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

Reference Handbook of Key Topics and Terms

Updated January 2013

Including updates from NDAA 2013

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

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

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

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

Background:

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

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

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

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

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

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

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

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

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

Background:

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

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

1. Assisting the Service member or family member/designee to understand medical status during care, recovery, and transition;

2. Assisting the Service member in receiving prescribed medical treatment during care, recovery, and transition; and

3. Conducting periodic reviews of the Service member's medical status with the Service member or, with a manager's approval, a designated family member, if the Service member cannot participate.[27]

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

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

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

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

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

Background:

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

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

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

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

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

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

U.S. Special Operations Command (USSOCOM). The USSOCOM Care Coalition provides mentorship, advocacy, non-medical case management, and support through return to duty or transition to civilian life.[66] While all SOF RWs are eligible for Care Coalition support, entry into the Care Coalition Recovery Program (CCRP) is limited to those who are seriously or very seriously injured, require hospitalization for more than two weeks, and are not expected to return to duty within six months.[67] As of February 2012, Care Coalition was assisting 4,857 WII currently-serving and retired special operators and families,[68] while CCRP was serving 121 members.[69] Care Coalition partners with governmental and non-governmental agencies to optimize RWs' access to services—particularly cutting-edge care—and works closely with unit leadership to facilitate swift return of SOF members to duty, as appropriate, and improve SOF readiness.[70] It also serves as a liaison with, and complements, the Services' wounded warrior programs by advocating that standards be met or exceeded and by promoting equality of benefits across the Services.[71]

Topic: Services for posttraumatic stress disorder and traumatic brain injury

Background:

Posttraumatic stress disorder (PTSD) is "a psychological condition that affects those who have experienced a traumatizing or life-threatening event such as combat, natural disasters, serious accidents, or violent personal assaults."[72] The prevalence rates of PTSD among Service members and Veterans vary widely. The Institute of Medicine's (IOM) "Committee on the Assessment of Ongoing Efforts in the Treatment of Posttraumatic Stress Disorder" estimated the prevalence of PTSD to be between 13 and 20 percent.[73] The average prevalence rate among infantry, post-deployment, is approximately 15 percent.[74] Between 2000 and the spring of 2012, there were 104,703 new diagnoses of PTSD among deployed and non-deployed Service members.[75]

DoD defines traumatic brain injury (TBI) as the "traumatically induced structural injury or physiological disruption of brain function as a result of external force to the head."[76] According to the Defense and Veterans Brain Injury Center (DVBIC), there were more than 253,330 diagnosed cases of TBI at all severity levels across the Services from Fiscal Year (FY) 2000 through the second quarter of FY2012.[77] PTSD and TBI frequently co-occur and affect moods, thoughts, and behavior, "yet these wounds often go unrecognized and unacknowledged."[78] Mild TBI (mTBI), or concussion, is particularly difficult to diagnose because symptoms are not typically obvious.

DoD's National Intrepid Center of Excellence (NICoE), which opened June 2010 on the Walter Reed National Military Medical Center (WRNMMC) campus in Bethesda, Maryland, offers cutting-edge diagnosis, treatment, rehabilitation, and follow-up for warriors with PTSD, TBI, and related conditions.[79] Effective August 10, 2011, the NICoE was transferred from the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) to the Department of the Navy (DON) for further alignment under WRNMMC.[80]

Several provisions of the 2013 National Defense Authorization Act (NDAA) addressed psychological health and TBI. Section 706 of NDAA 2013 authorized the Secretary of Defense (SecDef) to conduct a pilot to improve research, treatment, education, and outreach on mental health (MH) and substance abuse.[81] Section 724 instructed the SecDef and the Secretary of the Department of Veterans Affairs (VA) to enter into a memorandum of understanding (MOU) to allow Service members returning from combat operations to participate in VA peer support counseling programs.[82] Section 725 instructed the SecDef to "provide for the translation of research on the diagnosis and treatment of mental health conditions into policy on medical practices," and it required a July 2013 report to Congress on translation of research to practice.[83] Section 726 of NDAA 2013 tasked the VA with developing and implementing measures to assess the timeliness, quality, capacity, availability, and provision of evidence based treatments, and patient satisfaction of VA mental health care.[84] This section also required the VA to develop staffing guidelines for providers of mental health care and to contract the National Academy of Sciences to study VA mental health care. Section 739 required the SecDef to

submit a plan to improve coordination and integration of DoD programs for psychological health and TBI to Congress by July 2013.[85] The report shall include identification of gaps in services, identification of unnecessary redundancies, a plan to mitigate the identified gaps and redundancies, and identification of the DoD official responsible for leading the plan.

Prevention and early intervention of PTSD. A wide variety of DoD- and Service-level resources and initiatives exist to facilitate PTSD prevention and early intervention. DoD offers free, confidential counseling through Military OneSource and the Military Family Life Consultants (MFLC) Program. The Army's Comprehensive Fitness Program (CFP) trains Soldiers to improve resilience, decrease stress, and promote success.[86] Battlemind is a training curriculum that facilitates transition from combat zone to "home zone" through expectations management.[87] The Army also has begun to embed behavioral health teams within its Brigade Combat Teams.[88] The Marine Corps and Navy Reserves have established Psychological Health Outreach Program (PHOP) teams that provide access to psychological health services to increase resilience and facilitate recovery.[89, 90] Cognitive Behavioral Therapy (CBT), combat exposure-based therapies, and psychological first aid are treatment methodologies found to be effective for early intervention and prevention of PTSD.[91] There is a push across DoD toward providing early intervention and care for PTSD in integrated mental health and primary care settings.[92, 93, 94]

Screening for PTSD. According to legislation and DoD policy, Service members are required to receive medical examinations including mental health assessments before deployment, as deployment concludes, and during post-deployment.[95, 96, 97] NDAA 2012 added to requirements for screening and diagnosis, specifying a timetable in Section 705,[98] and requiring feedback on research into the efficacy of neuroimaging as a diagnostic tool in section 723.[99]

Treatment of PTSD. Service members can access PTSD treatment and information through several mental health services, including the National Center for PTSD (NCPTSD), NICoE, DCoE for Psychological Health and Traumatic Brain Injury, as well as other sources. NCPTSD's mission is to advance the clinical care and social welfare of America's Veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders.[100] Treatment options include psychotherapy, medication, and/or complementary and alternative approaches, such as acupuncture, yoga, and herbal/dietary supplements. The most empirically supported treatment modalities for PTSD include cognitive therapies, specifically Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), and Stress Inoculation Training (SIT). Eye Movement Desensitization Reprocessing (EMDR) has also been shown to be an effective treatment modality.[101] A number of installations offer Intensive Outpatient Therapy (IOP) programs for PTSD (e.g., Fort Campbell and the Naval Medical Center-San Diego).[102] In regards to pharmacological treatments, the evidence base is strongest for selective serotonin reuptake inhibitors (SSRIs)[103] and serotonin norepinephrine reuptake inhibitors (SNRI).[104]

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

no cost to the Reservist, including PTSD care and training on suicide prevention and response.[105]

