individual Reserve Support Activity

(MCIRSA) conducts huge, quarterly Individual Ready Reserve (IRR) mega-musters that include medical screening, VA enrollment, and job fairs.⁵⁸⁹ These regional events enable MCIRSA to touch the entire Marine Corps IRR over the course of one year. They provide an invaluable opportunity for MARFORRES to identify Service-connected medical issues and start LODs for at risk Reserve Marines who are “off contract.” The RMED cell and the full-time LNO and Force LDC positions, in combination with these more generic USMCR capabilities, provide the WWR a layered, robust system for managing Reserve RWs that the RWTF believes is a best practice.

Non-Voted Draft

Status of FY2013, FY2012, and FY2011 Recommendations

RWTF's founding legislation directed DoD to submit a report to Congress each year in response to RWTF's annual recommendations.⁵⁹⁰ This report was to include both an evaluation and an implementation plan for each RWTF recommendation. DoD and the Services also briefed this information to RWTF each year.⁵⁹¹ Exhibits 1 through 3 following present RWTF's assessment of the implementation status of each Year 1, Year 2, and Year 3 recommendation, based on reports and briefings from DoD and the Services.

Exhibit 1: FY2013 RWTF Recommendations, DoD Responses, and Status

FY2013 Recommendation	Summary of DoD Response	Status
1. Develop a DoDI to empower CoE and Oversight Board and direct Services to translate CoE discoveries into practice	DoDI not needed. Oversight Board will task CoRs to develop plans by late 2014 to promulgate CPGs.	Continue to follow. (see FY2014 Rec XXX)
2. Develop and implement measures of effectiveness for clinical case managers	DoDI 6025.20 published.	Met.
3. Implement policy standardizing the provision of evidence-based PTSD psychotherapies	DoD is conducting pilot to evaluate delivery of EBPs.	Continue to follow.
4. Ensure TBI treatments meet needs of RWs and standardize, document, and track efficacy	Reviewing inferential assessment of Service TBI programs.	Continue to follow.
5. Issue guidance for Services to ensure AD orders for RC RWs	DoD preparing issuance of publication.	Continue to follow.
6. Recommend VA and DoD, in concert with Congress, review inconsistencies with laws governing IDES	DoD is preparing a DoDM to ensure consistent interpretation and application for AC and RC SMs.	Continue to follow. (see FY2014 Rec XXX)
7. DoD must standardize LOD policy and implement an electronic LOD processing system	OASD(RA) is leading development of electronic DD Form for LOD determination.	Continue to follow.
8. NGB directs each JFHQ to establish formal strategic relationships with the VISN, VAMCs and the local VA OEF/OIF/OND Offices in their areas	Relationships have been established and efforts are being made to ensure they remain strong.	Continue to follow.
9. NGB should conduct a zero-based review of the staffing requirements for states/territories for DPHs	ARNG conducted review of staffing and is currently staffed at 100% fill.	Met.
10. DoD must establish policy to ensure the accuracy, timeliness, accessibility, and relevancy of information sources	DoD will inventory and assess online sources and call centers. DoD will continue to explore avenues to market the NRD.	Continue to follow.
11. WCP should work with VA to grant VTA access to more providers and locations supporting RWs in IDES	DoD's IDES Dashboard provides status as well as average timeliness to estimate when a SM will complete each phase and stage.	Continue to address. (see FY2013 Rec XXX)
12. Congress should eliminate the TDRL.	DoD will conduct a business case analysis of the TDRL program.	Continue to follow.
13. MEB processes must be standardized across Services and measures of effectiveness established	DoD is preparing a DoDM to ensure consistent interpretation and application for AC and RC SMs.	Continue to follow.
14. WCP should invite all RWs to complete each phase of IDES survey	Concurs.	Met.

FY2013 Recommendation	Summary of DoD Response	Status
15. Ensure implementation of JFTR and JTR for family members of RWs is consistent across Services.	Current policies provide clear guidance. DoD does not believe additional policy is warranted.	Continue to follow.
16. Optimize the implementation of the SCAADL benefit	DoD will analyze changes to compensation and evaluate an electronic tool for SCAADL.	Continue to address.
17. USAF liaisons at WRNMMC and LPMC must have minimum tour length of 24 months	Non-Concurs.	
18. Resource locations that have difficulty recruiting civilian behavioral health staff with primarily uniformed providers	Non-Concurs.	
19. Establish protocol for RC non-medical information	AC and RC RWs receive identical case management within their Services.	Continue to follow.
20. Should be 100% outreach for family members to attend in-processing and IDES orientation	DoD encourages family participation. It should not be imposed by the Service.	Continue to follow. (see FY2014 Rec XXX)
21. Publish timely guidance to standardize care to RWs	Still being addressed.	Continue to follow. (see FY2014 Rec XXX)

