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

Department of Defense Recovering Warrior Task Force

2012-2013 Annual Report

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Executive Summary

SUMMARY

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

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

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

This year's recommendations build upon those made in the previous two years with attention to lessons learned across DoD over the last twelve years, as well as the changing landscape of services and supports. Based upon the data collected and analyzed, the RWTF offers 21 recommendations, listed below. Findings for each of these recommendations are presented in Chapter 2.

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

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

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

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

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

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

4. DoD must ensure traumatic brain injury (TBI) treatments meet the needs of RWs and must standardize, document, and track the efficacy of TBI treatment.

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

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

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

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

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

Recommendations for the National Guard Bureau (NGB)

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

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

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

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

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

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

11. ODASD(WCP) should work with VA to grant Veterans Tracking Application (VTA) access to more providers and locations supporting RWs in the Integrated Disability Evaluation System (IDES), to include Medical Evaluation Board (MEB) attorneys and CBWTUs.

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

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

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

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

15. The Office of the Under Secretary of Defense for Personnel and Readiness (OUSD(P&R)) should ensure implementation of the Joint Federal Travel Regulations (JFTR) and Joint Travel Regulations (JTR) for family members of RWs is consistent across Service branches. Utilization of Invitational Travel Orders (ITO) and Non-Medical Attendant (NMA) orders, services provided, and payment processes should be the same across Services.

16. Implementation of the SCAADL benefit must be optimized through:

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

Recommendations for the Services

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

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

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

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

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

Recommendation for multiple agencies

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

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

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

Introduction

CHAPTER 1

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

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

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

In FY2013, the RWTF continued to explore the DoD/VA transition experience, transition outcomes, and strategies to improve transition. The concept of ensuring a seamless transition from DoD to VA appeared as early as 2003 with the creation of the VA Taskforce for the Seamless Transition of Returning Service Members.[14] The work of the Taskforce was continued by a Seamless Transition Working Group and, for a time, the Seamless Transition Office.[15, 16] Currently, the Joint Executive Council (JEC) directly engages issues related to seamless transition.[17] The RWTF supports and continues to follow the DoD/VA Care Coordination Committee (IC3) chartered January 8, 2013. IC3's efforts to provide an overarching interagency guidance document with "one mission-one policy-one plan" is the way forward for seamless transition.[18, 19]

While concerned with the current state of programs and services for the RW community, the RWTF has an eye on the future. Each year's efforts identifies problems and challenges that should be immediately addressed as well as strategies for the future care of today's RWs. Approaching its fourth and final year, the RWTF is acutely aware that it, along with DoD and the Services, must critically assess the lessons learned in RW care, management, and transition to determine which policies, programs, and services should be endorsed and sustained for the long term, so they will be available to support current and future generations of RWs. At the same time, the RWTF is looking at the fiscal adequacy of DoD RW resources going forward. Although the RWTF heard from headquarters-level proponents that sequestration was not directly impacting RW program budgets[20, 21, 22, 23], second- and third-order effects such as misguided hiring freezes and fewer post-transition federal job opportunities are impacting RWs[24, 25]. It is critical that RW programs and services retain their expertise and honor the investments made by DoD and the Services in these last dozen years, while appropriately responding to sequestration and fiscal constraints. The RWTF continues to emphasize, as it has since FY2011, the importance of timely publication of relevant policy. Publishing timely guidance not only standardizes care but also reduces redundancies and marshals resources across DoD, VA, and the Services—all high priorities in our current fiscal environment.

Chapter 2 of this report presents the RWTF's 21 FY2013 recommendations and associated findings. Chapter 2 concludes with promising practices that are making a difference for RWs and families, charts tracking the status of the FY2011 and FY2012 RWTF recommendations (Exhibits 1 and 2), and a topline overview of the FY2014 research plan. Full appendices with supporting documentation are available in the on-line version of the final report posted on the RWTF's website. Among these, Appendix C, Reference Handbook, provides an overview of the topics Congress directed the RWTF to examine, Appendix G lists the information sources used to assess congressionally mandated and other topics, and Appendix L identifies the topics addressed in each RWTF recommendation.

The Recovering Warrior Task Force's (RWTF's) recommendations are supported by findings from a variety of sources, including focus group and mini-survey results gathered by the RWTF from Recovering Warriors (RWs) and family members, briefings from site-level staff, briefings from each of the Services, briefings from other relevant individuals and organizations within and beyond the Department of Defense (DoD), and published articles and reports. Appendix D contains more detailed information about the methods by which the RWTF collected and analyzed data to inform these recommendations and findings. Best practices, charts that track the status of the FY2011 and FY2012 RWTF recommendations, and a topline overview of the FY2014 research plan are presented at the end of the chapter.

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

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

RECOMMENDATION 1

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

Requested Agencies to Respond: OASD(HA)

Finding: The RWTF recognizes the resources provided to the CoE and is eager to see that investment systematically improve the care of all RWs with psychological, brain, extremity, hearing, and vision injuries. Although each CoE has made progress[26, 27, 28, 29], the Veterans of Foreign Wars (VFW) identified the CoE's progress as one of its top concerns in testimony to Congress[30] and, in briefings to the RWTF, the Vision Center of Excellence (VCE) and the Hearing Center of Excellence (HCE) both expressed the continuing need for a mechanism for implementing their recommendations[31, 32]. The RWTF believes each CoE is approaching the point at which they must measure their progress not by such developmental milestones as concepts of operation and initial operating capabilities but by outputs and outcomes such as consistent application of research to practice and impact on the care and rehabilitation of injured Service members. The Oversight Board, if empowered to create joint policy through DoD instruction, would be able to facilitate this translation of CoE findings into policies and practices that improve care.[33] Currently, CoE successes are facilitated by relationships and networking, as in the case of the Fox Eye Shield.[34] Due to the work of the VCE, Individual First Aid Kits (IFAKs) are currently deployed with a Fox Shield in Navy units.[35, 36] Unfortunately, the VCE continues to struggle to get this practice implemented consistently across all the Services.[37] A

DoD Instruction documenting: 1) the authorities of OSD(HA) and the CoE Oversight Board, and their process for translating CoE findings to DoD-wide practices; and 2) the Services' requirements to support these initiatives will ensure that DoD's considerable investment in the CoE generates improved care and rehabilitation of injured Service members. DoDIs are essential to facilitating the promulgation of policy across the Department of Defense.

In FY2011, the RWTF recommended the alignment of each CoE under a Service as an Executive Agent. This recommendation has been successfully completed. The Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (DCoE PH and TBI) successfully published a DoD Directive empowering the Army as Executive Agent to provide logistical support including a structure for manning and funding channels to compete for resources, but appropriately routes policy decisions through OSD(HA), so that what DCoE PH and TBI identifies as best practices can be implemented throughout the DoD.[38] This is the practice that needs to be implemented for the remaining CoE and established in a DoDI. The intent is that the Service Executive Agent streamlines daily function while OSD(HA) oversight allows rapid translation of discoveries into DoD-wide practice.[39]

RECOMMENDATION 2

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

Requested Agencies to Respond: OASD(HA)

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

In the RW arena, MCCMs are a success story. Across three years of RWTF site visits, MCCMs are identified by RWTF RW focus group participants, as one of the most valuable members of the RW's recovery team.[42, 43, 44] On the FY2013 mini-survey administered to RWTF focus group participants, nearly two-thirds of RWs working with an MCCM rated their MCCM as very or extremely helpful.[45]

However, this year the RWTF noted disparities across locations. Just over 33 percent of Navy mini-survey respondents and 53 percent of Marine Corps mini-survey respondents, as compared to over 79 percent of Army mini-survey respondents, rated their MCCM as very or extremely helpful.[46] At two Army sites, several family members said they were not using Special Compensation for Assistance with Activities of Daily Living (SCAADL) because the Nurse Case Manager (NCM) did not provide them accurate or timely information when they

inquired about it.[47] In these instances, the NCM was described as more of a barrier to SCAADL than a facilitator.[48]

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

The RWTF also observed upstream and downstream challenges that Army NCMs face when transitioning RC RWs from WTUs to Community Based Warrior Transition Units (CBWTUs). A WTU NCM said there is too much to do and too little time to prepare RWs before they leave for the CBWTU.[49] At the CBWTU, the NCM confirmed that a large proportion of RWs arrive still needing care for their unfitting conditions—care that may not be readily available outside the military treatment facility (MTF).[50]

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

RECOMMENDATION 3

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

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

Requested Agencies to Respond: OASD(HA)

Finding: The RWTF continues to believe in the importance of promulgating policy to promote parity across the Services, ensure communication between DoD and the Services, and streamline

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

Significant progress has been made in training providers in EBPs; the Services report the vast majority of their behavioral health providers have received training in at least one EBP[53, 54, 55, 56], and the Center for Deployment Psychology (CDP) reports having trained more than 8,000 providers[57]. However, a single dose of training is not sufficient for sustaining skills; providers need to continue to use their training, access consultation and practice tools like checklists, and have the support and understanding of leadership.[58] While the Services' providers are receiving EBP training, there is no oversight standard or tracking method to ensure providers are correctly applying the training, and few are fully leveraging the consultation and other supports available through the CDP.[59] A trainer and champion at each MTF would make consultation more accessible to providers, promote awareness and use of EBPs, and advocate to healthcare and line leadership for the supports providers need to succeed in their delivery of EBPs.[60]

Others have also called for this level of support for behavioral health providers. In a 2010 memorandum, OASD(HA) recommended having a senior clinician consultant in each MTF and consultation available for each newly trained provider.[61] Similarly, the Army Task Force on Behavioral Health called for each installation to have a behavioral health clinical coordinator to advise the commander, ensure command support for compliance with behavioral health policies, and have visibility of the different resources at the installation.[62] The lack of an overarching policy to integrate the initiatives prevents them from being universally adopted and institutionalized.