Screening and treatment of TBI. Section 722 of Public Law 111-383, NDAA 2011, required the SecDef to develop and implement a comprehensive policy on consistent neurological cognitive assessments of Service members before and after deployment no later than January 31, 2011.[106] TBI screening occurs in theatre, at Landstuhl Regional Medical Center (LRMC), during PDHA and PDHRA, and VA Medical Centers.[107]

The Military Acute Concussion Evaluation (MACE) tool helps to systematize the diagnosis of TBI.[108] DoD TBI treatment programs have been established throughout the continental United States (CONUS) and overseas.[109] Evidence-based treatment protocols have been tailored to treatment location (e.g., in-theatre, CONUS), acuity of condition (e.g., acute, sub-acute, chronic), and severity of condition (e.g., mild, moderate, severe, penetrating).[110] Directive-Type Memorandum (DTM) 09-033, "Policy Guidance for Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting," established guidance for the management of concussions in deployed settings. Signed into policy on June 21, 2011, DTM 09-033 establishes mandatory protocols for exposure, medical evaluation, rest requirements, and resumption of activities that involve a concussion risk.[111] DoDI 6490.11, "DoD Policy Guidance for Management of Mild TBI/Concussion in the Deployed Setting," signed September 18, 2012, incorporated and cancelled DTM 09-033.[112]

A comprehensive brain injury rehabilitation program may include: visual, vestibular, vocational, physical, and cognitive rehabilitation; specialty services; and psychological counseling.[113] The focus of cognitive rehabilitation is on specific cognitive deficits and the effects of these deficits on social, communication, behavioral, and vocational/academic performance.[114]

Section 724 of NDAA 2012 required the SecDef to report on how to identify, refer, and treat Operations Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Service members who served before the 50-meter from explosion criterion was established. Additionally, it required SecDef to report on the effectiveness of several newer policies, including managing concussion and mTBI in deployed settings, identifying and treating blast injuries (including the 50-meter criterion), and operational effectiveness in theatre.[115]

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

Background:

The Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury was established November 2007 under DoD's Military Health System (MHS).[116] In an effort to address concerns about management and oversight raised by the Government Accountability Office (GAO)[117] and consistent with the 2011 recommendation of the RWTF, the Secretary of the Army was named executive agent for the DCoE in DoD Directive 6000.17E, dated January 2, 2013[118]; complete transition is expected by October 2013.[119] DCoE serves as DoD's "open front door" for needs associated with psychological health (PH) and traumatic brain injury (TBI) experienced by our Service members. The DCoE currently comprises five directorates and three component centers: Defense and Veterans Brain Injury Center (DVBIC), Deployment Health Clinical Center (DHCC), and National Center for Telehealth and Technology (T2).[120]

Established by Congressional mandate, the mission of the DCoE is to "improve the lives of our Service Members, families, and Veterans by advancing excellence in PH and TBI prevention and care."[121] DCoE compiles and coordinates the work of scientific researchers, clinicians, and other health professionals—from DoD, the Department of Veterans Affairs (VA), and other federal agencies, academic institutions, state and local agencies, and the non-profit and private sectors—to expand the state of knowledge about PH and TBI. The DCoE endeavors to drive the translation of research to practice in the areas of PH, TBI, and suicide prevention; and ensures best practices and quality standards are continuously and consistently implemented throughout the continuum of care, regardless of a Service member's branch, component, or location. The DCoE Director is Captain Paul S. Hammer, MC, USN.

Among its many activities, DCoE and its component centers develop and train providers in new techniques and technologies in PH and TBI treatment; sponsor and conduct research studies on posttraumatic stress disorder (PTSD), TBI, and promising treatments; create and disseminate guidelines to military and civilian practitioners; develop outreach programs for military and veteran communities and the public; and establish mechanisms to coordinate local, state, and federal resources to eliminate gaps in care for patients in transition between DoD and VA.[122]

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

NDAA 2011 required the SecDef to review DoD policies and procedures regarding the use of pharmaceuticals in rehabilitation programs for seriously ill or injured Service members.[123]

In addition to the DCoE, Congress directed the establishment of three other centers: 1) the Vision Center of Excellence (VCE) mandated by NDAA 2008[124]; 2) the Hearing Center of Excellence (HCE) mandated by NDAA 2009; and 3) the Extremity Trauma and Amputation Center of Excellence (EACE), also mandated by NDAA 2009.[125] Like the DCoE, these Centers of Excellence share a common purpose of addressing blast injuries, described as the signature wounds of the wars in Afghanistan and Iraq.[126] All four Centers of Excellence currently receive guidance and direction from the recently established Military Health System Center of Excellence Oversight Board.[127]

Vision Center of Excellence (VCE). The mission of the VCE, headed by COL Donald A. Gagliano, MD, USA, is to "lead and advocate for programs and initiatives to improve vision health, optimize readiness, and enhance quality of life for Service members and Veterans."[128] The concept of operations was approved January 10, 2012, and the VCE is continuing to evolve initial operational capability.[129] The VCE has two locations: clinical headquarters at Walter Reed National Military Medical Center (WRNMMC) in Bethesda, Maryland; and administrative personnel in Crystal City, Virginia.[130, 131] The VCE has made it a priority to coordinate and collaborate with other Centers of Excellence, including HCE, DCoE, and National Intrepid Center of Excellence (NICoE), on the Joint Theatre Trauma Registry (JTTR) and VA Eye Injury Data Store.[132]

Hearing Center of Excellence (HCE). Headquartered at Joint Base San Antonio, Texas, and headed by interim Director Col(s) Mark D. Packer, MD, USAF, the HCE began initial operating capability in May 2011 by drafting its concept of operations. Today, the HCE is organized in five directorates: Prevention & Surveillance; Clinical Care, Rehabilitation & Restoration; Research; Global Outreach; and Informatics.[133] As of December 2011, five directorate chiefs were appointed, and "hub" support personnel were partnering with VCE to develop a registry able to capture clinical audiogram data. The HCE was continuing to implement a communications/prevention campaign, prioritize ongoing research, and produce clinical practice guidelines. Full operating capability, defined as a functional DoD/VA hearing data registry, was expected by December 2013, and plans called for a staff of 37 to be hired incrementally over five years.[134]

Section 704 of Public Law 111-383, NDAA 2011, mandated several actions relevant to the HCE. Under this mandate, the SecDef was to identify the best tests currently available to screen Service members for tinnitus, develop a plan to ensure all Service members are screened prior to and after deployment to a combat zone. NDAA 2011 also required the SecDef to examine methods to improve the aural protection for Service members in combat.[135]

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

the multidisciplinary network for continuous care and study of amputations and extremity injuries resulting from trauma, point of injury through definitive care and rehabilitation, into lifelong surveillance in order to reduce the disability and optimize the quality of life for Service Members and Veterans."[136] The EACE is in the early stages of establishment.[137, 138] As of February 2012, the EACE was directed by Mr. John Shero and the hiring of staff was ongoing.[139] The concept of operations and decision to headquarter the EACE in San Antonio, Texas, was approved by the Centers of Excellence Oversight Board in January 2012.[140]

