Department of Defense Recovering Warrior Task Force

2011-2012 Annual Report



August 31, 2012

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

Preparation of this report/study cost the Department of Defense a total of approximately $2,665,000 for the 2012 Fiscal Year
Generated on 2012Jul09 0812 RefID: 1-57D0660

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Cover photo captions (left to right)

Physical therapy assistant John Inzinna (r) demonstrates the proper function of a knee joint to Capt. Wendy Koseka 19th Airlift Wing legal officer during her physical therapy session at Brooke Army Medical Centers outpatient physical therapy clinic. (U.S. Air Force photo/Steve Thurow)

San Diego (Nov. 25, 2008) A Sailor assigned to the Nimitz-class aircraft carrier USS Ronald Reagan (CVN 76) is greeted by his family during a homecoming celebration at Naval Air Station North Island. Ronald Reagan is returning from a six-month routine deployment to the western Pacific Ocean. (U.S. Navy photo by Mass Communication Specialist 2nd Class John P. Curtis/Released)

Marine Corps Air Ground Combat Center Twentynine Palms, Calif.-Lance Cpl. Tiofilo Corona Jr., a Marine with the 3rd Combat Engineer Battalion salutes after receiving a Purple Heart at the 3rd CEB command section. Corona's vehicle was hit with an improvised explosive device in Afghanistan.

Army Ten-Miler leaders Pvt. Reginaldo Campos Jr. of the Brazilian Army (471), U.S. All-Army Pvt. Philip Sakala (15) and Brazilian Joseuldo Nascimento (67) close the gap on a member of the Missing Parts in Action team during the 24th running of the Army Ten-Miler. Photo Credit: Tim Hipps

U.S. Navy Honorary Chief Aviation Ordnanceman David Eberhart, assigned to Marine Aviation Logistics Squadron 24, delivers a speech during a ceremony at the Tripler Army Medical Center, Marine Corps Base Hawaii, May 15, 2008. Eberhart was appointed an honorary Chief Petty Officer by Master Chief Petty Officer of the Navy Joe R. Campa, Jr. Eberhart has been diagnosed with Stage IV colon cancer and has continued to serve on active duty in his attempt to become a Chief Petty Officer while fighting the disease. (U.S. Navy photo by Mass Communication Specialist 2nd Class Michael A. Lantron)

Department of Defense
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The complete FY2012 report, including appendices, is available online at:
http://dtf.defense.gov/rwtf/2012report.pdf

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Executive Summary

SUMMARY

The Recovering Warrior Task Force's (RWTF's) Fiscal Year (FY) 2012 Annual Report captures the RWTF's recommendations and findings from its second year of effort. Several of this year's recommendations build upon FY2011 RWTF recommendations that were met and FY2011 RWTF recommendations that the RWTF continues to follow.

The Congress included important feedback mechanisms for DoD in its legislation for the RWTF.[1] According to the RWTF legislation, DoD is required to provide Congress an assessment of the RWTF's recommendations at 90 days and an implementation plan at 180 days after the RWTF's submission of the report to the Secretary of Defense (SecDef). The RWTF found several cases last year where FY2011 recommendations did not reach the Service or DoD agency that could provide the most insight into the assessment or the implementation plan, or were not thoroughly addressed by DoD. To assist DoD with the task this year, the RWTF suggests several Services and DoD agencies that may be appropriate to provide input into the 90-day assessment and 180-day implementation plan. Although the DoD assessment and implementation plan are requirements of Congress, receiving the correct agencies' thorough responses also helps the RWTF fulfill its legislative mandate of assessing the effectiveness of policies and programs for Wounded, Ill, and Injured (WII) Service members and making recommendations for continuous improvement.

The RWTF's FY2012 effort included the specific topics Congress listed in the RWTF's governing legislation and three additional lines of inquiry.

- The Reserve Component (RC) continues to be a high priority for the RWTF. In FY2012 the RWTF explored services and parity of support for the RC Recovering Warrior (RW) community and allocated more time in the site visit schedule for RC data collection, speaking with Reservists, their families, and their providers during visits to several Joint Forces Headquarters, an Army Community-Based Warrior Transition Unit, Naval Medical Hold (MEDHOLD) East, and several Active Duty sites.
- The RWTF recognized the need to examine how RWs and their families are faring post transition in order to truly evaluate the effectiveness of the DoD continuum of RW care. Accordingly, in FY2012 the RWTF examined "transition outcomes" by speaking with DoD proponents, such as Service Recovery Care Coordinators (RCCs), Army Wounded Warrior (AW2) Advocates, Air Force Wounded Warrior (AFW2) staff, Navy Safe Harbor staff, Marine Corps District Injured Support Cells (DISCs), and others who work with RWs and families post-transition. The RWTF also tapped the perspectives of select Department of Veterans Affairs (VA) field personnel on transition outcomes. Additionally, the RWTF asked these VA field personnel about their involvement in RW case management and care coordination pre-separation. VA personnel included Federal Recovery Coordinators (FRCs), VA Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Program Managers and Case Managers, VA Liaisons, VA Poly-Trauma Case Managers, and others.
- The RWTF's FY2012 effort included a visit to installations supporting RWs in Germany. Members learned firsthand about the medical and non-medical case management that Landstuhl Regional Medical Center (LRMC) provides RWs who are evacuated from the U.S. Central

Command (USCENTCOM), U.S. Africa Command (USAFRICOM), and U.S. European Command (USEUCOM) areas of responsibility (AORs), and about the operations of the Army Warrior Transition Battalion-Europe.

Based on cumulative FY2011 and FY2012 data collection and analysis, the RWTF identified 35 recommendations for this report. Among these are recommendations for the swift publication of several specific pieces of policy guidance, recommendations crafted to sustain DoD attention on key initiatives, such as the Integrated Disability Evaluation System (IDES) and the electronic health records initiatives, recommendations targeting WII RC personnel, and recommendations aimed at improving support for RW families/caregivers, among others. The 35 recommendations are listed below; substantiating findings are presented in Chapter 2.

Restoring Wellness and Function

1. DoD's failure to publish guidance on administrative and clinical care of RWs is unacceptable. DoD should publish timely guidance to standardize care to RWs without delay:
   - DoD Instruction (DoDI) on clinical case management
   - Update to Air Force Instruction (AFI) 34-1101
   - DoDI 1300.jj, Guidance for the Education & Employment Initiative (E2I) and Operation WARFIGHTER (OWF)

2. There is still confusion regarding the roles and responsibilities of the RCC and the FRC. Standardize and clearly define the roles and responsibilities of the RCC, the FRC, non-medical case manager (NMCM), VA Liaison for Healthcare, and VA Polytrauma Case Managers serving an RW and his or her family. Standardize the eligibility criteria for RCC (or equivalent) assignment. The RWTF looks forward to seeing the work of the newly formed VA-DoD Warrior Care and Coordination Task Force.

3. DoD should draft an RW Bill of Rights or content for a commander's intent letter to guide expectations for communication and treatment of RWs and their families.

4. Substantial rehabilitation expertise has developed over 11 years of war. DoD should partner with VA to further promote interagency collaboration and co-locate/integrate rehabilitation capability of both Departments to sustain DoD and VA capabilities, and to facilitate the seamless transition of RWs from DoD to the VA.

5. Congress should enact legislation to permanently establish the Office of Warrior Care Policy (WCP) within the Under Secretary of Defense for Personnel and Readiness portfolio at a level no less than Deputy Assistant Secretary of Defense.

6. After two visits to Marine Corps Air Ground Combat Center (MCAGCC) Twentynine Palms, the RWTF found both medical and non-medical resources available to RWs are not sufficient. The Navy and Marine Corps should provide MCAGCC the needed resources on station to meet the medical and non-medical requirements of RWs assigned to MCAGCC.

7. Extend Transitional Assistance Medical Program (TAMP) benefits to one year post deployment for RC in order to promote access to care for late arising diagnoses.

8. DoD must ensure 100 percent of DoD behavioral health providers receive training in evidence based posttraumatic stress disorder (PTSD) treatment and all primary care providers receive training in identification of PTSD patients.

9. DoD should audit military treatment records for RWs with diagnoses of PTSD to assess completion rates of evidence based PTSD treatment and incorporate lessons learned into clinical practice guidelines.

10. The Services should adopt a common comprehensive plan (Comprehensive Recovery Plan (CRP), Comprehensive Transition Plan (CTP), etc.) format for recovery and transition.

11. The Navy, Air Force, and Marine Corps should ensure that RWs and families can access their CRP and have ability for written comment on information in the CRP. There must be a feedback loop to ensure that the RCC is responsive to RW and family member input and that the CRP is used as a tool to facilitate dialogue.

Restoring Into Society

12. DoD should adopt a new definition of WII Category (CAT) 2 as below:

    - WII Service members of every Service should be designated as CAT 2 if they meet any of the following four criteria:
      - Identified as seriously ill/injured (SI) or very seriously ill/injured (VSI) on a casualty list
      - Referred to IDES for PTSD and/or traumatic brain injury (TBI)
      - RC retained for more than six months on medical Title 10 orders or
      - RC returned to Title 10 orders for medical conditions related to deployment.

    Direct the Services to adopt the new definition as the criteria for assignment of an RCC or an NMCM.

13. All RW squad leaders, platoon sergeants, fleet liaisons, Navy Safe Harbor NMCMs, AW2 advocates, section leaders, and AFW2 NMCMs should attend the joint DoD RCC training course.

14. The Services should provide support to family members/caregivers without requiring RW permission. Support should include a needs assessment, counseling, information, referrals, vocational guidance, financial management/assistance, and other resources as needed. Health Insurance Portability and Accountability Act (HIPAA) and Privacy Act should not interfere with support to family members/caregivers.

15. Each Service should clearly identify a readily available, principal point of contact for the RW in every phase of recovery. Initial and on-going contact with the family/caregiver is the responsibility of this individual. Provide this individual the requisite tools and equipment to help meet the family's/caregiver's needs.

16. Upon RW entrance into the IDES, the Services should educate family members/caregivers on potential benefits changes upon separation, the VA Caregiver Program, Vet Centers, and other federal/state resources for which families may be eligible. The Services should use social media, apps, fact sheets, pamphlets, videos, or other communication tools to educate family members on these topics.

17. The Services should require that, upon RW entry into IDES, Physical Evaluation Board Liaison Officers (PEBLOs) brief families/caregivers enrolled in the Exceptional Family Member Program (EFMP) on the potential loss of TRICARE Extended Care Health Option (ECHO) benefits upon completion of IDES if discharged.

18. The Services should seek every opportunity to unify family members/caregivers and RWs. It is important to preserve family dynamics and keep family members engaged in the recovery process.

19. WCP should rename the National Resource Directory (NRD) to reflect its target audience. Market the newly named portal with a goal to more than double the usage.

20. The Services should specify the RW program relationships with installation level family support centers and sufficiently resource Soldier and Family Assistance Centers (SFACs), Navy Fleet and Family Support Centers, Airman and Family Readiness Centers (A&FRCs), and Marine Corps Community Services (MCCS) family assistance facilities to effectively meet the needs of RWs and their families. Each family assistance center (FAC) should identify personnel responsible for meeting the needs of the RW community.

21. The Services should establish centralized case management for RC RWs on Title 10 orders. The size of the centralized staff, and the staff qualifications and training, must comply with staffing ratios and other criteria set forth in DoDI 1300.24 and Directive-Type Memorandum (DTM) 08-033. The centralized program must be sufficiently robust that it can meet surges in demand.

22. DoD must establish policies that allow for the rapid issuance of Title 10 orders to RC RWs who have sustained line of duty injuries/illnesses. Delays in Title 10 orders have resulted in the interim use of incapacitation (INCAP) pay. DoD should define specific criteria for the appropriate use of INCAP pay that will be consistent across all Services.

23. The Army Warrior Transition Command (WTC) should include out-processing with the RC Service member's home unit as part of the checklist for leaving Title 10 status.

Optimizing Ability

24. DoD should publish interim guidance to implement the National Defense Authorization Act (NDAA) of 2012, Section 551.

25. DoD and VA should expand their existing memorandum of understanding (MOU), in accordance with Section 1631 of the Wounded Warrior Act, so that all RWs receive Vocational Rehabilitation and Employment (VR&E) counseling upon entering the IDES process.

26. DoD should update DoD Directive (DoDD) 1332.35 and DoDI 1332.36 to include the following:

- Incorporate changes legislated by the Veterans Opportunity to Work (VOW) to Hire Heroes Act of 2011
- Ensure all RWs receive comprehensive information so that they can make informed decisions about accessing transition assistance opportunities
- Establish early referral (PEBLO checklist item) for the RW and his or her family member and/or caregiver to meet with the transition assistance program counselor.

Enabling a Better Future

27. Congressional action is required to establish the Deputy Secretaries of DoD and VA as co-chairs of the Joint Executive Council (JEC).

28. DoD should continue to evaluate processes to ensure only those RWs likely to separate enter the IDES process.

29. DoD should create individual electronic records of all IDES information and establish common standards for storage and retention of these records.

30. WCP should utilize survey results to improve the IDES program. Improvement goals should be balanced across three areas: timeliness, satisfaction (process vs. disability rating), and effectiveness.

31. Terminal leave should not be counted against IDES timelines.

32. DoD should consider a joint board modeled after the Physical Disability Board of Review (PDBR) to allow joint adjudication that replaces the Service Formal Physical Evaluation Board (FPEB) with a joint FPEB. The post Physical Evaluation Board (PEB) process would remain unchanged with appeals to the Board for Correction of Military Records (BCMR) adjudicated by the Service Secretary.

33. The current PEBLO staffing formula is inaccurate. DoD should develop new and more accurate PEBLO work intensity staffing models. The Services should ensure a minimum manning of two PEBLOs (of any Service) at every Medical Evaluation Board (MEB) site to prevent potential process delays due to a PEBLO being unavailable (e.g., leave).

34. The Services should ensure that 100 percent of RWs are individually contacted by an MEB outreach lawyer (in-person, phone, email, mail, etc.) upon notification to the PEBLO that a narrative summary (NARSUM) will be completed.

35. All military members, upon entering their Service, begin a relationship with the VA. DoD should widely market VA services and benefits to DoD leadership (commanders, senior enlisted leaders, etc.) and include this information at all levels of officer and enlisted professional development. All Active Component (AC) and RC should be encouraged to register in the VA e-Benefits online program.

A chart indicating the status of each FY2011 recommendation is presented in Chapter 2 (Exhibit 2).

Introduction

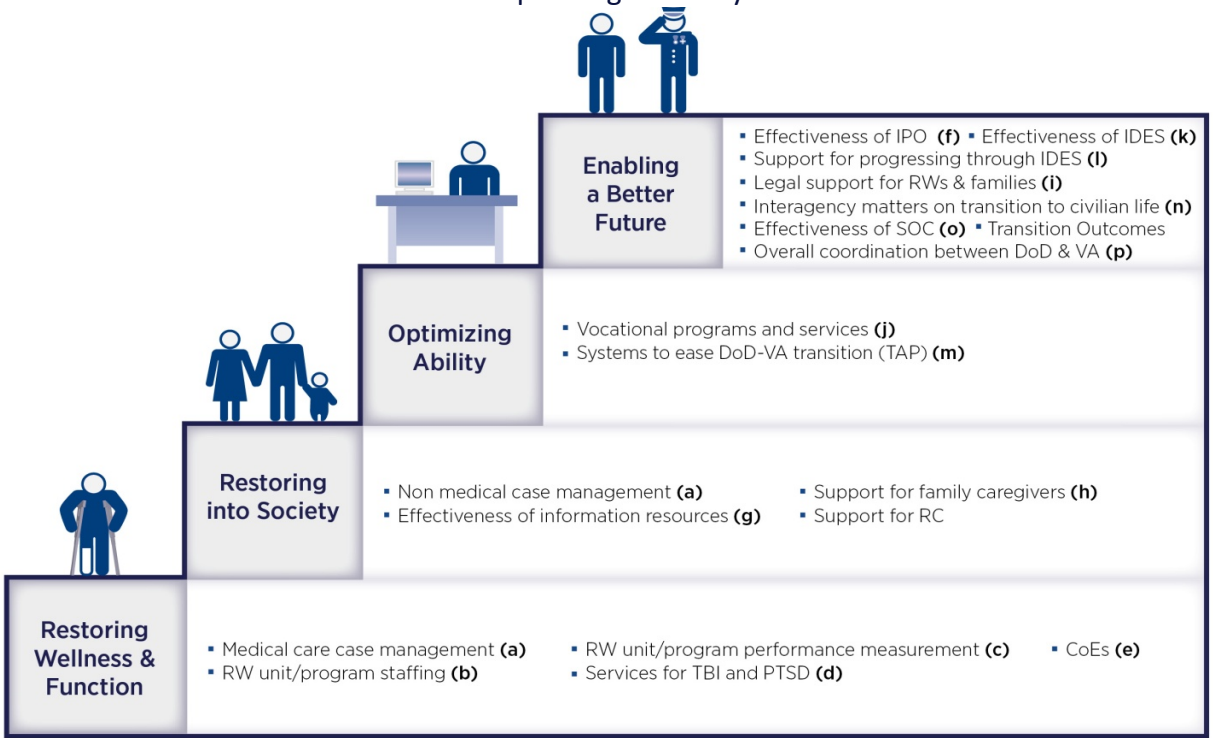
CHAPTER 1

The Congress directed the establishment of the DoD Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured members of the Armed Forces (hereafter referred to as the Recovering Warrior Task Force—or the RWTF) in the 2010 National Defense Authorization Act (NDAA). According to the legislation, the RWTF shall:

> (a) assess the effectiveness of the policies and programs developed and implemented by the Department of Defense, and by each of the Military Departments to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces; and (b) make recommendations for the continuous improvements of such policies and programs.[2]

The RWTF draws upon the experience and expertise of its Members, coupled with information gathered from diverse stakeholders at many levels, to assess how effectively DoD and the Services are meeting the needs of Recovering Warriors (RWs) and their families, and to provide recommendations for the improvement of relevant policies and programs.[3] Each year, the RWTF reviews and assesses more than a dozen diverse matters that Congress specified.[4] The RWTF *Reference Handbook of Key Topics and Terms* (Appendix C), which was updated in 2012, includes an overview of most of these matters. The RWTF groups these matters into four domains reflecting a holistic, progressive, and patient-centered approach for the recovery, rehabilitation, and reintegration of RWs.

Exhibit 1: Topics Organized by Domain



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

On September 2, 2011, the RWTF submitted its first Annual Report to the Secretary of Defense (SecDef), presenting a total of 21 recommendations grouped by domain. Since that time, the RWTF observed forward movement on several of its Fiscal Year (FY) 2011 recommendations:

- The Army and Marine Corps continued to expand and refine their respective training curricula for transition unit staff (FY2011 Recommendation 12).
- The national Joining Forces initiative includes the well-being and psychological health of military families as one of its four pillars.[5] This attention helps DoD and the Services to more fully and proactively meet the needs of family caregivers (FY2011 Recommendation 14)—an area which remains a high priority for the RWTF.
- DoD implemented the NDAA 2010, Section 603, directive to expedite policy to provide Service members with catastrophic injuries or illnesses Special Compensation for Assistance with the Activities of Daily Living (SCAADL) (FY2011 Recommendation 15).
- The Veterans Opportunity to Work (VOW) to Hire Heroes Act[6] made attendance of the DoD Transition Assistance Program (TAP) within 12 months of separation mandatory across the Services (FY2011 Recommendation 17) and extended the sunset provision from December 2012 to December 2014 that allows RWs to access the Department of Veteran Affairs Vocational Rehabilitation and Employment (VR&E) Program (FY2011 Recommendation 18).
- DoD and the Department of Veterans Affairs (VA) are addressing pre-separation access to VR&E services by placing VR&E Vocational Rehabilitation Counselors (VRCs) at select Integrated Disability Evaluation System (IDES) installations.[7] DoD, VA and the Services are working to expand this effort to 110 installations in FY2012[8] (FY2011 Recommendation 18).
- DoD and VA established high-level governance for the Interagency Program Office (IPO) and selected a single IPO Director vested with the necessary decision-making authority (FY2011 Recommendation 20).
- DoD and VA consolidated the joint DoD/VA Senior Oversight Committee (SOC) into the DoD/VA Joint Executive Council (JEC), as the JEC Wounded, Ill, and Injured Committee (WIIC) (FY2011 Recommendation 21).

Chapter 2 of this report presents the RWTF's 35 FY2012 recommendations and associated findings, organized under the four domains. Chapter 2 also includes a chart (Exhibit 2) that tracks the status of the FY2011 RWTF recommendations. Chapter 2 concludes with best practices that are making a difference for RWs and families. Appendices containing supporting documentation are available in the on-line version of the report posted on the RWTF's website. Among these, Appendix D addresses the RWTF's research methodology, Appendix G lists the information sources used to assess congressionally mandated and other topics, and Appendix K identifies the topics addressed in each RWTF recommendation.

Recommendations and Findings

CHAPTER 2

Each of the Recovering Warrior Task Force's (RWTF) following 35 recommendations is supported by findings from a variety of sources, including focus groups and mini-surveys with Recovering Warriors (RWs) and family members conducted by the RWTF, briefings from site-level staff, briefings from each of the Services, briefings from other relevant individuals and organizations within and beyond the Department, and published articles and reports. The recommendations are organized by domain and topic. More information about the method by which the RWTF collected and analyzed data to inform these recommendations and findings is in Appendix D. At the end of the chapter, best practices are highlighted.

Restoring Wellness and Function

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

RECOMMENDATION 1

DoD's failure to publish guidance on administrative and clinical care of RWs is unacceptable. DoD should publish timely guidance to standardize care to RWs without delay:

- DoD Instruction (DoDI) on clinical case management
- Update to Air Force Instruction (AFI) 34-1101
- DoDI 1300.jj, Guidance for the Education and Employment Initiative (E2I) and Operation WARFIGHTER (OWF)

Requested Agencies to Respond: DoD, Office of the Under Secretary of Defense for Personnel and Readiness (OUSD(P&R)), Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)), Office of Warrior Care Policy (WCP), United States Air Force (USAF)

> **Finding:** In addition to standardizing care and promoting parity across the Services, written policy marshals resources, facilitates information flow between DoD and the Services, and reduces redundancies. The RWTF believes DoD must prioritize the publishing and dissemination of written guidance related to the care and management of RWs, with immediate attention focused on the DoDI on clinical case management, the update to AFI 32-1101, and DoDI 1300.jj, Guidance for E2I and OWF.