Most sites the RWTF visited during FY2013 reported they review clinical documents in order to assess provider use of EBP; however, there are no standard charting procedures or forms in place to ensure treatment data are recorded in measurable and consistent ways across patients and providers.[63] The EBPs for PTSD call for specific steps in each treatment session; developing standardized AHLTA templates would facilitate compliance with EBPs and enable providers to track treatment progress and capture results of any assessments administered in each session. This ongoing data collection could be used to assess both fidelity to EBPs and treatment outcomes, at patient-, provider-, and systems-levels.[64]

A process to rapidly examine treatment outcomes and adjust protocols is essential to further standardize and maximize treatment efficacy across DoD. The Army and Navy have developed programs to address these issues; however, they do not span the enterprise.[65] Camp Pendleton has implemented the Psychological Health Pathways (PHP) program to track improvement and outcomes of therapy.[66] Similarly, the Army has implemented the Behavioral Health Data Portal (BHDP) in use at more than 30 MTFs to track patient outcomes, satisfaction, and risk factors.[67] The RWTF recognizes PHP and BHDP as best practices (see Best Practices at the end of this chapter for more information on PHP and BHDP).

Relative Value Units (RVUs), an output metric for healthcare providers, do not provide the flexibility needed for patients requiring more intensive attention.[68, 69, 70] At several locations visited by the RWTF, briefers indicated the providers were not set up for successful use of EBPs or did not feel adequately supported when delivering EBPs or providing supervising or consultation to EBP providers.[71] For example, providers did not receive extra RVU credit for conducting 90-

minute sessions as per the EBP manual, rather than the typical 60-minute sessions, and senior EBP practitioners did not receive RVU credit for providing supervision or consultation.

PTSD treatment is a difficult process for RWs, and undergoing treatment with a provider unfamiliar with military culture creates an additional barrier to treatment. A lack of cultural competence among civilian providers was mentioned by installation-based providers briefing the RWTF as one of the many reasons PTSD services are not better utilized.[72] CDP has recognized this concern and has included a military cultural competency module within the one-week training for civilian providers.[73] CDP also noted that some providers are brought in on contract without military cultural competence training and without time built into the contracts for such training.[74] The RWTF believes all contract employees providing behavioral health services should be culturally competent.

PTSD can have a significant impact on family members, who are too often uninvolved in treatment. Research has established that negative family interactions are associated with poorer treatment outcomes for the individual with PSTD.[75] Veterans have identified PTSD as a stressor amongst the family and expressed interest in additional participation of the family in treatment.[76] Treatment approaches may entail varying levels of family member involvement, from managing family member expectations about PTSD and treatment to targeting improvement in both PTSD symptoms and in family functioning.[77] The National Intrepid Center of Excellence (NICoE) takes a patient- and family- centered approach to PTSD and TBI care; requiring family member attendance when feasible and actively involving the family in treatment.[78] Approximately 20-25 percent of the patients bring their family—including spouse, children, parents, siblings, or other members of their support system—for a least part of their care at NICoE.[79] Among the sites visited by the RWTF, there are few programs that directly involve the family member in treatment or education, and even fewer that offer support for family members whose RW has PTSD.[80] In focus groups, the majority of family members were not aware of any available supports for family members of RWs with PTSD.[81] The RWTF believes intensive outpatient PTSD EBP programs should have at least one class where spouses are required to attend, to educate them on the treatment process and engage them in supporting their RW.

RECOMMENDATION 4

DoD must ensure TBI treatments meet the needs of RWs and must standardize, document, and track the efficacy of TBI treatment.

Requested Agencies to Respond: OASD(HA)

Finding: The RWTF acknowledges the publication of the DoDI that manages the care and treatment of mild TBI in-theater (DoDI 6490.11). The RWTF frequently hears in the field that this guidance has been a "game changer" in the immediate treatment of TBIs. With the current recommendation, the RWTF seeks to standardize care, treatment and processes for TBI treatment in the MTF setting. In a briefing given in 2011, the RWTF was made aware of a lack of standardization within TBI care.[82] During FY2013 site visits, insufficient standardization was still evident, as the RWTF noted no apparent standard TBI protocol or treatment design, documentation of TBI treatment, or tracking of efficacy of TBI treatment across DoD once members have returned to home station and are attempting to resume everyday activities.[83] At

the sites visited, the available TBI services varied greatly; for example, some treatment regimens consisted of as little as one visit a week for three to five weeks, while others entailed as much as 10 hours a week for up to 20 weeks.[84]

Furthermore, RW and family member focus group participants indicated current TBI treatment practices are not meeting their needs.[85, 86] Participants across several sites stated they had difficulty arranging to be evaluated for TBI, even though they had experienced trauma in theater and/or currently suffered from symptoms that suggested TBI.[87] Additionally, despite struggling with symptoms that cause hardship in their everyday lives, RW participants stated that evaluation results often indicated symptoms were not severe enough to warrant TBI diagnosis, or evaluations were too general and did not acknowledge symptoms being experienced by the participants.[88] In one case in particular, an RW reported that a Department of Veterans Affairs (VA) doctor was stunned that DoD had not diagnosed TBI.[89] In addition to such difficulties obtaining evaluation and treatment for TBI symptoms, RW focus group participants expressed dissatisfaction related to ineffective treatment, ineffective or under-qualified providers, as well as a lack of access to timely referrals, appointments, and follow-up.[90] Family member focus group participants echoed that available TBI treatments do not meet RWs' needs, noting that RWs often face long waits for appointments, poor continuity of care with providers, and insufficient effort from providers.[91] Family members were not aware of any support services for family members of RWs with TBI.[92] RWTF mini-survey results corroborated RWs' and family members' dissatisfaction with TBI services, with no more than one-half (48% of RWs; 13/25 family members) rating them as very or extremely helpful.[93, 94]

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

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

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

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

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

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

RECOMMENDATION 5

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

Requested Agencies to Respond: United States Army (USA), United States Navy (USN), United States Air Force (USAF), United States Marine Corps (USMC)

Finding: The active-duty orders of Recovering RC personnel often do not span the full length of time needed to complete the care plan. The RWTF heard during site visits with three Service branches that this places RC RWs at risk of expired orders, falling out of Defense Enrollment Eligibility Reporting System (DEERS) and the appointment system, and interrupted health care.[95]

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

Expired orders also interrupt pay.[96] While the RWTF did not hear of cases where orders actually expired, and benefits and pay were gapped, even the threat this may occur does place an unnecessary and unacceptable stress on RWs and those who care for them. DoD needs to standardize the window within which RC RW medical continuation orders must be renewed and establish a mechanism, possibly a dashboard interface, to raise the visibility of this issue and allow senior leaders to monitor compliance.

RECOMMENDATION 6

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

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

Requested Agencies to Respond: OASD(RA)

Finding: Several IDES laws and related DoD policies that may result in Reserve inequities were brought to the attention of the RWTF this year.[97] In Congressional testimony, the president of the National Guard Association of the United States noted that, according to the VA, disability benefit compensation claims from RC veterans of the Global War on Terror are denied at four times the rate of claims from AC Veterans.[98] DoD or Congress should examine relevant laws and policies for RC inequities and make modifications as warranted.

Per 10 United States Code (USC) 1207A, Service members who are currently activated and have at least eight years of active service are eligible for disability retirement for a pre-existing condition that was identified while not on active duty.[99] This law penalizes Reservists who have sufficient years of active service but are not currently activated. For example, if an arthritis condition that makes a Reservist unfit is identified while s/he is activated, the arthritis condition can be included in the disability evaluation. However, once that Reservist is deactivated, the arthritis condition is not considered and no longer counts toward the disability rating.

Veterans Affairs Schedule for Rating Disabilities (VASRD) 4.129 requires a minimum disability rating of 50 percent if the RW has PTSD so severe s/he must be removed from active status: "When a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veteran's release from active military service, the rating agency shall assign an evaluation of not less than 50 percent and schedule an examination within the six month period following the veteran's discharge to determine whether a change in evaluation is warranted."[100] RC RWs who are no longer on orders risk losing the guaranteed 50 percent rating.[101, 102] A Navy case study helps to illustrate the impact of this policy: An RC's Sailor's Post Deployment Health Reassessment (PDHRA) screening in January 2012 was positive for PTSD and alcohol use. The Sailor was released from active duty (REFRAD) and received care from the VA. The Sailor's mental health evaluation by the Medical Evaluation Board (MEB) took place in December 2012. If the Sailor were still on active duty, s/he would have automatically been entitled to a 50 percent disability rating.[103]

The inequity in both these laws comes into play upon the Reservist's deactivation. The RWTF notes that DoDI 1241.2, Reserve Component Incapacitation System Management, gives the Service Secretaries the authority to order RC members to active duty or continue them on active duty for treatment of an injury, illness, or disease incurred in the LOD.[104] While this

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

Going through IDES in a Reserve status potentially results not only in the loss of active duty IDES protections, but also the loss of no-cost medical treatment, and active duty pay and benefits.[108] The RWTF is aware of at least one case that was brought to the Court of Federal Claims, which ruled that the Service member was improperly separated from active duty and credited the Service member with back pay and allowances.[109]

The IDES timetable allows 10 days for the Service member, or a designated representative, to rebut the Informal Physical Evaluation Board (IPEB) determination (fit or unfit).[110] In cases where the Service member is found fit for continued service by the IPEB, the 10-day allocation may be used to gather and submit new information that the IPEB did not previously consider.[111] The 10-day limit for compiling medical records for IDES is insufficient, however, for RC RWs whose records are likely to be dispersed across military, VA, and/or civilian hospitals.[112] Overall, the medical evidence that RC RWs are able to submit is often poorer than that of their AC counterparts.[113]

RECOMMENDATION 7

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

Requested Agencies to Respond: OASD(RA)

Finding: LOD determinations are the gateway to appropriate healthcare and benefits for RC members who incur or aggravate conditions while on active duty, yet the LOD process is not implemented uniformly. DoD's LOD policy is currently captured in DoD Instruction 1241.2, Reserve Component Incapacitation System Management[114], and DoD Directive 1242.01, Reserve Component Medical Care and Incapacitation Pay for Line of Duty Conditions[115].

