

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



Reference Handbook of Key Topics and Terms

Updated February 2012

Including updates from NDAA 2012

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

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

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* *Pub. L. 111-84, 123 Stat. 2190, §724 Subsection c (Annual Report), paragraph 3 (Matters to be Reviewed and Assessed, subparagraphs A-Q). (No information paper was prepared on topic 3N: Interagency Matters Affecting Transition to Civilian Life).*



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

Background:

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

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

According to DoD policy, the assignment of an RCC is based on the care category (CAT) associated with the RW: an RW labeled CAT I has a mild injury or illness and is likely to return to duty in less than 180 days; an RW labeled CAT II has a serious injury or illness and is unlikely to return to duty in less than 180 days; and an RW labeled CAT III has a severe/catastrophic injury or illness and is likely to be medically separated from the military.⁵ RWs rated CAT II and above are assigned a DoD RCC; RWs rated CAT III are provided a VA federal recovery coordinator (FRC) in addition to the RCC.⁶ More simply, DoD policy requires RCCs be assigned, at a minimum, to RWs whose medical conditions are expected to last at least 180 days, and in addition, FRCs are available to RWs who are likely to separate from service because of their medical condition(s).⁷

RCCs are to be hired and jointly trained by DoD and the Services’ wounded warrior programs. Currently, more than 180 RCCs (49 Marine Corps⁸; 32 Air Force; 37 Army; 19 Army Reserve; 25 Special Operations Command; and 21 Navy⁹) are assigned to more than 40 locations.¹⁰ According to DoD guidance, the Services’ wounded warrior programs are to assign RCCs and NMCs caseloads of 40 RWs or fewer, depending on condition acuity and complexity of non-medical needs. Waivers are required for exceptions.¹¹ Training for RCCs is provided by the Office of Wounded Warrior Care and Transition Policy (WWCTP).



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The Services' wounded warrior programs differ in their use of—and nomenclature for—RCCs and NCMs. Army Warrior Transition Units (WTUs) assign RWs a Squad Leader who functions as the primary NCM (caseload 1:10); more severely injured RWs are assigned an AW2 Advocate (Warrior Transition Command (WTC) has indicated all AW2 Advocates will receive DoD RCC training¹²; as of February 2012, WWCTP indicated 37 of the 154 AW2 Advocates have done so¹³). The Marine Corps uses RCCs (49 located at 14 separate sites,¹⁴ caseload 1:25¹⁵) and Wounded Warrior Battalion Section Leaders as the primary NCMs (caseload 1:11).¹⁶ The Navy uses 21 RCCs (caseload 1:37).¹⁷ The Air Force uses 32 RCCs¹⁸, as well as Air Force Wounded Warrior (AFW2) NCMs for those meeting the AFW2 criteria (25, with an average caseload of 1:58¹⁹), and Family Liaison Officers. The Special Operations Command Care Coalition includes 22 Wounded Warrior Advocates (caseload 1:300) and 27 Liaison Officers (LNOs) (caseload 1:10).²⁰ Care Coalition caseloads are based on contact frequency, so although an Advocate may have up to 300 lifetime members of Care Coalition, the average caseload is 1 staff to 32 special operators needing weekly, monthly, or quarterly contacts.²¹



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

Background:

A medical care case manager (MCCM) is a licensed registered nurse or degreed social worker who provides coordination of medical care and treatment (also known as clinical case management).²² The MCCM works as a part of the recovery team with the Recovering Warrior (RW), the RW's commander, a recovery care coordinator (RCC) and/or federal recovery coordinator (FRC)²³, and a non-medical case manager (NMCM).²⁴

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

- Assisting the Service member or family member/designee to understand medical status during care, recovery, and transition;
- Assisting the Service member in receiving prescribed medical treatment during care, recovery, and transition; and
- Conducting periodic reviews of the Service member's medical status with the Service member or, with a manager's approval, a designated family member, if the Service member cannot participate.²⁵