- The current policy guidance for medical care case managers (MCCMs), Directive-Type Memorandum (DTM) 08-033, expired May 31, 2012.[9] OASD(HA) is in the process of completing a DoDI on clinical case management.[10] This guidance will largely address the activities of nurse case managers (NCMs), who provide medical care – or clinical – case management. RWTF focus groups revealed that NCMs are valued by both RWs and family members,[11, 12] and RWTF focus group mini-survey results indicated high RW and family member satisfaction with NCMs.[13, 14] RWs also noted that NCMs appeared short-staffed, had high caseloads, and turned over frequently.[15] The RWTF believes that the DoDI on clinical case management will help to address such concerns. Based on its observations in the field, the RWTF is particularly interested in seeing DoD's MCCM staffing guidance move beyond a straight ratio of one NCM to every 30 RWs[16] to an acuity-based staffing model.[17, 18, 19, 20] Although OASD(HA) acknowledged the value of such a model, the new DoDI apparently will not include one.[21] The RWTF remains concerned about the sufficiency of a non-acuity based standard, and it will continue to monitor NCM caseloads and watch for the implementation of acuity-based caseload standards.
- The update to AFI 34-1101 should capture all existing Air Force guidance on the care and transition of recovering Airmen and their families/caregivers. As part of the update, the Air Force should formally document the relationship between the Airman and Family Readiness Centers (A&FRCs) and the Air Force Wounded Warrior (AFW2) program, whose policy offices are co-located in the new Air Force Warrior and Family Operations Center in San Antonio.[22] A cornerstone of the relationship between these two programs is the use of designated Community Readiness Consultants (CRCs) with expertise in wounded warrior issues to serve as the "go to" for wounded warriors referred to A&FRCs.[23] The relationship between these programs is a best practice that promotes RW and family awareness of, and access to, priority A&FRC services.[24] Documenting this relationship in the AFI update will help to ensure that the warm handoff of AFW2 participants to A&FRCs that is envisioned at Air Force Headquarters is faithfully implemented at the installation level (See also Recommendation 20).
- National Defense Authorization Act (NDAA) 2012 §551 instructs DoD to allow apprenticeships outside the federal sector.[25] While U.S. Special Operations Command (USSOCOM) Care Coalition is proceeding with implementing non-federal internship opportunities,[26] the Army maintains a policy limiting internships to the federal sector[27] and the Marine Corps indicated they will not expand internship opportunities beyond the federal sector without DoD guidance.[28] Expanding internship and apprenticeship opportunities beyond the federal sector would increase the availability of meaningful vocational opportunities for RWs. Few RWs who participated in focus groups with the RWTF had heard of internship programs or opportunities, including Operation Warfighter (OWF).[29] RWs' mini-survey responses echoed the limited availability of vocational services, especially internships; only four percent (6/157) indicated they had first-hand experience with OWF.[30] Site briefings to the RWTF corroborated limited availability of internships.[31] Four Army and Marine Corps sites indicated RWs cannot currently have internships/work experience in the private sector, in accordance with current Service-level policies.[32, 33] Despite the limited availability, which could be ameliorated by expanding OWF and other opportunities beyond the federal sector, sites indicated internships are beneficial for RWs and that the staff were working to increase their offerings to RWs.[34]

RECOMMENDATION 2

There is still confusion regarding the roles and responsibilities of the Recovery Care Coordinator (RCC) and the Federal Recovery Coordinator (FRC). Standardize and clearly define the roles and responsibilities of the RCC, the FRC, non-medical case manager (NMCM), Department of Veterans Affairs (VA) Liaison for Healthcare, and VA Polytrauma Case Managers serving an RW and his or her family. Standardize the eligibility criteria for RCC (or equivalent) assignment. The RWTF looks forward to seeing the work of the newly formed VA-DoD Warrior Care and Coordination Task Force.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP

Finding: The RWTF recommended in Fiscal Year (FY) 2011 that DoD and VA clarify roles and responsibilities of RCCs and FRCs, NMCMs provided by the Services, and case managers provided by VA.

At inception, the Federal Recovery Coordination Program (FRCP) was intended for RWs and Veterans with traumatic brain injury (TBI), amputations, burns, spinal cord injuries, visual impairment, and PTSD, [35] and FRC support was to begin as early as arrival at a U.S. military treatment facility (MTF) and continue throughout care, rehabilitation, and transition back to duty or to Veteran status.[36]

Section 1611 of the 2008 NDAA directed DoD and VA to establish a comprehensive policy for improving the care, management, and transition of RWs.[37] That plan, according to Congress, was to encompass the Recovery Coordination Program (RCP), MCCMs, NMCMs, financial supports, assignments and duties, and vocational supports for RWs, as well as services and supports to families of RWs.[38] Congress instructed DoD and VA to review existing findings, recommendations, and practices, provide uniform standards and procedures for the development of a comprehensive recovery plan (CRP), and establish a uniform RCC program with caseloads, duties, training, supervision, and mechanisms to ensure RCCs had the needed resources.[39] Congress specified that RCCs were to oversee and assist RWs throughout care, management, transition, and rehabilitation, assisting with services provided by DoD, VA, Department of Labor (DOL), and Social Security Administration (SSA).[40]

On December 1, 2009, the DoD issued DoD Instruction (DoDI) 1300.24, detailing the RCP.[41] RCCs were to serve Category 2 RWs enrolled in the RCP, defined in the DoDI as having a serious illness or injury, unlikely to RTD within a time specified by his/her Service, and potentially being medically separated. Recovering Service members were also entitled to an NMCM and an MCCM from their Service. Category 3 RWs who have severe or catastrophic injuries or illnesses, are highly unlikely to return to duty (RTD), and will most likely be medically separated were to be enrolled in the FRCP.

VA Liaisons for Healthcare, Polytrauma case managers, and Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) case managers, along with NMCMs, RCCs, and FRCs, have similar roles in coordinating care and informing and supporting RWs and families.[42, 43] When the RWTF discussed the value of having multiple case managers with representatives of

these VA programs, one indicated the overlap results in strong partnerships, while another noted roles and responsibilities can become unclear to RWs and families.[44]

The RWTF noted many overlaps and similarities in the FRCP and the RCP, such as the responsibilities each have to develop and manage a recovery plan.[45, 46, 47] In a handbook for RWs on compensation and benefits, DoD describes both the RCC and the FRC as an RW's "own Command Center," both providing oversight and assistance and advocating for information and assistance.[48] It appears there is confusion about how the roles and responsibilities of RCCs and FRCs differ,[49, 50, 51] and there is concern that neither the RCP nor the FRCP are serving all of their eligible populations.[52, 53, 54, 55] The Government Accountability Office (GAO) also documented substantial overlap in RCC and FRC roles, leading to both redundancy and confusion for RWs and families.[56] GAO called for DoD and VA to explore options for integrating the two programs into one and expressed concern that the redundancy and confusion created by the overlap of FRCP and RCP is inhibiting both programs from meeting their purpose of better managing and facilitating services.[57, 58] The Senior Oversight Committee (SOC) directed FRCP and RCP leadership to form a workgroup to address GAO's concerns,[59] yet GAO remains concerned that DoD and VA have not yet presented a viable model for integration.[60] The House Committee on Veterans' Affairs Subcommittee on Health has been monitoring the GAO findings, the responses of DoD and VA to GAO, and the overlap of the programs.[61, 62, 63, 64]

FRCP and RCP representatives offered some distinction in the roles and responsibilities of FRCs and RCCs. FRCP leadership indicated FRCP is intended to be complementary to RCP and other VA case managers, and that FRCs interact with these other case managers and care coordinators as appropriate for the client.[65] RCP leadership noted that FRCs provide clinical expertise to the severely injured, while RCCs provide non-clinical assistance.[66, 67]

The RWTF believes that overlaps and seams must be eliminated, and that roles and responsibilities of DoD and VA NMCMs and care coordinators must be standardized in order to help RWs and family members better understand and use their recovery team.

RECOMMENDATION 3

DoD should draft an RW Bill of Rights or content for a commander's intent letter to guide expectations for communication and treatment of RWs and their families.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP

Finding: The RWTF acknowledges significant progress since last year with regard to command climate. In RWTF focus groups with RWs, RWs named unit staff including company commanders, platoon sergeants (PSGs), staff sergeants, and Army squad leaders and Marine Corps section leaders (SLs) as part of their recovery team, and frequently mentioned SLs as the most valuable team member.[68] While many remarks about the transition unit chain of command were positive, RWs and families also expressed concern about the climate within the transition units.[69, 70] RWs described an adversarial dynamic between staff and RWs which distracts them from focusing on healing.[71] Most frequently, RWs described a mentality of RWs needing "babysitting," which they said compromises their ability to focus on individual goals and

transition needs.[72] Other concerns included prioritizing athletic reconditioning, Warrior Games, or formations over needed medical and transition services, and being disrespected and inappropriately penalized by unit staff.[73] RWs also expressed concerns about their ability to trust unit staff to maintain RW privacy according to Health Insurance Portability and Accountability Act (HIPAA) requirements since unit staff broke confidentiality in the past.[74] In RWTF focus groups with family members, participants noted that the chain of command insists upon physical training (PT) early in the morning despite the impact of an RW's medication on his/her ability to meet this requirement.[75] The RWTF acknowledges that Army[76] and Marine Corps[77] transition unit staff receive training on counseling and communication but remains concerned about staff demeaning RWs and inappropriately shifting RWs' focus and priority away from medical care and transition preparation as applicable.

RWTF focus groups with RWs and families also documented some concerns with line unit leadership. Family members indicated line unit command was not meeting their needs,[78] and a large number of RWs reported a lack of support from the line unit, including poor treatment by commanders and/or peers, stigmatizing the RW for receiving a "welfare check", and not keeping in contact with the RW once wounded, ill, or injured.[79] Less frequently, RWs mentioned other issues with the line units, such as not sharing information on transition units, failure to recommend an RW for promotion, and being unaware that an RW was in a transition unit.[80]

The RWTF would like to see commanders consistently foster a climate where RWs are accepted, where recovery, rehabilitation, and transition are top priorities, and where RWs and families feel supported by the unit chain of command and staff. While the RWTF recognizes that there are times when unit responsibilities will take precedence, having staff assist RWs with the rescheduling of missed appointments, for example, would ensure priority care. The RWTF believes that having leaders issue an RW Bill of Rights or a commander's intent letter improves unit climate and unifies commanders, staff, and RWs on the prioritization of recovery, rehabilitation, and transition back to duty or to civilian life.

RECOMMENDATION 4

Substantial rehabilitation expertise has developed over 11 years of war. DoD should partner with VA to further promote interagency collaboration and co-locate/integrate rehabilitation capability of both Departments to sustain DoD and VA capabilities and facilitate the seamless transition of RWs from DoD to VA.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA)

Finding: Over the course of OEF/OIF/Operation New Dawn (OND), each Service developed its supports to RWs, including rehabilitation care, MCCMs, NMCMs, transition unit commanders, and other staff of the units and programs for Wounded, Ill, and Injured (WII). As the current conflict draws down, the demand for these resources will plateau and then decline. The OIF/OND campaign has ended,[81] and the numbers of wounded in action (WIA) in OEF are decreasing:[82] The total number of WIA in OEF in the first four months of 2012 was 52 percent lower than the total for the same period of 2011 and was 61 percent lower than the total

for the last four months of 2011.[83] Current staffing of transition units and rehabilitation facilities will not be sustainable as the decreases continue.

DoD and the Services invest greatly in these units and programs and their staff and, accordingly, must plan for how best to retain the expertise while responding to the decreasing numbers of RWs. The Army acknowledged the need to work with DoD and VA as the current conflict ends and Soldiers return home in order to meet needs now and into the long-term.[84] As DoD sees diminishing flows of casualties, it will need to develop guidance for which facilities to maintain and how to align with VA facilities that have a longer term rehabilitation role without losing DoD expertise. Co-locating DoD assets with VA assets could provide DoD and the Services a mechanism to streamline services and facilitate the transition of RWs from DoD to VA when patient censuses decline while continuing to cultivate expertise.

DoD and the Services benefit from finding ways to shift the knowledge and experience of these staff as well as the policies, guidance and training developed for them to co-located DoD/VA rehabilitation facilities. The Marine Corps demonstrated the value of locating their District Injured Support Coordinators (DISCs) within some VA facilities,[85] and the VA's Liaisons for Healthcare, located in MTFs, also indicate that DoD and VA are aware of the benefits of co-location.[86, 87]

RECOMMENDATION 5

Congress should enact legislation to permanently establish WCP within the Under Secretary of Defense for Personnel and Readiness portfolio at a level no less than Deputy Assistant Secretary of Defense.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA)

Finding: WCP is the DoD office coordinating the RCP, the National Resource Directory (NRD), and the Integrated Disability Evaluation System (IDES).[88] Although the OIF/OND campaign has ended[89] and the numbers of WIA in OEF are decreasing,[90] DoD will be coping with the casualties of these operations for decades to come, and WCP will continue to fill an important role in ensuring consistent and quality support to RWs. The RWTF believes the institutional knowledge grown within WCP should be preserved within the OUSD(P&R) with the level of leadership necessary to continue to respond effectively to the needs of RWs.

RECOMMENDATION 6

After two visits to Marine Corps Air Ground Combat Center (MCAGCC) Twentynine Palms, the RWTF found both medical and non-medical resources available to RWs are not sufficient. The Navy and Marine Corps should provide MCAGCC the needed resources on station to meet the medical and non-medical requirements of RWs assigned to MCAGCC.

Requested Agencies to Respond: Secretary of the Navy (SECNAV), United States Marine Corps (USMC), Navy Bureau of Medicine and Surgery (BUMED), USMC Wounded Warrior Regiment

Finding: In FY2012, the RWTF visited MCAGCC Twentynine Palms to follow up on the concerns observed during the FY2011 visit. The RWTF noted several concerns with the current resourcing of medical and non-medical services to RWs. Vocational services appeared insufficient to the RWTF, compared to available services at other installations visited.[91] The RWTF also noted that Navy BUMED is providing insufficient medical resources; at least one NCM position remains vacant.[92] The Limited Duty (LIMDU) Non-Commissioned Officer (NCO) saw a 17 percent caseload increase in a year.[93] The VA Military Service Coordinator (MSC) assisting Twentynine Palms RWs in IDES is in the Los Angeles area and covers five separate installations, limiting availability to answer RWs' questions.[94] Attorneys for IDES assistance are offsite, as well.[95] When an RW at MCAGCC is referred to IDES for an unfitting condition by a physician at Naval Medical Center San Diego (Balboa Naval Hospital) or Naval Hospital Camp Pendleton, they are assigned to a Physical Evaluation Board Liaison Officer (PEBLO) at the same location as the physician.[96] Staff at Twentynine Palms indicated RWs with offsite PEBLOs have difficulty accessing and fully utilizing their PEBLOs.[97]

When RWTF focus group participants were asked what they would change if they were able, RWs indicated they would want more and better quality staff and providers, more information, the option of 'home awaiting orders' for those transitioning out, and prioritization of medical care.[98] Family members participating in RWTF focus groups noted that their need to be kept informed was not being met, they did not know who to call for information, medical care is not prioritized by unit staff, they did not perceive group PTSD treatment as helpful, and they were not involved in the CRP for their RW.[99] Families indicated they would like more outreach and information for themselves, more treatment options for their RWs, and the option to heal closer to home.[100]

The Marine Corps must resource transition units and other RW services at Twentynine Palms at a level commensurate with the demand for them. Such a demand-driven resourcing model will not only better serve RWs but also will guide right-sizing of transition units and other RW services.

RECOMMENDATION 7

Extend Transitional Assistance Medical Program (TAMP) benefits to one year post deployment for Reserve Component (RC) in order to promote access to care for late arising diagnoses.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA)

Finding: TAMP currently provides "180 days of transitional health care benefits…to help certain uniformed services members and their families transition to civilian life… (including) a National Guard or Reserve member separating from a period of Active Duty (AD) that was more than 30 consecutive days in support of a contingency operation."[101] TAMP provides a bridge between the termination of the AD family health care benefit and initiation of other family health care options, such as health insurance through the civilian employer, health insurance through TRICARE Reserve Select,[102] or health care through the VA, for those eligible. TAMP is activated when Reservists leave AD,[103] which for many is shortly after redeployment. Consequently, Reservists' TAMP benefit currently may expire fewer than seven months post deployment.

TAMP coverage through six or seven months post deployment does not adequately account for certain disease processes and late arising diagnoses, often in the behavioral health arena. In one study, follow-on screenings revealed significantly higher rates of mental health concerns and referrals than initial screenings.[104] This is particularly salient within the RC RW community, where RC members are at greater risk than AC members for post deployment adjustment difficulties.[105, 106, 107] This year the Iowa Joint Forces Headquarters (JFHQ) reported that more than 25 percent of the 2,264 Soldiers with open eCases had behavioral health issues,[108] and the Air National Guard (ANG) reported that 123 of 178 ANG enrollees in AFW2 have sole diagnoses of PTSD.[109]

Due to factors such as geographic distance from military and VA facilities, long waits for VA appointments, and the screening/assessment/referral roles of state JFHQ Psychological Health programs, Reservists are likely to turn to local civilian providers for treatment.[110] The proposed extension of the TAMP benefit to 12 months post deployment will increase the likelihood that generally healthy RC members will be able to obtain health care from civilian providers when they need it.

The extension of TAMP is related to the implementation of FY2012 Recommendation 22, which calls for the rapid issuance of medical Title 10 orders for Reservists who have sustained line of duty (LOD) injuries/illnesses. When Title 10 orders are available to Reservists whose LOD conditions warrant them, fewer Reservists will seek care through TAMP.

RECOMMENDATION 8

DoD must ensure 100 percent of DoD behavioral health providers receive training in evidence based PTSD treatment and all primary care providers receive training in identification of PTSD patients.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), United States Army (USA), United States Navy (USN), USAF

Finding: DoD has grown a large inventory of behavioral health providers to meet the needs of the increasing number of diagnosed cases of PTSD over the last 10 years. The Army reports having 3,832 licensed behavioral health providers, including psychologists, psychiatrists, social workers, nurses and other behavioral health providers, and an additional 1,583 technicians/counselors/ auxiliary staff.[111] The Navy reports having 1,401 licensed behavioral health providers including psychologists, psychiatrists, social workers, nurses and other behavioral health providers, and an additional 539 technicians/counselors/auxiliary staff.[112] The Air Force reports having approximately 1,000 behavioral health providers and an additional 900 technicians/counselors/ auxiliary staff.[113] Primary care providers also play a key role in the care for individuals with PTSD. The DoD Task Force on Mental Health emphasized that "often, mental health concerns are first raised in primary care clinics, where stigma is lower."[114] The Re-Engineering Systems of Primary Care Treatment in the Military (RESPECT-Mil) program implemented in Army primary care facilities aims to increase recognition of symptoms and facilitate care for RWs with PTSD and depression through coordination between primary care providers, registered nurses (RNs) functioning as care facilitators, and behavioral health specialists.[115]

According to the VA/DoD Clinical Practice Guidelines, the most effective evidence based PTSD treatment methods include trauma focused therapies, such as prolonged exposure (PE), cognitive processing therapy (CPT), and stress inoculation training (SIT).[116] Effective pharmacotherapies include Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin Norepinephrine Reuptake Inhibitors (SNRIs).[117] Extensive training in evidence based PTSD treatment methods exists for behavioral health providers across the Services.[118, 119, 120] The Army offers four to five day advanced training in eye movement desensitization and reprocessing (EMDR), PE, and CPT.[121] Of 3,500 credentialed Army behavioral health providers, 2,400 were trained to date in one of the evidence-based treatments.[122] The Navy reports collaboration with the Center for Deployment Psychology (CDP) to provide trainings and with the Medical University of South Carolina to offer online cognitive processing therapy training.[123] Nearly 500 Navy and Marine Corps uniformed, contract, and civil service behavioral health providers attended the CDP training to date.[124] All Air Force psychology/social work interns attend CDP training in evidence-based treatment such as PE and CPT.[125] The CDP mobile training team trained 284 Air Force providers in FY2011.[126] The Air Force also has a Master Clinician Development Course to provide advanced clinical training in CPT/PE.[127]

The RWTF believes that initial and ongoing training for all DoD behavioral health providers in evidence based PTSD treatments and all DoD primary care providers in identification of PTSD is essential, and that DoD's efforts in these areas should remain a priority.

RECOMMENDATION 9

DoD should audit military treatment records for RWs with diagnoses of PTSD to assess completion rates of evidence based PTSD treatment and incorporate lessons learned into clinical practice guidelines.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), USA, USN, USAF, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE PH & TBI)

Finding: According to the VA/DoD Clinical Practice Guidelines, the most effective evidence based PTSD treatment methods include trauma focused therapies, such as PE, CPT, and SIT.[128] While fidelity to evidence based treatments is an important element of providing the best possible care to RWs with PTSD, providers must also attend to patient factors that can be critical barriers to treatment, such as stigma/views on the acceptability of behavioral healthcare, comfort with the chosen treatment method and/or elements, and willingness to continue participating in treatment.[129] These factors, along with barriers like taking time off from work and getting to and from appointments, may contribute to Service members not completing courses of treatment.[130] Many Service members who begin care do not finish; an incompletion rate of 50 percent is not uncommon in clinical practice.[131] Research indicates recovery from treatment among those who seek treatment is approximately 40 percent, while recovery from treatment for those who complete is as high as 70 to 80 percent, indicating completion of treatment is more important than selection of specific treatment techniques.[132]

Information that the RWTF gathered during site visits raised concerns about both fidelity to evidence based methods within DoD treatment settings and patient satisfaction. Despite DoD's clear commitment to training behavioral health providers in evidence based PTSD

treatments methods (see Recommendation 8), several behavioral health providers who see RWs discharged from Warrior Transition Units (WTUs) questioned whether PTSD patients were receiving evidence based care "upstream," based on their review of the RWs' health care records.[133] On the other hand, the Army's 2010 assessment of PTSD treatment techniques by behavioral health providers indicated that over 90 percent of Soldiers in treatment were receiving evidence based care.[134] From the patient's perspective, when RWs and family members were asked in RWTF focus groups about the helpfulness of available PTSD services, only about one-half reported services were helpful/met their needs. The RWTF believes that fidelity to evidence based treatment methods is a priority that practitioners must balance against the needs and preferences of individual patients in order to actively encourage patients to complete treatment.[135, 136]

DoD utilizes audits of PTSD services as a means to ensure quality care[137, 138] as well as appropriate diagnoses and benefits.[139] DoD is currently auditing PTSD diagnosis and compensation,[140] and the Army conducted a records audit to assess fidelity to evidence based treatments for PTSD.[141] To promote optimal care for RWs with PTSD, the RWTF recommends that DoD conduct a separate records audit across the Services to assess the rate of completion of evidence based treatments for PTSD and incorporate lessons learned into clinical practice guidelines.

RECOMMENDATION 10

The Services should adopt a common comprehensive plan (CRP, Comprehensive Transition Plan (CTP), etc.) format for recovery and transition.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP

Finding: DoD envisioned the CRP as an important resource to help RWs and their recovery teams navigate the recovery, rehabilitation, and reintegration processes,[142] as a cornerstone resource and a key step for RW recovery and transition.[143, 144] Few if any RWTF focus group participants experienced it this way this year or last year. The RWTF believes that the lack of parity across the Services in the effectiveness of and satisfaction with the current CRP/CTP tools and processes is problematic.

Last year, RWTF focus group participants shared misgivings about the transition process.[145] They identified impediments they believe jeopardize their ability to plan and transition effectively, such as a lack of authoritative and timely information and guidance.[146] Some voiced grave concern about how they would make ends meet if they were forced to leave the military.[147] Last year and this year, Air Force, Navy, and Marine Corps RWs were noticeably less aware of the CRP than their Army peers were of the CTP.[148, 149] Additionally, Marine Corps participants noted having access only to paper copies through their RCC.[150] Multiple participants in every focus group with Army RWs expressed dissatisfaction with the CTP process and the CTP tool, while satisfaction with the CTP was expressed in only a few sessions.[151] Army RWs noted that they were unaware of feedback to their CTP input, that the exercise of regularly inputting information into the CTP was repetitive rather than meaningful, and that the Army Knowledge Online (AKO) system has limitations that make input difficult and/or frustrating.[152] While the new CTP Guidance[153] and the Army's response to RWTF[154] addressed some of the concerns

with the CTP and problems reported by Army focus group participants, [155, 156, 157] the RWTF finds shortfalls in the implementation of both the CTP and the CRP and believes a common comprehensive plan should be used throughout DoD.