Topic: Interagency Program Office

Background:

The Interagency Program Office (IPO) was established by Congress in Section 1635 of Public Law 110-181, the 2008 National Defense Authorization Act (NDAA).[141] Congress mandated DoD and the Department of Veterans Affairs (VA) to work together to:

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

The IPO was formed by DoD and VA April 17, 2008, and chartered by January 2009.[142] At that time, the permanent staffing structure included seven government service (GS) civilian positions from DoD and seven GS positions from VA, led by a DoD Director and a VA Deputy Director, both Senior Executive Service (SES) positions.[143] In April 2009, at the direction of the Senior Oversight Committee (SOC), the IPO charter was changed to include coordinating and overseeing the development of the Virtual Lifetime Electronic Record (VLER), which provides Veterans, Service members, their families, care-givers, and their service providers with a single source of information for health and benefits in a way that is secure, and is authorized by the Service member or Veteran.[144,145]

Since 2008, the IPO has received substantial scrutiny from Congress and the Government Accountability Office (GAO), which has issued a number of reports on the interoperability of DoD and VA health information systems and the IPO.[146, 147, 148, 149, 150] NDAA 2011 required the Secretary of Defense to assess and report on existing health information technology systems and future plans for legacy systems and new electronic health record initiatives, including IPO's role.[151]

Although significant data sharing has existed between DoD and VA for years, the Departments had been taking separate paths to replace their existing legacy Electronic Health Record (EHR) systems: DoD's AHLTA (Armed Forces Health Longitudinal Technology Application) and VA's VISTA (Veterans Health Information Systems and Technology Architecture).[152] Starting March 2011, the Department Secretaries committed to jointly developing and implementing the next generation of EHR capabilities. The IPO has organized teams comprised of clinicians from both departments to define individual EHR (iEHR) capabilities and processes, and is communicating with private health care providers pioneering the exchange of information through VLER. In October 2011, the Department Deputy Secretaries signed a new IPO charter giving more authority to the joint program office and making the IPO the single point of accountability for the iEHR.[153]

The iEHR will enable DoD and VA to align resources and investments with business needs and programs to implement a common EHR platform. This single system will enable sharing of health care information to allow both departments to track medical care from the time an individual joins the military until they become a Veteran and through the rest of their lives.[154]

The common platform will be developed using the following sequentially ordered business rules:[155]

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

In addition, the Department Secretaries agreed to implement a high-level governance structure that includes the IPO, whose Director serves as the Program Executive, and an IPO Advisory Board.[156] In essence, the IPO serves as the single point of accountability for the Departments in the development and implementation of the iEHR, and coordinates with the existing DoD/VA Joint Executive Council to integrate capability, functional requirements, and business process re-engineering (BPR). Mr. Barclay Butler assumed the position of Director of the IPO February 27, 2012. As of that date, a staff of approximately 100 personnel was anticipated, with half from DoD and half from VA.[157]

In February 2012, the IPO indicated that, while it aggressively pursues the development and phased implementation of the iEHR, other initiatives of the IPO would continue uninterrupted. This includes the demonstration project underway at the North Chicago DoD/VA medical facility—an interagency collaboration leveraging interoperable legacy electronic DoD and VA health records that "speak to one another."[158] Section 1098 of NDAA 2011 required ongoing review of the North Chicago pilot by the Comptroller General in July of 2011, 2013, and 2015.[159]

Topic: Wounded warrior information resources

Background:

National Resource Directory (www.nationalresourcedirectory.gov). One of four cornerstones of the Recovery Coordination Program (RCP) established through the Senior Oversight Committee (SOC),[160] the National Resource Directory is a joint venture of DoD, the Department of Labor (DOL), and the Department of Veterans Affairs (VA). It is an online partnership "connecting Wounded Warriors, Service Members, Veterans, their families and caregivers with those who support them."[161] The directory provides access to national, state, and local governmental and non-governmental services and resources for recovery, rehabilitation, and reintegration.[162] Major topic areas include benefits and compensation, education and training, employment, family and caregiver support, health, homeless assistance, housing, transportation and travel, volunteer opportunities, and other services and resources.[163] In November 2011, the National Resource Directory added a tab with access to the new Veterans Job Bank, an online tool that allows veterans to search for jobs by their military skills and zip code.[164] The National Resource Directory web page also provides the phone number to access the Wounded Warrior Resource Center/Military OneSource.[165]

Wounded Warrior Resource Center (800-342-9647 or wwrc@militaryonesource.com). A companion to the National Resource Directory, this initiative provides "wounded warriors, their families, and their primary caregivers with a single point of contact for assistance with reporting deficiencies in covered military facilities, obtaining healthcare services, receiving benefits information, and any other difficulties encountered while supporting wounded warriors."[166] It is staffed 24/7 by Wounded Warrior specialty consultants who are Master's level professionals with specialties in the social sciences.[167] It is accessible at 800-342-9647 or via email at wwrc@militaryonesource.com.[168] (Previously, there was also a Wounded Warrior Resource Center website,[169] but this has been replaced by the National Resource Directory website.[170]) Specialty consultants work with the Services' wounded warrior programs and the VA in order to make referrals to help address callers' needs.[171] Individuals can learn about this resource through Military OneSource staff, briefings, or webinars.[172] Within 24 hours following each call, a consultant must reach out to the Services and/or VA, and within 96 hours, the Services and/or VA must release a plan of action.[173]

Military OneSource (www.militaryonesource.com or 800-342-9647). Military OneSource is an all-purpose portal for Active and Reserve Component Service members, spouses, families, and service providers, through which DoD's Office of Military Community and Family Policy (MC&FP) disseminates information to the military community.[174] Military OneSource is staffed 24/7 by Master's level professionals.[175] The Military OneSource Wounded Warrior tab provides a link to the National Resource Directory and the phone number for the Wounded Warrior Resource Center/Military OneSource.[176]

The "Keeping It All Together" binder from Military OneSource consolidates information across a range of websites, hotlines, and programs.[177, 178] It is a valuable tool for family members, filling an identified need for a "one-stop" information resource.[179, 180] The Marine Corps Wounded Warrior Regiment (WWR) has had particular success customizing and distributing the binder to families.[181, 182]

Family Assistance Centers. The Army has established Soldier and Family Assistance Centers (SFACs) at all medical treatment facilities (MTFs) with Warrior Transition Units (WTUs) to facilitate family and Soldier access to information and resources.[183] Army SFACs offer a wide variety of services, including information and referral; human resources/military benefits; education counseling; financial counseling/Army Emergency Relief; social services; outreach services; transition support; child, youth, and school services; and computer rooms.[184, 185] As of February 2011, the Army had 32 SFACs (29 locations within the continental U.S. (CONUS) and three major locations outside of CONUS).[186] As of July 2011, six of 18 CONUS SFAC construction locations were open and operating in centrally located, campus-like RW settings.[187, 188], and 12 more new construction projects were underway or in the planning stages.[189, 190] Also as of July 2011, SFACs employed an Army-wide staff of over 200.[191] Sister Services and Army Reserve Component sites provide information to RWs and their families but do not have dedicated site-level facilities for them.[192]