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

LOD documentation for Reservists is supposed to begin in theater, but frequently does not.[116, 117] The Center for Army Lessons Learned described the LOD report as the "number one document that WTs (warriors in transition) and WTUs need, yet parent RC units consistently fail to provide…" and noted "without this form, medical authorities cannot complete the medical

evaluation board (MEB) process, doctors may not obtain the WT's medical history, and benefits can be delayed or denied."[118]

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

Upon redeployment without LOD documentation, Reservists can be demobilized before their LOD conditions are identified or addressed.[119, 120, 121] This is not limited to the National Guard; for example, Navy NMCMs told the RWTF that the demobilization process for Navy Reservists can fail to identify and address health issues.[122] Once demobilized without an LOD, Reservists' access to medical care for conditions they incurred or aggravated while on Title 10 is jeopardized. Local health care resources may be meager. Reservists may have to travel long distances to obtain care; they may have a co-pay; they do not receive the level of case management provided active-duty RWs; they lose the active-duty pay and other benefits to which they are entitled.[123, 124, 125] A November 2012 Government Accountability Office (GAO) report independently observed that RC access to DoD and VA resources is impeded when it has not been established that the Service member's condition was incurred/aggravated in the line of duty.[126] What is more, once Reservists are deactivated, it is difficult to reinstate their Title 10 orders.[127, 128, 129] This is true both for conditions that may have been overlooked at the demobilization site and for conditions that manifest later, such as PTSD.[130, 131] Staff at one JFHQ mentioned they are case managing 13 RWs who are being treated locally for PTSD, of whom nine belong at the WTU.[132]

For a variety of reasons, the LOD process is particularly problematic for PTSD cases. It is difficult to trace psychological symptoms to a specific incident/date in theater.[133] It may be many months post-deployment before symptoms emerge and more months still before the individual is ready to acknowledge them.[134] The diagnostic process is complex and lengthy but must be completed before an LOD determination can be made.[135] Medical documentation regarding the treatment of RWs being seen by civilian providers, including the VA, can be very difficult to obtain.[136] An interim LOD may be necessary in order for the RW to be assessed and a diagnosis determined.[137] The National Guard Bureau (NGB) indicated to the RWTF that DoDI 1241.2, Reserve Component Incapacitation System Management[138], provides for such an interim LOD determination (paragraph 6.4.2)[139], although it is unclear to the RWTF whether RC proponents in the field are familiar with it.

Recent Congressional testimony presented by the National Guard Association of the U.S. reinforces the presented LOD findings. Specifically, it highlighted the lack of a reliable method for preserving the records of RC personnel in theater, inadequate medical screening at the demobilization site, and under identification of service-connected conditions at separation.[140] Inasmuch as the LOD is the gateway to active-duty health care and benefits for Reservists who qualify, it must be a viable process. A standardized and easy-to-implement electronic LOD processing system must be developed and implemented. Implementation should include

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

Recommendations for the National Guard Bureau (NGB)

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

RECOMMENDATION 8

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

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

Requested Agencies to Respond: NGB, VA (optional)

Finding: It was apparent from the RWTF's interactions with JFHQ and VA personnel during FY2013 site visits that, for the most part, these key players in the care of RC RWs were not regularly communicating.[141] The State Surgeon's Office and the OEF/OIF/OND Office—the specific entities within the JFHQs and VAMCs that could greatly benefit from working interdependently—lacked established channels of communication, much less mutual understanding or formal agreements.[142] At the same time, NGB indicated that with the VA it is developing a duty-to-warn initiative that will establish the criteria for mandatory reporting by VA providers to JFHQs regarding at-risk cases.[143] This is a promising step toward communication and collaboration between these organizations. NGB and VA should capitalize on this first step and provide top-down leadership for the establishment of formal strategic relationships, ongoing contact and dialogue, and coordinated processes at every level, with emphasis on where the rubber meets the road, between the JFHQ State Surgeon's Office and the VA OEF/OIF/OND Office.

The RWTF visited three JFHQs during FY2013, for a total of eight JFHQ visits over the past three years. It was apparent from many of the FY2013 JFHQ briefings that, despite these two organizations' mutual concern for this common population, the JFHQs have difficulty obtaining needed information from the VA. JFHQs' inability to obtain medical documentation from the VA can delay LOD determinations and IDES processes.[144] JFHQs have no systematic visibility of the RWs who are receiving VA care, even if the referral originated at the JFHQ, which inhibits medical officers' or other appropriate JFHQ personnel's ability to monitor and intervene when an RW is at risk.[145] Given drilling RWs' access to weapons, it is particularly vital that the

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

In conjunction with the JFHQ site visits, the RWTF also visited several VAMCs and received briefings from VA proponents including OEF/OIF/OND Program Managers and Case Managers, VA Caregiver Program Case Managers, and others. By and large, the OEF/OIF/OND Program Offices indicated they tend to have little or sporadic communication with the JFHQs, to include the JFHQ Directors of Psychological Health.[147] One VA care provider explained they communicate directly with command when military patients who enter through a TRICARE referral miss appointments, but they cannot do so when military patients enter through combat veteran status.[148] VA providers expressed concerns about confidentiality and Health Insurance Portability and Accountability Act (HIPAA) constraints but also acknowledged that, with appropriate permissions, more sharing of information with the JFHQ might be possible.[149]

Additional strategic relationship-building by the JFHQs is needed. Just as the JFHQ shares a mutual population with the VA, so the JFHQ Army National Guard (ARNG) shares a mutual population with servicing Army WTUs. This common population confronts certain Guard-unique challenges that the WTU is not necessarily equipped to address. RWTF RW mini-survey results highlighted, for example, how challenging it is to provide family caregiver support for families who are not co-located with their RW at the WTU. Thirteen percent of AC assigned to WTUs reported first-hand experience with family caregiver support, as compared to none of the Reserve and National Guard.[150] On the RC side, the JFHQ and line unit often are not told when Guard members are released from WTUs, which disadvantages both the Service member and the National Guard.[151] JFHQs have the means to support local RW families, facilitate RWs' transition out of the WTU, and otherwise address needs of Guard Solders assigned to WTUs, but cannot do so absent two-way communication with these units. Unfortunately, the RWTF's FY2013 JFHQ site visits suggested that interaction and communication between JFHQ Army entities and WTUs is inconsistent at best.[152] Strategic relationships must be forged between JFHQ ARNG and servicing WTU entities, starting with the personnel branches (G1s) and WTB/WTU commanders.

RECOMMENDATION 9

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

Requested Agencies to Respond: NGB

Finding: The National Guard Bureau created the Psychological Health contract in order to task 54 DPHs—one for each state/territory—to develop community-based behavioral health networks, educate Guard members and families, assess and refer Guard members and families, conduct leadership education and training, and build psychological health fitness and resilience and minimize stigma.[153] Behavioral health case management is also part of the DPH's responsibilities.[154] In 2013, NGB funded an additional 24 DPHs to high risk states, based on operational temp (OPTEMPO), mission sets, and suicide rates.[155] The RWTF believes the DPHs

can and should play a key role in building the behavioral health care infrastructure within the states and territories; however, the DPH contract is not currently resourced adequately for the full breadth of this mission or the size of the target population. For a general order of magnitude, DPHs appear responsible for approximately 333,939 ARNG members (ARNG end strength[156] minus ARNG deployed[157] and ARNG assigned to WTUs or CBWTUs[158]). With PTSD prevalence estimated at up to one in five[159], then at least that many (approximately 66,788) need DPH attention. The resulting average ratio of DPHs to target population is 1:856.[160]

Deactivated RC RWs who return to their home communities have less access to behavioral health care than the personnel who continue to receive their care at the MTF. Fairly consistently during JFHQ site visits and briefings from the ARNG and ANG, National Guard proponents identified a shortage of local qualified behavioral health providers trained in evidence-based psychotherapies (EBPs).[161] The JFHQ briefers also expressed misgivings about the behavioral health resources at local VA medical centers, identifying concerns about the adequacy and rigor of PTSD treatment provided through the VA and availability of appointments.[162] Some speculated that the National Guard's and the VA's therapeutic objectives for NG members seeking behavioral health care may not be fully aligned.[163]

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

The CBWTU that the RWTF visited during FY2013 indicated that local VA PTSD resources are not commensurate with the level of need among the Soldiers assigned to the CBWTU.[164] They send their Service members needing in patient or comprehensive treatment to Laurel Ridge, Texas or NICoE.

During a JFHQ site visit, a State Surgeon told the RWTF that with additional staff he could show dramatic improvement in his state's ability to manage the behavioral health needs of its ARNG population.[165] This particular State was not eligible for one of the newly hired 24 DPHs. The RWTF believes that State Surgeon spoke for many JFHQs across the country and NGB must provide the JFHQs additional DPH support to enable them to more effectively meet the behavioral health needs of their ARNG populations—through engagement with Guard members and their families via assessment, referral, and case management, as well as through engagement with local civilian behavioral health providers and cultivation of local evidence-based treatment capacity.

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

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

RECOMMENDATION 10

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

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

Requested Agencies to Respond: ODASD(WCP)

Finding: A variety of information resources, websites, and call centers are available to educate and support RWs and their families during the recovery process. Congress specifically instructed the RWTF to explore the effectiveness of Military OneSource (MOS), WWRC (now MOS Wounded Warrior Specialty Consultations[166]), NRD, Service Family Assistance Centers (FACs) and hotlines. To that end, the RWTF gathers data about these resources from DoD, the Services, and the RW community. It is apparent to the RWTF that there is redundancy in these information resources, differences across Services, as well as a general lack of awareness and under-utilization among RWs and family members.[167, 168, 169, 170, 171, 172] (See Appendix K, "Other Results," for further data regarding utilization and assessment of these information resources.) The RWTF is also concerned about the frustration and confusion experienced by RWs and family members due to the sheer number of existing information resources.[173] A DoD Instruction will reduce redundancies, eliminate gaps, create efficiencies, clarify roles and responsibilities across DoD, and increase knowledge of and access to information resources by RWs and family members. The DoDI should identify common utilization and satisfaction metrics to be gathered and reported in order to allow ongoing assessment and comparison of the effectiveness of information resources for RWs and family members.