RECOMMENDATION 11

The Navy, Air Force, and Marine Corps should ensure that RWs and families can access their CRP and have ability for written comment on information in the CRP. There must be a feedback loop to ensure that the RCC is responsive to RW and family member input and that the CRP is used as a tool to facilitate dialogue.

Requested Agencies to Respond: USN, USAF, USMC

Finding: RWTF focus groups indicated Navy, Air Force, and Marine Corps family members and RWs do not have adequate access to or input in the CRP. USSOCOM and Navy participants in focus groups with the RWTF reported not knowing what the CRP is, while Marines in focus groups with the RWTF indicated that the CRP is not helpful to them because many had only seen their CRP a limited number of times, had recently completed the CRP for the first time, and/or felt that their input was not included in the CRP.[158] Many family members in RWTF focus groups were unaware of or at least uninvolved in the CRP,[159] despite guidance in DoDI 1300.24 to include family members.[160] Marine Corps RCCs must print a paper copy for the RW, and the RW must rely upon that RCC to input any changes the RW requests.[161] The RWTF remains concerned about RW and family member access to the CRP, noting that whether through a technological solution or on paper, the CRP should be accessible to the RW and the family member.

Restoring into Society

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

RECOMMENDATION 12

DoD should adopt a new definition of WII Category (CAT) 2 as below:

- WII Service members of every Service should be designated as CAT 2 if they meet any of the following four criteria:
  - Identified as seriously ill/injured (SI) or very seriously ill/injured (VSI) on a casualty list
  - Referred to IDES for PTSD and/or TBI
  - RC retained for more than six months on medical Title 10 orders
  - RC returned to Title 10 orders for medical conditions related to deployment.

Direct the Services to adopt the new definition as the criteria for assignment of an RCC or a NMCM.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP

Finding: DoDI 1300.24 establishes a three-category system for differentiating a WII Service members' level of acuity, based upon definitions of "recovering Service member" and "serious injury or illness" in Section 1602 of NDAA 2008.[162, 163] According to the Instruction, WII Service members are classified as CAT 2 and assigned an RCC if they have a serious illness or injury, are unlikely to RTD within a time period specified by their Service, and may be medically separated.[164]

The RWTF observed again this year that there is a lack of parity across the Services with regard to who receives an RCC. The RWTF believes that Service members identified as having a serious or very serious illness or injury who do not meet the criteria for CAT 3, those who have PTSD and/or TBI that is potentially unfitting, those RC RWs who have stayed on Title 10 orders for more than six months for treatment of a medical condition, and those RC RWs who have been brought back onto Title 10 for treatment of a medical condition need the support of the RCC to ensure continuity of care and benefits. The RWTF notes that this change to CAT 2 should not change the existing CAT 3 criteria. While most RWs identified as SI or VSI on a casualty list receive non-medical case management and/or an RCC (or equivalent),[165, 166] the RWTF remains concerned that individuals with PTSD and/or TBI proceeding through IDES may not be sufficiently supported during that transition if not already receiving RCC services. The RWTF is also concerned about RC RWs retained post deployment for more than six months on Title 10 orders for medical conditions and RC RWs returned to Title 10 orders for medical conditions post deployment, particularly since RC members have been shown to be at greater risk than AC members for post deployment adjustment difficulties.[167, 168, 169] This recommendation, in combination with Recommendation 22, will increase the support available to RC RWs, including Navy Reservists retained in Medical Hold (MEDHOLD) Departments for several months.

During its visit to MEDHOLD EAST, the RWTF learned many Navy Reservists are retained in MEDHOLD EAST in Norfolk, Virginia, and MEDHOLD WEST in Balboa, California, for several months without access to Safe Harbor NMCM (RCC equivalent) support.[170, 171] MEDHOLD is described as a short-term medical treatment program for RC Sailors to address ambulatory conditions incurred or aggravated after the completion of continuous AD orders for more than 30 days.[172] MEDHOLD EAST has a patient population of 67 RC members and a staff of 13 including chain of command, medical officer, three Navy corpsmen and three RN medical case managers (contractors).[173] The case managers provide assistance with medical and nonmedical needs, including for dependents, as warranted.[174] MEDHOLD WEST has a population of 44 RC members.[175] The RWTF's February 2012 visit to MEDHOLD EAST revealed problems related to RC Sailors' access to health care, access to non-medical case management, and morale.[176, 177] While the Navy Safe Harbor Program indicated 29 individuals in MEDHOLD EAST had received support from Safe Harbor and 11 are enrolled,[178] RWTF heard from focus group participants that they did not have an RCC/Safe Harbor NMCM and did not have a CRP.[179] This recommendation will ensure that every Sailor who remains in MEDHOLD

beyond six months is classified as CAT 2 and thus enrolled in Safe Harbor and assigned Safe Harbor NMCM (RCC equivalent) support.

The RWTF believes linking CAT 2 status with the assignment of an RCC or NMCM is important, given how valuable the RCC is to RWs. Sixty percent of RWs responding to the RWTF focus group mini-surveys indicated their RCC was very or extremely helpful.[180] In RWTF focus groups, RWs named RCCs as part of their recovery team and indicated they were helpful.[181] The Marine Corps WWR reports 87 percent of their Care Coordination Survey respondents were satisfied with RCCs, with 86 to 90 percent satisfied with their RCC's abilities to solve problems (88%), to follow through (86%), and to provide referrals (89%).[182, 183] While RWs and family members also had some significant concerns about the efficacy of RCCs,[184, 185] the RWTF believes they are an important resource for any RW meeting the above criteria. Adopting the above definition for CAT 2 designation, to serve as the criteria for being assigned an RCC for non-medical case management will allow resources to be allocated to a more targeted population of RWs and will create parity across the Services, and between AC and RC, that is currently lacking.

RECOMMENDATION 13

All RW squad leaders, platoon sergeants, fleet liaisons, Navy Safe Harbor NMCMs, Army Wounded Warrior (AW2) advocates, section leaders, and AFW2 NMCMs should attend the joint DoD RCC training course.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP, USA, USN, USAF, USMC, USSOCOM

Finding: RWTF focus groups indicated mixed satisfaction with transition unit staff, RCCs, and other supports,[186] and surveys conducted by the Services also suggest mixed RW satisfaction with these personnel.[187, 188] RWs responding to the RWTF focus group mini-survey had mixed feelings on the helpfulness of RCCs and chain of command, while helpfulness ratings were generally higher but still varied for AW2 Advocates.[189] Such mixed satisfaction suggests there may be room for improvement in staff training.

Joint, interdisciplinary training would advance the collaborative practices already in place at some of the sites the RWTF visited, where staff acknowledged the advantages of interdisciplinary teams and idea sharing.[190] Army Warrior Transition Command (WTC) has continued to augment and expand its training for WTU cadre and acknowledged that cross-training is a best practice.[191] The Marine Corps Wounded Warrior Regiment (WWR) has also augmented its training for section leaders, ensuring mentorship among RCCs and Battalion staff supervision of RCC training, and has acknowledged the value of training some topics across job titles with its phased-implementation of a 25-module computer-based training for all permanent WWR staff.[192] The RWTF believes that joint cross-training would improve care to RWs through increased collaboration and communication among the staff supporting them.

RECOMMENDATION 14

The Services should provide support to family members/caregivers without requiring RW permission. Support should include a needs assessment, counseling, information, referrals, vocational guidance, financial management/assistance, and other resources as needed. HIPAA and Privacy Act should not interfere with support to family members/caregivers.

Requested Agencies to Respond: DoD, OUSD(P&R), USA, USN, USAF, USMC, USSOCOM

Finding: While the Services may have directed increased attention and resources to outreach to family members/caregivers, the RWTF focus groups with family members indicated family member needs for communication remain. What RW family members want in the way of outreach and communication from the military emerged as an overall focus group theme: improved, direct communication from and with the military rather than relying on their RWs as a conduit.[193, 194] Specific recommendations made by some family member focus group participants included providing new family members information early in the recovery process, providing an information session on available programs for family members, contacting family members more frequently, having someone available to direct family members to resources, and checking in on families on a monthly or bi-monthly basis to ensure their needs are being addressed and they are connected to services as appropriate.[195]

Many family members are not receiving information about existing resources or adequate services to assist them during their RW's recovery process. Several overall themes in this regard emerged from the RWTF family member focus groups. Most importantly, it was clear that additional information and communication for family members is needed.[196] For example, some family members reported they are not provided enough information, do not know who to call for information, and/or do not know what available resources exist.[197] Some family members reported that they rely on their RWs to supply them information; but their RWs often do not have it, may forget it, and/or may not want to share it with them. The RWTF's family member focus group mini-survey asked respondents to rate their satisfaction with information/education to help family members care for their Service members (n=44) and information/education about available benefits and services (n=45). In both cases, about as many respondents reported that they were dissatisfied/very dissatisfied as satisfied/very satisfied.[198] Similarly, it was not unusual for some family focus group participants at the same location to report that they did not receive consolidated reference information while other participants reported that they did receive information resources in some form.[199] Many family members observed that not knowing about available supports and benefits prevents family members from taking fuller advantage of these resources.[200]

The briefings that the RWTF received during site visits corroborated that many sites provide information and/or resources to RWs instead of directly providing them to family members/caregivers.[201] In particular, a Community Based Warrior Transition Unit (CBWTU) site and an outside the continental United States (OCONUS) site reported depending heavily on RWs to involve family members.[202] Many sites reported high rates of "contact" with family members when asked about reaching out to family members during the recovery process.[203] However, contact was defined in varying ways, including contacting RWs and asking them to pass information on to family members; emailing or mailing information to all family members

without confirmation that they received this information; and making outreach telephone calls to family members directly.[204] Many sites also reported that HIPAA and privacy concerns present a barrier to contacting family members. For example, many sites reported contacting family members only if RWs provide their contact information or sign a form giving permission for the family member to be contacted.[205] Sites often followed this procedure even when the information to be provided was not HIPAA-protected – such as to provide families information regarding available individual counseling, financial counseling, and other services for them – leaving family members without assistance to address their own needs during the recovery process. Some sites added that providing information and services directly to family members who are remotely located is particularly challenging as the geographic dispersion of Guard families constrains face-to-face and personal contact with families.[206] To be effective, outreach efforts must ensure that family members actually receive the information and support they need.

Family member focus group mini-survey results revealed mixed views of satisfaction with the military's support during various stages of the recovery process and different types of support, emphasizing a need for improvement in services delivered to family members.[207] Over half of the respondents indicated they were satisfied/very satisfied with support getting family members to the RW's bedside after the family member was notified (n=22); for subsequent stages of the recovery process, including support for family during inpatient care (n=33), outpatient care or partial hospitalization (n=39), and follow-up care (n=32), about as many respondents indicated satisfaction as dissatisfaction.[208]

With respect to family members' satisfaction with the types of support the Services provide them, the RWTF's family member focus group mini-survey asked respondents to rate their satisfaction with military support in a variety of areas, including overall (n=46), financial (n=37), assistance/advocacy (n=40), logistics (n=30), condition of facilities (n=43), dealing with family members' emotions (n=41), and helping children cope with RW's injuries (n=30). The respondents were divided in the proportion of satisfied/very satisfied versus dissatisfied/very dissatisfied for overall support, financial support, and assistance/advocacy, and more respondents were satisfied/very satisfied than dissatisfied/very dissatisfied with support for logistics and condition of facilities.[209] However, more respondents were dissatisfied/very dissatisfied than satisfied/very satisfied with support for family member's emotions and support for helping children cope with RW's injuries.[210] RW family member dissatisfaction also was reflected in results from the DoD-level IDES Satisfaction Survey administered by the Defense Manpower Data Center (DMDC) to IDES participants (January 2008 to September 2011) – specifically, family members typically expressed a lower rate of satisfaction than RWs with the helpfulness of Disability Evaluation System (DES) program staff to them.[211]

Family member participants recommended increasing education, communication, outreach, information, and support for family members focused on coping with having a spouse or parent who is an RW.[212] Specific recommendations made by some family members included providing spouses and children skills/tips for interacting with their RWs, providing family members a psychologist with knowledge of military culture, offering programs for children, providing family members information on how to cope with an RW who has PTSD, and helping school children to understand the situation and to manage negative feedback from their peers.[213] The National Military Family Association (NMFA) has also advocated for additional services family

members/caregivers need, such as caregiver employment, peer to peer mentoring, and care for the caregiver.[214]

The Marine Corps has the most robust protocol for contacting family members/caregivers,[215, 216] which includes aggressively encouraging RWs to consent to Marine Corps communication, persuasively briefing RWs on the benefits of family involvement, and making RW family support a commander's responsibility. The Marine Corps involves the family caregiver early in the process by using the WWR RCP Family Contact Authorization Form to obtain permission from the Marine to provide communication and support to the family caregiver. While it is not mandatory for RWs to provide family member contact information authorizing family member/caregiver support from the RCC, Marines who do not provide this information will be counseled by leadership about the benefits they will give up and must sign a form acknowledging that they are informed of the benefits and still do not wish for the family member to benefit.[217] The Marine's RCC will continue to provide support to the family member until this form is signed.[218] While the RWTF believes that the Marine Corps' protocol for contacting family members is a best practice, the RWTF also urges the Services to ensure that requiring RW permission does not needlessly inhibit family support outreach efforts to provide non-HIPAA-protected information to family members in order to meet their needs.

RECOMMENDATION 15

Each Service should clearly identify a readily available, principal point of contact for the RW in every phase of recovery. Initial and ongoing contact with the family/caregiver is the responsibility of this individual. Provide this individual the requisite tools and equipment to help meet the family's/caregiver's needs.

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

Finding: Although Army and Marine Corps sites identified a wide range of supports for families, sites also identified a number of different individuals as being responsible for linking family members/caregivers to those supports.[219] The RWTF believes that having multiple points of contact for family member needs can be confusing for family members and diffuses responsibility for ensuring these needs are met. Across seven site visits to Army and Marine Corps sites, the RWTF encountered one site (an OCONUS Army program) where the unit social worker conducts home visits with each family, ensuring face-to-face contact immediately following intake.[220] The social worker meets the whole family and tells family members to contact her should they need anything.[221] This practice is an example of how family members can be introduced to one point of contact to whom they can turn for information resources, referrals, and support services.

Many indicated the need for one point of contact available to family members to improve communication and the flow of information. NMFA reported that "there is a lack of a single point person to help guide families/caregivers in making lifetime decisions about themselves and the RW. The FRC is designed to do this, but does not enter the picture early enough to provide this valuable role."[222] The RWTF heard in focus groups that family members desire increased/improved general communication from and with the military, suggesting that the status quo of multiple points of contact does not meet the needs of family members.[223] Specific

recommendations made by some family member focus group participants included providing new family members information early in the recovery process, providing an information session on available programs for family members, contacting family members more frequently, having someone available to direct family members to resources, and checking in on families on a monthly or bi-monthly basis to ensure their needs are being addressed and they are connected to services as appropriate.[224]

The Army CTP Policy and CTP-Guidance emphasizes the importance of including family members as part of the CTP process and identifies caregiver support responsibilities.[225] There is no specific guidance identifying which member of the RW's recovery team should contact the family member, how, or when.[226] Consequently, it is up to the industrious staff member to self-identify and reach out to the family member, which may or may not occur. In addition, no specific individual is responsible for proactively reaching out to family members to see how they are coping. Thus, unless the RW tells unit staff that there are family issues or the family is savvy or assertive enough to contact the unit, families in need are unlikely to receive assistance.[227] The Army reported that it does not believe it is necessary to specify a single recovery team member responsible for family members' needs and that the success of the Army programs and services for RWs relies on shared responsibility for the RW and family caregiver[228]; but, in the experience of the RWTF, this process may not meet family member needs.

Neither the Navy Safe Harbor Program nor the Air Force Warrior and Survivor Care Program specify an individual responsible for providing family support. Staff from one Navy Fleet and Family Support Program (FFSP) reported that they respond to needs on a case by case basis and do not actively inquire whether customers are families of RWs.[229] They noted that other regions (such as FFSP Bethesda) with larger populations of RWs may operate differently.[230] Navy Safe Harbor reported that "the way ahead" for them includes creating an "interactive family outreach network" and increasing "outreach and communication efforts," however.[231] Within the Air Force, although the RCC is primarily responsible for "engaging the RW and family and ensuring they actively participate throughout the entire CRP process,"[232] the Family Liaison Officer (FLO)[233] and the AFW2 NMCM[234] are also involved in providing for family member needs.

The Marine Corps has the most robust protocol for contacting family members/caregivers.[235, 236] This protocol includes proactively reaching out to family members through the RCC and tasks commanders with proactively identifying and solving family support needs for family members of Marines and Sailors at the Wounded Warrior Battalion and its detachments.[237] The RWTF believes that the Marine Corps' protocol for contacting family members is a best practice and should be extended to family members of Marines in line units, including those with and without an RCC.

There is a need across each of the Services to task and hold accountable one individual to proactively reach out to family members/caregivers initially – without waiting for family members to seek help – and throughout the recovery process, in order to provide information and referral, assess the needs of family members/caregivers, and resolve family member/caregiver issues. This individual must be provided the necessary tools and equipment to facilitate family member/caregiver needs being met. For example, FLOs should not be required to use private cell phones or computers in their efforts on behalf of family members.[238]

An additional equipment challenge is transporting family members who are not on orders and, thus, are unauthorized to ride in official vehicles.[239]

RECOMMENDATION 16

Upon RW entrance into the IDES, the Services should educate family members/caregivers on potential benefits changes upon separation, the VA Caregiver Program, VA Vet Centers, and other federal/state resources for which families may be eligible. The Services should use social media, apps, fact sheets, pamphlets, videos, or other communication tools to educate family members on these topics.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP, USA, USN, USAF, USMC, USSOCOM

Finding: VA has a number of resources that can help family members/caregivers cope with challenges once the RW has transitioned to being a Veteran. For eligible caregivers, there is the VA Caregiver Support program, which provides caregiver training, education, and a stipend.[240] There are also a number of positions tasked with providing family member/caregiver support, including the VA Caregiver Coordinator, VA Liaisons,[241] OEF/OIF case managers,[242] Polytrauma case managers,[243] and VA Vet Center counselors.[244] Eligible Caregiver Assistance Program enrollees are not identified until the Veteran is receiving care in the VA and the caregiver has been identified by the VA OEF/OIF Program,[245] and the Services do not systematically brief eligible family caregivers on the VA Caregiver Assistance Program, or generally brief RW family members on the VA resources that will be available to them post transition.[246] For example, Crystal Nicely, a caregiver and spouse of a severely wounded OEF Veteran, testified before Congress in 2011 that she was not provided any information about the VA Caregiver Program or other VA programs and benefits.[247] In addition, no formal process exists to ensure families learn well in advance how and why pay and other benefits may change when the RW transitions to Veteran status. The RWTF believes that family members must be counseled on resources, services, and benefits well prior to separation in order to prepare for the next chapter in their lives and to facilitate a smooth transition. Families should also be informed about additional federal and state resources available to them, such as state financial and educational benefits.[248, 249] This proactive communication with RW families should be institutionalized by incorporating it into the Comprehensive Recovery Plan that DoDI 1300.24 requires for all CAT 2 and CAT 3 RWs.[250] Family members should also be encouraged to seek legal counsel in addition to meeting with VA personnel.

The need to ensure that families are fully educated on their post DD-214 benefits was underscored in the RWTF briefings and panels from individuals who assist RWs through the DoD/VA transition. The most dominant theme in these discussions, emerging in a majority of the briefings/panels, was that RWs/families experience discontinuity in the key resources that were available to them while on AD after transitioning from DoD.[251] They lose a community of friends and comrades as well as a familiar network of base-centric medical and non-medical services.[252] At the VA, they experience reduced access to health care, with long waits for medical appointments, particularly specialty appointments, and less frequent behavioral health therapy.[253] Because Reservists often lose their AD status very shortly after re-deploying, they experience a more profound loss of resources than do their Active Component (AC) counterparts.[254]

Additional overall themes emerged from the briefings/panels, including the financial hardship that transitioning RWs and families experience when RWs' post-DD214 pay – such as disability compensation, education stipend, or civilian pay, if employed – falls short of military pay and the difficulty of navigating the complex VA healthcare system.[255]

Themes also emerged from the briefings/panels specifically related to the needs of transitioning RW families. Touch-points spoke of tangible challenges such as relocation, adjustment challenges for children and spouses (including marital role reversals and the risk of divorce), family safety issues related to the risk of secondary trauma and the potential for RW violence, and access to healthcare.[256] Only families whose RWs are 100 percent disabled are eligible for VA healthcare.[257] Proponents also noted a disparity in the implementation of the health insurance benefit associated with VA's Comprehensive Caregiver Assistance Program.[258] As implemented, a caregiver who has been paying for insurance despite being unable to afford it is ineligible for the benefit while a caregiver of comparable means who has chosen to go uninsured is eligible for the benefit.[259]

The proposed recommendation to systematically educate families/caregivers upon their RW's entry into IDES about the benefits and resources that will be available to them when he/she becomes a Veteran will help them prepare for life post-transition, make optimal use of available resources, and navigate the transition process.

RECOMMENDATION 17

The Services should require that, upon RW entry into IDES, PEBLOs brief families/caregivers enrolled in the Exceptional Family Member Program (EFMP) on the potential loss of TRICARE Extended Care Health Option (ECHO) benefits upon completion of IDES if discharged.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), Office of the Assistant Secretary of Defense for Readiness and Force Management (OASD(R&FM)), Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy (ODASD(MC&FP)), WCP, USA, USN, USAF, USMC

Finding: TRICARE offers ECHO to qualifying AD Service members who are enrolled in EFMP.[260] ECHO covers the cost of additional services and supplies for the exceptional family member's care.[261] Service members lose their ECHO eligibility upon retirement, which, according to a 2011 study by the National Council on Disability in partnership with the Marine Corps, is a concern for those AD families who rely on it.[262] Change in ECHO benefits during a Service member's transition from AD to Veteran status contributes to a lack of seamless transition of programs and benefits for military families.[263] Families in EFMP and TRICARE ECHO whose RW are separating need information and time to explore state resources, such as Medicaid waivers for home and community based care that can offset the loss of ECHO.[264]

RECOMMENDATION 18

The Services should seek every opportunity to unify family members/caregivers and RWs. It is important to preserve family dynamics and keep family members engaged in the recovery process.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP, USA, USN, USAF, USMC, USSOCOM

Finding: When redeployed Service members are held for further medical evaluation at the MTF, families are unable to be reunited with their Service members as anticipated. For some, this unexpected family separation after the deployment may be as long as the deployment itself. For example, the average stay in the Army WTU system is 265 days.[265] This is particularly challenging for RC families and AC families who are located great distances from the MTF and who endure prolonged separations from their RWs and/or pay out-of-pocket for periodic visits to their RWs. The RWTF was informed that RC family member travel to and lodging near the RC RW assigned to a WTU is not funded, which creates a financial burden or inhibits contact when the RC RW is detained for further medical evaluation.[266]

Separation can be emotionally difficult for all concerned,[267] may be logistically challenging for the family,[268] and is not conducive to the RW's recovery.[269] According to a DoD survey of AD spouses regarding their Service member's deployment, the most frequent problems experienced, to a "large" or "very" large extent, included loneliness, being a "single" parent, emotional problems, and difficulty maintaining an emotional connection with their spouse.[270] In earlier DoD spouse surveys, the most frequent problems both AC and RC spouses reported experiencing, to a "large" or "very" large extent, while their spouse was deployed included loneliness, feelings of anxiety or depression, difficulty sleeping, household repairs, yard work, car maintenance, and job or education demands, which emphasize how difficult prolonged separation can be for family members.[271] During post deployment, separation makes it challenging for families to get information, since they rely on the Service member for accurate information about what is occurring at this time. [272] The Service member may also be unable or unwilling to provide information, particularly if he or she suffers from TBI or PTSD.[273] Not only is separation problematic on several levels but on-site family support has been found to help the RW during the recovery process and is associated with improved recovery,[274, 275] reduced medication use,[276] and return to work.[277] Healthy family functioning as a whole is associated with a lower level of disability/functional impairment and higher employability.[278] Thus it is important for the well-being of the family as a whole, the RW, and the individual family members to optimize their opportunity to be together.