In the same legislation, Congress mandated uniform standards for the training and skills of MCCMs—and others who work with wounded, ill, and injured Service members—to detect and report signs of posttraumatic stress disorder (PTSD), suicidal or homicidal thoughts, and other behavioral health concerns. DoD policy guidance also requires that as an RW transitions to veteran status, MCCMs communicate directly with the accepting physician or facility.²⁶ Congress tasked DoD and the Department of Veterans Affairs (VA) to develop policies for MCCMs on caseloads and training requirements, as well as rank and occupation specifications for supervisors of MCCMs. Congress also specified that MCCMs must be fully trained before assuming the duties of the job, and that DoD and VA must provide the necessary resources to operate a medical care case management program.²⁷

DoD Instruction (DoDI) 1300.24, Recovery Coordination Program, tasks the Assistant Secretary of Defense for Health Affairs (ASD(HA)) and the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) with ensuring the development and consistent implementation of policies and procedures for MCCMs across the Services, including training, qualifications, and caseloads.²⁸

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



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management and establishes the MHS medical and clinical policies and procedures for wounded, ill, and injured care. The DTM was reauthorized on August 16, 2011, and remains in effect through May 31, 2012.²⁹

In accordance with DTM 08-033, to support MCCM training, DoD Health Affairs developed basic and advanced medical management trainings available through the MHS Learn Portal.³⁰ To further unify MCCM efforts across DoD, Health Affairs identified required clinical case management training modules utilizing a patient-centered approach to clinical case management, common combat-related injuries, and transition care coordination.³¹ DTM 08-033 states, “the standard number of cases to be managed by each case manager shall be no more than 30.”³² Figures provided by the Service branches show variation across the Department.³³

In February 2012, Health Affairs indicated the process of coordinating the DoDI that will drive the standardization of clinical case management across the Services was ongoing. At that time, the draft DoDI had been informally agreed upon with the Services and was in internal coordination within the Office of the Under Secretary of Defense for Personnel and Readiness.³⁴



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

Background:

The wounded warrior units and programs are the vehicles through which the Services execute the Recovery Coordination Program (RCP) and manage the transition of Recovering Warriors (RWs), as directed by the 2008 National Defense Authorization Act (NDAA) and DoD Instruction (DoDI) 1300.24.³⁵

Army. The Army Warrior Transition Command (WTC) oversees two mutually dependent programs: the Warrior Transition Unit (WTU); and the Army Wounded Warrior (AW2) Program. WTUs are brigade-, battalion-, or company-level units to which RWs are assigned while preparing to transition back to duty or to civilian status. WTUs are located at major medical treatment facilities (MTFs) and provide “command and control, administrative support, and clinical and non-clinical case management to wounded, ill, and injured (WII) Soldiers (and their families) who are expected to require six months or more of rehabilitative care or who require complex medical management.”³⁶ Today, approximately 9,718 Soldiers are assigned to 38 WTUs, including 9 community-based WTUs (CBWTUs) for Reservists requiring only outpatient care.^{37, 38} More than 1200 Soldiers with severe disabilities currently participate in the AW2 Program, which assigns RWs and their families an AW2 Advocate “for life” to assist with needs related to career and education, benefits, transition, information, and more.^{39, 40, 41}

U.S. Marine Corps (USMC). The USMC Wounded Warrior Regiment (WWR) provides non-medical case management throughout the recovery period to post 9/11 WII Marines and Sailors assigned to or directly supporting Marine units. WWR supports Active and Reserve Component Marines, including those who have separated or retired.⁴² The WWR is comprised of a battalion at Camp Lejeune (WWBn-East) and at Camp Pendleton (WWBn-West), which have detachments at 12 principal MTFs and four Department of Veterans Affairs (VA) polytrauma rehabilitation centers. Fifteen to 20 RWs are assigned to each detachment.⁴³ The USMC program emphasizes outreach and reintegration through resources such as the Battalion Contact Centers, the Sergeant Merlin German Call Center, 29 District Injured Support Coordinators (DISCs) located in 22 VA Veterans Integrated Service Networks (VISNs – VA-defined regions),⁴⁴ and the Marine For Life (M4L) Program.⁴⁵ As of February 2012, 794 WII Marines and Sailors were assigned to the WWR.⁴⁶