The RWTF's concerns about the adequacy of existing information resources are magnified by the substantial unmet information needs it observes within the RW community. RWTF RW[174] and family member[175] focus group findings revealed significant unmet needs for information at various stages of the recovery process, including during orientation, during the process of finding providers, and during IDES. (See also Recommendations 16 and 20.) Both AC and RC RWs said that they had to search for information on steps to take throughout the recovery process.[176] The proposed DoDI will provide the coordination needed to reverse low utilization by the RW community and, in so doing, close the information gap.

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

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

When considering how to maximize information dissemination, it is critical to take into account the burgeoning use of mobile devices. According to the Pew Internet and American Life Project, since 2011, every major demographic group has seen growth in smartphone use, especially users in their 20's and 30's.[178] This holds true across income, race, and education levels with almost 80 percent of the under 35 population owning a smartphone. For smartphone users in their 20's, 88 percent are using their phones to meet immediate information needs.[179] Content can be made available via a custom application, such as the DoD Compensation and Benefits Handbook app[180] and the Marine Corps Wounded Warrior Regiment (WWR) app[181, 182], both free and launched in 2012[183, 184, 185]. Content can also be made available via a website optimized for viewing on mobile devices, which does not require a separate download and is more accessible through search engines and promotable with social media.[186] While the MOS website and NRD are both mobile-accessible,[187, 188] as noted, neither currently meets the needs of RWs and family members. Responsive web design enables users on any device to access information seamlessly[189], and in combination with tools like Google Analytics, can maximize access while giving the website owner insights into how the tool is being used and where[190]. DoD's promotion plan for mobile devices must take into consideration the information seeking patterns of RWs and family members, leveraging social media, in-person, and direct-to-consumer outreach tactics to ensure information reaches RWs and families where they are.

The NRD is a government web portal maintained by DoD, DOL, and VA connecting Wounded Warriors, Service members, Veterans, and their families to more than 14,000 services/resources at the national and state level.[191] The RWTF is concerned about the extremely low awareness and utilization of the NRD consistently reported by RWs and family members in the focus group mini-surveys in each year of data collection.[192, 193, 194, 195, 196, 197] In FY2012, the RWTF recommended that DoD market the NRD portal with a goal to double its usage.[198] Although ODASD(WCP)reported in FY2013 that the NRD has approximately 100,000 visits per month[199], ODASD(WCP) cannot discern how many of these visits were RW visits versus family member visits and how many unique RWs/family members these visits represent. Additionally, ODASD(WCP) described a marketing strategy that included NRD commercials in the National Capital Region (NCR), utilization of social media, distribution of NRD postcards and Fact Sheets, NRD demonstrations at the quarterly RCC trainings, and increased campaigns to get NRD widgets onto websites of Senators, Congress members, and corporations.[200] However, it is unclear whether these marketing efforts are reaching individuals outside the NCR. The RWTF believes a comprehensive marketing strategy that targets RWs and family members across the

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

Additionally, the RWTF recommends DoD develop a mechanism to track the success of the NRD marketing campaign in reaching RWs and family members. The RWTF notes that ODASD(WCP) uses Google Analytics to record the number of NRD users/hits, such as the total number of separate computers to access NRD in FY2011[201], and approximate number of visits per month in 2013[202] (though not unique visits). Google Analytics could be further used to track total number of user visits, number of pages viewed, and where users are located.[203] ODASD(WCP) might also consider establishing custom URLs to better analyze changes in RW/family member user groups responding to the marketing campaign.[204]

RECOMMENDATION 11

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

Requested Agencies to Respond: ODASD(WCP)

Finding: During its first two years of data collection, the RWTF frequently heard about the length of time it takes to get through the disability evaluation system; this year the RWTF consistently heard about how difficult it is to get visibility of the status of an RW case in IDES, particularly at the DES Rating Activity Site (D-RAS) stage. RW focus groups held by the RWTF revealed that many RWs experienced what some described as a "black hole" when they have to wait for results (e.g., from boards or medical tests) and/or responses to forms they have completed.[205] That the VA does not regularly update eBenefits pages adds to RWs' sense of a "black hole."[206]

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

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

Because the VTA is updated to show the Service member's status throughout IDES processing,[207] the RWTF believes wider access to the VTA would allow for increased visibility of progress through IDES. By granting VTA access to more IDES support roles such as legal staff and CBWTU staff, RWs will be better informed and less likely to experience the "black hole."[208] In combination with ODASD(WCP)'s May 2013 expansion of the IDES case workbook, which provides additional detail on where each packet is in the IDES process (e.g., 'VA preliminary rating time' in days, 'IPEB to DRAS Transit Time,' 'VA Preliminary Rating Core Time'), wider access to VTA will give RWs better access to information about the status of their case.[209, 210]

Further challenges that may be ameliorated by wider VTA access for IDES providers include managing the IDES timeline and the potential negative impact of an uncertain timeline on RW well-being. A joint base noted that Physical Evaluation Board Liaison Officers (PEBLOs)

never know how long processing of any particular packet will take and have no direct line of communication to D-RAS to check on the status (though all PEBLOs should have access to VTA).[211] The same site noted that individual IDES sites are not authorized to contact D-RAS to inquire into a case's status, regardless of how many months it has been dormant. Briefers at this site further pointed out how important it is for RWs to be informed of the status of their case, especially during the last phases of the IDES process, in order for them to plan appropriately (e.g., enroll in education programs, seek civilian employment, etc.).[212] Another site observed that the wait between seeing the narrative summary (NARSUM) and receiving orders can be difficult for RWs who are often anxious about the process but have no control over it nor visibility of their case's status.[213]

In addition, VTA access for lawyers would help to address RWTF's FY2012 Recommendation 34: "The Services should ensure that 100 percent of RWs are individually contacted by an MEB outreach lawyer (in-person, phone, email, mail, etc.) upon notification to the PEBLO that a NARSUM will be completed."[214] With access to VTA, all legal staff would be able to immediately identify Service members referred to IDES and reach out to them with information and contact information.

RECOMMENDATION 12

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

Requested Agencies to Respond: ODASD(WCP)

Finding: Upon completion of the Physical Evaluation Board (PEB) phase of IDES, the Service member may be 1) returned to duty, 2) placed on TDRL, 3) separated from the military, or 4) medically retired (i.e., placed on the permanent disability retirement list/PDRL).[215] If put on TDRL, a determination will be made within five years as to whether or not an RW is fit for duty, or will be separated or medically retired.[216] However, very few TDRL members are found fit upon TDRL review, making TDRL a costly and seemingly ineffective option. During the first quarter of FY2013, over three-quarters (78%) of TDRL Service members were moved to the PDRL, and about one-fifth were either kept on the TDRL (10%) or separated with benefits (11%); fewer than five percent were returned to duty.[217] As very few TDRL members are ultimately found fit, the RWTF questions the usefulness of the program. Additionally, the RWTF has been briefed that TDRL reviews are time consuming, complex, and do not cover all conditions.[218] Furthermore, after TDRL the Services use the Legacy Disability Evaluation System (LDES) and the Service member may get a lower rating than what he or she would have received had they gone through IDES.[219] Despite the low percentage of Service members returned to duty, and the inefficient nature of the process, the percentage of Service members assigned to TDRL remained stable between February 2012 and February 2013 (approximately 28%).[220] In order to afford RWs the best disability evaluation possible, the RWTF recommends elimination of TDRL and urges Congress to take this action.

RECOMMENDATION 13

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

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

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

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

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

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

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

The RWTF noted that the Army's most recent IDES/MEB Integrated Narrative Summary Guidebook requires that diagnoses both meeting and not meeting medical retention standards are included in the NARSUM.[228] The RWTF believes this practice is a good step toward ensuring all medical conditions are addressed by the MEB. (See Recommendation 21, Publish timely guidance for the care of RWs.)

The RWTF believes consistent enforcement of these policies by DoD also will enhance the experience of RWs during IDES. For example, failure to cover all conditions in the MEB phase oftentimes leads to delays when the PEB must reach back for additional information on conditions that were not covered in the MEB/NARSUM, thus leading to delays in IDES processing.[229] These delays could be eliminated by ensuring all conditions are covered in the MEB phase, and assembling all RW medical records as early as possible.

RECOMMENDATION 14

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

Requested Agencies to Respond: ODASD(WCP)

Finding: ODASD(WCP)'s ongoing IDES Satisfaction survey is used to track Service member satisfaction with the Integrated Disability Evaluation System.[230] The Defense Manpower Data Center (DMDC) administers these voluntary surveys via telephone to IDES participants at the completion of each major IDES phase: MEB, PEB, and the Transition Phase just prior to return to duty or transition to veteran status.[231] The RWTF views these IDES surveys as an important source of data for DoD, and is concerned by the significant drop in participation from the MEB phase survey to the Transition phase survey. Between the inception of the survey and September 30, 2011, eligible respondent counts decreased from 9,567 for the MEB Phase survey to 3,482 for the Transition Phase survey (a decrease of approximately 64%).[232] Diminishing participation between the MEB Phase survey and Transition Phase survey is likely due to two major factors: a) survey non-response (an RW simply decides not to participate again) and b) a rule in the methodology allowing only those who completed the previous phases of the survey to complete the next phase of the survey (i.e., if a RW completed the MEB Phase survey, but not the PEB Phase survey, he/she is not eligible to take the Transition Phase survey).[233] The exclusion of IDES participants who have not completed the previous survey inevitably leads to significantly lower responses for the final (Transition Phase) survey, which is administered when RWs have completed the entire process and are likely to have the best insight about the system as a whole. The "whole story" may be captured by allowing all Service members/veterans who have been through IDES to complete each phase of the survey regardless of whether they completed the survey for the previous phase(s).