RECOMMENDATION 19

WCP should rename the NRD to reflect its target audience. Market the newly named portal with a goal to more than double the usage.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP

Finding: Several information resources, websites, and call centers are available to educate and support RWs and their family members during the recovery process. Congress specifically instructed the RWTF to explore the effectiveness of the NRD, Military OneSource, Family Assistance Centers (FACs), Wounded Warrior Resource Center (WWRC), and Service hotlines. The RWTF gathered data about these resources from DoD, the Services, and the RW community. It is apparent to the RWTF that there is redundancy in these resources and, in some cases, under-utilization. The RWTF is concerned about the number of existing information

resources because of the potential for confusion and frustration for RWs and family members. Others noted that because of the large number of websites and programs, family members do not know how to ask for many resources or are overwhelmed completely.[279] The RWTF is particularly interested in the NRD as a portal that specifically addresses the needs of the RW community. The RWTF believes that changing the name of the NRD to reflect RWs and their family members as its target population would increase recognition among this population that this resource is designed for them, and thus increase its use.

The RWTF recognizes recent efforts to decrease the number of existing websites and to link existing resources. For example, the former WWRC website was replaced by a portal in the NRD website that allows RWs and FMs to email questions, which are then answered by the WWRC Wounded Warrior specialty consultants.[280] The Military OneSource Wounded Warrior tab provides a link to the NRD and to the phone number for the WWRC.[281] Some of these resources can be difficult to find, such as the Wounded Warrior tab on Military OneSource, where users must first click on the Military Life & Deployment tab in order to see the Wounded Warrior tab.[282]

The RWTF study participants were more familiar with Military OneSource than the NRD. Many RWTF RW and family member focus group mini-survey respondents reported that they had used Military OneSource (29/45 family members[283] and 71/162 RWs[284]). Of those, they were divided in their ratings of how helpful this resource was for them.[285, 286] The family member focus group discussions echoed these mixed reviews about Military OneSource's helpfulness: some family member participants at the same locations reported that Military OneSource was helpful for them, while others reported that it was not – though slightly more fell into the "not helpful" side.[287] Some family members elaborated on why this resource, which includes online as well as telephonic support, was not helpful for them, noting a lack of applicable information for Wounded Warriors, buried information, and disorganization.[288] The RWTF believes that some of these shortfalls in meeting RWs' and family members' needs occur because this information resource is targeting the needs of the entire military community rather than the specific needs of RWs and their family members.

The RWTF found that only a small proportion of RWTF family member and RW focus group mini-survey respondents reported use of information resources designed to meet the needs of RWs and their families. For example, fewer participants reported that they had used the NRD (1/45 family member respondents[289] and 12/159 RW respondents[290]), a military hotline (1/44 family member respondents[291] and 13/158 RW respondents[292]), and the WWRC (12/46 family members[293] and 50/160 RWs[294]). Those who had used these resources, however, indicated that they were helpful.[295, 296] These findings suggest the NRD, military hotlines, and the WWRC are helpful resources but underutilized by RWs and family members. (Note that the Marine Corps hotline may be an exception as utilization among RWs in the WWR appears higher, which may be in part due to the outreach function of the call center. The Marine Corps WWR 2012 Care Coordination Survey found that over 75 percent of 717 survey participants were satisfied overall with the call center/contact cell, which also implies higher utilization among this population.[297])

The RWTF is particularly interested in the NRD to connect RWs and their families to vetted information resources specific to their needs. In its 2012 Care Coordination Survey, the Marine Corps WWR found that 12 percent of their WII Marines reported using the NRD.[298] In its

October 2011 briefing to the RWTF, the DoD WCP reported that 180,000 unique users had visited the NRD webpage, but could not yet break out how many of these users were RWs and/or family members.[299] WCP also indicated it was expanding its NRD outreach and marketing efforts, including providing additional resources/budget to the outreach division, changing the information technology (IT) platform so that when an RCC pulls up a file to discuss RW needs it now has the NRD on it, adding the NRD as an item to the counseling checklist, increasing RCC training on the NRD, partnering with private organizations, using social networks, adding a community blogger to promote the NRD, and adding radio interviews/discussions.[300] However, the RWTF remains concerned about the underutilization of this resource among RWs and family members. Changing the name of the NRD to more explicitly target the RW/family population, while continuing WCP's recent multi-faceted marketing efforts, should increase recognition and use of this vital resource by the RW community.

RECOMMENDATION 20

The Services should specify the RW program relationships with installation level family support centers and sufficiently resource Soldier and Family Assistance Centers (SFACs), Navy Fleet and Family Support Centers, A&FRCs, and Marine Corps Community Services (MCCS) family assistance facilities to effectively meet the needs of RWs and their families. Each family assistance center (FAC) should identify personnel responsible for meeting the needs of the RW community.

Requested Agencies to Respond: DoD, OUSD(P&R), ODASD(MC&FP), USA, USN, USAF, USMC

Finding: Relatively few RWTF RW and family member focus group mini-survey respondents reported that they had used a FAC or SFAC (18/45 family members[301] and 40/151 RWs[302]). However, those who had used them rated them highly.[303, 304] Specific factors that family member focus group participants mentioned as contributing to the helpfulness of the FAC/SFAC included staff who did their best to help, were honest, searched for information, and provided useful information.[305] Family members also seem to appreciate having the same person help them each time.[306] These findings suggest that FACs/SFACs are helpful resources that may be underutilized by RWs and family members. While this may be true across the board, it is important to note the relationship between FACs/SFACs and RW programs is not consistent across the Services. The RWTF believes consistent policy linking RW programs to FACs will increase utilization of this valuable and helpful resource.

The Army SFACs are co-located with WTUs expressly to provide targeted information resources and other services to address the needs of RWs and family members.[307] At continental United States (CONUS) sites the RWTF visited, Army SFACs reported high utilization by RWs.[308] In some cases, sites reported 100 percent utilization, though one SFAC reported a lower percentage for in processing personnel attached (72%) versus assigned (95%) to the WTU.[309] Note that these percentages specifically addressed those RWs who in processed through the SFAC as opposed to those who utilized other SFAC services.[310] One site reported additional utilization over 60 percent within 30 days, depending on the RW's goals.[311] Other sites did not specify utilization other than in-processing rates.[312] Some sites reported that the percentage of family members who had used the SFAC was difficult to capture, but in all cases, estimates of

family usage were lower than RW usage.[313] At CONUS SFACs, percentages for family usage ranged from 20-30 percent.[314]

Within the Air Force, A&FRCs serve all Airmen and family members, including the RW community. Most centers have a Community Readiness Consultant (CRC) with expertise in wounded warrior issues who serves as the "go to" when a wounded warrior is referred.[315] The A&FRC and AFW2 policy management team are co-located in the new Air Force Warrior and Family Operations Center in San Antonio, linking the A&FRCs with the AFW2 mission to ensure warm handoffs at the installation level for AFW2 participants.[316] The relationship between the Air Force A&FRCs and the AFW2 Program is a best practice that promotes RW and family member awareness of, and access to, priority services.[317] This model for pulling together two types of installation programs for maximum utilization of resources is consistent with the observation of NMFA, that "there needs to be better coordination of existing Service Family Support Centers with a medical and non-medical component with all Recovering Warrior case managers."[318] Per FY2012 Recommendation 1, the relationship between the A&FRCs and the AFW2 Program must be formally specified in Air Force policy to ensure that the warm handoff of AFW2 participants to A&FRCs that is envisioned at Air Force Headquarters is faithfully implemented at the installation level.

The Navy and Marine Corps have not yet established comparable relationships between their base-level FACs and their RW programs. At one Navy site, the Director for Fleet and Family Support Services reported that her organization serves RWs and their families, when asked, but suggested that, in partnership with Safe Harbor, they could be doing much more.[319] The Marine Corps has a very robust Wounded Warrior Regiment Program that has developed a number of information resources for RWs and family members, including a customized Keeping It All Together notebook,[320] numerous fact sheets,[321] a smart phone application that allows users to access information resources electronically,[322] and a robust call center.[323] However, apart from the Hope and Care Centers already at Camp Pendleton and planned for Camp Lejeune, it does not yet appear that the WWR has established a formal relationship with base-level Marine Corps Community Services.[324] The Navy and the Marine Corps should write policy to formally link base family assistance/information resources and RW programs in order to increase RW and family member awareness and utilization of existing base services. At minimum, each Navy Fleet and Family Support Center (FFSC) and Marine and Family Readiness Center should equip and designate a "go-to" to address the targeted needs of the RWs and their families.

As the current conflict draws down, the number of war casualties will decline and the infrastructure of RW programs may shrink; but Service members will continue to sustain injuries and illnesses and the needs of RWs and their family members will continue. Systems must be in place to provide them the information resources and services they need. The RWTF believes the Navy, Air Force, and Marine Corps should capitalize on existing base-level systems, such as each Service's FACs and that the Army should continue their use of the SFAC. Recognizing that funding for "family programs" may be at risk in the post-war fiscal environment, the RWTF recommends the Navy, Air Force, and Marine Corps prioritize funding for base-level FACs to ensure they can retain sufficient high quality staff and train them appropriately to meet needs of the RW community that may otherwise go unaddressed.

With respect to the SFACs, in particular, an Army site reported to the RWTF that Installation Management Command (IMCOM) funding for SFACs is being decreased.[325] The Army SFAC is an integral component of the Army's RW program. As the RWTF stated in last year's report, Army SFACs are co-located with WTUs and offer a wide slate 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 a computer room.[326, 327, 328, 329] When asked to brief on caregiver support, the Army focused its presentation on SFACs, demonstrating the centrality of this resource to the Army's caregiver support strategy.[330, 331, 332] The Army has 32 SFACs – 29 locations within CONUS and three major locations OCONUS.[333, 334] Of 18 CONUS SFAC construction locations, six were open as of July 2011 and operating in centrally situated, campus-like RW settings.[335, 336] Twelve more new construction projects were under way or in the planning stages. Army-wide, the SFACs employ 208 staff.[337, 338] The CTP Policy and CTP-Guidance published by the Army WTC in December 2011 states that the SFAC will provide a number of important functions in providing information resources to RWs and family members as SFACs are directed to "in-process the Soldier and his Family members within 30 days of arrival and ensure they receive a copy of the SFAC Hero Handbook, conduct an orientation tour, and schedule referrals as needed to social worker services, finance, Army Substance Abuse Program (ASAP) education, Army Career and Alumni Program (ACAP)/Transition Assistance Program (TAP), Child & Youth Services (CYS) Outreach, Veterans Benefits Administration (VBA) representatives, Veterans Health Administration (VHA) representatives, state VAs, and REALifelines/DOL representative."[339] The RWTF urges IMCOM to prioritize and maintain current funding for SFACs to ensure they can continue to fulfill the pivotal role in RW care and transition that the Army intends.

RECOMMENDATION 21

The Services should establish centralized case management for RC RWs on Title 10 orders. The size of the centralized staff, and the staff qualifications and training, must comply with staffing ratios and other criteria set forth in DoDI 1300.24 and DTM 08-033. The centralized program must be sufficiently robust that it can meet surges in demand.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), Office of the Assistant Secretary of Defense, Reserve Affairs (OASD(RA)), WCP, National Guard Bureau (NGB), United States Army Reserve (USAR), Air Force Reserve, Navy Reserve, United States Marine Corps Reserve (USMCR)

Finding: Diverse stakeholder groups and sources at varying levels indicated that medical care case management for demobilizing and demobilized Reservists is inadequate.[340, 341, 342, 343] During site visits and business meetings, the RWTF received nearly 30 briefings and panels from approximately 50 individuals who assist RWs through the DoD/VA transition. Nearly one-fourth of the briefings/panels addressed shortfalls in medical care case management for Reservists who incur/aggravate wounds, illnesses, or injuries while on Title 10 status.[344] The briefers observed that LOD documentation for Reservists often is not completed in theatre as intended and the absence of LOD documentation delays continuation or reinstatement of Title 10 orders.[345] They said Reservists are regularly demobilized before their medical issues incurred

or aggravated in the LOD are addressed, jeopardizing access to medical care and/or creating an undeserved financial burden.[346]

The RWTF visited three state JFHQs – Indiana, Massachusetts, and Iowa – and received extensive site-level briefings from joint, Army National Guard (ARNG), and ANG proponents. All three JFHQs identified significant problems obtaining post-mobilization medical care for National Guard members who are injured, ill, or wounded while on Title 10.[347] Redeployed ARNG Soldiers are eligible to be assigned to the Army WTU system, which provides them not only medical care through the MTF but also clinical and non-medical case management. Currently, ARNG Soldiers comprise 53 percent of the total WTU population,[348] however, two JFHQs identified barriers to use of the Army WTU system for redeployed RC RWs.[349] Indiana reported the WTU accepted four of 104 potentially eligible candidates.[350] Iowa projected that 300 to 500 of their redeployed Soldiers would be eligible for assignment to a WTU, yet only eight were accepted.[351] The majority of Indiana and Iowa RC RWs return to their states from the demobilization site directly, with referrals and profiles, placing an un-resourced burden on the state for care and case management.[352] JFHQ proponents said many AC, RC, and contract demobilization site providers have insufficient knowledge of National Guard health benefits and how they change when Service members switch from Title 10 to Title 32 and, in some cases, have insufficient familiarity with Title 32 terminology, programs, and constraints.[353] This compromises their capacity to appropriately advise demobilizing Guard members.[354] The JFHQ proponents also expressed concerns about parity for Guard members after they return from AD and enter Title 32 status.[355] They observed that frequent medical appointments can jeopardize a Title 32 Soldier's civilian employment.[356] Subject to how competently their case is managed, a Title 32 Soldier with a Title 10 condition also may have a co-pay, creating an unjust burden and possible financial hardship.[357] The JFHQ proponents noted that some Guard Soldiers enter the Medical Evaluation Board (MEB) while on Title 32 despite the fact that MEB is a Title 10 process.[358]

The 14-state pilot ARNG RC Managed Care (RCMC) program[359] has a total of 100 contract Case Managers, including 95 RNs and five Masters of Social Work (MSWs), 328 contract care coordinators, and an unknown number of Active Duty Operational Support (ADOS) healthcare specialists (68W).[360] The ARNG lacks visibility on MCCM staffing in states that are not RCMC pilot sites.[361] While the RCMC is a start, the scale of this pilot effort is not equal to the ARNG's 57,276 "working case management cases."[362] As of March 2012, the 89 plus medical groups and geographically separated units of the ANG had no personnel designated in a position description to work wounded warrior issues.[363]

The recommended centralized case management program for Reservists on Title 10 orders is modeled after the ARNG RCMC program, the centralized AFW2 Program[364] and the pending centralized Air Force Case Management Officer (CMO) Program to expedite care, RTD, or IDES for Reservists who are remotely located from an MTF.[365] It will increase the inventory of case managers for RC RWs receiving care in the community through TRICARE, establish common qualifications and training – including RC-specific training where applicable – and standardize the baseline quality of case management services across the RCs, regardless of component or state. It will enhance access to health care, free of unintended financial burden, commensurate with the level of access and quality of care available to their AC counterparts.

This is primarily a program for low-risk/low-acuity/ambulatory RWs whose conditions are conducive to community-based care. While case managers will prioritize care in the community to the extent possible, there may be circumstances when it is necessary to refer RWs to the WTU system or an MTF, such as if an RW's condition becomes severe or needs become complex, or if he/she is non-compliant with the treatment plan.

As noted, the proposed program is for Reservists on Title 10 orders. The potential of this initiative to meaningfully impact the RC community as a whole will depend in large part on ensuring that all Reservists who have sustained LOD injuries/illnesses are on Title 10 orders, which is the objective of FY2012 Recommendation 22.

RECOMMENDATION 22

DoD must establish policies that allow for the rapid issuance of Title 10 orders to RC RWs who have sustained line of duty injuries/illnesses. Delays in Title 10 orders have resulted in the interim use of Incapacitation (INCAP) pay. DoD should define specific criteria for the appropriate use of INCAP pay that will be consistent across all Services.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(RA), NGB, USAR, Navy Reserve, Air Force Reserve, USMCR

Finding: Many sources reported during site visits and business meetings that Reservists are regularly demobilized before their LOD conditions are addressed, jeopardizing access to medical care and/or creating an undeserved financial burden.[366] The RWTF received nearly 30 briefings and panels from approximately 50 individuals who assist RWs through the DoD/VA transition. Nearly one-fourth of the briefings/panels addressed shortfalls in access to medical care and medical care case management for Reservists who sustain line of duty injuries or illnesses.[367] Specifically, the briefers observed that Reservists' LOD documentation often is not completed in theater as intended and the absence of LOD documentation delays continuation or reinstatement of Title 10 orders.[368]

Joint, ARNG, and ANG proponents at three state JFHQs identified significant problems obtaining post mobilization medical care for National Guard members who are injured, ill, or wounded while on Title 10.[369] They also expressed concerns about parity for Guard members after they return to Title 32 status, observing that frequent medical appointments can jeopardize a Title 32 Soldier's civilian employment and, unlike the Title 10 Soldier, the Title 32 Soldier may have a co-pay.[370] The JFHQ proponents noted that some Guard Soldiers enter the MEB while on Title 32 despite the fact that MEB is a Title 10 process.[371]

Within the National Guard, some states use INCAP pay to support Title 32 Soldiers who were prematurely separated from AD with LOD conditions or to cover Guard members who are sent home to go through the disability evaluation system.[372] The Navy Reserve offers RC Sailors the choice of remaining on AD orders in MEDHOLD EAST in Norfolk, Virginia, or WEST in San Diego, California, or entering the LOD Program, which enables them to be treated through TRICARE in their home community and to receive INCAP pay for loss of civilian wages.[373] Sailors in the LOD Program generally receive lower remuneration than Sailors in MEDHOLD and are responsible for filing a monthly claim for INCAP pay, while pay for MEDHOLD

Sailors is automatic.[374] While perhaps financially and logistically preferable, MEDHOLD entails prolonged separations from family and friends.

INCAP pay is a complex matter and it appears to the RWTF that the Services lack a common understanding of how it is to be used.[375] An Army Guard briefer noted, "The regulation does not exclude Title 10 (conditions) so we do it. It was not put in black and white that you cannot pay Title 10." [376] According to DoD policy, "the Military Departments shall authorize pay and allowances…for a Reserve Component member who is not medically qualified to perform military duties…because of an injury, illness, or disease incurred or aggravated in the line of duty, or to provide pay and allowances to a member who is fit to perform military duties, but experiences a loss of earned income because of an injury, illness, or disease incurred or aggravated in the line of duty. This is commonly referred to as INCAP pay."[377] The policy defines "incapacitation" as "physical disability due to injury, illness, or disease that prevents the performance of military duties as determined by the Secretary concerned, or which prevents the member from returning to the civilian occupation in which the member was engaged at the time of the injury, illness, or disease."[378]

The RWTF envisions that the implementation of this recommendation will afford similar benefits to RC Sailors in the LOD Program as those within MEDHOLD. They will continue to recover in their home communities, will no longer have to apply monthly for INCAP pay, and will receive Title 10 pay. Consistent with FY2012 Recommendation 21, as Title 10 Reservists they will receive centralized case management. Similarly, ARNG Title 32 Soldiers with LOD conditions will receive Title 10 pay and centralized case management, including an assessment to determine whether their care is best delivered in the community, at the MTF, or elsewhere. Thus, establishing policy for the rapid issuance of Title 10 orders to RC RWs who have sustained line of duty injuries/illnesses is not only an essential step toward parity of pay and benefits for RC RWs but is linked to other FY2012 recommendations, namely Recommendation 21 (centralized case management for RC RWs on Title 10) and Recommendation 12 (redefining CAT 2 designation, including two criteria that are tied to Title 10 status).

The rapid issuance of Title 10 orders is especially critical for Title 32 Reservists who experience late arising diagnoses, or worsening, of LOD conditions. Those with PTSD may exhibit increased symptoms after deactivation. If severe, these symptoms may interfere with their civilian employment, create financial hardship, and put their closest relationships at risk.[379] In such cases, reliance on the TAMP benefit (see Recommendation 7) is neither appropriate nor sufficient and the RC RW requires the comprehensive health care, case management, non-medical supports, and pay that Title 10 status affords.

It should be noted that the sequencing of the implementation of this two-part recommendation is important. Because some Title 32 Reservists with LOD injuries/illnesses currently rely on INCAP pay as their primary source of income, the establishment of policy to rapidly issue eligible Reservists Title 10 orders must precede any decision to eliminate use of INCAP pay.

RECOMMENDATION 23

The Army WTC should include out-processing with the RC Service member's home unit as part of the checklist for leaving Title 10 status.

Requested Agencies to Respond: DoD, OUSD(P&R), USA, WTC

Finding: ARNG proponents reported difficulty maintaining command and control over redeployed Guard Soldiers who are leaving transition units and/or completing the IDES.[380] There is no formal warm handoff from the WTU to the RC unit and, consequently, the line unit often is unaware that the Guard Soldier has been released.[381] One JFHQ reported to the RWTF that there is no communication or tracking mechanism in place other than informal telephone calls that they may receive based on personal relationships at certain WTUs.[382] A second JFHQ indicated they often do not know which of their Soldiers are assigned to the WTU.[383]

The release of Guard members without the knowledge of the line unit can disadvantage both the member and the unit.[384] The Guard member may not receive the pay and benefits to which he or she is entitled.[385] A JFHQ proponent said, "It is not uncommon that we will not be notified that someone is released and they are sitting at home waiting for their check to come in for disabilities and these individuals have not gotten a medical board yet."[386] In turn, the unit is carrying the Guard member on its manning roster, which counts against unit strength.[387] Additionally, the unit is unable to recover equipment.[388]

While briefing the RWTF in February 2012, Brigadier General Darryl Williams, Commanding General, Army WTC, acknowledged a significant problem with "pitching and catching" when National Guard Soldiers go off Title 10.[389] He suggested that pending Army restructuring should help to address this handoff issue.[390] In the meantime, the RWTF recommends the Army establish policy requiring Guard Soldiers who are being released from the WTU system and/or completing IDES to out-process with the Guard unit; thus formalizing the warm handoff that currently is lacking.

Optimizing Ability

Topics included in this domain address a central aspect of successful transition to civilian life – preparing for employment after military service. This includes vocational programs and services as well as the TAP and other systems to ease the DoD/VA transition.