Navy. The Navy Safe Harbor Program provides non-medical case management for severely injured—and high-risk, non-severely injured—WII Sailors, Coast Guardsmen, and their families.⁴⁷ Safe Harbor is available to those with injuries, whether combat-related or due to a shipboard or liberty accident, and to those with serious physical or psychological illness(es); enrollees remain assigned to their parent unit.⁴⁸ The Safe Harbor Operations Department consists of non-medical case managers (NMCMS) geographically dispersed at major MTFs and VA polytrauma hospitals, and a Strategic Support Department of subject matter experts who



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assist the NMCMS.⁴⁹ As of February 2012, 789 Sailors were in the Safe Harbor program.⁵⁰ Safe Harbor partners with voluntary and community organizations to offer the Anchor Program, which provides mentorship to Reserve and separating/retiring members during their transition to civilian life, thereby extending their contact with Safe Harbor.⁵¹ (Navy Medical Hold is a program that allows Reservists to be retained beyond the expiration of their orders in order to obtain medical treatment).⁵²

Air Force. The Air Force Wounded Warrior (AFW2) Program is a component of Air Force (AF) Warrior and Survivor Care, which also manages the Recovery Coordination Program (RCP), all non-medical support to RWs, and the Air Force Survivor Assistance Program (AFSAP).⁵³ The AFW2 Program is for Airmen who have a combat-related injury or illness, necessitating long-term care that will require a Medical Evaluation Board (MEB) or Physical Evaluation Board (PEB) to determine fitness for duty.⁵⁴ AFW2 leverages existing resources, such as AFSAP and installation Airman and Family Readiness Centers (A&FRCs), to provide services, including expanded transition assistance, extended case management, follow-up, and advocacy.⁵⁵ As part of AFSAP, RWs and their families are assigned a Family Liaison Officer to facilitate the logistics of medical treatment away from home.^{56, 57} As of February 2012, Warrior and Survivor Care was undergoing reorganization and restructuring of staff responsibilities to allow it to remain compliant with DoDI 1300.24 and to meet the needs of recovering Airmen, despite slated reductions in AFW2 personnel.⁵⁸

U.S. Special Operations Command (USSOCOM). The USSOCOM Care Coalition “is chartered to track, support, and advocate for Special Operations Forces (SOF) casualties from the Global War on Terror for life.”⁵⁹ While all SOF RWs are eligible for Care Coalition support, entry into the Care Coalition Recovery Program (CCRP) is limited to those who are seriously or very seriously injured, require hospitalization for more than two weeks, and are not expected to return to duty within six months.⁶⁰ Care Coalition currently assists 4,857 WII currently-serving and retired special operators and families,⁶¹ while CCRP currently serves 121 members.⁶² Care Coalition partners with governmental and non-governmental agencies to optimize RWs’ access to services—particularly cutting-edge care—and works closely with unit leadership to facilitate swift return of SOF members to duty, as appropriate, and improve SOF readiness.⁶³ It also serves as a liaison with, and complements, the Services’ wounded warrior programs by advocating that standards be met or exceeded and by promoting equality of benefits across the Services.⁶⁴



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Topic: Services for posttraumatic stress disorder and traumatic brain injury

Background:

Posttraumatic stress disorder (PTSD) is “a psychological condition that affects those who have experienced a traumatizing or life-threatening event such as combat, natural disasters, serious accidents, or violent personal assaults.”⁶⁵ The prevalence rates of PTSD among Service members and veterans vary widely. According to a 2010 RAND report, “In samples representative of previously deployed personnel, rates were commonly five percent to 20 percent, based primarily on self-reported symptoms on questionnaires.”⁶⁶ The average prevalence rate among infantry, post-deployment, is approximately 15 percent.⁶⁷

The DoD definition of traumatic brain injury (TBI) is “traumatically induced structural injury or physiological disruption of brain function as a result of external force to the head.”⁶⁸ According to the Defense and Veterans Brain Injury Center (DVBIC), there were more than 233,000 diagnosed cases of TBI, at all severity levels, across the Armed Forces between the beginning of Fiscal Year (FY) 2000 and the end of FY2011.⁶⁹ PTSD and TBI frequently co-occur and affect moods, thoughts, and behavior, “yet these wounds often go unrecognized and unacknowledged.”⁷⁰ Mild TBI (mTBI), or concussion, is particularly difficult to diagnose because symptoms are not typically obvious.