Compounding the missed opportunity for tapping a valuable perspective, lower responses to the Transition survey have led to results that are not reportable due to low respondent counts. For example, data collected between July and September 2011 on helpfulness of DES program staff (e.g., PEBLO, VA Military Service Coordinator (MSC)) to the Service member's family during the transition phase was not reportable for Army National Guard, Navy Reserve, Marine Corps Reserve, Air National Guard, and Air Force Reserve due to very small sample sizes ($n<30$).[234]

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

Non-reportable data are not unique to DoD's IDES Satisfaction Survey. Many estimates of the TRICARE Management Activity Telephone Survey of Ill or Injured Service Members Post-Operational Deployment, which includes items on Service member experiences with the disability evaluation system, are not reportable due to low respondent counts.[235]

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

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

RECOMMENDATION 15

The Office of the Under Secretary of Defense for Personnel and Readiness (OUSD(P&R)) should ensure implementation of the Joint Federal Travel Regulations (JFTR) and Joint Travel Regulations (JTR) for family members of RWs is consistent across Service branches. Utilization of Invitational Travel Orders (ITO) and Non-Medical Attendant (NMA) orders, services provided, and payment processes should be the same across Services.

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

Finding: During FY2013 site visits, the RWTF found that ITO and NMA coverage and processes were not consistent for all eligible family members across Service branches. For example, when a RW moves from a MTF to a VA or civilian hospital, orders for family caregivers are not executed uniformly across the Services. When a Soldier moves from an MTF to a VA polytrauma center, another VA inpatient facility or a civilian inpatient facility, ITOs end for the three or fewer family members at bedside, and one (or two, for those with more severe conditions) family members are placed on NMA orders.[236] In effect, this means one or two of the family members are sent home, while one or two continues with the RW to the new facility on NMA orders. Furthermore, once family members are off ITOs, they cannot be re-initiated should the RW return to an MTF for treatment.[237] However, the other Services keep up to three family members on ITOs as long as the RW is moving between in-patient facilities.[238] This disparity across the Services is attributed to Army Regulation 600-8-1, which deems transfers to VA or civilian facilities equivalent to transfer to outpatient status, regardless of whether the RW will receive inpatient care at the receiving facility.[239]

Additionally, the RWTF was told that the amount of time it takes to generate orders to allow family members to get to their RW's bedside varied within Services and between Services.[240] For Army family members, the process is dependent upon the requirement by Army Human

Resources Command for Form 2984 to be signed by attending/accepting physicians before cutting orders for family members. As a result of this requirement, family members of RWs scheduled to arrive at Walter Reed National Military Medical Center (WRNMMC) on a weekend often are unable to be bedside when their RWs arrive. These delays do not apply with very seriously injured or critical care transport team patients. In comparison, the US Special Operations Command is able to ensure family members are present whenever the RW arrives.

The RWTF also was made aware of inequities in reimbursement processes at certain installations.[241] At Fort Bragg and possibly other Army posts, family members on travel orders are required to itemize and submit receipts rather than receiving a flat per diem rate for meals and incidentals, potentially resulting in Army family members receiving less daily compensation and experiencing greater administrative burden.[242] At Walter Reed National Military Medical Center, some family members are sent to a nearby Marriott Hotel for lodging.[243] However, only the Army has an arrangement directing the hotel to accept family members' ITOs in lieu of payment for lodging expenses.[244] In contrast, family members of RWs in other Services must provide their own credit card or a pre-paid debit card given to them, such as the card provided by the Navy.[245] Paying up front with a personal credit card is a significant financial burden for some families.

The RWTF found significant dissatisfaction with payment and reimbursement processes in general. Participants in RWTF family member focus groups reported difficulties related to travel expenses, particularly for family members of Reserve Component personnel recovering at locations distant from their home of record.[246] Family members described having to cover the cost of the travel with no assistance or reimbursement from the military. In one instance, the family member was unable to cover this expense and the RW and family did not see each other for a protracted period. [247]

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

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

RECOMMENDATION 16

Implementation of the SCAADL benefit must be optimized through:

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

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

Finding: SCAADL is an important benefit that provides monthly compensation to catastrophically injured RWs whose family member is providing high-level care similar to that found at a hospital or nursing home. An RW and family member panel told the RWTF that many family caregivers of RWs receiving SCAADL have given up their careers or reduced their own work hours in order to support their RWs[248], making SCAADL a significant source of income. During RWTF focus groups, some family members specifically mentioned unmet financial needs related to caregiving and their reduced ability to work.[249] SCAADL payments are taxable[250, 251, 252], however, and the RWTF is concerned that the tax burden considerably diminishes the value of the SCAADL benefit to RWs and families. In briefings to the RWTF, the Army and Marine Corps stressed that the reduction in net SCAADL payment due to taxation has a significant negative impact on the RWs and family members receiving it.[253, 254]

In U.S. tax code, SCAADL payments are listed as "special pay" under the heading "taxable income" with an exception written as "unless the pay is for service in a combat zone."[255] Also in the tax code, "disability, including payments received for injuries incurred as a direct result of a terrorist or military action" is listed under "other pay" in "excluded items" or tax-free payments.[256] The RWTF recommends that SCAADL legislation be changed to eliminate the tax burden just as "disability" noted above is excluded. This recommendation is supported by the Report of the Eleventh Quadrennial Review of Military Compensation, which also recommends making SCAADL payments tax exempt as is done with the VA caregiver compensation.[257]

The RWTF also believes that the number of Army SCAADL recipients is low relative to the number of WTU enrollees and is concerned that eligible RWs and families are going unserved. Only approximately seven percent of those within the WTU system—the largest of the Services' Wounded Warrior units and programs— have submitted applications for SCAADL and only approximately five percent were receiving SCAADL payments as of November 12, 2012.[258] To ensure that eligible RWs and families are aware of SCAADL resources, the RWTF believes that marketing must be increased. A large number of family member focus group participants stated they did not know what supports were available.[259] In several instances, family members suggested they were not using SCAADL because they were not provided accurate or timely information when they inquired about it.[260] The RWTF also observed a lack of familiarity with SCAADL across ARNG, ANG, and NOSC briefers[261], suggesting there may be eligible RC RWs who are unfamiliar and unconnected with the SCAADL benefit.

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

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

Over the course of FY2013 site visits the RWTF also noted that increasing collateral duties for medical care case managers (MCCMs), such as completing SCAADL applications and supervising NMAs, were burdensome to them and were hampering their effectiveness.[262] The

RWTF recommends that, at all installations, the PCM have final decision authority on SCAADL, and that an electronic SCAADL application process be developed in AHLTA to improve MCCM/PCM access and reduce the burden of completing non-electronic SCAADL paperwork.

Recommendations for the Services

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

RECOMMENDATION 17

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

Requested Agencies to Respond: USAF

Finding: Air Force liaisons at WRNMMC and LRMC are not able to provide continuity and adequate support to RWs and their families because the position turns over frequently.[263, 264] Andrews AFB currently provides the WRNMMC liaison position, but the term is too short.[265] At LRMC, Air Force liaisons are assigned for six months with only a one-week overlap.[266] A significant portion of the liaison's assignment is spent in train-up, and RWs and families with acute needs during these train-up times are not getting the best possible services and support.[267, 268, 269] The RWTF believes that extending the Air Force liaisons' assignments at WRNMMC and LRMC would increase their number of productive months on the job and enhance the quality of service that the liaisons deliver to RWs and families.

RECOMMENDATION 18

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

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

Finding: Remote locations face unique challenges staffing behavioral health services. This year, the RWTF visited a remotely located WTU in Alaska. The visit to the WTU at Joint Base Elmendorf Richardson (JBER), in Anchorage, Alaska, included video teleconferences (VTCs) with personnel at the WTU's Bravo Company, located in Fairbanks, Alaska. Staff at both Alaska locations noted a limited pool of qualified civilian behavioral health providers and an increasing caseload of RWs presenting with behavioral health issues.[270] JBER in particular mentioned great difficulty in filling contract positions in a remote environment and had a particularly under-resourced TBI program.[271, 272] The Army Behavioral Health Task Force (ABHTF) expressed a similar concern, noting behavioral health provider hiring difficulties for MTFs in remote locations was impacting continuity of care for RWs.[273]

RECOMMENDATION 19

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

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

Finding: The RWTF's FY2013 site visits included six RC locations: three JFHQs, a NOSC, a Navy MEDHOLD unit, and an Army CBWTU. The RWTF was gratified during visits to these sites that RC leadership appears to be well versed in IDES terms, processes, and roles. For example, when leadership was asked how their wounded, ill, and injured (WII) are informed of their right to request an independent physician or find dedicated IDES legal counsel to review their MEB packet, they consistently replied that this occurs through the servicing MTF and/or PEBLO[274], demonstrating a level of understanding of IDES that the RWTF did not observe in previous years. In RWTF focus groups with AC and RC members, the large majority of participants indicated familiarity with the term *Disability Evaluation System,* or *DES*.[275] When AC and RC focus group participants in the IDES process were asked what types of support and assistance was available to them and from whom, the most consistent response, by a significant margin, was the PEBLO.[276]

The RWTF did not observe the same level of RC awareness of other RW policies and benefits. The RWTF was distressed to discover little knowledge of key resources such as SCAADL, the RCC, Service Members' Group Life Insurance Traumatic Injury Protection (TSGLI), and the CRP.[277] At least one organization was unaware that its headquarters had released an important policy update.[278] The RWTF is concerned that limited awareness of RW policies and benefits within RC organizations may impact access to resources for their RC RWs and families. The information presented in the following paragraphs lends credence to the concern that the RC RW community is not as connected to RW resources as they could be, or as their AC counterparts are.

While the RWTF does not know how many RC personnel qualify for entry into the Services' respective RW programs (Army WTU/CBWTU, Air Force Warrior and Survivor Care, NWW-SH, WWR), there is some indication that the proportion of RC in these programs may be lower than expected in certain Services. For example, although Reservists comprise 15 percent of the Navy[279] and 12 percent of Navy wounded in action[280], they make up only eight percent of NWW-SH enrollees[281]. Similarly, although Reservists comprise 13 percent of the Marine Corps[282] and 10 percent of Marine Corps wounded in action[283], they make up only three percent of Marines joined to the WWR[284]. (See Appendix K, Other Results, for full results by component.)