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

- Army Wounded Soldier and Family Hotline (800-984-8523) is designed to allow Soldiers and their families to seek information and share concerns about medical care. Concerns can also be shared anonymously through the website: http://www.armymedicine.army.mil/wsfh/index.html[193]

- Marine Corps Sergeant Merlin German Wounded Warrior Call Center (877-487-6299) is for wounded Marines, their families, and eligible Sailors, and is also used for outreach.[194]

- Navy Safe Harbor established the Navy Wounded Warrior Call Center (NWCC) as of October 2012. Safe Harbor staff indicated the NWCC was established because most calls received through Military OneSource required Service-specific consultation and follow up.[195]

The Air Force wounded warrior website provides key links and telephone numbers.[196] However, Air Force Warrior and Survivor Care does not operate a hotline for RWs.[197]

Topic: Support for family caregivers

Background:

The financial burden experienced by caregivers and families has been well documented.[198,199,200] Several pieces of legislation have been written to address this burden and to support caregivers as they, in turn, support their Recovering Warriors (RWs).

Special compensation for members of the uniformed Services with catastrophic injuries or illnesses requiring assistance in everyday living. Catastrophic injury or illness is defined as "a permanent, severely disabling injury, disorder, or illness that the Secretary [of the military Service] … determines compromises the ability of the afflicted person to carry out the activities of daily living to such a degree that the person requires personal or mechanical assistance to leave home or bed, or constant supervision to avoid physical harm to self or others."[201] Section 603 of Public Law 111-84, the 2010 National Defense Authorization Act (NDAA),[202] amends federal law[203] to authorize monthly compensation to RWs to pay for aid and attendance care without which they would require hospitalization, nursing home care, or other residential institutional care. Eligibility expires on the earliest of the following dates: after a 90-day period following the date of separation or retirement; when a Service member dies or is determined to no longer be afflicted with the catastrophic injury or illness; or when the Service member begins receiving comparable veteran's compensation under Title 38.[204] Section 634 of Public Law 111-383, NDAA 2011, changed the basis for determining the amount of special compensation paid to Service members from the Department of Veterans Affairs (VA), Veterans Administration Schedule for Rating Disabilities (VASRD) to personal caregiver stipends established under 38 United States Code (U.S.C.) Section 1720G. [205]

On August 31, 2011, this law was promulgated through the publication of DoD Instruction (DoDI) 1341.12 "Special Compensation for Assistance with Activities of Daily Living (SCAADL)." SCAADL pays Service members for the time and assistance their caregivers provide them at home.[206] In order to be eligible for this stipend, a Service member must have a catastrophic illness or injury incurred in the line of duty and must be certified by a licensed physician as 1) requiring assistance from another person in order to perform activities of daily living and 2) requiring some form of institutional care if such assistance was not available.[207] As of January 31, 2012, the Army had received 258 applications and 231 individuals were receiving the stipend,[208] the Air Force had received 11 applications and 10 individuals were receiving the stipend,[209] the Navy had received 24 applications and 20 individuals were receiving the stipend,[210] and the Marine Corps had processed 194 applications and 178 were rated for benefits.[211] DoDI 1341.12 was updated May 24, 2012, to remove the requirement that the Service member be homebound.[212]

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

individuals other than family members chosen by the Service member.[213] Eligible Service members may be hospitalized due to combat injury or other serious illness or injury.[214] This requirement is implemented in the current Joint Federal Travel Regulation (JFTR).[215]

Authorized travel and transportation allowances for non-medical attendants for very seriously and seriously wounded, ill, or injured members. A qualified non-medical attendant (NMA) is defined as a person whose presence, in the judgment of the attending physician or surgeon and commander or head of the military medical facility, "may contribute to the health and welfare of the [Service] member" while hospitalized for treatment of the wound, illness, or injury or during continuing outpatient treatment.[216] Section 633 of NDAA 2010 amended federal law by authorizing round-trip transportation for NMAs between their home and the location at which the member is receiving treatment, as well as additional transportation while accompanying the member for further treatment.[217] NMAs are also authorized a per diem allowance or reimbursement for actual and necessary travel expenses.[218] This requirement is implemented in the current JFTR.[219]

Respite care for seriously ill or injured active duty members. Respite care is defined as "short-term care for a patient to provide rest and change for the primary caregivers who have been caring for the patient at home," to include assisting the Service member with activities of daily living (e.g., dressing, feeding, hygiene)[220] and respite care for seriously ill or injured active duty members is currently available through DoD. [221] Respite care is available if the Service member's care includes more than two "interventions during the eight-hour period per day that the primary caregiver would normally be sleeping."[222] Respite care is limited to eight hours per day, five days per week, and must be provided by a TRICARE-authorized home health agency.[223] Federal law authorizing respite for TRICARE ECHO participants—family members of Service members—was amended to allow this benefit for Service members.[224]

VA support for caregivers of RWs. On May 5, 2010, the President signed Public Law No. 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010.[225] The law expanded VA support for family caregivers of active duty (i.e., still serving) RWs.[226] Sections 101 through 104 provided for a program of comprehensive assistance, including: 1) instruction, preparation, and training in providing personal care services; 2) ongoing technical support; 3) counseling; 4) lodging and subsistence; 5) mental health services; 6) respite care of not less than 30 days annually, including 24-hours per day; 7) medical care; and 8) a monthly stipend.[227] The VA launched this comprehensive caregiver program in May 2011 and began the first care-giving training in June 2011.[228]

When the program began, it was projected that caregivers would receive an average of $1,600 per month.[229] The total amount of the stipend is calculated based on the Veteran's condition, the amount of care the Veteran requires, and where the Veteran lives.[230] Under the program of comprehensive assistance, caregivers must complete caregiver training developed by Easter Seals in collaboration with the VA.[231] As of January 10, 2012, 4,575 applications had been filed with 2,671 approved, 692 disapproved, 449 withdrawn, and 763 still in process.[232]

Inclusion in pre-separation counseling. Section 529 of Public Law 112-81, NDAA 2012, authorizes the inclusion of a spouse in portions of pre-separation counseling and added more content areas to that counseling.[233] Pre-separation counseling is required for transitioning Service members (see also information paper on the *Transition Assistance Program*).[234]

Topic: Legal support

Background:

Directive-Type Memorandum (DTM) 11-015, "Integrated Disability Evaluation System (IDES)," issued guidance for providing legal support during the IDES process.[235] Each Service branch is required to provide uniformed or civilian legal counsel at no cost to the Service member.[236] In addition, each Service branch was required to establish procedures to inform Service members—upon referral to the IDES—of available government legal counsel and the alternative options of retaining private counsel at their own expense or using the services of a representative of a service organization recognized by the Department of Veterans Affairs (VA).[237]

The Services historically assign attorneys to Physical Evaluation Board (PEB) locations where they offer legal counsel and representation to Service members undergoing formal PEB (FPEB) hearings. The Army has more than 15 Soldiers' Counsel—mostly mobilized Reservists on one-year tours—assigned to support three PEB sites in the continental United States (CONUS), and, to provide legal support for overseas FPEBs via video teleconference.[238] The Navy provides legal support for the FPEB process at the Navy Yard in Washington, DC, which is the sole PEB site for Sailors and Marines.[239] The Air Force provides legal support for the FPEB process at Lackland Air Force Base, which is the sole PEB site for Airmen.[240] Apart from their consistent support for FPEB hearings, the Services vary in their legal support to WII Service members in the disability evaluation system, including the legal resources the Services have allocated and where these resources are housed organizationally. In addition, the Services vary in how early in the process they seek to engage Service members.