DOD’s National Intrepid Center of Excellence (NICoE), which opened June 2010 on the campus of Walter Reed National Military Medical Center (WRNMMC), offers cutting-edge diagnosis, treatment, rehabilitation, and follow-up for warriors with PTSD, TBI, and related conditions.⁷¹ Effective August 10, 2011, the NICoE was transferred from the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) to the Department of the Navy for further alignment under WRNMMC.⁷²

Prevention and early intervention of PTSD. A wide variety of DoD- and Service-level resources and initiatives exist to facilitate PTSD prevention and early intervention. DoD offers free, confidential counseling through Military OneSource and the Military Family Life Consultants (MFLC) Program. The Army’s Comprehensive Fitness Program trains Soldiers to improve resilience, decrease stress, and promote success.⁷³ Battlemind is a training curriculum that facilitates transition from combat zone to “home zone” through expectations management.⁷⁴ The Army also has begun to embed behavioral health teams within its Brigade Combat Teams.⁷⁵ The Marine Corps Reserve and Navy Reserve have established Psychological Health Outreach Teams that provide access to psychological health services to increase resilience and facilitate recovery.^{76, 77} Cognitive Behavioral Therapy (CBT), combat exposure-based therapies, and “psychological first aid” are treatment methodologies found to be effective for early intervention and prevention of PTSD.⁷⁸

Screening for PTSD. The DoD Pre-Deployment Health Assessment, Post-Deployment Health Assessment, and Post-Deployment Health Re-Assessment are screening tools. According to DoD Instruction 6490.03, Deployment Health, all re-deploying Service members must



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participate in a post-deployment health assessment (PDHA)⁷⁹ and a post-deployment health reassessment (PDHRA),⁸⁰ both of which include PTSD screening. Section 712 of Public Law 111-383, the 2011 National Defense Authorization Act (NDAA), advances DoD's ability to detect and treat psychological changes in deployed personnel by mandating pre-deployment medical examinations, post deployment medical examinations that include the assessment of mental health, and post deployment health reassessments.⁸¹

Section 705 of the 2012 NDAA requires the Secretary of Defense (SecDef) to provide in-person mental health assessments 60 days before deployment, every 180 days during deployment, and once between 90 and 180 days after a deployment, at approximately the same time as required periodic health assessments.⁸² Section 723 of NDAA 2012 requires the SecDef to report on the benefits of research on neuroimaging studies aimed at improving PTSD diagnosis. The report is due one year after enactment, on December 31, 2012.⁸³

Treatment of PTSD. Veterans can access PTSD treatment and information through several mental health services, including the National Center for PTSD (NCPTSD), NICoE, DCoE for Psychological Health and Traumatic Brain Injury, and other sources. NCPTSD's mission is to advance the clinical care and social welfare of America's Veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders.⁸⁴ Treatment options include psychotherapy, medication, and/or complementary and alternative approaches, such as acupuncture, yoga, and herbal/dietary supplements. The most empirically supported treatment modalities for PTSD include cognitive therapies, specifically Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), and stress inoculation training. Eye Movement Desensitization Reprocessing (EMDR) has also been shown to be an effective treatment modality.⁸⁵ A number of installations offer Intensive Outpatient Therapy (IOP) programs for PTSD (e.g., Fort Campbell and Naval Medical Center San Diego).⁸⁶ In regards to pharmacological treatments, the evidence base is strongest for selective serotonin reuptake inhibitors (SSRIs)⁸⁷ and serotonin norepinephrine reuptake inhibitors (SNRI).⁸⁸