The RWTF also notes that only approximately one in five RC Sailors in MEDHOLD East and West (19%) are receiving NWW-SH NMCM support.[285] Additionally, the RWTF is uncertain whether in all Services the number of RC personnel receiving SCAADL payments is commensurate with the number who qualify. For example, RC personnel comprise 53 percent of the Army WTUs and CBWTUs[286] but only 28 percent of Army SCAADL recipients[287]. Similarly, RC personnel comprise 21 percent of Air Force Warrior and Survivor Care enrollees[288] but only eight percent of Air Force SCAADL recipients[289]. (See Appendix K, Other Results, for percentages for each component.)

Results of the FY2013 mini-survey the RWTF administered to the approximately 200 FY2013 RW focus group participants underscore a disparity between AC and RC access to non-medical supports. With respect to use of care coordinators and NMCMs, there was consistently higher use of Recovery Care Coordinators (RCCs) (44% of AC, 14% of Reserve, 22% of Guard) and Service specific non-medical case managers for AC respondents.[290] Although the large majority of all three components indicated no first-hand experience with programs that provide support for family caregivers, the proportion lacking first-hand experience was higher among the Reserve and Guard than the AC (75% of AC, 90% of Reserve, 90% of Guard).[291]

A theme of insufficient support or awareness of resources emerged from the RC RW focus group discussions. The ARNG members who participated in the JFHQ focus groups were unable to identify anyone who is providing them non-medical case management. Furthermore, these individuals did not recognize the term Transition Assistance Advisor (TAA)[292], which is the individual(s) in each state that the NGB Warrior Support Office charges with facilitating RWs' non-medical transition[293].

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

According to the results of the DoD-wide TRICARE Management Activity (TMA) Survey of Ill or Injured Service Members Post-operational Deployment, Army AC Service members were significantly more satisfied with DoD support in transitioning from the DoD to the VA health care system than Army RC Service members (81% versus 56%, $p<.01$).[294]

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

RECOMMENDATION 20

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

- Invite and encourage family member/family caregiver to attend the initial unit/program orientation (i.e., at the WTU/CBWTU/WWR or, for Air Force/Navy, the initial RCC/NMCM contact) and the initial briefing upon entry into IDES (i.e., for all Services, initial briefing with PEBLO). (RC family members may attend in person when the RW is attending in person and will receive TDY.)

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

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

Finding: Since its inception, the RWTF has been concerned that RW family members lack the information they need and are not adequately connected to the resources available to them. The RWTF also is concerned by continuing difficulties in outreach to this vulnerable population. Accordingly, the RWTF strongly recommends DoD institutionalize systematic outreach with RW family members to optimize their participation in initial unit/program orientations, including transition unit in-processing such as into a WTB, CBWTU, or WWR Battalion or Detachment for Soldiers and Marines, initial RCC/NMCM contact for Sailors and Airmen, as well as the initial IDES briefing. Family member involvement at these critical points in the recovery process will increase family member knowledge of units and programs as well as family member knowledge of resources for caregivers. The RWTF notes NICoE represents a potential model for greater family member participation, as family members (including spouses, children, parents, siblings, or other members of the support system) are required to attend with RWs, when feasible.[295] Common metrics will allow for consistent monitoring and reporting of 100 percent outreach, family member participation in initial in-briefs, and family member awareness and use of available resources.

The RWTF acknowledges that some RW family members are receiving the information they need. A number of RWTF family member focus group participants stated that available information meets their needs and described regularly receiving information that is both accurate and useful.[296] In addition, RWTF family member mini-survey results indicated that more family members were satisfied/very satisfied than dissatisfied/very dissatisfied with information/education to help family members care for their Service members (33/69 versus 21/69) and information/education about available benefits and services (35/67 versus 20/68).[297]

At the same time, over the past three years, the RWTF has found that many family members feel uninformed about and/or disconnected from resources and benefits available to family caregivers and/or their RWs.[298, 299, 300, 301, 302] A large number of FY2013 family member focus group participants stated that they do not know what supports are available to them; have a significant number of questions that are not being answered; and do not get the appropriate information at the right time, or receive inaccurate information.[303, 304] Family members stated they primarily receive information from their RWs, and emphasized the limitations of relying on RWs who may forget information, may be unwilling to disclose information, or may be unaware of available resources.[305]

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

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

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

Service-level policy holds unit commanders responsible for outreach to family members.[306, 307, 308] Service-level briefings to the RWTF either indicated they had 100 percent family member involvement in the CRP/CTP and IDES processes or did not comment on the percentage of families involved.[309, 310, 311, 312] Site-level briefers indicated that, while family members are invited to participate in events such as the unit in-processing, CRP/CTP meetings, and IDES in-processing, attendance is low.[313] It is important to note that the RWTF lacks visibility of how family members are encouraged/invited to attend. Family member focus group findings corroborate that a majority of family members are not included in in-processing, IDES, and perhaps most notably, are largely uninvolved in the CRP/CTP process.[314] Most family member focus group participants stated they were unfamiliar with term CRP/CTP; the RWTF infers that family members may not have been adequately informed of their option to participate in this process.

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

Not a clue. (Family Member)

Similar concerns have been raised by other entities. A November 2012 Warrior-Family roundtable determined that caregivers were not receiving the information they need during the right stage of recovery due to, "a disconnect between policy and the translation at the grass roots level where the care is occurring or programs are being implemented," resulting in, "barriers in outreach, communication, and implementation."[315] The Military Coalition (TMC) called upon Congress and DoD to integrate family caregivers into the rehab and recovery team and to ensure family caregivers are informed about care, treatment, DES, and the CRP.[316]

As shown in a number of studies, on-site family support helps RWs during the recovery process and is associated with improved recovery[317, 318], reduced medication use[319], and more expedient return to work[320]. Healthy family functioning as a whole is associated with a lower level of disability/functional impairment and higher employability.[321] Consistent with these studies, RW focus group data indicated that being separated from family members had a negative impact on the RW's recovery.[322] The RWTF believes the full benefit of DoD's considerable investment of time and money in the RW units and programs cannot be fully realized without family member involvement.

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

Recommendation for multiple agencies

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

RECOMMENDATION 21

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

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

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

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

- **DTM 11-015, Integrated Disability Evaluation System (IDES) and Navy and Air Force Service-level Guidance.** The current policy guidance on the Integrated Disability Evaluation System, DTM 11-015, is scheduled to expire on August 1, 2013. DTM 11-015

establishes policy, assigns responsibilities, and prescribes procedures for the IDES.[323] It is imperative this publication not expire. As a DTM, it has a span of only six months and has been extended several times; the RWTF urges publication of the permanent DoDI as soon as possible. The RWTF also notes that, although the DTM requires each Service to establish IDES procedures, the Navy and the Air Force have not yet published Service-level guidance in accordance with the DTM.

- **WTC Policy Memo 11-098, Comprehensive Transition Plan Policy and CTP-Guidance (CTP-G).** The current Army Comprehensive Transition Plan Policy and CTP-Guidance (CTP-G), MEDCOM Policy Memo 11-098, is scheduled to expire on November 29, 2013. MEDCOM Policy Memo 11-098 standardizes staffing and establishes common understanding of programs and procedures at each of the 29 WTUs and nine CBWTUs, including implementation of the CTP.[324]
- **DTM 12-007, Implementation of Mandatory Transition Assistance Program Participation for Eligible Service Members.** The current policy guidance on implementation of the new mandatory Transition Assistance Program (called Transition GPS), DTM 12-007, was originally scheduled to expire on May 21, 2013. The RWTF recognizes DoD's successful efforts to extend DTM 12-007 prior to its expiration through May 21, 2014. Transition GPS is still undergoing its roll out and expired policy could have been damaging to its implementation.[325] As full implementation of Transition GPS is not expected until October 2014,[326] the RWTF notes that May 21, 2014 is still not an appropriate expiration date for this policy guidance. The RWTF recommends the publication of the permanent DoDI.
- **DoDI 1322.bb, Implementation Guidance for Job Training, and Employment Skills Training (JTEST) Authority for Eligible Service Members.** In briefings to the RWTF, ODASD(WCP)[327], the Army[328], the Air Force[329], and the Marine Corps[330] indicated they all await further implementation guidance from DoD on non-federal internships. ODASD(WCP) stated the forthcoming DoDI 1322.bb, Implementation Guidance for Job Training, and Employment Skills Training (JTEST) Authority for Eligible Service Members will provide the necessary implementation guidance[331]. DoD must clarify what, if any, additional policy is needed and ensure that RWs quickly gain access to non-federal internships. If DoDI 1322.bb will provide the needed guidance, it must be published without delay. RWs who participated in RWTF focus groups were as likely to say that currently available vocational opportunities met their needs as not,[332] underscoring that current opportunities are insufficient. Expanding internship and apprenticeship opportunities beyond the federal sector would increase the availability of meaningful vocational opportunities for RWs.[333, 334] Thus, for the second consecutive year, the RWTF recommends DoD publish implementation guidance on non-federal internships.