Army. In 2008, the Army initiated the Soldiers' MEB Counsel (SMEBC) program to introduce legal support earlier in the disability evaluation process.[241] SMEBC teams also assist severely injured Soldiers receiving care at VA polytrauma centers.[242] In late 2011, the Army authorized the hiring of additional SMEBC attorney/paralegal teams, in order to increase the total number of SMEBC teams Army-wide.[243] As of November 2012, the Army had more than 40 SMEBC teams—mostly permanent civilian employees—at Army locations worldwide.[244]

The SMEBC teams are available to educate and advise WII Soldiers one-on-one before and during the MEB process, and to help them formulate—and optimize the likelihood of attaining—their goals.[245] SMEBC teams also prepare MEB appeals, requests for impartial provider reviews, requests for reconsideration, requests for formal hearings, and requests for rating reconsiderations.[246] In addition, SMEBC teams conduct regular outreach briefings at Warrior Transition Units (WTUs), Soldier and Family Assistance Centers (SFACs), MEB in-processing briefings, and town hall meetings, and they coordinate with PEB Liaison Officers (PEBLOs).[247] WII Soldiers should be referred to the servicing SMEBC office for an informational briefing on the DES and their rights in the process within 14 days of initiation of the MEB process.[248]

Navy. The Navy has designed a program specifically to address the legal needs of WII shipmates.[249] As of February 2012, the Navy DES Outreach Attorney Program was staffed with 12 civilian attorneys, including a Program Manager, who provide legal counsel to Sailors and Marines as they navigate the DES process.[250] The Program is expanding an outreach campaign that will ensure that those Sailors and Marines pending review by the PEB are made aware of, and have access to, Navy DES Outreach Attorney Program services at the earliest opportunity, including the limited duty and referral phases.[251] The early use of Outreach Attorney services will help ensure that the most complete and accurate medical information is submitted to the PEB, assisting in expediting Sailors and Marines through the DES process.[252] The Program also seeks to bridge the transition between the informal and formal PEB phases (IPEB and FPEB, respectively) of the DES process, allowing for an efficient overall evolution that instills confidence in Service members and their families.[253] Navy DES Outreach Attorneys are located at the major medical treatment facilities (MTFs) that process Navy and Marine Corps DES cases.[254] In November 2012, the Navy reported a total of 19 Navy Informal PEB (IPEB) disability attorneys, including six Marine Corps assets, were assigned to provide legal advice and assistance to Service members at Navy medical treatment facilities (MTFs).[255]

Marine Corps. The Marine Corps provides legal counsel to assist and advise Marines and Sailors as soon as they are referred to the MEB.[256] As of January 2012, the Marine Corps had mobilized six Reserve judge advocates within the Wounded Warrior Regiment and Judge Advocate Division who provide legal support on the East and West coasts, as well as at Quantico, Virginia, and Bethesda, Maryland.[257] The Program Manager, one of the six mobilized Reservists, is located at Marine Corps Headquarters.[258] In addition, two Reserve judge advocates were mobilized to provide legal support for the FPEB process at the Navy Yard in Washington, DC.[259] The Judge Advocate Division was evaluating future use of active duty judge advocates.[260] As of November 2012, the Marine Corps' IPEB counsel staffing continued to consist of six Reserve judge advocates.[261]

Air Force. The Air Force provides disability evaluation legal support through the Office of Airmen's Counsel (OAC), at Lackland AFB, Texas.[262] Formerly under the Air Force Personnel Center, this program was moved to the Air Force Trial Defense Division in April 2011 to best serve the interests of Recovering Airmen.[263]

In August 2011, the Air Force began supplementing its staffing with Reserve support of three attorneys and two paralegals.[264] As of December 2011, the Air Force had six attorneys and three paralegals providing Airmen legal support after the IPEB decision and, on a space available basis, during the IPEB and MEB stages.[265] In January 2012, the Air Force planned to increase OAC staffing, with the help of newly authorized active duty positions, to 13 attorneys and 10 paralegals.[266] The expanded staff will enable OAC to provide legal support at the MEB, IPEB, FPEB, and appellate stages of the DES conduct outreach briefings, and provide educational support to affiliated service providers, such as PEBLOs, Military Service Coordinators (MSCs), and Transition Assistance Program (TAP) and family support personnel.[267]

Topic: Vocational Services

Background:

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

The VA Vocational Rehabilitation and Employment (VR&E) Program. The VR&E program can include free tuition at any institution of higher learning or vocational training where the Veteran is accepted, academic counseling, special tutoring if needed, dental care, job referrals, job placement, and other benefits.[268] VR&E is available to Veterans with a combined disability rating of 20 percent or more and to some Service members awaiting discharge.[269, 270] Access to VR&E for active duty Service members was mandated by NDAA 2011 which had a sunset provision ending their access by December 31, 2012.[271] The VOW to Hire Heroes Act of 2011 extended this sunset provision by an additional two years, until December 31, 2014.[272] In Fiscal Year (FY) 2012, VR&E began placing its counselors at all Integrated Disability Evaluation System (IDES) sites; at these sites, Service members referred to the Physical Evaluation Board (PEB) were mandated to meet with a VR&E counselor for information, evaluation, and to begin VR&E services where appropriate.[273]

DoD Operation Warfighter (OWF) Program. OWF is a federal internship program for RWs that strives to place RWs in work experiences that support recuperation.[274] The program provides RWs an opportunity to build their resumes, explore federal employment, develop job skills, and gain valuable federal government work experience.[275] While there is no promise of permanent employment with a federal agency upon completion of the OWF assignment, the program helps federal agencies experience the talent and skills of transitioning Service members. Many employers participating in the OWF program hire transitioning Service members; of the more than 2,000 RWs placed in OWF internships, 350 transitioned into federal employment.[276]

Additional Initiatives. Vocational services are often included in the annual National Defense Authorization Acts (NDAA), to pilot new services, or expand availability of existing services.[277, 278] Many of these provisions target the needs of all Service members rather than RWs specifically. For example, Section 551 of NDAA 2012 allows the Secretaries of the Services to offer job skills training programs, including apprenticeships, for Service members preparing to transition to civilian employment and civilian life.[279] For RWs, this means internship opportunities beyond the federal sector. Section 555 of NDAA 2012 allowed the Secretary of the Air Force to permit certain post-9/11 RWs to enroll in degree programs of the Community College of the Air Force.[280]

Topic: Disability Evaluation System

Background:

Under the Legacy Disability Evaluation System (LDES), Service members are separately evaluated by DoD to determine fitness for duty and compensation for injury or disease incurred in the line of duty that inhibits a Service member's ability to perform the duties of her or his office, grade, rank, or rating.[281, 282] In LDES, the Department of Veterans Affairs (VA) evaluates the Service member separately to determine VA benefits, factoring in "all disabilities incurred or aggravated during military service" warranting a disability rating of 10 percent or higher.[283, 284, 285] This difference in what was considered by DoD and VA evaluations accounted for differences in ratings that transitioning Service members received from DoD and VA. Implementation of a new process has been underway since at least 2002 to address these discrepancies and other shortcomings in the Disability Evaluation System (DES).[286, 287]

The Senior Oversight Committee (SOC) called for pilot testing of an Integrated Disability Evaluation System (IDES) in 2007 as an alternative to the LDES; pilots began November 2007[288] at three military installations, and Congress included the pilots in the 2008 National Defense Authorization Act (NDAA).[289] The pilots were intended to provide a singular evaluation—using VA protocols and rating—in lieu of the separate DoD and VA evaluations. Specifically, the SOC called for increased consistency in ratings for Service members and veterans, protecting appellate procedures, ensuring direct hand-off from DoD case managers to VA case managers when a Service member transitions, and a reduction in the time from referral to DES to receipt of VA benefits.[290] At the direction of the SOC co-chairs, IDES was expanded worldwide.[291] Full DoD-wide implementation—replacing LDES—was achieved by the end of September 2011.[292] In December 2011, DoD published the first comprehensive Directive-Type Memorandum (DTM) 11-015, "Integrated Disability Evaluation System."[293] This DTM compiled numerous previous letters and guidelines published by the SOC and established in work groups. [294] This is the first comprehensive policy document on the DES since DoD Directive 1332.18, "Separation or Retirement for Physical Disability," in 1996.[295] DTM 1332.18 was reauthorized May 3, 2012, with an expiration date of January 1, 2013.[296]

The IDES features a single set of disability medical examinations designed for determining both fitness and ability to return to duty, and disability. Evaluation of a Service members' fitness for duty by DoD runs concurrently with VA determination of a disability rating, and has led to a streamlined process that reduces the amount of time it takes for Recovering Warriors (RWs) to receive benefits.[297] While the Physical Evaluation Board Liaison Officer (PEBLO) is assigned to assist the Service member through the process in both LDES and IDES, the assistance of a Military Service Coordinator (MSC) is a new support available in IDES. [298] Legal support related to DES is also available (see also information paper on *legal support*).

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

the Defense Manpower Data Center. The IDES population continues to grow and, as of October 2012, the average number of days to completion was 375 as compared to the goal of 295 and the average of 355 days for the previous month.[299]

Several sections of Public Law 111-383, NDAA 2011, addressed disability benefits and the disability process, including Sections 533, 534, 631, 632, and 633. Section 533 introduced a modification of the PEB process, expanding the rights of Service members by broadening the criteria for those eligible to request a review of their retirement or separation without pay for physical disability—this eligibility was formerly restricted to officers.[300] In an additional step, Section 534 prohibited a Service branch from authorizing an involuntary administrative separation of a Service member because of that member's unsuitability for deployment or worldwide assignment, when the unsuitability is because of a medical condition already assessed by a PEB.[301] Sections 631, 632, and 633 modified the criteria for calculating disability retirement pay. Section 631 allowed benefits to exceed the 75 percent cap on disability retirement for members who served on active duty for more than 30 years while retaining the retired pay multiplier based on years of service.[302] Section 632 specified that disability pay will be paid on the first day of each month, beginning after the month in which the right to such pay accrues.[303] Section 633 amended the method by which eligibility for receiving retired pay is calculated for Reserve Component (RC) Service members; the new method awards credit for time receiving medical care to be counted toward years of service.[304]

NDAA 2012 introduced additional provisions regarding disability evaluations. Section 527 prohibited Services from administratively separating a Service member based on medical conditions for which s/he was found fit for duty by a PEB.[305] Section 596 required the Secretary of Defense (SecDef) to report on the feasibility and advisability of an expedited disability determination process for RWs with certain specific diseases or conditions.[306] According to WCP, an expedited DES process is available for the most severely wounded, ill, or injured, but very few take advantage of it.[307]

NDAA 2013 also contained provisions related to IDES. Section 518 expands authority to conduct pre-separation medical exams for PTSD to licensed clinical social workers and psychiatric advanced practice registered nurses.[308] Section 524 instructs the Secretary of Defense to standardize, assess, and monitor the Services' quality assurance programs for MEBs, PEBs, and PEBLOs to ensure accuracy, consistency, and regular monitoring.[309]

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

Background:

Section 502 of Public Law 101-510, the 1991 National Defense Authorization Act (NDAA), as codified in 10 USC §1141-1143 and 1144-1150, authorized comprehensive transition assistance benefits and services for military personnel and their spouses separating or retiring from the Armed Forces within the last 180 days of service and beginning no fewer than 90 days prior to separation.[310, 311, 312] The transition assistance program (TAP) is a mutual responsibility of DoD, the Department of Labor (DOL), the Department of Veterans Affairs (VA), and the Department of Homeland Security (DHS), representing the Coast Guard).[313, 314]

The Veterans Opportunity to Work (VOW) to Hire Heroes Act, enacted November 21, 2011, made TAP mandatory for all eligible Service members, exempting only those the Secretaries of DoD and DHS, in consultation with DOL and VA, determined would not benefit because they "are unlikely to face major readjustment, health care, employment, or other challenges associated with the transition to civilian life" and those whose specialized skills are needed to support a deploying unit.[315]

Directive-Type Memorandum (DTM) 12-007, issued on November 21, 2012, implements the redesigned TAP in accordance with Section 221 of Public Law 112-56, the VOW to Hire Heroes Act of 2011. [316] According to the DTM, TAP consists of mandatory pre-separation counseling and the newly created Transition Goals, Plans, and Success (GPS). [317] The redesign of TAP was led by an interagency team with representatives from DoD, DHS, DOL, VA, and the Department of Education (ED), with the Office of Personnel and Management (OPM) and the Small Business Administration (SBA).[318] Transition GPS consists of a core curriculum, tracks (additional curriculum components designed to prepare Service members to transition into education, technical training, or entrepreneurship), and a mandatory capstone. [319] The DOL employment workshop and VA benefits briefing that were part of the legacy TAP are now mandatory components of the Transition GPS core curriculum, though the DTM does allow some exemptions to participation in the DOL workshop.[320] Other components of the core curriculum (transition overview, military occupation code crosswalk, resilient transitions, financial planning, and individual transition plan review) are not mandatory.[321] Rollout of Transition GPS to all military installations is expected to be complete by the end of 2013.[322, 323]