Access to mental health care for a specific segment of the Armed Forces is addressed by Section 703 of NDAA 2012. This law affords Reservists in training—not on Active Duty—access to mental health care including PTSD care. The law also provides for training on suicide prevention and response. These benefits are to be offered at no cost to the Reservist.⁸⁹

Screening and treatment of TBI. Section 722 of Public Law 111-383, NDAA 2011, required the SecDef to develop and implement a comprehensive policy on consistent neurological cognitive assessments of Service members before and after deployment no later than January 31, 2011.⁹⁰ TBI screening occurs in theatre, at Landstuhl Regional Medical Center (LRMC), during PDHA and PDHRA, and at the Department of Veterans Affairs (VA) Medical Centers.⁹¹

DoD TBI treatment programs have been established throughout the continental United States (CONUS) and overseas. Evidence-based treatment protocols have been tailored to treatment location (e.g., in-theatre, CONUS), acuity of condition (e.g., acute, sub-acute, chronic), and



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severity of condition (e.g., mild, moderate, severe, penetrating). The Military Acute Concussion Evaluation (MACE) tool helps to systematize the diagnosis of TBI.⁹² Directive-Type Memorandum (DTM) 09-033, Policy Guidance for Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting, established guidance for the management of concussions in deployed settings. Signed into policy on June 21, 2011, the DTM includes mandatory protocols for exposure, medical evaluation, rest requirements, and resumption of activities that involve a concussion risk.⁹³ A comprehensive brain injury rehabilitation program may include: visual, vestibular, vocational, physical, and cognitive rehabilitation; specialty services; and psychological counseling.⁹⁴ The focus of cognitive rehabilitation is on specific cognitive deficits and the effects of these deficits on social, communication, behavioral, and vocational/academic performance.⁹⁵

Section 724 of NDAA 2012 requires a report from SecDef on how to identify, refer, and treat Operations Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Service members who served before the 50-meter from explosion criterion was established. Additionally, SecDef is required to report on the effectiveness of several newer policies, including managing concussion and mTBI in deployed settings, identifying and treating blast injuries (including the 50-meter criterion), and operational effectiveness in theatre. This report is due 180 days after the law passed, by June 2012.⁹⁶



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

Background:

The Defense Centers of Excellence (DCoE) for Psychological Health (PH) and Traumatic Brain Injury (TBI) was established November 2007 under DoD's Military Health System (MHS).⁹⁷ In an effort to address concerns about management and oversight raised by the Government Accountability Office (GAO)⁹⁸ and consistent with the 2011 recommendation of the RWTF, support responsibility for DCoE is transferring from DoD MHS to the U.S. Army Medical Research and Materiel Command (MRMC); complete transition is expected by October 2013.⁹⁹ DCoE serves as DoD's "open front door" for needs associated with PH and TBI experienced by our Armed Forces. The DCoE currently comprises five directorates and three component centers: Defense and Veterans Brain Injury Center (DVBIC), Deployment Health Clinical Center (DHCC), and National Center for Telehealth and Technology (T2).¹⁰⁰

Established by Congressional mandate, the mission of the DCoE is to "improve the lives of our Service Members, families, and Veterans by advancing excellence in PH and TBI prevention and care."¹⁰¹ DCoE compiles and coordinates the work of scientific researchers, clinicians, and other health professionals—from DoD, Department of Veterans Affairs (VA), and other federal agencies, academic institutions, state and local agencies, and the non-profit and private sectors—to expand the state of knowledge about PH and TBI. The DCoE endeavors to drive the translation of research to practice in the areas of PH, TBI, and suicide prevention; and ensures best practices and quality standards are continuously and consistently implemented throughout the continuum of care, regardless of a Service member's branch, component, or location. The DCoE Director is Captain Paul S. Hammer, MC, USN.