Exhibit 2: 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	DoD continues to work with VA through cooperative scheduling of resources.	Continue to follow.
5. Establish WCP within USD(P&R) portfolio	Non-concur.	Continue to follow.
6. Provide needed resources on station for 29 Palms	BUMED believes MCAGCC is appropriately staffed.	Continue to follow.
7. Extend TAMP to one year post deployment	TCSRC provides RC Service members care for late rising diagnosis.	Continue to follow.
8. Ensure training for evidence based PTSD treatment/identification	Training implemented.	Met. (however see FY2013 Rec 21)
9. Audit records for completed evidence based PTSD treatment	Procedures are in place to audit AD records in Direct Care system.	Continue to follow.
10. Adopt a common comprehensive recovery/transition plan format	Being addressed by by the Interagency Care Coordination Committee.	Continue to follow. (see FY2013 Rec 21)
11. Provide more access to and input into CRP for RWs and families	Being addressed by by the Interagency Care Coordination Committee.	Continue to follow.
12. Redefine WII Category 2	Non-concurs.	Continue to follow.

FY2012 Recommendation	Summary of DoD Response	Status
13. Send non-RCC RW proponents to joint DoD RCC training	DoD's intent is to train all WWP support staff that fulfills a RCC, NMCM, or Advocate role.	Continue to follow.
14. Support to family members/caregivers unconstrained by HIPAA	Services provide various support resources.	Continue to follow.
15. Designate principal point of contact for family/caregiver	Being addressed by by the Interagency Care Coordination Committee.	Continue to follow.
16. Educate family members/caregivers about VA/other resources	Services taking steps to ensure benefits upon separation information is known.	Continue to follow. (see FY2013 Rec 10, 16, 20)
17. Provide PEBLO briefing for EFMP families	All Services ensure EFMP enrollees are referred to a TRICARE Benefits Counselor	Met.
18. Unify families/caregiver with RW	DoD covers family/caregiver travel to be with RW during recovery.	Continue to follow. (see FY2013 Rec 15)
19. Rename NRD and market the new portal	Non-concurs.	Continue to follow. (see FY2013 Rec 10)
20. Resource base family support centers and specify relationships with RW programs	Services agree on importance of family support centers and commit to resources.	Continue to follow.
21. Centralize case management for RC RWs on Title 10	DoD verifies compliance of RC RWs on Title 10 and receiving LOD care.	Continue to follow.
22. Establish policies for issue of Title 10 orders and use of INCAP pay	New issuance of policy will give Services authority to retain RC RWs on AD orders.	Continue to follow. (see FY2013 Rec 21)
23. Include RC unit in out-processing for RWs leaving Title 10	USA identified actions to complete warm handoff from WTU/CBWTU to RC unit.	Met.
24. Publish interim guidance for NDAA 2012 Section 551	New policy to be published.	Continue to follow. (see FY2013 Rec 21)
25. Expand DoD/VA MOU on RW access to VR&E counseling	MOU still being coordinated.	Continue to address. (see FY2011 Rec 18 and FY2013 Rec 21)
26. Update DoDD and DoDI on TAP	Concurs.	Continue to address. (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	WCP monitors RTD rates for inappropriate IDES referrals.	Met.
29. Create electronic record for individual IDES information	Pending pilot outcomes.	Continue to follow.
30. Utilize WCP survey to improve IDES program	WCP revised survey upon guidance from Congress, GAO, DMDC.	Continue to address. (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	Training standards will formalize instruction requirements to availability of legal advice..	Continue to follow. (see FY2013 Rec 11)

FY2012 Recommendation	Summary of DoD Response	Status
35. Market VA services and benefits to DoD leadership at all levels	Ensure SMs are aware of VA benefits through NRD, RCC training, LES	Continue to follow.

Exhibit 3: FY2011 RWTF Recommendations, DoD Responses, and Status

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

FY2011 Recommendation	Summary of DoD Response	Status
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)
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)

This is the fourth and final Annual Report of the congressionally mandated RWTF. RWTF is greatly indebted to the thousands of stakeholders who helped RWTF accomplish its mandate by sharing extensive objective and subjective data over four years on myriad matters related to the care, management, and transition of RWs and RW families. These entities included Headquarters and field elements of DoD, VA, DOL, and the military Services and Components, as well as private organizations. RWTF is especially grateful to the nearly 1,000 RWs and RW FCGs who participated in RWTF focus groups and panels. Our nation will forever be grateful to them and to all transitioning Veterans for choosing to serve.

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¹⁷ Ibid, paragraph (c)(3)(matters A-Q).

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