The scope of Transition GPS encompasses all Active Component (AC) separations and retirements and all Reserve Component (RC) deactivations.[324] DTM 12-007 indicates eligible Service members may begin the transition process up to 12 months prior to separation for those who are not retiring and, in the case of Service members anticipating retirement, 24 months prior to retirement.[325] Specifically, the DTM indicates pre-separation counseling should begin "as soon as possible during the 12-month period before separation," and that the capstone should be completed no later than 90 days before separation.[326] Prior to release from active

duty, demobilizing Reserve Component (RC) Service members are encouraged to "begin pre-separation counseling as soon as possible within their remaining period of service."[327]

For those without easy access to an installation's Transition Assistance Office, DoD established a TAP web portal—www.TurboTAP.org—that provides a series of resources.[328] These resources include guidebooks and checklists, materials for transitioning personnel to help prepare for mandatory counseling, resources for TAP counselors and state transition assistance providers, links to partner websites, and other tools and information to help facilitate successful transition. The "Pre-separation Guide – Active Component" and "Transition Guide – Reserve Component" are available through TurboTAP.[329] Changes to TurboTAP will take place as part of the rollout of Transition GPS.[330]

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

Background:

As early as 2002, Congress recognized the need for health care collaboration between DoD and the Department of Veterans Affairs (VA). To foster such collaboration, Congress established the Joint Executive Council (JEC), which "provides senior leadership for collaboration and resource sharing between VA and DoD."[331] Federal law describes the purpose of the JEC as follows:

"The Secretary of Veterans Affairs and the Secretary of Defense shall enter into agreements and contracts for the mutually beneficial coordination, use, or exchange of use of the health care resources of the Department of Veterans Affairs and the Department of Defense with the goal of improving the access to, and quality and cost effectiveness of, the health care provided by the Veterans Health Administration and the Military Health System to the beneficiaries of both Departments."[332]

The JEC's charter encompasses four areas: 1) overseeing development and implementation of the VA/DoD Joint Strategic Plan (JSP); 2) overseeing the Health Executive Council (HEC), the Benefits Executive Council (BEC), and Interagency Program Office (IPO); 3) identifying opportunities to enhance mutually beneficial services and resources; and 4) submitting an annual report to Department Secretaries and Congress, including progress on the JSP.[333, 334] The JEC laid a foundation of interagency collaboration which was furthered through the creation of the Senior Oversight Committee (SOC) for the Wounded, Ill, and Injured (WII) by Congress as part of the 2008 National Defense Authorization Act (NDAA). The SOC consisted of a team of senior DoD and VA officials co-chaired by the respective Deputy Secretaries. In early 2012, and consistent with the 2011 recommendation by the Recovering Warrior Task Force (RWTF), the SOC was folded into the JEC becoming the Wounded, Ill, and Injured Committee (WIIC) (see RWTF Reference Handbooks from Fiscal Years 2011 and 2012 for more information on the SOC). Subsequent JEC meetings have included review of the VA/DoD Warrior Care and Coordination Task Force and other Recovering Warrior (RW) matters.[335]

JEC's Fiscal Year (FY) 2011 Annual Report summarizes JEC accomplishments under three goal areas.[336] Below is a sampling of accomplishments related to RWs, many of which are also under the purview of federal entities other than the JEC.

- Goal 1: Benefits and Services

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

2. A Wounded Warrior Care Coordination Summit was held on March 28-31, 2011, "to determine high priority wounded warrior issues and best practices to identify actionable recommendations to be worked by four chartered working groups."

3. A total of 75 Recovery Care Coordinators were trained across the services (including Special Operations Command); as well as nine Non-Medical Case Managers and 20 other participants from various Service Wounded Warrior Programs.

4. National Resource Directory (NRD) unique visitors increased from less than 50,000 per month in August 2010 to more than 150,000 per month in September 2011. By the end of FY 2011, the NRD averaged more than 4,900 hits per day. Additionally, the number of resources on the NRD grew from 12,000 to nearly 14,000.

5. The Federal Recovery Coordination Program (FRCP) successfully ensured that all referrals to the program were evaluated and assigned appropriately. In cases where it was not appropriate for an individual to be enrolled in FRCP, the evaluation process identified and facilitated access to that service or benefit. The FRCP program also met its goal of 100 percent participation in targeted educational activities for the FRCs.

6. VA worked with DoD at all levels to ensure program integration between their complementary care coordination programs. Twice DoD and VA jointly participated in hearings with the United States House of Representatives, Veterans Affairs Committee in order to discuss the importance of the FRCP and the Recovery Coordination Program and how the programs complement each other.

- Goal 2: Health Care

1. VA and DoD continued ongoing work to develop consistent standards for training in Evidence- Based Psychotherapy (EBP) for psychological health (PH) conditions. The Departments are working to consistently increase the availability of effective treatments for posttraumatic stress disorder (PTSD), major depression, and other PH conditions.

- Goal 3: Efficiency of Operations

1. Building upon the success of the Disability Evaluation System (DES) Pilot, particularly the ability to rapidly and effectively assist a larger number of Service members and their families, VA and DoD achieved their goal of extending the Integrated Disability Evaluation System (IDES) to 100 percent of Service members.

2. Registered user accounts of the eBenefits portal increased by 500 percent from FY 2010 to FY 2011. The increase in registered eBenefits users suggests that VA/DoD outreach efforts were successful.

3. The Departments launched the first survey mechanism to specifically gather input regarding the VA portion of the Transition Assistance Program (TAP). The surveys will be used for recording attendance and for the continued improvement of TAP.

4. The Departments worked cooperatively to develop a common Integrated Electronic Health Record (iEHR), including designing a governance structure consisting of a Program Executive and an Interagency Program Office (IPO) Advisory Board.

5. The Departments continued to demonstrate their shared commitment to the Virtual Lifetime Electronic Record (VLER) Initiative, enabling access to individuals' information in databases produced by VA, DoD, other federal and state agencies, and private sector partners.

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

Topic: Other matters: Resources for Reserve Component

Background:

The Reserve Components (RC) of each Service branch—Army Reserve (USAR), Air Force Reserve, Navy Reserve, Marine Corps Reserve, Coast Guard Reserve, Army National Guard (ARNG), and Air National Guard (ANG)—total nearly 1.1 million Service members.[337] Members of the Ready Reserve comprise 29 percent of the military force. [338] The ARNG and USAR have deployed more than 475,000 Soldiers—many Soldiers have been deployed more than once—in support of Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND).[339] The Services are required to "ensure their Recovery Coordination Programs (RCPs) are extended to include Recovering Service members (RSMs) in their RCs and incorporate all program services, to include identifying RSMs, assigning RSMs to Recovery Care Coordinators (RCCs), and preparing recovery plans."[340] The Services' wounded warrior programs do not differentiate between Active Component (AC) members and activated Reservists (see also information paper on *wounded warrior units and programs*).[341] However, certain resources are unique to the RC as a whole and to specific RCs.