Among its many activities, DCoE and its component centers develop and train providers in new techniques and technologies in PH and TBI treatment; sponsor and conduct research studies on posttraumatic stress disorder (PTSD), TBI, and promising treatments; create and disseminate guidelines to military and civilian practitioners; develop outreach programs for military and veteran communities and the public; and establish mechanisms to coordinate local, state, and federal resources to eliminate gaps in care for patients in transition between DoD and VA.¹⁰²

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



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pharmaceuticals in rehabilitation programs for seriously ill or injured members of the Armed Forces, and to submit recommendations to Congress by September 20, 2011.¹⁰³

In addition to the DCoE, Congress directed the establishment of three other centers: 1) the Vision Center of Excellence (VCE) mandated by NDAA 2008¹⁰⁴; 2) the Hearing Center of Excellence (HCE) mandated by NDAA 2009; and 3) the Extremity Trauma and Amputation Center of Excellence (EACE), also mandated by NDAA 2009.¹⁰⁵ Like the DCoE, these Centers of Excellence share a common purpose of addressing blast injuries, described as the signature wounds of the wars in Afghanistan and Iraq.¹⁰⁶ Since spring 2010, stakeholders have identified challenges in establishing the centers (e.g., reaching a common vision; infrastructure; governance and control; duplication; leveraging existing efforts, interagency partners, and the academic community; integration across centers; and reconciling operational and policy development responsibilities).¹⁰⁷ All four Centers of Excellence currently receive guidance and direction from the recently established Military Health System Center of Excellence Oversight Board.¹⁰⁸

Vision Center of Excellence (VCE). The mission of the VCE is to “lead and advocate for programs and initiatives to improve vision health, optimize readiness, and enhance quality of life for Service members and Veterans.”¹⁰⁹ The concept of operations was approved January 10, 2012, and the VCE is continuing to evolve initial operational capability.¹¹⁰ The VCE has two locations: clinical headquarters at Walter Reed National Military Medical Facility in Bethesda, Maryland; and administrative personnel in Crystal City, Virginia.^{111, 112} As of February 2012, the VCE was transitioning to align under the Navy Bureau of Medicine and Surgery (BUMED).¹¹³ The VCE has made it a priority to coordinate and collaborate with other Centers of Excellence, including HCE, DCoE PH & TBI, National Intrepid Center of Excellence (NICoE) on the Joint Theatre Trauma Registry (JTTR) and VA Eye Injury Data Store.¹¹⁴

Hearing Center of Excellence (HCE). Headquartered at Joint Base San Antonio and headed by interim Director Lieutenant Colonel Mark D. Packer, MD, USAF, the HCE began initial operating capability in May 2011 by drafting its concept of operations. As of December 2011, five directorate chiefs were appointed, and “hub” support personnel were addressing a registry in tandem with the VCE for capturing clinical audiogram data. The HCE continues to implement a communications/prevention campaign, prioritize ongoing research, and produce clinical practice guidelines. Full operating capability, defined as a functional DoD/VA hearing data registry, is expected by December 2013. HCE plans call for a staff of 37 to be hired incrementally over five years.¹¹⁵

Section 704 of Public Law 111-383, NDAA 2011, mandated several actions relevant to the HCE. Under this mandate, the SecDef was to identify the best tests currently available to screen Service members for tinnitus, develop a plan to ensure all Service members are screened prior to and after deployment to a combat zone, and report on these actions to the congressional defense committees no later than December 31, 2011. NDAA 2011 also required the SecDef to



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examine methods to improve the aural protection for Service members in combat and to submit a report on these methods to Congress within one year of enactment of NDAA 2011. All results of these activities were to be transmitted to the HCE, as well.¹¹⁶

Extremity Trauma and Amputation Center of Excellence (EACE). The EACE is directed by Mr. John Shero.¹¹⁷ Its mission is to “Serve as the joint DoD/VA lead organization for policy direction and oversight of the multidisciplinary network for continuous care and study of amputations and extremity injuries resulting from trauma, point of injury through definitive care and rehabilitation, into lifelong surveillance in order to reduce the disability and optimize the quality of life for Service Members and Veterans.”¹¹⁸ The EACE is in the early stages of establishment.^{119, 120} The concept of operations and decision to headquarter the EACE in San Antonio, Texas, was approved by the Centers of Excellence Oversight Board in January 2012.¹²¹ Hiring of staff is ongoing.^{122, 123}