RECOMMENDATION 24

DoD should publish interim guidance to implement NDAA 2012, Section 551.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(R&FM)

Finding: Section 551 of NDAA 2012 instructs DoD to allow apprenticeships outside the federal sector.[391] While USSOCOM Care Coalition is proceeding with implementing non-federal internship opportunities,[392] the Army maintains a policy limiting internships to the federal sector,[393] and the Marine Corps indicates it will not expand internship opportunities beyond the federal sector without DoD guidance.[394]

Expanding internship and apprenticeship opportunities beyond the federal sector would increase the availability of meaningful vocational opportunities for RWs. Few RWs who participated in

focus groups with the RWTF had heard of internship programs or opportunities.[395] Three RWs reported doing current internships but did not specify the program or resource; only one RW mentioned OWF, implying a lack of name recognition of this program among RWs.[396] Among those who had used vocational services more generally, some found them to be helpful, while others indicated vocational services had not met their needs.[397] Some noted concern that internships fill the time but do not further the RW's career.[398] Remote location of some transition units limits opportunities; RWs reported that being in an OCONUS transition unit or geographically remote results in fewer internship, educational, and/or career opportunities.[399] RWs' mini-survey responses echoed the limited availability of vocational services, especially internships; only four percent (6/157) indicated they had first-hand experience with OWF.[400]

Site briefings to the RWTF also indicated limited availability of internships; three sites mentioned using OWF, one site noted two percent of RWs are in OWF, and four sites mentioned using other internship programs.[401] Sites noted these did not always meet the needs of RWs; one site noted internships and other opportunities are not available in the professions/trades some RWs want, one site indicated OWF was understaffed and slow to respond to their RWs, and two sites indicated their location was not near federal internship opportunities.[402] Four Army and Marine Corps sites indicated RWs cannot have internships/work experience in the private sector, in accordance with current Service-level policies.[403, 404] Despite the limited availability, which could be ameliorated by expanding OWF and other opportunities beyond the federal sector, sites indicated internships are beneficial for RWs and were working to increase their offerings to RWs.[405] One site noted that 17 of its RWs had been hired through an internship program.[406] The Wounded Warrior Employment Hiring Rate Tiger Team, in September 2011, also noted that internship opportunities are a successful means of addressing RW unemployment and recommended such opportunities be expanded.[407]

RECOMMENDATION 25

DoD and VA should expand their existing memorandum of understanding (MOU), in accordance with Section 1631 of the Wounded Warrior Act, so that all RWs receive Vocational Rehabilitation and Employment (VR&E) counseling upon entering the IDES process.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP

Finding: VA VR&E is an important resource for vocational services for RWs, with a 77 percent rehabilitation rate for its active participants.[408] While Congress extended RW access to VR&E to December 2014 in the Veterans Opportunity to Work (VOW) to Hire Heroes Act,[409] the RWTF remains concerned about RWs' access to VR&E prior to separation, based on information from site briefings and focus groups.[410, 411] Several Veterans service organizations (VSOs) also expressed concern to Congress about access to and sufficiency of vocational services.[412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422]

In February 2012, DoD and VA signed a MOU to provide VR&E Vocational Rehabilitation Counselors (VRCs) at designated Military installations as identified by the Services and VA. This effort expands access to VR&E prior to separation by ensuring all RWs in IDES at selected installations sites can receive initial VR&E counseling.[423] This began with three sites, and planning continues to expand the number of sites.[424] While VR&E attempts to outreach to RWs

at several times during the separation process,[425] the RWTF believes the model established in the pilot whereby RWs in IDES are required to receive initial counseling from an onsite VRC should be the minimum standard outreach and intake for RWs pre-separation.

RWTF focus group and mini-survey results as well as Marine Corps survey results provide insight into RWs' access to and satisfaction with VR&E services. While VR&E was mentioned by some focus group participants as a helpful service, it was noted by others as ineffective in actually getting RWs employed.[426] FY2011 RWTF focus group participants indicated that the information about VR&E was not consistent, available, accessible, and/or understandable.[427] The FY2011 RWTF mini-survey findings corroborated this limited availability; only 19 percent of RWTF mini-survey respondents participated in VR&E,[428] yet most of the respondents who participated in VR&E found it helpful (67%).[429] This year's Marine Corps Care Coordination Survey revealed that 28 percent of respondents said they were unaware of VR&E, while 31 percent had used VR&E.[430] In last year's Marine Corps' Reintegration Phase Survey, 20 percent of respondents were participants in VR&E, and among those who were participants, 59 percent found it helpful.[431]

Across sites and Services, access to VR&E varies. Site briefings on vocational services this year showed that installations are collaborating with VR&E in different ways and with varying levels of success: five sites referred RWs to VR&E staff, four sites used VR&E staff to inform RWs of their options at briefings and musters, and one site had issued no memorandum ratings needed to begin VR&E pre-separation, nor did its staff who briefed the RWTF know how to prepare or request a memorandum rating.[432] While three sites had a VRC onsite at least periodically, three other sites' onsite VA representatives were not from VR&E. [433] Many sites had concerns about collaborating with VR&E, including inability to get memorandum ratings issued, VR&E's refusal to honor memorandum ratings, miscommunication with command about how well VR&E is utilized, and VR&E understaffing which led one installation to discourage RW participation.[434] During FY2011 RWTF site visits, installation staff cited VR&E and TAP as the programs providing vocational services and touted strong collaboration between unit/program staff and onsite or local VA and/or DOL personnel.[435] Air Force Warrior and Survivor Care staff indicated that only Airmen at San Antonio Military Medical Center (SAMMC) and Walter Reed National Military Medical Center (WRNMMC) have VR&E access now, though the pilot at Nellis Air Force Base (AFB) was forthcoming as of February 2012.[436] Where VR&E is available in the Air Force, access to VR&E services is determined in part by military duties.[437]

At the installations visited, RWTF has not yet seen adequate access to VR&E. Because it is valued by RWs and is one of few programs available for RWs who will transition from military service, it is critically important that DoD takes steps to ensure that RWs can access VR&E. Memorandum ratings must be provided to qualifying RWs, in accordance with current policy, to facilitate their participation in VR&E prior to separation. Without formal guidance from DoD, the lack of consistent and accurate information on how to utilize VR&E pre-separation impedes RW access to the service.

RECOMMENDATION 26

DoD should update DoD Directive (DoDD) 1332.35 and DoDI 1332.36 to include the following:

- Incorporate changes legislated by the VOW to Hire Heroes Act of 2011
- Ensure all RWs receive comprehensive information so that they can make informed decisions about accessing transition assistance opportunities
- Establish early referral (PEBLO checklist item) for the RW and his or her family member and/or caregiver to meet with the transition assistance program counselor.

Requested Agencies to Respond: DoD, OUSD(P&R), Office of the Secretary of Defense for Readiness and Force Management (OASD(R&FM))

Finding: In its FY2011 Annual Report, the RWTF recommended that all components of TAP become mandatory (Recommendation 17). Through TAP, DOL, VA, and DoD prepare Service members for their transition to civilian life, and this preparation is critical. Post-9/11 RWs are more likely than other generations of wounded Veterans to say "transition to the civilian world has been difficult" and to say "government has not done enough to help them".[438] Seventy-five percent say transition after military was difficult and 67 percent say "government failed to provide them with all the help it should."[439] These percentages are higher than other generations of wounded Veterans and higher than among post-9/11 non-RW Veterans.[440] Many recognized that RWs face particular challenges in transitioning from Service member to Veteran.[441, 442] In September 2011, the Wounded Warrior Employment Hiring Rate Tiger Team noted several key issues impeding RW employment, including unimpressive resumes, inability to translate military skills to the civilian sector, and incomplete transition plans.[443] TAP, while in need of continued improvement and updating, is designed to address these key issues.

The RWTF appreciates the efforts to increase access to and quality of TAP. DOL is implementing a curriculum redesign that should improve the usefulness of and satisfaction with TAP among Service members;[444] clear progress has been made with the passage of the VOW to Hire Heroes Act.[445] The latest DoD policies issued on transition assistance were DoDI 1332.36, Pre-separation Counseling for Military Personnel (1994),[446] and DoDD 1332.35, Transition Assistance for Military Personnel (1993).[447] Issuance of a new DoDI will ensure consistent implementation of the VOW to Hire Heroes Act across the Services, meeting the intent of RWTF FY2011 Recommendation 17.

VA provides Disabled Transition Assistance Program (DTAP), generally aimed at those likely to be eligible for VR&E. Nearly half (81/164) of RWTF focus group mini-survey respondents had attended DTAP. Of those, 10 percent (5/50) indicated it was not at all helpful, while 40 percent (20/50) indicated it was very or extremely helpful.[448] Only five of 46 family members had first-hand experience with DTAP.[449]

WCP surveys of transitioning RWs assess satisfaction with TAP, as administered by DOL, as well as satisfaction with DTAP. Between 72 and 92 percent were satisfied with the half-day DTAP.[450] Navy appears to have the highest satisfaction while Army Guard has the lowest.[451] Between 60 and 73 percent of survey respondents indicated they better understand their VR&E options since DTAP.[452] Army AC appears to most strongly agree that their understanding of VR&E increased with DTAP participation, while Army Reservists and Air Force Reservists were less likely to agree than their AC counterparts. There were also differences among the Services and Components on satisfaction with TAP. Between 56 and 73 percent agreed they were better

prepared to transition to civilian job market since attending TAP.[453] USMCR, USAR, and ARNG were least likely to agree that TAP had prepared them for transition to the civilian job market, while AC Airmen were most likely to agree.[454] While 70 to 85 percent of respondents indicated they were satisfied or very satisfied with the 3-day TAP administered by DOL, RC respondents appear less satisfied than AC respondents, and Army and Marine Corps respondents appear less satisfied than Navy and Air Force respondents.[455] DoD is expanding ways by which Service members can access TAP in order to make TAP more successful, especially for RC and remotely located RWs who cannot easily utilize transition offices at installations, through expanded offerings on TurboTAP.org.[456, 457]

The RWTF believes that linking RWs and family members/caregivers, through the PEBLO, to the transition assistance program counselor will ensure more robust utilization of that resource, and bolster RWs' confidence about the transition from DoD to VA.[458] This early contact will allow for more informed transition planning, enabling RWs to explore how best to use their time during the IDES process. As the Services work to reduce the number of RWs in the IDES process who ultimately RTD, IDES is increasingly becoming more focused on those who will separate.[459, 460, 461] The RWTF believes DoD should promote efforts to prepare RWs in IDES for transition to civilian life.

Enabling a Better Future

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

RECOMMENDATION 27

Congressional action is required to establish the Deputy Secretaries of DoD and VA as co-chairs of the JEC.

Requested Agencies to Respond: DoD, OUSD(P&R)

Finding: In February 2012 the SOC was integrated into the JEC as the WIIC.[462] However, the JEC remains co-chaired by the Under Secretary of Defense for Personnel and Readiness. Because there was general consensus among key SOC stakeholders that having the Deputy Secretary of Defense co-chair the SOC was a key component to its effectiveness,[463, 464, 465] the RWTF recommends that Congress ensure the Deputy Secretary of Defense co-chairs the JEC. The RWTF feels this level of leadership is needed to sustain Departmental attention on key initiatives such as IDES and electronic health records.

The VA Deputy Secretary has co-chaired the JEC since its inception. According to NDAA 2004, the JEC is to be comprised of:[466]

"(A) the Deputy Secretary of Veterans Affairs and such other officers and employees of the Department of Veterans Affairs as the Secretary of Veterans Affairs may designate; and (B) the Under Secretary of Defense for Personnel and Readiness and such other officers and employees of the Department of Defense as the Secretary of Defense may designate."

The RWTF recommends that Congress amend 38 U.S. Code (U.S.C.) Section 320 (a)(2)(B) to the following:

"(B) the Deputy Secretary of Defense and such other officers and employees of the Department of Defense as the Secretary of Defense may designate."

RECOMMENDATION 28

DoD should continue to evaluate processes to ensure only those RWs likely to separate enter the IDES process.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP

Finding: The RWTF believes it is imperative that the Services pre-screen IDES applicants to ensure the Services are aware of, and prepared for, the bow wave of those likely to enter IDES. The pre-screen also serves to RTD those who do not need to be referred to IDES. The mechanism for identifying the population likely to enter IDES may give the Services visibility on IDES staffing needs, improve timeliness of the process, and increase RWs' satisfaction with the process.

Each of the Services implemented a program for screening or monitoring of the pre-IDES population.[467, 468, 469, 470, 471] The RWTF believes DoD should review the existing programs to ensure the pre-IDES population is being accurately and consistently identified, decrease RTD rates in the IDES population, and marshal the resources necessary to administer the IDES process. Screening prior to IDES allows resources to be focused on those most likely to separate and not on those who will RTD. IDES outcome results indicate 11 percent to 14 percent of the total DoD IDES population was returned to duty between September 2011 and February 2012; in February 2012, 11 percent of the Army IDES population, 23 percent of the Navy IDES population, eight percent of the Marine Corps IDES population, and 23 percent of the Air Force IDES population was returned to duty.[472] This high RTD rate has implications for both the cost of and timeliness of IDES.

In March 2012, the Air Force implemented a pre-IDES screening process to reduce the proportion of Airmen that are referred to IDES and ultimately RTD.[473] The goal of the process is to screen Service members with potentially unfitting conditions – including conditions or occurrences which may indicate a Service member has a medical and/or mental health condition(s) that is/are inconsistent with retention standards or deployability – so they are appropriately referred to the IDES only when a RTD adjudication is not likely.[474]

Army Medical Command tracks Soldiers with temporary conditions on profiles.[475] The goals of this process include consistent, command-driven management of the temporary conditions population to maximize the return of Soldiers to available and deployable status.[476] Additionally,

the Army is piloting a program at Fort Stewart and Fort Knox designed to implement policy, provide medical management to decrease recovery time, and decrease the length of time a Soldier cannot perform duties.[477]

The Navy tracks Sailors and Marines on LIMDU status in order to monitor the care, recovery, and rehabilitation process and to recommend next steps.[478] Sailors and Marines on LIMDU are assigned a Limited Duty Coordinator to coordinate between command and the MTF and to track light duty, limited duty, and disability evaluation appointments, with the goal of returning the Service member to full duty or to the MEB/Physical Evaluation Board (PEB) process as quickly as possible.[479, 480]

RECOMMENDATION 29

DoD should create individual electronic records of all IDES information and establish common standards for storage and retention of these records.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP, IPO

Finding: The RWTF observed the process of an electronic file being created for all IDES records during its visit to Camp Lejeune.[481] IDES results distributed by WCP indicate Camp Lejeune recently saw substantial improvement in their timeliness goals over DoD averages. Between July 2011 and January 2012, the average AC MEB Stage Days for Camp Lejeune decreased by 32 percent (from 68 to 46 days) while the DoD average decreased by four percent (78 to 75 days).[482] During the same time, the average AC Exam Days at Camp Lejeune dropped 30 percent (50 to 35 days) while the DoD average remained the same (45 days).[483] The RWTF infers that Camp Lejeune's practice of creating an electronic file has likely reduced processing times.[484]

Instituting the DoD-wide creation of an electronic file for all IDES records will decrease processing times and contribute to further development of a unified electronic process between DoD and VA. As common standards for storage and retention of individual electronic records are established, a scanned electronic record should be created simultaneously whenever making a copy of a record; this will ensure that there is always a digital back up.

The Army is introducing electronic case processing throughout the pre-IDES and IDES processes to address low-performing IDES sites.[485] The VA has noted that receiving Service member separation data electronically will improve the timeliness of benefits delivery, and is implementing plans to do so this fiscal year.[486] The RWTF also observed VA's use of a digitized health records system[487] and believes having DoD personnel at MTFs input records directly into VA's system will further increase efficiency.

The ARNG is using the Medical Electronic Data for Care History and Readiness Tracking System (MED-CHARTS) to test the Case File (Electronic) Transfer program between DoD and VA.[488] MED-CHARTS, a "customizable, centralized approach to managing all aspects of a Soldier's medical readiness and care history," is used to track all medical records for Service members, including routine care and treatment for illness and injury.[489] MED-CHARTS may

prove to be a useful tool in creating and archiving electronic records should it be released DoD-wide.

RECOMMENDATION 30

WCP should utilize survey results to improve the IDES program. Improvement goals should be balanced across three areas: timeliness, satisfaction (process vs. disability rating), and effectiveness.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP

Finding: WCP's IDES Satisfaction Survey assesses several aspects of the IDES process, including, but not limited to, the RW's overall experience, awareness and usefulness of legal support, and satisfaction with their PEBLO and VA MSC.[490] In addition, WCP monitors IDES timeliness by tracking IDES stage completion times at each MTF, producing a monthly report of each site's performance.[491] Although the satisfaction survey is informative about RWs' perceptions of IDES, results have not been fully utilized to guide policy to improve the process. Similar to the actions taken in response to WCP's reports on IDES stage completion times, such as establishing several accountability systems like site-by-site performance tracking and reporting of timelines and distribution of a weekly report of IDES "top 20" outliers, WCP's satisfaction survey results should be used to take action to improve IDES.[492]

In order to make the survey results more actionable, adjustments to the methodology as well as some of the survey items may be necessary. Although the WCP survey asks Service members to assess their overall experience since entering the IDES process (i.e., very poor to very good), Service member satisfaction with the IDES process is likely influenced by the Service member's IDES outcome/disability rating, thus producing biased satisfaction rates.493 Results of the survey will be more useful if satisfaction with the IDES process and satisfaction with the IDES outcome/disability rating are assessed separately, enabling a more precise measurement of how Service members perceive IDES. Although WCP tracks IDES timeliness, the satisfaction data are not linked to timeliness metrics. 494,495 In addition, WCP does not currently link indicators of IDES effectiveness, such as the percent of PEBs that are appealed and ultimately overturned, and the time to receipt of VA benefits after separation, to the satisfaction data collected in the survey.

RECOMMENDATION 31

Terminal leave should not be counted against IDES timelines.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP

Finding: The IDES goal for AC members is 295 days and, although many believe it to be an achievable number, the Task Force repeatedly heard during site visits and briefings that the Services' ability to reach this goal is impacted by the number of days RWs spend on terminal leave.[496, 497, 498] The Service Member Transition Phase includes processing the Service member for RTD or to VA care; for separating members, it is measured from the date of approval of the final disability disposition to the date of the Service member's separation from military service.[499] Days spent on terminal leave that exceed the 45 days allocated for the Transition phase

artificially inflate Service-level averages and Services' performance against the 295-day goal for AC.[500] By excluding days spent on terminal leave from the calculation of days in IDES, DoD will have a more accurate picture of how long the IDES process is taking. It is important to note that this recommendation should in no way interfere with Service members' opportunity to take their terminal leave.

RECOMMENDATION 32

DoD should consider a joint board modeled after the Physical Disability Board of Review (PDBR) to allow joint adjudication that replaces the Service Formal Physical Evaluation Board (FPEB) with a joint FPEB. The post PEB process would remain unchanged with appeals to the Board for the Correction of Military Records (BCMR) adjudicated by the Service Secretary.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP

Finding: The PDBR was established to review disability determinations of post-9/11 Veterans with a disability rating of 20 percent or less by PEBs.[501] The PDBR will re-evaluate records for anyone who served in the Armed Forces between September 11, 2001, and December 31, 2009, and provides a DoD-level review of previously filed disability ratings.[502] As of May 29, 2012, 40 percent of the 1,862 cases reviewed by the PDBR resulted in upgraded disability determinations, which means these Veterans had their medical separation changed to a disability retirement. The Army's rate has been the highest at 45 percent, followed by Air Force (33%), Navy/Marine Corps (32%), and Coast Guard (9%).[503] Given the high rate of medical separations changed to disability retirements by the PDBR, DoD should consider replacing the individual Service's FPEBs with a joint FPEB similar to the PDBR. The joint FPEB would convene prior to separation and would look at all requests for appeals.

RWs found unfit for duty by the informal PEB (IPEB) have the option to rebut the IPEB and request a FPEB or a one-time reconsideration of their disability rating(s) for unfitting condition(s) if they have new medical evidence or can establish that an error was made in the rating determination.[504] RWs found fit for continued service by the IPEB can rebut the IPEB and request a FPEB if they can submit information not previously considered by the IPEB.[505] However, for members found fit, the Services are not granting requests for a FPEB at the same rate, with the Army and the Air Force granting nearly all requests most recently, and the Navy denying most.[506] In addition, some proponents indicate the MEB frequently fails to cover all medical conditions with all required medical data, assigns improper VA ratings, and makes arbitrary fitness determinations, thus leading to more adjudications following IPEBs and lengthened IDES timelines due to the need to update documentation and rating errors.[507] Although many adjudication errors are fixed via a formal board request and, thus, a formal board is not held, Service members do not appear to have equal access to a formal board.[508] In addition, the individual Service formal boards can revoke a disability separation (granted by the IPEB) if they determine that the condition existed prior to Service.[509] By consolidating the FPEB appeals process into a joint DoD adjudication, increased equity and consistency may be seen across the Services.

The Services have seen shifts in appeal rates since the implementation of IDES, and on average, the number of FPEBs has decreased. Of members who went through the IDES process in

FY2010, 2.6 percent (n=112) appealed the IPEB and went through a FPEB; 6.4 percent (n=914) of members who went through the Legacy Disability Evaluation System (LDES) process appealed the IPEB in FY2010.[510] Thus, the number of appeals reviewed by a joint FPEB is expected to be manageable. If the Service member is unsatisfied with the joint FPEB decision, they would still have the right to appeal the decision within their Service (Army Review Boards Agency, Navy Council of Review Boards, or Air Force Personnel Council, up to and including the Secretary of their Service).[511]

RECOMMENDATION 33

The current PEBLO staffing formula is inaccurate. DoD should develop new and more accurate PEBLO work intensity staffing models. The Services should ensure a minimum manning of two PEBLOs (of any Service) at every MEB site to prevent potential process delays due to a PEBLO being unavailable (e.g., leave).

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP, USA, USN, USAF

Finding: A PEBLO is assigned to assist each Service member through IDES, and remains an integral part of the process from the point of MEB referral to the Service member's RTD or separation.[512] The PEBLO is expected to be knowledgeable about the RW's case, coordinate medical appointments, and act as a liaison to ensure RWs and families understand the processes and procedures of IDES.[513] The current formula to calculate the PEBLO staffing ratio at each site, following, is based on the estimated number of days a PEBLO works on a case in a given year, without respect to level of effort and the average number of hours necessary to complete each task.[514]

$$PEBLO\ Ratio = \#\ of\ PEBLOS \div \left(\left(\frac{100}{365}\right) * (Number\ of\ MEBs\ per\ year)\right)$$

Using the current formula, an MTF with one PEBLO and 73 MEBs in a given year would meet the required PEBLO ratio of 1:20. For sites whose caseloads only warrant one PEBLO according to the above ratio, the RWTF believes training an additional PEBLO at that site, possibly as a secondary duty, will ensure coverage when the PEBLO is on leave, improve IDES timeliness, and improve patient-centered care and RW satisfaction with their support during IDES. In addition, a new PEBLO ratio formula based on the average number of hours necessary to complete each task will further aid in ensuring that the proper number of PEBLOs are assigned to each site. It is important to note that as DoD and VA move to an electronic-based system – electronic health records – the PEBLO's work intensity will be impacted.