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

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

- **DoD/VA Interagency Complex Care Coordination Policy for Service Members and Veterans.** The DoD/VA Interagency Care Coordination Committee (IC3) was created to establish interagency guidance and a common governance structure, develop an interagency community of practice, develop a single comprehensive interagency recovery plan, and develop a sustainable model for both peacetime and wartime support requirements.[335, 336] Currently, the IC3 is developing the DoD/VA Interagency Complex Care Coordination Policy for Service Members and Veterans, a source document for current and future policy that implements the new operational model of complex care coordination. The Policy defines terms and common guidelines and assigns responsibilities during care coordination. In an April 2013 presentation to the RWTF, the IC3 co-chairs noted that IC3 goals align with a number of RWTF recommendations[337] and priority issues, such as information dissemination, standardization across the Services, and synchronization among care coordinators and non-medical case managers. Publication of the DoD/VA Interagency Complex Care Coordination Policy for Service Members and Veterans is needed to improve quality and parity across RW programs and services in all of these areas.
- **DoDI on VA Vocational, Rehabilitation & Employment (VR&E) counseling for Service members transitioning through IDES.** In an April 2013 briefing to the RWTF, DoD stated a DoDI, "on the vocational rehabilitation and employment counseling for Service members transition from IDES" was in coordination and should be published by the end of the fiscal year.[338] The RWTF places significant value on VR&E, having recognized the key role VR&E plays in supporting transitioning RWs and will continue to play after the current conflict ends and drawdowns are completed. The RWTF has sought and received briefings on the availability of VR&E at numerous site visits[339, 340, 341], and made recommendations on VR&E in both the FY2011 and FY2012 reports. RWTF RW focus group participants more often than not stated that job readiness activities including VR&E met their needs[342], and mini-survey results from participants with first-hand experience with VR&E indicated high satisfaction[343]. However, despite such positive satisfaction, mini-survey results also indicated that VR&E utilization was low; only 18 percent of respondents had first-hand experience. Site briefers identified a number of barriers that likely contribute to the low utilization. At several installations, the chain of command and RWs displayed a lack of awareness of VR&E and/or a misunderstanding of the program.[344] The RWTF also observed poor coordination between VR&E counselors and other installation staff, or poor integration of VR&E into the IDES process.[345] Publication of the DoDI will further formalize and standardize VR&E for current Service members and assist in overcoming implementation barriers.

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

- **DoD Instruction (DoDI) on Reserve Component incapacitation status.** In FY2012, the RWTF recommended that DoD establish policies that allow for the rapid issuance of Title 10 orders to RC RWs who have sustained line of duty injuries/illnesses (Recommendation 22). RWTF FY2013 site visits to JHFQs in Arkansas, Iowa, and North Carolina served to reinforce the salience of this recommendation. In its April 2013 response to the FY2012 recommendations, DoD concurred with Recommendation 22 and stated implementation would involve consolidating existing policy (DoDI 1241.2, "Reserve Component Incapacitation System Management," and DoDD 1241.01, "Reserve Component Medical Care and Incapacitation Pay for Line of Duty Conditions") into a single issuance to better support RC needs related to incapacitation status.[346] The RWTF appreciates DoD's concurrence on FY2012 Recommendation 22 and urges DoD to publish the new policy as soon as possible.

Summary

The final section of this chapter includes best practices and charts that document RWTF's FY2012 and FY2011 recommendations, summarize DoD's formal responses, and note the RWTF's assessment of each recommendation's current status. The section concludes with a topline overview of the FY2014 research plan.

BEST PRACTICES

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

PTSD Services

The RWTF has made several recommendations to improve the services for RWs with PTSD, addressing access to care, EBP training for all DoD behavioral health providers, and non-completion of treatment protocols. In three years of site visits, the RWTF has observed PTSD treatment programs that vary in their attentiveness to treatment outcomes[347, 348, 349] and that are not able to consistently meet the needs of RWs[350, 351, 352] and their families[353, 354, 355]. The RWTF believes that without measuring outcomes and monitoring effectiveness, programs cannot respond and adapt to patient needs and therefore cannot reach their full potential. The following best practices in PTSD services address the need for monitoring care, measuring outcomes, and adapting treatment programs individually and at systems levels to improve services and ensure effectiveness.

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

Psychological Health Pathways (PHP)

PHP was implemented in 2009[356] on the campus of Naval Medical Center San Diego (NMCSD)[357]. The mission of the program is to provide education, build resilience, aid research, and promote best practices in the treatment of combat and operational stress injuries.[358]

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

RWs in PHP are notified at the outset of treatment of the expectations for compliance, and are asked to sign an agreement giving permission to notify the command of missed appointments.[359] This requirement has not been a deterrent to participation; in fact, the demand for this program has grown with cohort sizes and number of cohorts increasing each year. The program offers multiple treatment options to allow for use of a variety of modalities before reaching a determination of treatment non-completion. For example, in the event a RW in the trauma track is not compliant with weekly sessions, the RW will return to the outpatient clinic provider for supportive therapy and monitoring.[360] The Commanding Officer or the medical care team is notified when multiple appointments are missed.[361]

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

- Clinical Pathways: a standardized set of clinical practices from the initial collection of demographics and screening measures used to assess individual treatment outcomes, through final transition of care.[362] The program is designed to be flexible and tailored to the resources at any given clinic or treatment facility as it expands beyond NMCSD.[363]
- Care Management: Facilitation of patient advocacy, education, tracking, reporting and timely access to providers and resources. Case managers are able to work collaboratively with the patient and mental health providers to facilitate coordination and continuity of care.[364]
- Data Management: Coordinated and centralized data capture. Data are collected starting with initial contact, to include demographics and self-report outcome measures, re-evaluation measures, and clinical treatment reviews.[365] The outcome measures collected throughout treatment inform clinician and program treatment decisions, program evaluations, and staffing and funding decisions.[366]

Army Behavioral Health Data Portal (BHDP)

The Army BHDP allows behavioral health providers to document treatment progress and clinical outcomes.[367] As of late 2012, the BHDP was in use at 31 MTFs.[368] The intent of the program is to track patient outcomes, satisfaction, and risk factors. This tracking improves communication among providers and commanders and increases the availability of data on individual patients and on overall program/treatment efficacy.[369]

Patients self-report behavioral health data in a secure web application, and providers can quickly access the benchmarked data to assess clinical progress and the patient's response to current interventions, informing their clinical decisions in real time.[370] Providers are alerted to adjust treatment if the patient is not meeting the expected treatment response.[371] In the future, the program will also link to deployment health assessments to compile a more robust record of Soldiers' behavioral health.[372]

The Army Task Force on Behavioral Health recommended Army-wide implementation of the BHDP to improve efficacy and documentation of behavioral health care provided to Soldiers.[373]

Behavioral Health Teleconferences with Network Providers

The Fort Carson Director of Behavioral Health holds weekly teleconferences with the network providers treating RWs with PTSD in inpatient settings.[374] (As of the RWTF's January 2013 visit to Fort Carson, 25 RWs were receiving inpatient PTSD care on the network.) Together, the Director of Behavioral Health and network providers go over each patient's status, ensuring frequent and open communication and collaboration on the RW's treatment and progress. These teleconferences allow the Behavioral Health Director to maintain accountability and oversight over the quality of inpatient PTSD care provided to RWs outside the MTF.

Reserve Component: North Carolina National Guard Integrated Behavioral Health System

The North Carolina State G-1 stated as part of the introduction to the RWTF visit that they spend approximately $3M a year of their own money on the Integrated Behavioral Health System (IBHS) and would rather give up a tank engine than this program.[375] Established by the NCNG November 1, 2010, the IBHS "is dedicated to helping NCNG Service members and their families by assessing for immediate behavioral health needs and offering connection and case management services to all NCNG support programs as well as federal, state, and community programs for both clinical and non-clinical needs."[376] The IBHS serves NCNG members and their families who are currently serving or left military service within the last six months.[377] The primary target population comprises individuals whose connection or re-connection with available services is inadequate or untimely, are in crisis, and/or are uninsured and not VA-eligible—for whom the IBHS provides short-term, crisis support services.[378] Members of other Service branches and components are not turned away.[379] Participation in IBHS services is voluntary, confidential, and free of charge.[380] Not only is the IBHS completely separate from the fitness for duty determinations and the command-directed referral process[381], but IBHS records are maintained separately from documentation maintained by the JFHQ State Surgeon's Office.[382]

The portal of entry into the IBHS is a confidential, toll-free call line monitored 24/7 by a qualified clinician. Calls must be returned within 30 minutes.[383] The IBHS portal voice mail greeting refers callers to alternatives including the National Veteran's Crisis Line and Military OneSource.[384] The IBHS provides consultation for callers who are concerned about someone else, such as callers from the chain of command or a battle buddy, and assessment for callers who are troubled themselves.[385] Since inception, the IBHS has fielded 1,891 calls and conducted 825 clinical assessments and 877 consultations.[386] Consultations are protected by appropriate levels of professional ethics.[387]

The IBHS is staffed by qualified professionals.[388] IBHS positions include: the State Behavioral Health Programs Director, who functions as administrative and clinical lead; the State Behavioral Health Programs Coordinator, who functions as the assistant to the Director; the Directors of Psychological Health who fill clinical roles including assessment, triage, referral, follow-up, crisis intervention, and critical incident stress management (CISM); behavioral health clinicians, who conduct short-term, crisis support services; and non-clinical behavioral health case managers, who follow up on clinical referrals and engage with non-clinical referral sources.[389]

Following initial assessment and referral, IBHS clinical staff may provide eligible individuals counseling services or "bridging behavioral or crisis support"[390] services. IBHS also refers to such counseling/non-clinical resources as Military Family Life Consultants, Military OneSource, employee assistance programs (for employed m-day Guard members), and Give an Hour, and such clinical resources as VA Medical Centers, VA Vet Centers, Department of Health and Human Services managed care organizations, TRICARE providers, and others.[391] IBHS also addresses non-medical needs that may be associated with behavioral health issues.[392] In addition to the services outlined above, IBHS staff members conduct educational and marketing briefs at Soldier Readiness Processing, demobilization, Yellow Ribbon Reintegration Program, and other events.[393]

Vocational and Transition Services: Fort Carson Access to Internships

While visiting Fort Carson, members of the RWTF observed a method of preserving employment opportunities for RWs who are not yet certain exactly when they will leave the military. The RWTF heard in RW focus groups this year and last[394, 395], as well as during briefings at a majority of sites visited [396, 397], that the uncertainty inherent in the IDES process hampers RWs' ability to seek employment. RWs often postpone pursuing employment because they are unable to commit to a start date until IDES is nearly complete. However, once IDES is nearly complete, RWs often find themselves with too little time left to participate in programs such as Operation Warfighter (OWF) and E2I.