Army Community-Based Warrior Transition Units (CBWTUs). CBWTUs allow qualified ARNG and USAR Reservists to recover in their home communities. As of March 2012, 56 percent of the 9,718 Soldiers assigned to WTUs/CBWTUs were ARNG or USAR Soldiers, and 23 percent of the 9,718 were managed by a CBWTU.[342]

USAR RCCs. As of February 2012, 19 RCCs, trained by DoD, are located in high-density areas throughout the USAR. The USAR RCC program does not support ARNG Soldiers.[343, 344]

National Guard Bureau (NGB) Transition Assistance Advisor (TAA) Program. NGB TAA serves all redeploying or separating RC members, injured or not. TAAs are in each of the 50 states and four territories, co-located with the state Adjutants General and working with the Department of Veterans Affairs (VA) sectors and the CBWTUs.[345] TAAs assist RC members and families with reintegration into the unit or transition to civilian life by establishing one-on-one contact and educating them on federal, state, local, and community benefits and entitlements. TAAs partner extensively with entities such as the Joint Family Support Assistance Program (JFSAP), Employer Support of the Guard and Reserve (ESGR), Psychological Health (PH), Yellow Ribbon Reintegration Program (YRRP), CBWTUs, job assistance programs, veterans service organizations (VSOs), and others.[346] As of December 2012, there were 65 contracted TAAs and a handful of TAAs working as state employees or in Active Duty for Operational Support (ADOS) status. TAAs carry caseloads of approximately 1:64 for wounded, ill, or injured (WII) members and 1:6020 for all separating/returning members.[347] While TAAs serve all RC members, and even some AC members, ARNG members comprise their largest clientele.[348]

ARNG. The ARNG has taken several steps to address gaps in RC medical care, and the management of Soldiers who are not medically ready for deployment. One such step was creating a process for Soldiers with low risk-low acuity conditions, who were injured or became ill during mobilization or training, to return to active duty on short-term orders to resolve those duty-related limiting conditions. The Reserve Component Managed Care (RCMC) Pilot Program included 14 states (12 actively involved) from the ARNG with a formal application process for putting eligible Soldiers on active duty orders for up to 179 days. Soldiers participating in this program were managed through the Medical Management Processing System (MMPS). MMPS systematically monitors, manages, and facilitates authorized medical care for Soldiers who are medically non-available for deployment and focuses on facilitating a final disposition of their medical condition. MMPS utilizes many of the full-time medical staff that the ARNG has brought on board over the past 10 years to assist in building and maintaining medical readiness. Overseen by the Deputy State Surgeon, the staff that support the MMPS include case managers, care coordinators and medical readiness non-commissioned officers (NCOs). The RCMC pilot expired August 2012; as of December 2012, the National Guard Bureau was awaiting Army Headquarters approval for full implementation of the RCMC Program across the ARNG.[349]

Another recent initiative was the implementation of the RC Soldier Medical Support Center (SMSC). Established in Pinellas Park, Florida, in January 2011 and staffed by USAR and ARNG Soldiers, it was conceived as a short-term solution to facilitate the screening of the backlog of RC Medical Evaluation Board (MEB) packets, and a gateway for RC Integrated Disability Evaluation System (IDES) medical processing support. The RC SMSC screens RC MEB packets for accuracy/completeness; validates and submits RC MEB packets to Medical Command; and provides administrative /medical subject matter expertise regarding IDES RC medical processing.[350] Aligned in 2012 under the U.S. Army Physical Disability Agency (USAPDA),[351] SMSC indicated in December 2012 that it was moving toward expanding its mission beyond the screening, validation, and submission of MEB packets, and will begin to work directly with states and Regional Support Commands (RSCs) to help them identify cases that warrant disability evaluation.[352]

Marine Corps Reserve. The Marine Corps Reserve established its PH Outreach Program in 2009 to provide activated Reserve Marine forces access to appropriate PH care services, to increase resilience, and to facilitate recovery. Much like the Navy Psychological Health Outreach Program (PHOP), six teams of five licensed clinicians work throughout the country in Washington, California, Missouri, Georgia, Louisiana, and Massachusetts. They provide Marines and family members initial screenings, referrals, and telephone/email follow-up services to ensure clients have received needed information and services, whether through military, VA, or civilian community resources. In addition, PHOP provides psycho-educational briefs and consultation to command, and interfaces with civilian resources to ensure they have the background necessary to effectively serve the Marine Corps population.[353]

Navy Reserve. The Navy Region Mid-Atlantic (NRMA) RC Command Medical Hold Department (MEDHOLD) East, located in Norfolk, Virginia, provides case management services for RC members who are authorized a medical hold status.[354] Eligible Sailors must be unfit for duty and have "conditions incurred or aggravated after completion of continuous active duty orders for more than 30 days."[355] MEDHOLD case management is provided by RN case managers, with an emphasis on medical matters, although non-medical case management is provided as warranted.[356]

The Navy Reserve established a PHOP in 2008 aimed at maintaining psychological health and promoting resilience and recovery of Reserve Service members and their families.[357] PHOP staff, including clinically licensed outreach coordinators and outreach support team members, are co-located with RC Command staff in five regions—Mid-Atlantic, Southeast, Southwest, Northwest, and Midwest. They conduct a thorough behavioral health screening to holistically assess an individual's psychological, physical, and social functioning, and family well-being. Based on this screening, PHOP staff link individuals with appropriate military or community-based providers and provide follow-up. PHOP also conducts outreach calls with recently demobilized Sailors and provides psycho-educational briefings on a variety of topics of interest to the Navy Bureau of Medicine and Surgery (BUMED).[358]

YRRP. The 2008 National Defense Authorization Act (NDAA) called for the establishment of the YRRP to provide information, services, referral, and proactive outreach programs to RC members and families throughout the deployment cycle.[359] DoD Instruction 1342.28, "DoD Yellow Ribbon Reintegration Program (YRRP)" provides comprehensive guidance regarding YRRP policy, responsibilities, and implementation, replacing earlier departmental guidance.[360] For reintegration purposes, the YRRP is organized on a 30-60-90-day post-deployment model.[361] Official health screening in the form of the post-deployment health reassessment (PDHRA) is to be incorporated into 90-day YRRP activities (see also information paper on *services for posttraumatic stress disorder and traumatic brain injury*).[362]

NDAA 2011 introduced YRRP several enhancements, including 1) expansion of partnerships with the VA and Service and state-based programs, 2) a mechanism for the Center for Excellence in Reintegration to evaluate the effectiveness of YRRP, 3) authorization of resiliency training, and 4) authorization of transportation and per diem allowances for YRRP participants.[363] Section 590 of NDAA 2012 restated the function of the Center for Excellence in Reintegration to focus on lessons learned from states' Guard/Reserve, training for state representatives, and identifying best practices in information dissemination and outreach.[364] Section 703 of NDAA 2012 provides for mental health care and training on suicide prevention and response for un-activated Reservists during training, at no cost to the Reservists.[365]

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Appendix:

Acronyms used in Handbook

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

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

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

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

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

PWWBn	Wounded Warrior Battalion
WWBn-East	Wounded Warrior Battalion-East (Camp Lejeune)
WWBn-West	Wounded Warrior Battalion-West (Camp Pendleton)
WWCTF	Wounded Warrior Care and Transition Policy
WWR	Wounded Warrior Regiment
YRRP	Yellow Ribbon Reintegration Program