PEBLOs have an array of responsibilities and RWs in RWTF focus groups described how PEBLOs can help or hinder their IDES process. The RWs frequently spoke about the length of time it takes to complete the DES/IDES process, and many reported they were not confident or had concerns about their transition from DoD to VA.[515] They acknowledged PEBLOs as part of their team, providing support during the IDES process.[516] While some RWs indicated PEBLO support met their needs, others indicated it did not.[517] They offered reasons such as rarely seeing their PEBLO, difficulty getting an appointment with the PEBLO, and the PEBLO not initiating contact with the RW.[518] These reasons allude to the problem one RW reported – that PEBLOs

have too many cases and are short-staffed.[519] Last year's focus group participants also had limited knowledge of the PEBLO's role, limited contact with PEBLOs, and generally negative comments about the PEBLO, although a few noted the PEBLO was helpful.[520] Forty-six percent (37/81) of this year's RWTF RW focus group mini-survey respondents indicated their PEBLO was only a little or moderately helpful.[521] Family members responding to the RWTF mini-survey also had concerns with the helpfulness of the PEBLO; seven of the 16 respondents indicated the PEBLO was only a little helpful.[522] In addition, results of WCP's IDES Transition Phase Satisfaction Survey through September 2011 show that 21 to 30 percent of RWs – depending on Service – found their PEBLO only slightly or somewhat helpful; 10 to 12 percent indicated their PEBLO was not at all helpful.[523] RC RWs were more likely than their AC counterparts to describe the PEBLO as not at all helpful.[524]

RECOMMENDATION 34

The Services should ensure that 100 percent of RWs are individually contacted by an MEB outreach lawyer (in-person, phone, email, mail, etc.) upon notification to the PEBLO that a narrative summary (NARSUM) will be completed.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP, USA, USN, USAF, USMC

Finding: DTM 11-015 issued guidance for providing legal support during the IDES process, mandating that each Military Department provide uniformed or civilian legal counsel at no cost to the member to represent them before DoD at all steps of the PEB determinations, and before the VA during the pre-separation portion of the IDES process.[525] However, results from RWTF's focus groups revealed that awareness of legal support is a challenge. In four focus group sessions, approximately half of RWs reported knowing that legal support was available to them.[526] Use of legal supports during DES/IDES was discussed in over a third of RWTF focus groups with RWs; approximately a third of RWs in these focus groups indicated they did not use and/or were not provided legal support.[527] Reasons cited by some RWs included lack of information or misinformation about the existence and/or purpose of legal support, not knowing how to access existing legal support, perceived conflicts of interest for the attorneys, geographic distance from legal support particularly for RC RWs, and limited availability, e.g., no available appointments prior to separation date, only one lawyer for IDES at the installation. Only 11 percent (16/153) of the RWs in RWTF focus groups indicated in their mini-survey responses they had first-hand experience with legal support for RWs and their families.[528] Similarly, the RWTF found last year that the majority of RWTF RW focus group participants lacked personal experience with, or knowledge of, these specialized legal resources.[529] Results from WCP's IDES Transition Phase Satisfaction Survey show that 84 percent of RWs who had reached transition and had participated in both previous IDES satisfaction surveys had legal counsel available to them throughout the DES process.[530]

RC respondents to the WCP IDES Satisfaction Survey were generally less aware than their AC counterparts of the availability of legal counsel.[531] During onsite briefings to the RWTF, personnel at three sites across two Services indicated communication with Reservists is challenging, thus impacting their access to legal services.[532] Two sites reported that access and availability of legal supports to RC soldiers is a challenge because they are stationed outside of

the local vicinity or, if they are not in MEDHOLD, they are juggling the demands of civilian life and work while going through the DES. (One proponent suggested that denial of MEDHOLD often means effective denial of access to legal supports).[533] Two of the JFHQs the RWTF visited stated they have no dedicated legal resources to support RC RWs going through the disability evaluation process.[534]

Although the RWTF saw improvement since last year in the amount of legal support available, it continued to hear from legal staff at installations that they are not sufficiently staffed to support those who need it.[535, 536] The RWTF believes that under-staffing of legal support for IDES, combined with an understandable command focus on reducing delays in the IDES process, compromises RWs' opportunities for redress. By requiring 100 percent outreach to RWs as proposed, which will likely require additional resources, DoD will ensure that all RWs are aware of their legal rights and the legal support available to them.

RECOMMENDATION 35

All military members, upon entering their Service, begin a relationship with the VA. DoD should widely market VA services and benefits to DoD leadership (commanders, senior enlisted leaders, etc.) and include this information at all levels of officer and enlisted professional development. All AC and RC should be encouraged to register in the VA e-Benefits online program.

Requested Agencies to Respond: DoD, OUSD(P&R), OASD(HA), WCP, USA, USN, USAF, USMC

Finding: The RWTF received nearly 30 briefings and panels from approximately 50 individuals who assist RWs through the DoD/VA transition. These briefers highlighted some of the challenges inherent in the transition from DoD to VA, many of which also apply to personnel who are not wounded, ill, or injured.[537]

Service members and family members experience the VA as a new culture and a complex organization.[538] One proponent said that navigating the extensive VA health care system requires "a liaison to the liaisons to figure out who to go to."[539] Family caregivers find some OEF/OIF Case Managers more supportive than others.[540] VA, in turn, experiences special challenges caring for the newest generation of Veterans, such as a high rate of dependence on prescription medication; disincentives to recover and work, which they linked to a particularly high no-show rate among OEF/OIF/OND Veterans; and ARNG Soldiers who are prematurely pushed into the VA when, it was suggested, they should instead be cared for under Title 10 in the WTU.[541] The VA also finds some family caregivers more difficult to engage than others.[542] Some proponents observed that the level of support DoD provides RWs creates expectations that cannot be met by the VA, which impedes RWs' positive adjustment to the VA.[543]

The transition of Service members from military treatment facilities to VA facilities, i.e., the transfer and referral process, is not seamless.[544] Although the VA OEF/OIF Program was established to facilitate OEF/OIF Veterans' integration into the VA, some RWs leave the military with no prior contact with the VA OEF/OIF Program or Case Manager.[545] Similarly, although the VA Liaison for Healthcare is supposed to collect transitioning Service members' medical records, make initial appointments in the appropriate VA Medical center, and execute a

warm handoff to that facility, DoD does not consistently refer Service members to this office.[546] Proponents observed that a formal trigger to systematically notify the VA OEF/OIF Program of incoming personnel, including RC and AC, is lacking.[547] While the VA sends staff to some Yellow Ribbon Reintegration Program events, which facilitates referrals of Reservists to the VA, there exists no comparable referral mechanism for AC personnel.[548]

Even when the handoff of an RW from DoD to VA is successfully accomplished, continuity of transition plans and continuity of health care is at risk.[549] The RW's Comprehensive Recovery/Transition Plan is not always included in the documentation that DoD provides the VA.[550] Electronic health record limitations interfere with the sharing of vital medical information, although more information tends to be shared when cases transfer with the help of a VA liaison.[551] DoD and VA family caregiver programs do not align.[552] There are long waits for specialty appointments at the VA, particularly for behavioral health.[553] Medication discontinuity also can be a problem, due to the absence of medication lists or notes and differing DoD/VA medication formularies and guidelines, particularly for psychotropic and addictive pain medications.[554]

Many Service members will be associated with the VA for several decades – for as long as they were part of DoD, if not longer. Often this long-term relationship will be vital to their well being and quality of life as Veterans; as such, Service members' relationship with the VA must be cultivated from day one.[555] The RWTF believes DoD should take several key steps, in partnership with the VA, to prepare Service members to successfully navigate the transition from DoD to the VA:

- In order to indirectly influence how AD Service members think of the VA and use VA services upon becoming Veterans, DoD should market VA services and benefits to military leaders, i.e., proactively train them regarding the VA as a service provider, an organization, and a culture.
- In order to directly influence how AD Service members think of the VA and use VA services upon becoming Veterans, DoD should incorporate the same information into each Service's progressive officer and enlisted professional development curricula. The RWTF encourages the schoolhouses to include visits to VA facilities in the professional development programs, as feasible.

On a practical level, in order to accelerate AD Service members' access to VA health care and other VA benefits, DoD should ensure all Service members register with e-Benefits, which is a portal to access benefits-related online tools and information.[556]

Summary

The final section of this chapter includes a chart that documents RWTF's FY2011 recommendations, summarizes DoD's formal responses, and notes the RWTF's assessment of each recommendation's current status. Best practices from FY2012 are also highlighted.

STATUS OF FY2011 RECOMMENDATIONS

Exhibit 2

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.	DTM 08-033 addresses MCM. FRAGO 3 & HQDA Executive Order (EXORD) 118-07 reinforces WTU/CBWTU cadre numbers.	Met (however see FY2012 Rec 1)
8. Shape strategic solutions that address the unique needs of RC RWs.	There is only one standard. Working on restructuring the Remote Care program.	Continue to follow (see FY2012 Rec 21, 22, 23)
9. Provide the needed support for the Centers of Excellence (CoEs) to enable full operational capability.	CoE Advisory Board established. DCoE PH & TBI realigned. EACE funded.	Met
10. Ensure timely access to routine PTSD care across the continuum of Service.	Took multiple steps to ensure timely access	Continue to follow (see FY2012 Rec 7, 8, 9)
11. Standardize and define the roles/responsibilities of care coordinators, VA personnel, and NMCMs.	DoDI 1300.24 provides eligibility criteria. Fragmentary Order (FRAGO) 3 & Headquarters Department of Army (HQDA) Executive Order (EXORD) 118-07 provide guidance	Continue to follow (see FY2012 Rec 2)
12. Develop minimum qualifications, ongoing training, and skill identifiers specializing in recovery and transition for transition unit personnel.	USMC Section Leaders are a mix of RC & AC; moving toward only AC. WTC working to enhance training.	Continue to follow
13. As part of the intake process, and on a regular and recurring basis, review available resources for support, to include the NRD and Keeping It All Together, with the RW and the family caregiver.	WTC recognized the need to better educate Service members and families on transition. These are reflected in the 12.1.11 CTP guidance & policy.	Met (however see FY2012 Rec 19)
14. Empower family caregivers with the resources they need to fulfill their roles in the successful recovery of RWs.	WTC recognized the need to better educate SMs and families; reflected in the 12.1.11 CTP guidance & policy.	Continue to follow (see FY2012 Rec 14, 15, 16, 17, 18)
15. The DoD should expedite policy to provide special compensation for SMs with catastrophic injuries or illnesses requiring assistance in everyday living, as directed by Section 603 of the NDAA 2010.	DoD issued policy for Special Compensation for Assistance with Activities of Daily Living on 8.31.11. Eligible WII started receiving payments 9.15.11.	Met

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

BEST PRACTICES

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

Reserve Component

The Indiana National Guard created a J9 section, which facilitates action synchronicity and cooperation, directorate-level attention, and funding procurement, e.g., for chaplains, Employment Program, Transition Assistance Advisors (TAA), JFHQ Crisis Team, and so forth.[557]

Landstuhl Regional Medical Center

Landstuhl Regional Medical Center (LRMC) established the Deployed Warrior Medical Management Center (DWMMC) to coordinate and facilitate the reception, triage, and onward movement of WII warriors from the U.S. Central Command (USCENTCOM), U.S. Africa Command (USAFRICOM), and U.S. European Command (USEUCOM) areas of responsibility (AORs).[558] The DWMMC model, or elements of this model, could be replicated within the Pacific Regional Medical Command. The DWMMC model also may be relevant to civilian emergency management and mass evacuation planning.

Units and Programs

Various site briefers attested to the benefits of transition units, stating that those who are assigned to them experience better access to resources and more favorable transition outcomes than those who are not.[559]

Camp Lejeune, Wounded Warrior Battalion-East (WWBn-East), is authorized to overlap unit staff, bringing new staff in before departing staff leaves.[560]

Services for Posttraumatic Stress Disorder

LRMC has a Consultation-Liaison Service with Behavioral Health assets in inpatient wards for early intervention and consultation, including prevention rounds through the Deployed Warrior Behavioral Health Service.[561] These psychiatric prevention rounds are patterned after a Walter Reed Army Medical Center (WRAMC) program and are part of an effort to incorporate psychiatric prevention rounds across military medical facilities.

Portsmouth Naval Medical Hospital (NMH) established Trauma and Operational Stress Services (TAOSS), which provides evidence-based services to RWs with combat-related trauma using PE, EMDR, and CPT.[562]

Portsmouth NMH also has the Back on Track (BOT) Program, where RWs are provided 70 hours of information on combat readjustment over a two-week period.[563] The goal of the program is to front-load information provided to those RWs who have been identified early, which may allow for better outcomes.

Camp Lejeune offers civilian providers training on military culture and has the Psychiatric Medical Home Model, which focuses on a multi-disciplinary team approach, stability in treatment, and continual evaluations/adjustments to ensure increased access to care.[564]

Mental health providers are embedded in Operational Stress Control and Readiness (OSCAR) teams along with other team members who identify, support, and advise Marines on combat operational stress control at Camp Lejeune.[565]

Fort Carson offers an Intensive Outpatient Program (IOP) and the embedded Behavioral Health model of care, which embeds a Behavioral Health team within each Brigade Combat Team (BCT).[566] The Embedded Behavioral Health Team (EBHT) has been broadly implemented across Army BCTs.

The Indiana JFHQ uses the Star Behavioral Health Providers (SBHP) program, which was developed by the Indiana National Guard, NGB via Indiana Director of Psychological Health, Purdue Military Family Research Institute (MFRI), Family Social Services Association (FSSA), and in collaboration with CDP.[567] This program provides training for therapists in the community interested in working with Service members, lessens geographic limitations, and provides a directory of trained therapists. They trained over 250 therapists to date and Service members have shown a great deal of interest. The next step they identified is to provide similar training for ministers since they are so involved in marriage counseling. The effectiveness of the SBHP is

potentially enhanced by practices such as National Guard staff following up to verify provider competence, using pre/post tests to assess outcomes, and the use of an assessment and referral protocol (flow diagram).

The Indiana National Guard has five full time chaplains.[568] Service members say chaplains understand them since they deployed themselves.

Fort Stewart uses a contract with the Soldier's command to secure command support for the Soldier to be assigned for two weeks to the clinic to participate in the IOP and then to return to duty as soon as possible.[569]

Mental Health Services (PTSD and TBI)

Diverse initiatives have been established across DoD to increase Service members' access to mental health services.[570] Some of these initiatives deliver services within a military environment; others take place in civilian settings; some bridge the two. Some target Service members while others are also for family members. Services include assessment, referral, prevention, education, and treatment. The initiatives are often staffed by credentialed masters-level mental health personnel, who seem to be in abundant supply. Some of the initiatives strike the RWTF as promising efforts that could potentially be applied more broadly throughout the Department of Defense.

At Fort Knox, a PTSD/TBI spouse and family support group is offered at the WTB.[571]

LRMC embeds behavioral health provider(s) within a family practice setting for behavioral health assessment and preventative treatment.[572]

The White House/DoD/VA collaboration through Joining Forces, a national initiative to mobilize support for the military community, received commitments from 135 medical schools and 500 nursing schools to ensure training of future physicians and nurses using leading research on diagnosis and treatment of PTSD and TBI.[573]

Services for Traumatic Brain Injury

Portsmouth NMH has a Brain Trauma Recovery Intervention Program (BTRIP) that is being duplicated within Naval Medicine East.[574] It is a brief program focused on restoring hope and optimism. It provides a single point of entry for assessment of RWs with TBI and bundles Interdisciplinary Assessment Appointments, which expedites the assessment and reduces the burden on the RW.

Fort Knox offers Neuro-Vision Rehabilitation, which provides real time and space interactive feedback that integrates vision, auditory, proprioceptive, balance and visual motor control.[575]

Medical Care Case Management

Camp Lejeune identified the "Welcome Back MEDEVAC" program as a best practice.[576] This program standardizes the process and supports provided to medically evacuated (MEDEVACed) Marines and Sailors upon arrival in country and at the Naval Hospital, (e.g., transport, boxed meal,

information package, lodging assistance, barracks room with Semper Fi Fund provided items, front of line privileges in the specialty clinic, prompt meeting with MCCM).

U.S. Army Medical Command (MEDCOM) established the Medically Not Ready (MNR) Policy and Program and Army Medical Management Centers to: 1) provide for the consistent and command-driven management of the MNR population (i.e., Soldiers with temporary conditions and profiles); 2) provide for the maximum return of Soldiers to available and deployable status; 3) provide better distinction within the Military Occupation Specialties (MOS)/Medical Retention Board (MMRB) and MEB/PEB populations; and 4) decrease MEB/PEB processing time.[577] This can be considered a "pre-Integrated Disability Evaluation System (IDES)" initiative that reduces unnecessary burden on the IDES process.

To address gaps in RC medical care and the management of Soldiers who are not medically ready for deployment, the ARNG created 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.[578] The 14-state RCMC Pilot Program puts eligible Soldiers on active duty orders for up to 179 days. Soldiers participating in this program are managed through the Medical Management Processing System (MMPS), which systematically monitors, manages, and facilitates authorized medical care for Soldiers and focuses on facilitating a final disposition of their medical condition.

The Massachusetts JFHQ hired a physician one day per week (ADOS), as of October 1, 2011, so units no longer have to wait for drill weekends to do state boards.[579] This helps with the MEB review process and helps the Health Care NCOs deal with issues more promptly.

At least one state, Indiana, currently conducts its Post Deployment Health Reassessments (PDHRAs) at the VA site (Roudebush VA Medical Center, Indianapolis), bringing each Guard member, allowing a face-to-face assessment by a VA health care provider.[580] This is a policy of the Adjutant General (TAG) of Indiana implemented to facilitate transition to Veterans Health Administration (VHA) services. Indiana reports this practice resulted in a 50 percent increase in usage of VA services by redeployed Indiana National Guard members.[581]

In the Iowa National Guard, the line commander allows Title 32 RWs to attend a specified number of medical appointments per Unit Training Assembly (UTA) of drill.[582] (The RWTF speculates that engaging Title 32 leadership in this way enhances line unit visibility of RW medical issues and obstacles, increases RW compliance with medical re-set, and promotes unit strength.)

Currently at 60 demobilization sites across the country, returning Service members complete VA form 1010-EZ, Application for Health Benefits, during an informational heath care briefing.[583] The applications are consolidated and mailed to the Health Eligibility Center for processing. Through a partnership between the VA Health Eligibility Center and the First Army Division East, returning Service members at Camp Shelby, the test site, are able to register for health benefits online during the demobilization process, allowing them to attend without distraction to the informational briefing and completely eliminating the lag time in the paper submission process. Service members receive more prompt notification from the VA of their enrollment status and can access their medical benefits sooner. (This best practice is not RW specific.)

Non-Medical Case Management

The Massachusetts CBWTU, Camp Lejeune, and Fort Stewart described their team meetings/musters/triads, and integrating the relevant unit staff into those efforts, as best practices.[584] The Massachusetts CBWTU indicated the 70 percent RTD rate is evidence of the success of this and other best practices. Camp Lejeune noted these meetings increase understanding and have a positive impact when a RW is in crisis.

The AFW2 Program described their auditing of retired pay, through which they caught hundreds of payroll errors.[585]

Fort Carson and Fort Stewart have RWs working with service/therapy dogs; Fort Carson also has equine therapy available.[586]

Kleber Kaserne identified the CTP as a best practice; CTP metrics have improved. Kleber Kaserne offers a goal setting class for RWs in connection with CTP.[587]

Three USSOCOM sites – at Fort Carson, Camp Lejeune, and Little Creek – reported that their best practices include continuity of care afforded by longevity of Care Coalition staff, mentorship, tenacity, attention to detail, collaboration, integration of Care Coalition staff into installation command daily operations, lifetime involvement with Special Operations Forces (SOF) RWs and families, leaving RWs in line units, and alternative therapies.[588] They report very positive regular feedback from RWs and families; RWs refer others to Care Coalition for help.

The Army WTC reported that their best practices in training include integrated team training, incorporating feedback and needs from the field and from the Organizational Inspection Program (OIP), incorporating response technology (described as fun, providing rapid feedback to instructor and participants, engaging), updating the distance learning component (to be more interactive and current), using posttest surveys to inform training changes, involving subject matter experts (SMEs) in training development, and adding scenarios and role play to training.[589]

The Marine Corps WWR reported that computer-based training modules for unit staff are a best practice.[590]

In Massachusetts, the National Guard has a dedicated TAA for working with RWs.[591] The TAA meets with RWs one-on-one during quarterly musters, assesses any issues (e.g., financial problems, legal issues, educational, benefit barriers), briefs the Soldier on all available services in the state, and works with them to solve their issues. The TAA receives the daily activity report from the LRMC.[592]

The Massachusetts CBWTU reported that the AW2 Program hired an experienced Advocate with VR&E experience in Massachusetts to supplement and support the transitional activities of the Massachusetts CBWTU. In addition, the AW2 Program hired a combat Veteran and currently serving National Guard social worker.[593]

Information Resources

The Marine Corps WWR application is available for the iPhone/Android/iPad and was launched in February 2012.[594, 595] This application allows patients, caregivers, and staff/medical personnel to access Wounded Warrior resources, including fact sheets (33 information topics for Marines and Veterans, eight information topics for family members and caregivers) and also offers news, pictures, videos, contact information, and a user profile. This also allows information to reach individuals who live in any area.

Within the Air Force, co-locating the A&FRC programs and policy management team with the AFW2 program in the new Warrior and Family Operations Center provides a best practice for linking the FACs with the wounded warrior population.[596]

Support for Family Caregivers

The Marine Corps involves the family caregiver early in the process by using the WWR RCP Family Contact Authorization Form to obtain permission from the Marine to provide communication and support to the family caregiver.[597] It is not mandatory for WII Marines to provide family member contact information authorizing family/caregiver support from the RCC. However, if Marines do not provide this information they will be counseled by leadership about the resources/benefits they will give up and must sign a form acknowledging that they have been informed of the importance and that they do not wish for their family member to benefit. The RCC will continue to provide support to the Marine and his/her family members until this form is signed. The RWTF saw this best practice model in action at Camp Lejeune.

At the Army Warrior Transition Battalion (WTB) in Europe, the Family Readiness Support Assistant (FRSA) took Army Family Team Building (AFTB) I, II, III, and Rear Detachment Training.[598]

At an Army WTU site in Europe, Kleber Kaserne, the unit social worker conducts home visits with each family.[599] This allows face-to-face contact with the family shortly following intake, and provides the opportunity to meet the children and other family members and to encourage continued contact.

Three sites, Fort Knox, Camp Lejeune, and Fort Carson, reported that they are currently running support groups.[600] At Fort Knox, the SFAC Social Service Coordinator (SSC) co-facilitates the family member support group. At Camp Lejeune, caregiver support groups are facilitated by the Families OverComing Under Stress (FOCUS) team. At Fort Carson, they have Warrior support groups.

The TRICARE Assistance Program (TRIAP) is a free Skype online service that gives enrollees 24/7 confidential access to a counselor.[601] Users can go to this website and receive an appointment to "call" with Skype, which provides access to a professional who can help with problem solving. Guard and Reserve on drill status can also use this resource.

Integrated Disability Evaluation System

Members of the RWTF observed a paperless or nearly paperless system for IDES records while visiting Camp Lejeune. An electronic/scanned copy of each record is created simultaneously with

making a paper copy and the paper copy is provided to the requesting user, typically VA.[602] Camp Lejeune also adopted an "assembly" line approach to creating a complete medical record for VA.[603] Those providers most familiar with a portion of the record are responsible for integrating the necessary information into the record instead of one person assimilating the entire record.[604] This led to decreases in processing time. IDES results distributed by the WCP Office indicate Camp Lejeune saw substantial improvement over DoD averages.[605] Between July 2011 and January 2012, the average AC MEB Stage Days for Camp Lejeune decreased by 32 percent (from 68 to 46 days) while the DoD average decreased by four percent (78 to 75 days).[606] During the same time, the average AC Exam Days at Camp Lejeune dropped 30 percent (50 to 35 days) while the DoD average remained the same (45 days).[607]

In addition, Camp Lejeune built trigger points into the IDES process to prevent the circular problem of an RW missing an appointment, an exam request expiring, and having to restart the process.[608] When an exam request is approaching expiration, an alert goes out to the NCM for action to be taken. Ultimately, this is likely to reduce delays.