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

The Transition Coordinator, Employment and Education Initiative (E2I) Coordinator, and VA VR&E staff at Fort Carson have developed a method of assisting RWs in IDES who have a specific job they wish to pursue.[398] In these cases, Fort Carson staff work with the employers to reconfigure the job opportunities into temporary unpaid internships for the RWs. As an internship, the employer is able to moderate the duration as necessary to accommodate the uncertain timeframe of the IDES process. The work contribution made by the RW during the internship allows the employer to hold the official position open until the RW is able to transition out of the military into the job full time, and the RW is able to receive training and gain experience during the internship. Because the RW is also participating in VR&E, s/he is able to receive a VA stipend during the internship. The RWTF has often advocated for greater collaboration between DoD and VA in preparing RWs for civilian life, and recognizes the efforts made at Fort Carson as an example of collaboration resulting in improved opportunities for RWs.

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

In FY2013 RW focus groups, a number of participants described general dissatisfaction with IDES, including an insufficient understanding of how the IDES functions.[399] FY2011 and FY2012 RWTF focus group participants expressed similar confusion about the IDES process. [400, 401] While visiting Fort Bragg, members of the RWTF learned of a comprehensive IDES briefing for RWs, developed by a Fort Bragg IDES lawyer, that is an impressive effort to provide the information needed about the IDES process.[402, 403] In particular, the RWTF considers the detailed content on how specific medical terminology translates into VA rating(s) to be invaluable. The following is illustrative of other specific information provided in this extensive briefing:

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

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

STATUS OF FY2012 AND FY2011 RECOMMENDATIONS

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

FY2012 Recommendation	Summary of DoD Response	Status
1. Publish RW policy/program guidance	All publications completed.	Met. (however see FY2013 Rec 21)
2. Standardize case management and care coordination roles	Being addressed by the Interagency Care Coordination Committee.	Continue to follow. (see FY2011 Rec 2 and FY2013 Rec 21)
3. Draft RW Bill of Rights or content of Commander Intent Letter	Warrior Care Policy office requirement.	Continue to follow. (see FY2011 Rec 5)
4. Co-locate/integrate DoD and VA rehabilitation capacity	Concurs. Awaiting Implementation Plan.	Continue to follow.
5. Establish WCP within USD(P&R) portfolio	Non-concurs.	Continue to follow.
6. Provide needed resources on station for 29 Palms	Still being addressed.	Continue to follow.
7. Extend TAMP to one year post deployment	Still being studied.	Continue to follow.
8. Ensure training for evidence based PTSD treatment/identification	Concurs.	Met. (however see FY2013 Rec 21)
9. Audit records for completed evidence based PTSD treatment	Partially concurs.	Continue to follow.
10. Adopt a common comprehensive recovery/transition plan format	Non-concurs.	Continue to follow. (see FY2013 Rec 21)
11. Provide more access to and input into CRP for RWs and families	Partially concurs.	Continue to follow.
12. Redefine WII Category 2	Partially concurs.	Continue to follow.
13. Send non-RCC RW proponents to joint DoD RCC training	Concurs.	Continue to follow.
14. Support to family members/caregivers unconstrained by HIPAA	Concurs.	Continue to follow.
15. Designate principal point of contact for family/caregiver	Concurs.	Continue to follow.
16. Educate family members/caregivers about VA/other resources	Concurs.	Continue to follow. (see FY2013 Rec 10, 16, 20)
17. Provide PEBLO briefing for EFMP families	Concurs.	Met.
18. Unify famiies/caregiver with RW	Concurs.	Continue to follow. (see FY2013 Rec 15)
19. Rename NRD and market the new portal	Non-concurs.	Continue to follow. (see FY2013 Rec XX)
20. Resource base family support centers and specify relationships with RW programs	Concurs.	Continue to follow.
21. Centralize case management for RC RWs on Title 10	Concurs.	Continue to follow.
22. Establish policies for issue of Title 10 orders and use of INCAP pay	Concurs.	Continue to follow. (see FY2013 Rec 21)

FY2012 Recommendation	Summary of DoD Response	Status
23. Include RC unit in out-processing for RWs leaving Title 10	Concurs.	Met.
24. Publish interim guidance for NDAA 2012 Section 551	Concurs.	Continue to follow. (see FY2013 Rec 21)
25. Expand DoD/VA MOU on RW access to VR&E counseling	Concurs.	Continue to follow. (see FY2011 Rec 18 and FY2013 Rec 21)
26. Update DoDD and DoDI on TAP	Concurs.	Continue to follow. (see FY2013 Rec 21)
27. Establish DoD and VA Deputy Secretaries as Co-Chairs of JEC	Non-concurs.	Continue to address.
28. Evaluate processes to limit IDES population	Concurs.	Met.
29. Create electronic record for individual IDES information	Concurs. Pending pilot outcomes.	Continue to follow.
30. Utilize WCP survey to improve IDES program	Concurs.	Continue to follow. (see FY2013 Rec 14)
31. Exclude terminal leave from calculation of IDES timelines	Non-concurs.	
32. Consider replacing Service FPEB with a joint FPEB	Still being studied.	Continue to follow.
33. Develop staffing models/ensure adequate PEBLO staffing	Still being studied.	Continue to follow.
34. Provide legal outreach to RWs	Partially concurs.	Continue to follow. (see FY2013 Rec 11)
35. Market VA services and benefits to DoD leadership at all levels	Partially concurs.	Continue to follow.

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

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)

FY2011 Recommendation	Summary of DoD Response	Status
6. Enforce the existing policy guidance regarding transition unit entrance criteria.	WWR works to maintain awareness. Army fragmentary orders (FRAGOs) provide specific guidance.	Met (however see FY2012 Rec 12)
7. Ensure that there are sufficient numbers of medical care case managers available at WTUs, WWRs, and CBWTUs.	DoDI 1300.25 published	Met
8. Shape strategic solutions that address the unique needs of RC RWs.	There is only one standard. Working on restructuring the Remote Care program.	Continue to follow (see FY2012 Rec 21, 22, 23)
9. Provide the needed support for the Centers of Excellence (CoEs) to enable full operational capability.	CoE Advisory Board established. DCoE PH & TBI realigned. EACE funded.	Met
10. Ensure timely access to routine PTSD care across the continuum of Service.	Took multiple steps to ensure timely access	Continue to follow (see FY2012 Rec 7, 8, 9)
11. Standardize and define the roles/responsibilities of care coordinators, VA personnel, and NMCMs.	DoDI 1300.24 provides eligibility criteria. Fragmentary Order (FRAGO) 3 & Headquarters Department of Army (HQDA) Executive Order (EXORD) 118-07 provide guidance	Continue to follow (see FY2012 Rec 2)
12. Develop minimum qualifications, ongoing training, and skill identifiers specializing in recovery and transition for transition unit personnel.	USMC Section Leaders are a mix of RC & AC; moving toward only AC. WTC working to enhance training.	Continue to follow
13. As part of the intake process, and on a regular and recurring basis, review available resources for support, to include the NRD and Keeping It All Together, with the RW and the family caregiver.	WTC recognized the need to better educate Service members and families on transition. These are reflected in the 12.1.11 CTP guidance & policy.	Met (however see FY2012 Rec 19 and FY2013 Rec 20)
14. Empower family caregivers with the resources they need to fulfill their roles in the successful recovery of RWs.	WTC recognized the need to better educate SMs and families; reflected in the 12.1.11 CTP guidance & policy.	Continue to follow (see FY2012 Rec 14, 15, 16, 17, 18)
15. The DoD should expedite policy to provide special compensation for SMs with catastrophic injuries or illnesses requiring assistance in everyday living, as directed by Section 603 of the NDAA 2010.	DoD issued policy for Special Compensation for Assistance with Activities of Daily Living on 8.31.11. Eligible WII started receiving payments 9.15.11.	Met
16. Continue to support the SFACs and take steps to increase utilization.	WTC working to educate and inform about SFACs.	Continue to follow (see FY2012 Rec 20)
17. Make TAP attendance mandatory for RWs within the 12 months prior to separation.	Section 221 of the Vow to Hire Heroes Act, Public Law 112-56, signed 11.21.11, contained a mandatory TAP provision.	Met (however see FY2012 Rec 26)
18. Ensure that the VA VR&E Program is available and accessible to RWs before their separation from the Services.	MOU signed 2.1.12 to implement at earliest opportunity. Process will be expanded further in FY2012.	Continue to follow (see FY2012 Rec 25 and FY2013 Rec 21)
19. Develop a uniform DoD manpower and staffing model for PEBLOs and legal support.	Army reviewing staffing needs in the DES. USAF increased staff.	Met (however see FY2012 Rec 33 & 34)
20. Pending the implementation of a common electronic health record (EHR), find interim solutions to grant access to EHR for disability assessment.	Working on multiple electronic health records systems with the VA.	Continue to follow
21. Consolidate the SOC functions into the JEC. The JEC will be co-chaired by the Deputy Secretaries of DoD and VA.	The SOC has become the WIIC of the JEC.	Continue to follow (see FY2012 Rec 27)

OVERVIEW OF FY2014 RESEARCH PLAN

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

Notes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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ANNEX 1: MEMBER BIOGRAPHIES

Vice Admiral Matthew L. Nathan, MD
United States Navy

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

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

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

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

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

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

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

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.

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

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

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

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

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

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.

Technical Sergeant Alex J. Eudy
United States Air Force and Special Operations Command

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Major General Richard P. Mustion
United States Army

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

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

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

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

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

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

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

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

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

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

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

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 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 focus specialty in medical industry and informatics, Dr. Turner's expertise extends to surveying electronic medical records, coding and syndrome surveillance for detection of disease patterns.

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

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

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

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

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

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

ANNEX 2: ACRONYM LISTING

Acronyms Used in Report

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

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

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

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

Acronym	Meaning of Acronym
WWCTP	Wounded Warrior Care and Transition Policy
WWR	Wounded Warrior Regiment
WWRC	Wounded Warrior Resource Center

The complete FY2013 report, including appendices, is available online at:
http://rwtf.defense.gov/Reports/FY2013AnnualReport