Two sites, Fort Carson and Portsmouth, cited the benefits of having all of the key players in one centralized location, including medical and mental health providers and support staff such as the VA MSC, PEBLOs, and other DoD support staff.[609] They consider it an ideal set-up for the RW and the IDES process. Being co-located with all parties involved in the IDES process at the MTF level created an atmosphere of cooperativeness and cohesiveness, in terms of the entire IDES process, and "one-stop shopping" for the patient. Significant delays in the process have been eliminated due to the co-location and communication between the parties involved. This set-up has been referred to as the "model." Camp Lejeune indicated that having a joint facility for the PEBLO and VA MSC has alone improved coordination. Transportation is an issue when a Service member in IDES needs an exam at the VA. Co-locating the providers on the installation will help alleviate this issue.[610]

A Portsmouth NMH PEBLO created a program using raw data from the Veterans Tracking Application (VTA) to allow unit leaders to see where RWs are in the IDES process and how well the MTF is progressing RWs through the phases, and to monitor the performance of the MTF PEBLOs.[611] This allowed the MTF to establish a "watch board" that identifies outlier cases inappropriately assigned to the MTF, cases that were thought to have been closed, cases with dates entered incorrectly, and cases requiring immediate attention. Staff at Portsmouth indicated that this program has been accepted and utilized by Navy Medicine East (NAVMEDEAST); Naval Hospital (NH), Quantico; BUMED leadership; and NH, Jacksonville.

In November 2011, the Marine Corps WWR developed a tracking system that combines data from Marine Corps-specific databases, Recovery Coordination Program – Support Solution (RCP-SS), and the VTA to assist RCCs and other staff in identifying where Marines are in the IDES.[612] Marines can be tracked as soon as the MEB process starts. Monthly meetings with VA, BUMED, and the Marine Corps are held and specifically address Marines who have been in the MEB process for more than 100 days or have been in the PEB process for more than 120 days. In addition, the tracking system will allow RCCs to proactively engage MEB and PEB staff when a case is not progressing on schedule and to discuss the status of the case with the Marine in order to manage expectations.

The Marine Corps WWR provides several resources to advocate for WII members going through the IDES process, including an IDES Pocket Guide and Fact Sheet, DES Attorneys, and a RCC

IDES Handbook for Marines training to become an RCC with easy to follow steps.[613] The Marine Corps WWR also enhanced access to information for WII Marines and their families via strategic communication efforts, including social media (e.g., Facebook) and a Web-based WWR Resource Center/tool kit.

Legal Support

Two sites – Camp Lejeune and Portsmouth – reported that some RWs have disabilities that prevent their understanding of the utility of lawyers and whether they need help.[614] Camp Lejeune reported they provide take-home advice sheets for clients with cognitive issues to enable them to directly communicate legal advice to health care providers, family members, and so forth, should they choose to do so.

Fort Stewart noted that the MEB paralegal attends the unit briefings to give guidance and answer questions for the commanders.[615]

At Fort Carson, tracking who attends the WTU/MEB in-processing briefings and having the Soldiers' Medical Evaluation Board Counsel (SMEBC) Office reach out to those new to the MEB who do not attend were identified as best practices.[616]

Vocational Services

Three Army sites – Kleber Kaserne, Fort Carson, and Fort Stewart – identified the Functional Capacity Evaluation or similar occupational therapy (OT) assessment of capabilities/requisite job abilities as a best practice.[617] One of the ways Fort Carson is using this is to support RWs who want to utilize Continue on Active Duty/Continue on Active Reserve (COAD/COAR) to become cadre.

Two sites from two Services – Joint Base San Antonio (JBSA) and Camp Lejeune – highlighted programs to employ RWs as civilian employees of the Air Force and Marine Corps, respectively.[618]

Two Army sites – Fort Knox and Fort Carson – indicated they had increased OWF participation by increasing available internship sites.[619] Fort Carson had increased participation in OWF among RWs by 18 percent in 60 days through the work of a new transition coordinator.

The Services jointly held a two-day event at Fort Belvoir for employers and employment services providers.[620] The agenda included a networking session for RWs and employers.

The VA conducted a clinical trial using random assignment to compare a new method to the existing standard of care: 43 Veterans with PTSD were given standard vocational rehabilitation program (VRP) and 42 were given individual placement and support (IPS).[621] These Veterans were followed for 12 months: 76 percent of IPS participants "gained competitive employment",[622] compared to 28 percent of VRP participants. IPS focuses on "client choice, rapid job finding where appropriate, competitive education programs, integrated education and work settings, and follow-along supports".[623]

The Massachusetts CBWTU identified a number of successful practices associated with vocational services. VA Vocational Rehabilitation & Employment staff, Vet Center staff, and the AW2

Advocate come to the CBWTU each Wednesday and attend the CBWTU quarterly musters. The CBWTU also has 10 to 15 different organizations attend the quarterly musters to give informational lectures as well as meet with smaller groups for more in-depth question-and-answer periods. The TAAs help the CBWTU platoon sergeants stay abreast of career fair opportunities outside the Boston area by sending emails with information on events in Pennsylvania, New York, New Jersey, and so forth.[624]

In FY 2013, its third year of effort, the RWTF will continue to assess the RW matters outlined in the legislation, make recommendations for improvement, and identify emerging and best practices for possible replication across DoD. To gather information, the RWTF will again employ briefings by Headquarters-level proponents and other stakeholders during RWTF business meetings; Headquarters-level data calls; reviews of major reports, congressional testimony, and peer-reviewed journal articles; and visits to Army, Air Force, Navy, and Marine Corps RW sites. The RWTF's agenda on site will be two-fold, consistent with prior years: to receive briefings from proponents of site-level RW programs and services, and to hear directly from the customers of these programs and services, i.e., RWs and family members. Recognizing that DoD and VA are partners in RW recovery and transition, as feasible the RWTF will again seek briefings from local VA proponents who work with RWs. To complement its qualitative focus group results, the RWTF will continue to examine quantitative results of WCP and Service-specific surveys. Additionally, the RWTF will analyze results from the FY 2012 DoD AC and RC Status of Forces Surveys, to which the RWTF contributed survey questions.

Notes

[1] NDAA of 2010, Pub. L. No. 111-84, 123, Stat. 2190, §724 (2010) (a)(2).

[2] Ibid.

[3] For the purposes of this report, the RWTF considers "Warrior" synonymous with "member of the Armed Forces."

[4] NDAA of 2010 Pub. L. No. 111-84, 123, Stat 2190, §724 (2010).

[5] Joining Forces (January 2011). About Joining Forces. Retrieved June 1, 2012, from http://www.whitehouse.gov/joiningforces/about

[6] VOW to Hire Heroes Act of 2011, Pub. L. No. 112-56, §221 (2011).

[7] DoD and Department of Veterans Affairs (February 1, 2012). Memorandum of Understanding between the DoD and VA: Providing VR&E services at the earliest opportunity to active duty Servicemembers.

[8] Cocker, M. Briefing to the RWTF. VA Vocational Rehabilitation and Employment Service. October 4, 2011.

[9] DoD (August 26, 2009; Rev. August 16, 2011). DoD Directive-Type Memorandum 08-033: Interim guidance for clinical case management for the wounded, ill, and injured service member in the military health system.

[10] Quisenberry, G. C. Briefing to the RWTF. Clinical case management services. February 22, 2012.

[11] RWTF RW focus group results, October 2011-March 2012.

[12] RWTF family member focus group results, October 2011-March 2012.

[13] RWTF RW mini-survey results, October 2011-March 2012.

[14] RWTF family member mini-survey results, October 2011-March 2012.

[15] RWTF RW focus group results, October 2011-March 2012.

[16] DoD (August 26, 2009; Rev. August 16, 2011). DoD Directive-Type Memorandum 08-033: Interim guidance for clinical case management for the wounded, ill, and injured service member in the military health system. The Army's goal for the Nurse Case Manager ratio is 1:20, while the Directive-Type Memorandum required 1:30.

[17] Guice, K. Briefing to the RWTF. 2010 Federal Recovery Coordination Program Survey Results. May 18, 2011.

[18] CAPT Willis, M. Navy Response to RWTF FY2012 draft report. June 12, 2012. The Navy considers patient acuity when managing caseloads.

[19] CAPT Carter, B. Navy Safe Harbor briefing to the RWTF, March 31, 2011.

[20] Site-level briefings to the RWTF. March/April 2011.

[21] Quisenberry, G. C. Briefing to the RWTF. Clinical case management services. February 22, 2012.

[22] Site Briefings to the RWTF, October 2011-March 2012.

[23] Ibid.

[24] Ibid.

[25] National Defense Authorization Act of 2012 Pub. L. No. 112-81. §551 (2011).

[26] McDonnell, K. Special Operations Command Care Coalition briefing to the RWTF. February 22, 2012.

[27] Army Warrior Transition Command (December 1, 2011). Comprehensive Transition Plan Policy and CTP-Guidance. Alexandria, VA: Author. p.8, section 5d (2)(d) of Office of the Surgeon General/Medical Command Policy Memo 11-098, as printed in the CTP-Guidance. p.8: "Soldiers will not participate in internships with any non-federal entities, such as agencies of state, county, or local governments, non-profit organizations, or commercial/for-profit organizations."

[28] Col Mayer, J. L. and Williamson, P.D. Marine Corps Wounded Warrior Regiment briefing to the RWTF. February 23, 2012.

[29] RWTF RW focus group results, October 2011-March 2012.

[30] RWTF RW mini-survey results, October 2011-March 2012.

[31] Site Briefings to the RWTF, October 2011-March 2012.

[32] Army Warrior Transition Command (December 1, 2011). Comprehensive Transition Plan Policy and CTP-Guidance. Alexandria, VA: Author. p.8, section 5d (2)(d) of Office of the Surgeon General/Medical Command Policy Memo 11-098, as printed in the CTP-Guidance. p.8: "Soldiers will not participate in internships with any non-federal entities, such as agencies of state, county, or local governments, non-profit organizations, or commercial/for-profit organizations."

[33] Col Mayer, J. L. and Williamson, P.D. Marine Corps Wounded Warrior Regiment briefing to the RWTF. February 23, 2012. Colonel Mayer indicated RWs can only access federal internships in Operation WARFIGHTER until DoD issues guidance on non-federal work experience.

[34] Site Briefings to the RWTF, October 2011-March 2012.

[35] Government Accountability Office (March 2011). DoD and VA health care: Federal Recovery Coordination Program continues to expand but faces significant challenges. GAO-11-250.

[36] The Federal Recovery Coordination Program: From concept to reality: Hearing before the Subcommittee on Health, House Committee on Veterans' Affairs, 112th Cong. (13 May 2011) (Prepared statement of Karen Guice, Executive Director, Federal Recovery Coordination Program, Department of Veterans Affairs).

[37] National Defense Authorization Act of 2008, Pub. L. No. 110-181, §1611 (2008).

[38] Ibid.

[39] Ibid.

[40] Ibid.

[41] DoD (December 2009). DoD Instruction 1300.24: Recovery Coordination Program.

[42] Amdur, D., Batres, A., Belisle, J., Brown Jr, J. H., Cornis-Pop, M., Mathewson-Chapman, M., et al. (2011). VA integrated post-combat care: A systemic approach to caring for returning combat Veterans. Social Work in Health Care, 50, 564-575. DOI: 10.1080/00981389.2011.554275.

[43] RWTF transition outcomes briefing/panel results, October 2011-March 2012.

[44] Ibid.

[45] DoD (October 2011). Wounded, ill, and injured compensation and benefits handbook. Retrieved January 17, 2012, from http://warriorcare.dodlive.mil/files/2011/11/2011-DoD-Compensation-and-Benefits-Handbook1.pdf. Recovery Care Coordinators work with RWs on the Comprehensive Recovery Plan.

[46] Weese, C. Briefing to the RWTF. Federal Recovery Care Program. February 21, 2012. Federal Recovery Coordinators work with RWs on a Federal Individualized Recovery Plan.

[47] The Federal Recovery Coordination Program: Assessing progress toward improvement: Hearing before the Subcommittee on Health, House Committee on Veterans' Affairs.112th Cong. (October 6, 2011) (Prepared statement of Phillip Burdette, Principal Director, Wounded Warrior Care and Transition Policy, Office of the Under Secretary of Defense for Personnel and Readiness, U.S. DoD). Until recently, Federal Recovery Coordinators did not have access to the Comprehensive Recovery Plan. The name of the Wounded Warrior Care and Transition Policy office changed to Warrior Care Policy in June 2012.

[48] DoD (October 2011). Wounded, ill, and injured compensation and benefits handbook. Retrieved January 17, 2012, from http://warriorcare.dodlive.mil/files/2011/11/2011-DoD-Compensation-and-Benefits-Handbook1.pdf p.1.

[49] Government Accountability Office (October 6, 2011). DoD and VA health care: Action needed to strengthen integration across care coordination and case management programs. GAO-12-129T.

[50] Joint House and Senate Committee on Veterans Affairs Hearing to Receive Legislative Presentation of VSOs, 112th Cong. (March 22, 2012) (Prepared statement of COL Robert F Norton (Ret.), Deputy Director, Government Relations, Military Officers Association of America).

[51] Examining the lifetime costs of supporting the newest generation of Veterans: Hearing before the Senate Committee on Veterans' Affairs, 112th Cong. (July 27, 2011) (Prepared statement of Crystal Nicely, Caregiver and Spouse of OEF Veteran).

[52] Burdette, P.A., Carrington, R.S., Stevens, B., and Sobota, A.E., Wounded Warrior Care and Transition Policy Office, personal communication with the RWTF, March 29, 2012. The Army is sending Army Wounded Warrior Program Advocates to Recovery Care Coordinator training, but the criteria for Army Wounded Warrior Program Advocates are not the same as criteria for the Recovery Care Program, and squad leaders'(not DoD Recovery Care Coordinator-trained) responsibility for the Army's Comprehensive Transition Plan parallels the Recovery Care Coordinator's responsibility for the Comprehensive Recovery Plan. The name of the Wounded Warrior Care and Transition Policy office changed to Warrior Care Policy in June 2012.

[53] RWTF RW focus group results, October 2011-March 2012. Participants in a RWTF focus group in Portsmouth indicated they were not receiving Safe Harbor Non-Medical Case Manager support (Recovery Care Coordinator-equivalent).

[54] RWTF family member focus group results, October 2011-March 2012. Many family members indicated they were unaware of having a Recovery Care Coordinator.

[55] Government Accountability Office (October 6, 2011). DoD and VA health care: Action needed to strengthen integration across care coordination and case management programs. GAO-12-129T.

[56] Ibid. Government Accountability Office also found care coordinator roles overlapped with Non-Medical Case Manager roles.

[57] Ibid.

[58] The Federal Recovery Coordination Program: Assessing progress toward improvement: Hearing before the Subcommittee on Health, House Committee on Veterans' Affairs.112th Cong. (October 6, 2011) (Prepared statement of Debra A. Draper, Director, Health Care, U.S. Government Accountability Office).

[59] The Federal Recovery Coordination Program: Assessing progress toward improvement: Hearing before the Subcommittee on Health, House Committee on Veterans' Affairs.112th Cong. (October 6, 2011) (Prepared statement of Phillip Burdette, Principal Director, Wounded Warrior Care and Transition Policy, Office of the Under Secretary of Defense for Personnel and Readiness, U.S. DoD). The name of the Wounded Warrior Care and Transition Policy office changed to Warrior Care Policy in June 2012.

[60] Government Accountability Office (October 6, 2011). DoD and VA health care: Action needed to strengthen integration across care coordination and case management programs. GAO-12-129T. Government Accountability Office also found care coordinator roles overlapped with Non-Medical Case Management roles.

[61] The Federal Recovery Coordination Program: Assessing progress toward improvement: Hearing before the Subcommittee on Health, House Committee on Veterans' Affairs.112th Cong. (October 6, 2011) (Prepared statement of Phillip Burdette, Principal Director, Wounded Warrior Care and Transition Policy, Office of the Under Secretary of Defense for Personnel and Readiness, U.S. DoD). The name of the Wounded Warrior Care and Transition Policy office changed to Warrior Care Policy in June 2012.

[62] The Federal Recovery Coordination Program: Assessing progress toward improvement: Hearing before the Subcommittee on Health, House Committee on Veterans' Affairs.112th Cong. (October 6, 2011) (Prepared statement of Debra A. Draper, Director, Health Care, U.S. Government Accountability Office).

[63] The Federal Recovery Coordination Program: From concept to reality: Hearing before the Subcommittee on Health, House Committee on Veterans' Affairs, 112th Cong. (May 13, 2011) (Prepared statement of Karen Guice, Executive Director, Federal Recovery Coordination Program, U.S. Department of Veterans Affairs).

[64] The Federal Recovery Coordination Program: Assessing progress toward improvement: Hearing before the Subcommittee on Health, House Committee on Veterans' Affairs.112th Cong. (October 6, 2011) (Prepared statement of John Medve, Executive Director, Office of the U.S. Department of Veterans Affairs- DoD Collaboration, U.S. Department of Veterans Affairs).

[65] Weese, C. Briefing to the RWTF. Federal Recovery Care Program. February 21, 2012.

[66] The Federal Recovery Coordination Program: Assessing progress toward improvement: Hearing before the Subcommittee on Health, House Committee on Veterans' Affairs.112th Cong. (October 6, 2011) (Prepared statement of Phillip Burdette, Principal Director, Wounded Warrior Care and Transition Policy, Office of the Under Secretary of Defense for Personnel and Readiness, U.S. DoD). The name of the Wounded Warrior Care and Transition Policy office changed to Warrior Care Policy in June 2012.

[67] Langley, K. (October 18, 2011). Two federal agencies testify on way forward together for recovering Service members. Retrieved November 22, 2011, from http://warriorcare.dodlive.mil/2011/10/18/two-federal-agencies-testify-on-way-forward-together-for-recovering-service-members/

[68] RWTF RW focus group results, October 2011-March 2012.

[69] Ibid.

[70] RWTF family member focus group results, October 2011-March 2012.

[71] RWTF RW focus group results, October 2011-March 2012.

[72] Ibid.

[73] Ibid.

[74] Ibid.

[75] RWTF family member focus group results, October 2011-March 2012.

[76] COL Bair, D., COL Scott, S. and Emerich, S. Briefing to the RWTF. Army Warrior Transition Command cadre training. December 9, 2011.

[77] Marine Corps Wounded Warrior Regiment (December 5, 2011). Wounded Warrior Regiment Order 1540.1: Computer based training order.

[78] RWTF family member focus group results, October 2011-March 2012.

[79] RWTF RW focus group results, October 2011-March 2012.

[80] Ibid.

[81] Defense Manpower Data Center, Data Analysis and Programs Division. Global war on terrorism – Operation New Dawn by month September 1, 2010 through May 7, 2012. Retrieved May 24, 2012, from http://siadapp.dmdc.osd.mil/personnel/CASUALTY/ondmonth.pdf

[82] Defense Manpower Data Center, Data Analysis and Programs Division. Global war on terrorism – Operation Enduring Freedom by month October 7, 2001 through May 7, 2012. Retrieved May 24, 2012, from http://siadapp.dmdc.osd.mil/personnel/CASUALTY/oefmonth.pdf

[83]Ibid; 1204 in January-April 2011; 1482 in September-December 2011.

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[85] SSgt Gallardo, M. and MSgt Schiller, B. Panel presentation to the RWTF: Provider perspectives on post-DD214 challenges. Wounded Warrior Regiment District Injured Support Coordinators. December 8, 2011.

[86] Amdur, D., Batres, A., Belisle, J., Brown Jr, J. H., Cornis-Pop, M., Mathewson-Chapman, M., et al. (2011). VA integrated post-combat care: A systemic approach to caring for returning combat Veterans. Social Work in Health Care, 50, 564-575. DOI: 10.1080/00981389.2011.554275.

[87] Ray, L. and Santiago, Y. Panel presentation to the RWTF: Provider perspectives on VA services pre-DD214. South Texas Veterans Health Care System: VA Liaisons for Healthcare. December 8, 2011.

[88] Campbell, J.R. and Burdette, P. A. Briefing to the RWTF. Office of Wounded Warrior Care and Transition Policy update brief. October 5, 2011. The name of the Wounded Warrior Care and Transition Policy office changed to Warrior Care Policy in June 2012.

[89] Defense Manpower Data Center, Data Analysis and Programs Division. Global war on terrorism – Operation New Dawn by month September 1, 2010 through May 7, 2012. Retrieved May 24, 2012, from http://siadapp.dmdc.osd.mil/personnel/CASUALTY/ondmonth.pdf

[90] Defense Manpower Data Center, Data Analysis and Programs Division. Global war on terrorism – Operation Enduring Freedom by month October 7, 2001 through May 7, 2012. Retrieved May 24, 2012, from http://siadapp.dmdc.osd.mil/personnel/CASUALTY/oefmonth.pdf

[91] Site Briefings to the RWTF, October 2011-March 2012.

[92] Ibid.

[93] Ibid.

[94] Ibid.

[95] Ibid. The briefer addressing legal supports estimated only 25% of Twentynine Palms RWs in the Integrated Disability Evaluation System are getting legal support.

[96] Site Briefings to the RWTF, October 2011-March 2012.

[97] Ibid.

[98] RWTF RW focus group results, October 2011-March 2012.

[99] RWTF family member focus group results, October 2011-March 2012.

[100] Ibid.

[101] DoD (2011). Wounded, ill, and injured compensation and benefits handbook. Retrieved January 25, 2012, from http://warriorcare.dodlive.mil/files/2011/11/2011-DoD-Compensation-and-Benefits-Handbook1.pdf; p. 7.

[102] Ibid.

[103] Ibid.

[104] Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. Journal of the American Medical Association, 298(18), 2141-2148.

[105] Hourani, L.L., Bray, R.M., Marsden, M.E., Witt, M., Vandermaas-Peeler, R., Schleffer, S., et al. (2007). 2006 Department of Defense survey of health related behaviors among Guard/Reserve military personnel: A component of the Defense Lifestyle assessment Program. Research Triangle Park, NC: RTI.

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[109] Col Kirk, J., Air National Guard Advisor to the Air Force Surgeon General, personal communication with the RWTF, March 30, 2012.

[110] Site briefings to the RWTF, October 2011-March 2012.

[111] Hoge, C. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Army. February 23, 2012.

[112] CDR Malone, R.C. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Navy and Marine Corps. February 23, 2012.

[113] Lt Col Dickey, D.H. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Air Force. February 23, 2012.

[114] DoD Task Force on Mental Health. (2007). An achievable vision: Report of the DoD Task Force on Mental Health. Falls Church, VA: Defense Health Board; p. 16.

[115] RESPECT-Mil (n.d.). About. Retrieved June 22, 2012, from http://www.pdhealth.mil/respect-mil/index1.asp

[116] CAPT Hammer, P.S. Briefing to the RWTF. Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. February 23, 2012.

[117] Ibid.

[118] Hoge, C. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Army. February 23, 2012.

[119] CDR Malone, R.C. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Navy and Marine Corps. February 23, 2012.

[120] Lt Col Dickey, D.H. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Air Force. February 23, 2012.

[121] Hoge, C. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Army. February 23, 2012.

[122] Ibid.

[123] CDR Malone, R.C. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Navy and Marine Corps. February 23, 2012.

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[125] Lt Col Dickey, D.H. Air Force Response to RWTF FY2012 draft report. June 11, 2012.

[126] Ibid.

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[128] CAPT Hammer, P.S. Briefing to the RWTF. Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. February 23, 2012.

[129] Hoge, C. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Army. February 23, 2012.

[130] Site briefings to the RWTF, October 2011-March 2012.

[131] Hoge, C. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Army. February 23, 2012.

[132] Ibid. Slide 9.

[133] Site briefings to the RWTF, October 2011-March 2012.

[134] Hoge, C. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Army. February 23, 2012.

[135] RWTF RW focus group results, October 2011-March 2012.

[136] RWTF family member focus group results, October 2011-March 2012.

[137] Hoge, C. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Army. February 23, 2012. The Army used the 2010 Army Behavioral Health Provider Survey to assess the fidelity of posttraumatic stress disorder treatment techniques by surveying Behavioral Health providers who systematically reviewed randomly selected patients treated in the past week. In their sample, over 90 percent of Soldiers in treatment were receiving evidence based care, although clinicians frequently did not administer every technique in the treatment manual.

[138] Lt Col Dickey, D.H. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Air Force. February 23, 2012. Air Force Medical Operations Agency is repeating an earlier study of fidelity of evidence based posttraumatic stress disorder treatment techniques among providers due to methodological concerns.

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[141] Hoge, C. Panel Presentation to the RWTF: Evidence-based treatment modalities for PTSD in the Army. February 23, 2012. The Army used the 2010 Army Behavioral Health Provider Survey to assess the fidelity of PTSD treatment techniques by surveying Behavioral Health providers who systematically reviewed randomly selected patients treated in the past week. In their sample, over 90 percent of Soldiers in treatment were receiving evidence-based care, although clinicians frequently did not administer every technique in the treatment manual.

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ANNEX 1: MEMBER BIOGRAPHIES

Lieutenant General Charles B. Green, MD
United States Air Force

Lieutenant General (Lt Gen) Charles B. Green, M.D. is the Surgeon General of the Air Force. Lt Gen Green serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force members.

Lt Gen Green has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. He exercises direction, guidance and technical management of more than 42,800 people assigned to 75 medical facilities worldwide. Lt Gen Green was commissioned through the Health Professions Scholarship Program and entered active duty in 1978 after completing his doctorate of medicine at the Medical College of Wisconsin in Milwaukee. He completed residency training in family practice at Eglin Regional Hospital, Eglin AFB, FL, in 1981, in aerospace medicine at Brooks AFB, TX, in 1989, and is board certified in aerospace medicine.

An expert in disaster relief operations, Lt Gen Green planned and led humanitarian relief efforts in the Philippines after the Baguio earthquake in 1990, and in support of Operation Fiery Vigil following the 1991 eruption of Mount Pinatubo. Lt Gen Green has served as commander of three hospitals and Wilford Hall Medical Center. As command surgeon for three major commands, he planned joint medical response for operations Desert Thunder and Desert Fox, and oversaw aeromedical evacuation for operations Enduring and Iraqi Freedom. He has served as Assistant Surgeon General for Health Care Operations and, prior to his current assignment, Deputy Surgeon General. Lt Gen Green is the recipient of numerous military awards.

Mrs. Suzanne Crockett-Jones

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

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

Justin Constantine, JD

Mr. Justin Constantine graduated from James Madison University in 1992 with a double major in English and Political Science and a minor in German. He graduated from the University of Denver School of Law in 1998; while there he was a member of the International Law Journal and Chairman of the Honor Council. Mr. Constantine joined the U.S. Marine Corps after his second year of law school. While on active duty, Mr. Constantine served as a Judge Advocate specializing in criminal law, and was stationed both in Okinawa, Japan, and at Camp Pendleton, California, where he worked as a defense counsel and criminal prosecutor.

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

Upon recovering from his injuries, Mr. Constantine started a new job with the U.S. Department of Justice. In November of 2008, Mr. Constantine was invited to serve as Counsel for the Senate Veterans' Affairs Committee. In 2009, Mr. Constantine was accepted into the Fellowship program of the Truman National Security Project, and was the Honor Graduate of his class at the Marine Corps Command and Staff College.

In early 2011, Mr. Constantine started a job with the Federal Bureau of Investigation working on a counterterrorism team. Also, Mr. Constantine was recently selected for promotion to Lieutenant Colonel in the Marine Corps Reserve. He serves on the Board of Directors of the Wounded Warrior Project, and spends much of his spare time on wounded warrior activities, including fundraising and raising awareness of the myriad issues faced by our wounded warriors and their families. In addition, Mr. Constantine will begin the Master of Laws (LLM) program at Georgetown University in the Fall of 2012.

Based on his remarkable recovery and continued advocacy for veterans, in 2011 Mr. Constantine received the annual Courage award from the Wounded Warrior Project and the Commitment to Service Award from the Give An Hour Foundation in 2012. He has also received significant recognition from the White House, the Commonwealth of Virginia, the Washington Redskins, James Madison University, and the Tri-State Troopers Fund.

Mr. Constantine recently started his own business as an Inspirational Speaker - over the last several years he has spoken at numerous military, educational and corporate events about the value of a positive attitude, teamwork and community values in overcoming adversity. He has been featured in magazines and programs such as CNN, Mens Health, the Huffington Post, the Atlantic, James Madison University's Madison Magazine, the Wounded Warrior Project's After Action Report, Vetrepreneur Magazine, Financial Times, the Verizon FIOS Channel 1 magazine show "Push-Pause," the Department of Labor's America's Heroes at Work Success Stories, and the 2011 USMC Commandant's Birthday Message Video.

Command Sergeant Major Steven D. DeJong
United States Army National Guard

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

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

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

In 2010 CSM DeJong was promoted to sergeant major and was assigned to his current assignment as the Command Sergeant Major of 2/152nd Reconnaissance and Surveillance Squadron. He is currently enrolled in class 37 distance learning class of the United States Sergeant Major Academy and is also pursuing a bachelor's degree in fire science and administration. He is a certified firefighter/paramedic in a south suburb of Chicago. CSM DeJong is the recipient of numerous military awards.

Mr. Ronald Drach

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

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

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

Captain Constance J. Evans, BSN, MHA
United States Navy, Nurse Corps

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

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

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

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

Lieutenant Colonel Sean P. K. Keane
United State Marine Corps

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

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

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

Master Sergeant Christian S. MacKenzie
United States Air Force and Special Operations Command

On April 12, 2004, while conducting missions in Fallujah, Iraq, Master Sergeant (MSgt) MacKenzie was critically wounded when a rocket propelled grenade struck the cockpit of his helicopter in flight. He suffered severe facial trauma, a Traumatic Brain Injury (TBI), and the destruction of one eye. He spent 16 months in and out of the hospital, numerous surgeries, and, consequently, painful rehabilitation experiences.

On August 25, 2005 MSgt MacKenzie won the battle to recover and was returned to full active duty, and re-instated as an Enlisted Aviator. While undergoing treatment and rehab, from 2004-2005 he served as Non-Commissioned Officer in Charge (NCOIC) Helicopter Operations, Air Force Special Operations Command, Special Operations Liaison Element, and NCOIC Training for the Special Operations Forces Air Operations Center, from 2005 until 2006. MSgt MacKenzie was then assigned to 1st Airlift Squadron, Andrews AFB, MD as a Flight Attendant supporting the Vice President, Chairman Joint Chiefs of Staff, Commander US Central Command, and numerous other missions.

MSgt MacKenzie was called upon to be an Air Force Family Liaison Officer for a critically wounded airman at Walter Reed Army Medical Center. Through his tenacity and compassion for caring for the family and service member he received recognition from the US Special Operations Command casualty assistance liaison chief.

In September 2007, MSgt MacKenzie was selected by the Commander, Air Force Special Operations Command, for a full time position with the US Special Operations Command Care Coalition as a liaison for the wounded, ill, and injured Special Operations Forces and their families in the National Capital Region. In April 2010, MSgt MacKenzie was assigned to HQ USSOCOM Care Coalition as a liaison for the critically wounded TBI and SCI patients at the James A. Haley VA Medical Center. Currently, he serves as Superintendent, Community Outreach, managing benevolent resourcing, wellness events, and transition/ reintegration initiatives for Special Operations Wounded, Ill, and injured warriors. MSgt MacKenzie is the recipient of numerous military awards.

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

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

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

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

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

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

Dr. Steven Phillips is the Director, Specialized Information Services, and Associate Director, National Library of Medicine (NLM), National Institutes of Health (NIH), Department of Health & Human Services. Dr. Phillips was on active duty from 1968-70. He served in Vietnam with the 101st Airborne, the 27th Surgical Hospital and then at the Walter Reed Army Institute of Research. In 1970 he returned to Vietnam with a research team to study the effects of altitude on the wounded being flown from Vietnam to the Philippines and Japan. He remained a reserve officer until his retirement as a Lieutenant Colonel in 1993. He is a life member of the 101st Airborne Association and an invited Associate Life Member of the UDT/SEAL Association. Dr. Phillips is on the Board of the Vietnam Wall Memorial Reception Center.

On February 1, 2007, Dr. Phillips returned to the National Library of Medicine (NLM), National Institutes of Health (NIH), as an Associated Director to lead the NLM in establishing a Disaster Information Management Research Center. The Center, which he directs and is located in the NLM Division of Specialized Information Services, is totally devoted to disaster informatics. It is the first of its kind in the world. Dr. Phillips is a graduate of Hobart College and Tufts Medical School and is board certified both in general and thoracic surgery.

In 1967, Dr. Phillips was on the team that implanted the first intraaortic balloon pump in a human, and performed the first heart transplant in the U.S. In 1974 he co-founded the Iowa Heart Center that has grown approximately 60 physicians, all specializing in cardiovascular disease. Dr. Phillips pioneered techniques for emergency coronary bypass surgery for evolving heart attacks, implanted the first artificial heart in Iowa, performed the first heart transplant in central Iowa, and invented the technology for percutaneous cardiopulmonary bypass.

In 1997, Dr. Phillips was interviewed by the White House search committee for the position of Commissioner of the Food and Drug Administration and in 1998 testified before the Full Committee on Commerce as a witness on the Implementation of the Food and Drug Administration Modernization Act of 1997. Dr. Phillips has received numerous military, scientific and humanitarian awards. He serves and has served on numerous corporate and medical society boards, and as president of national and international medical societies. He has approximately 125 peer reviewed medical publications and has been granted six patents.

David K. Rehbein, MS

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

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

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

Major General Richard A. Stone, MD
United States Army Reserve

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

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

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

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

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

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

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

ANNEX 2: ACRONYM LISTING

Acronyms Used in Report

Acronym	Meaning of Acronym
1SG	First Sergeant
A&FRCs	Airmen & Family Readiness Centers
ABA	American Bar Association
AC	Active Component
AD	Active Duty
ADOS	Active Duty Operational Support
AF	Air Force
AFB	Air Force Base
AFI	Air Force Instruction
AFSAP	Air Force Survivor Assistance Program
AFTB	Army Family Team Building
AFW2	Air Force Wounded Warrior
AKO	Army Knowledge Online
ANG	Air National Guard
AMEDD	Army Medical Department
AMVETS	American Veterans
AOR	Area of Responsibility
ARNG	Army National Guard
ASAP	Army Substance Abuse Program
ASD(HA)	Assistant Secretary of Defense for Health Affairs
AW2	Army Wounded Warrior
BCMR	Board for Correction of Military Records
BCT	Brigade Combat Team
BEC	Benefits Executive Council
BHIE	Bidirectional Health Information Exchange
BOT	Back on Track
BPR	Business Process Re-Engineering
BTRIP	Brain Trauma Recovery Intervention Program
BUMED	Navy Bureau of Medicine and Surgery
C&P	Compensation and Pension
CAPT	Captain
CAT	Category
CBT	Cognitive Behavioral Therapy
CBWTU	Community-Based Warrior Transition Unit
CCRP	Care Coalition Recovery Program
CDL	Commercial Driver's License

Acronym	Meaning of Acronym
CDP	Center for Deployment Psychology
CDR	Commander
CFR	Code of Federal Regulations
CMO	Case Management Officer
COAD/COAR	Continue on Active Duty/Continue on Active Reserve
COL, Col, Col.	Colonel
Cong.	Congress
CONUS	Continental United States
CMSgt	Command Master Sergeant
CNS	Clinical Nurse Specialist
CPC	Construction Planning Committee
CPT	Cognitive Processing Therapy
CRCs	Community Readiness Consultants
CRP	Comprehensive Recovery Plan
CSM	Command Sergeant Major
CSTS	Center for the Study of Traumatic Stress
CTP	Comprehensive Transition Plan
CYS	Child and Youth Services
DACOWITS	Defense Advisory Committee on Women in the Services
DAV	Disabled American Veterans
DCoE	Defense Centers of Excellence
DCoE PH & TBI	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DD214	Department of Defense Form 214: Certificate of Release or Discharge from Active Duty
DEERS	Defense Eligibility Enrollment Reporting System
DES	Disability Evaluation System
DHCC	Deployment Health Clinical Center
DHS	Department of Homeland Security
DHWG	Deployment Health Working Group
DISC	District Injured Support Cell
DISCs	District Injured Support Coordinators
DMDC	Defense Manpower Data Center
DoD	Department of Defense
DoDD	DoD Directive
DoDI	DoD Instruction
DOL	Department of Labor
DTAP	Disabled Transition Assistance Program
DTM	Directive-Type Memorandum
DVBIC	Defense and Veterans Brain Injury Center

Acronym	Meaning of Acronym
DVOPS	Disabled Veterans' Outreach Program Specialists
DWMMC	Deployed Warrior Medical Management Center
E2I	Education and Employment Initiative
EACE	Extremity Injury and Amputation Center of Excellence
EBHT	Embedded Behavioral Health Team
ECHO	Extended Care Health Option
EEI	Employment, Education, and Internship
EFMP	Exceptional Family Member Program
EHR	Electronic Health Record
EMDR	Eye Movement Desensitization and Reprocessing
ESGR	Employer Support of the Guard and Reserve
ETT	Embedded Tactical Trainer
EXORD	Executive Order
FAC	Family Assistance Center
FSSA	Family Social Services Association
FFSC	Fleet and Family Support Centers
FFSP	Fleet and Family Support Program
FLO	Family Liaison Officer
FOCUS	Families Over Coming Under Stress
FPEB	Formal Physical Evaluation Board
FRAGO	Fragmentary Order
FRC	Federal Recovery Coordinator
FRCP	Federal Recovery Coordinator Program
FRSA	Family Readiness Support Assistant
FTE	Full-Time Equivalents
FY	Fiscal Year
GAO	Government Accountability Office
GS	Government Service
HCE	Hearing Center of Excellence
HEC	Health Executive Council
HIPAA	Health Insurance Portability and Accountability Act
HQDA	Headquarters Department of Army
HQMC	Headquarters Marine Corps
H.R.	House Resolution
ICF	ICF International
IDES	Integrated Disability Evaluation System
iEHR	Individual Electronic Health Record
IIP	Information Interoperability Plan
IMCOM	Installation Management Command

Acronym	Meaning of Acronym
INCAP	Incapacitation
IOP	Intensive Outpatient Program
IPEB	Informal Physical Evaluation Board
IPO	Interagency Program Office
IPS	Individual Placement and Support
IT	Information Technology
JBSA	Joint Base San Antonio
JEC	Joint Executive Council
JFHQ	Joint Forces Headquarters
JFSAP	Joint Family Support Assistance Program
JFTR	Joint Federal Travel Regulation
JSP	Joint Strategic Plan
JTF	Joint Task Force
JTTR	Joint Theatre Trauma Registry
LCDR	Lieutenant Commander
LDES	Legacy Disability Evaluation System
LIMDU	Limited Duty
LLM	Masters of Law
LNO	Liaison Officers
LOA	Line of Action
LOD	Line of Duty
LRMC	Landstuhl Regional Medical Center
LRS-D	Long Range Surveillance Detachment
LT	Lieutenant
LTC, LtCol, Lt Col	Lieutenant Colonel
Lt Gen	Lieutenant General
LVERS	Local Veterans' Employment Representatives
M4L	Marine For Life
MAJ, Maj, Maj.	Major
MARADMIN	Marine Administrative Message
MACE	Military Acute Concussion Evaluation
MC&FP	Military Community and Family Policy
MCAGCC	Marine Corps Air Ground Combat Center
MCCM	Medical Care Case Manager
MCCS	Marine Corps Community Services
M.D.	Medical Doctor
MEB	Medical Evaluation Board
MEBOC	Medical Evaluation Board Outreach Counsel
MED-CHARTS	Medical Electronic Data for Care History and Readiness Tracking System

Acronym	Meaning of Acronym
MEDCOM	Medical Command
MEDCON	Medical Continuation
MEDEVAC	Medical Evacuation
MEDHOLD	Medical Hold
MFLC	Military Family Life Consultants
MFRI	Military Family Research Institute
MG	Major General
MH	Mental Health
MHS	Military Health System
MNR	Medically Not Ready
MMPS	Medical Management Processing System
MOA	Memorandum of Agreement
MOS	Military Occupation Specialties
MOU	Memorandum of Understanding
MRB	Medical Retention Board
MRMC	Medical Research and Materiel Command
MS	Master of Science
MSC	Military Service Coordinator
MSgt	Master Sergeant
MSN	Master of Science in Nursing
MSW	Master of Social Work
mTBI	Mild Traumatic Brain Injury
MTF	Military Treatment Facility
NGAUS	National Guard Association of the United States
NAVADMIN	Navy Administrative Message
NAVMEDEAST	Navy Medicine East
NARSUM	Narrative Summary
NCMs	Nurse Case Managers
NCO	Non-Commissioned Officer
NCOIC	Non-Commissioned Officer in Charge
NCPTSD	National Center for Posttraumatic Stress Disorder
NDAA	National Defense Authorization Act
NGB	National Guard Bureau
NH	Naval Hospital
NICoE	National Intrepid Center of Excellence
NIH	National Institutes of Health
NLM	National Library of Medicine
NMA	Non-Medical Attendant
NMCM	Non-Medical Case Manager

Acronym	Meaning of Acronym
NMFA	National Military Family Association
NMH	Naval Medical Hospital
No.	Number
NOD	National Organization on Disabilities
NRD	National Resource Directory
NRMA	Navy Region Mid-Atlantic
NVLSP	National Veterans Legal Service Program
OAC	Office of Airmen's Counsel
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
OASD(R&FM)	Office of the Assistant Secretary of Defense for Readiness and Force Management
OASD(RA)	Office of the Assistant Secretary of Defense for Reserve Affairs
OCONUS	Outside the Continental United States
ODASD(MC&FP)	Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OIP	Organizational Inspection Program
OND	Operation New Dawn
OPCON	Operational Control
OSCAR	Operational Stress Control and Readiness
OSD	Office of the Secretary of Defense
OT	Occupational Therapy
OTP&CC	Office of Transition Policy and Care Coordination
OUSD(P&R)	Office of the Under Secretary of Defense for Personnel and Readiness
OWF	Operation Warfighter
PDBR	Physical Disability Board of Review
PDHA	Post Deployment Health Assessment
PDHRA	Post Deployment Health Reassessment
PE	Prolonged Exposure
PEB	Physical Evaluation Board
PEBLO	Physical Evaluation Board Liaison Officer
PH	Psychological Health
PhD	Doctor of Philosophy
PHOP	Psychological Health Outreach Program
PSGs	Platoon Sergeants
PT	Physical Training
PTSD	Posttraumatic Stress Disorder
Pub. L.	Public Law
RA	Reserve Affairs

Acronym	Meaning of Acronym
RC	Reserve Component
RCC	Recovery Care Coordinator
RCMC	Reserve Component Managed Care
RCP	Recovery Coordination Program
RCP-SS	Recovery Coordination Program Support Solution
REALifelines	Recovery and Employment Assistance Lifelines
RESPECT-Mil	Re-Engineering Systems of Primary Care Treatment in the Military
Ret.	Retired
RNs	Registered Nurses
RSM	Recovering Service Members
RT	Recovery Team
RTD	Return to Duty
RWs	Recovering Warriors
RWTF	Recovering Warrior Task Force
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMMC	San Antonio Military Medical Center
SBHP	Star Behavioral Health Providers
SCAADL	Special Compensation for Assistance with the Activities of Daily Living
SecDef	Secretary of Defense
SECNAV	Secretary of the Navy
SES	Senior Executive Service
SFAC	Soldier and Family Assistance Center
SGT	Sergeant
SI	Seriously Ill/Injured
SIGINT	Signals Intelligence
SIT	Stress Inoculation Training
SLs	Section Leaders
SME	Subject Matter Expert
SMEBC	Soldiers' Medical Evaluation Board Counsel
SNRIs	Serotonin Norepinephrine Reuptake Inhibitors
SOC	Senior Oversight Committee
SOF	Special Operations Forces
SOP	Standard Operating Procedure
SSA	Social Security Administration
SSC	Social Service Coordinator
SSG	Staff Sergeant
SSRI	Selective Serotonin Reuptake Inhibitors
Stat.	Statute
T2	National Center for Telehealth and Technology

Acronym	Meaning of Acronym
TAA	Transition Assistance Advisors
TAG	The Adjutant General
TAOSS	Trauma And Operational Stress Services
TAP	Transition Assistance Program
TAMP	Transitional Assistance Medical Program
TBI	Traumatic Brain Injury
TDRL	Temporary Disabled/Retired List
TRIAP	Tricare Assistance Program
UDT/SEAL	Underwater Demolition Team/ SEa Air and Land
USA	United States Army
USAF	United States Air Force
USAFRICOM	United States Africa Command
USAIG	United States Army Office of the Inspector General
USAR	United States Army Reserve
U.S.C.	United States Code
USCENTCOM	United States Central Command
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USERRA	Uniformed Services Employment and Reemployment Rights Act
USEUCOM	United States European Command
USMC	United States Marine Corps
USMCR	United States Marine Corps Reserve
USN	United States Navy
USSOCOM	United States Special Operations Command
UTA	Unit Training Assembly
VA	Department of Veterans Affairs
VASRD	Veterans Administration Schedule for Rating Disabilities
VBA	Veterans Benefits Administration
VCE	Vision Center of Excellence
VETS	Veterans Employment and Training Service
VHA	Veterans Health Administration
VISNs	Veterans Integrated Service Networks
VLER	Virtual Lifetime Electronic Record
VR&E	Vocational Rehabilitation and Employment
VRCs	Vocational Rehabilitation Counselors
VRP	Vocational Rehabilitation Program
VSI	Very Seriously Ill/Injured
VSO	Veterans Service Organization
VTA	Veterans Tracking Application
VOW	Veterans Opportunity to Work

Acronym	Meaning of Acronym
WCP	Office of Warrior Care Policy
WIA	Wounded in Action
WII	Wounded, Ill, and Injured
WIIC	Wounded, Ill, and Injured Committee
WRAMC	Walter Reed Army Medical Center
WRNMMC	Walter Reed National Military Medical Center
WTB	Warrior Transition Battalion
WTC	Warrior Transition Command
WTU	Warrior Transition Unit
WWBn-East	Wounded Warrior Battalion-East
WWBn-West	Wounded Warrior Battalion-West
WWCTP	Wounded Warrior Care and Transition Policy
WWR	Wounded Warrior Regiment
WWRC	Wounded Warrior Resource Center
YRRP	Yellow Ribbon Reintegration Program

The complete FY2012 report, including appendices, is available online at:
http://dtf.defense.gov/rwtf/2012report.pdf