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Topic: Interagency Program Office

Background:

The Interagency Program Office (IPO) was established by Congress in Section 1635 of Public Law 110-181, the 2008 National Defense Authorization Act (NDAA).¹²⁴ Congress mandated DoD and the Department of Veterans Affairs (VA) to work together to:

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

The IPO was formed by DoD and VA April 17, 2008, and chartered by January 2009.¹²⁵ At that time, the permanent staffing structure included seven government service (GS) civilian positions from DoD and seven GS positions from VA, led by a DoD Director and a VA Deputy Director, both Senior Executive Service (SES) positions.¹²⁶ In April 2009, at the direction of the Senior Oversight Committee (SOC), the IPO charter was changed to include coordinating and overseeing the development of the Virtual Lifetime Electronic Record (VLER), which provides Veterans, Service members, their families, care-givers, and their service providers with a single source of information for health and benefits in a way that is secure, and is authorized by the Service member or Veteran.^{127,128}

Since 2008, the IPO has received substantial scrutiny from Congress and the Government Accountability Office (GAO), which has issued a number of reports on the interoperability of DoD and VA health information systems and the IPO.^{129, 130, 131, 132, 133} NDAA 2011 required the Secretary of Defense to assess and report on existing health information technology systems and future plans for legacy systems and new electronic health record initiatives, including IPO's role.¹³⁴

Although significant data sharing has existed between DoD and VA for years, the Departments had been taking separate paths to replace their existing legacy Electronic Health Record (EHR) systems: DoD's AHLTA (Armed Forces Health Longitudinal Technology Application) and VA's VISTA (Veterans Health Information Systems and Technology Architecture).¹³⁵ Starting March 2011, the Secretaries of the Departments committed to jointly developing and implementing the next generation of EHR capabilities. To that end, the IPO has organized teams comprised of clinicians from both departments to define individual EHR (iEHR) capabilities and processes, and is communicating with private health care providers pioneering the exchange of information through VLER. In October 2011, the Deputy Secretaries of both Departments signed a new IPO charter giving more authority to the joint program office and making the IPO the single point of accountability for the iEHR.¹³⁶



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The iEHR will enable DoD and VA to align resources and investments with business needs and programs to implement a common EHR platform. This single system will enable sharing of health care information to allow both departments to track medical care from the time an individual joins the military until they become a Veteran and through the rest of their lives.¹³⁷

The common platform will be developed using the following sequentially ordered business rules:¹³⁸

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

In addition, the Secretaries of Defense and Veterans Affairs agreed to implement a high-level governance structure that includes the IPO, whose Director serves as the Program Executive, and an IPO Advisory Board.¹³⁹ In essence, the IPO serves as the single point of accountability for the Departments in the development and implementation of the iEHR, and coordinates with the existing DoD/VA Joint Executive Council to integrate capability, functional requirements, and business process re-engineering (BPR). The current Director of the IPO, Mr. Barclay Butler, assumed his position February 27, 2012. As of that date, a staff of approximately 100 personnel was anticipated, with half from DoD and half from VA.¹⁴⁰

While the IPO aggressively pursues the development and phased implementation of the iEHR, other initiatives of the IPO will continue uninterrupted. This includes the demonstration project underway at the North Chicago DoD/VA medical facility—an interagency collaboration leveraging interoperable legacy electronic DoD and VA health records that “speak to one another.”¹⁴¹ Section 1098 of NDAA 2011 required ongoing review of the North Chicago pilot by the Comptroller General in July of 2011, 2013, and 2015.¹⁴²



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Topic: Wounded warrior information resources

Background:

National Resource Directory (www.nationalresourcedirectory.gov). One of four cornerstones of the Recovery Coordination Program (RCP) established through the Senior Oversight Committee (SOC)¹⁴³ (see also information paper on *Senior Oversight Committee*), the National Resource Directory is a joint venture of DoD, the Department of Labor (DOL), and the Department of Veterans Affairs (VA). It is an online partnership “connecting Wounded Warriors, Service Members, Veterans, their families and caregivers with those who support them.”¹⁴⁴ The directory provides access to national, state, and local governmental and non-governmental services and resources for recovery, rehabilitation, and reintegration.¹⁴⁵ Major topic areas include benefits and compensation, education and training, employment, family and caregiver support, health, homeless assistance, housing, transportation and travel, volunteer opportunities, and other services and resources.¹⁴⁶ In November 2011, the National Resource Directory added a tab with access to the new Veterans Job Bank, an online tool that allows veterans to search for jobs by their military skills and zip code.¹⁴⁷ The National Resource Directory web page also provides the phone number to access the Wounded Warrior Resource Center/Military OneSource.¹⁴⁸

Wounded Warrior Resource Center (800-342-9647 or wwrc@militaryonesource.com). A companion to the National Resource Directory, this initiative provides “wounded warriors, their families, and their primary caregivers with a single point of contact for assistance with reporting deficiencies in covered military facilities, obtaining healthcare services, receiving benefits information, and any other difficulties encountered while supporting wounded warriors”.¹⁴⁹ It is staffed 24/7 by Wounded Warrior specialty consultants who are Master’s level professionals with specialties in the social sciences.¹⁵⁰ It is accessible at 800-342-9647 or via email at wwrc@militaryonesource.com.¹⁵¹ (Previously, there was also a Wounded Warrior Resource Center website¹⁵², but this has been replaced by the National Resource Directory website.¹⁵³) The specialty consultants work with the Services’ wounded warrior programs and the VA in order to make referrals to help address callers’ needs.¹⁵⁴ Individuals can learn about this resource through Military OneSource, Military OneSource briefings, or webinars.¹⁵⁵ Within 24 hours following each call, a consultant must reach out to the Services and/or VA, and within 96 hours, the Services and/or VA must release a plan of action.¹⁵⁶

Wounded Warrior Resource Center utilization statistics show that 2,939 calls were received by consultants in Fiscal Year (FY) 2011 with the top three issues being health care, VA benefits, and military benefits.¹⁵⁷ Of 111 Recovering Warrior (RW) and family member survey participants from FY 2011, 73 percent rated the overall quality of the service as good or better, 77 percent agreed or strongly agreed that they would use the service again if another need arose, and 66 percent believed that the consultants improved response time.¹⁵⁸



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Military OneSource (www.militaryonesource.com or 800-342-9647). Military OneSource is an all-purpose portal for Active and Reserve Component Service members, spouses, families, and service providers, through which DoD's Office of Military Community and Family Policy (MC&FP) disseminates information to the military community.¹⁵⁹ Military OneSource is staffed 24/7 by Master's level professionals.¹⁶⁰ Recent utilization statistics indicate that 1,725,169 Service members and 847,409 family members accessed this resource during FY 2011.¹⁶¹ The Military OneSource Wounded Warrior tab provides a link to the National Resource Directory and the phone number for the Wounded Warrior Resource Center/Military OneSource.¹⁶²

The "Keeping It All Together" binder from Military OneSource consolidates information across a range of websites, hotlines, and programs.^{163, 164} It is a valuable tool for family members, filling an identified need for a "one-stop" information resource.^{165, 166} The Marine Corps Wounded Warrior Regiment has had particular success customizing and distributing the binder to families.^{167, 168} Military OneSource's requirement that this resource be ordered individually for Recovering Warriors and family members rather than in bulk may limit utilization.¹⁶⁹

Family Assistance Centers. The Army has established Soldier and Family Assistance Centers (SFACs) at all medical treatment facilities (MTFs) with Warrior Transition Units (WTUs) to facilitate family and Soldier access to information and resources.¹⁷⁰ Army SFACs offer a wide variety of services, including information and referral; human resources/military benefits; education counseling; financial counseling/Army Emergency Relief; social services; outreach services; transition support; child, youth, and school services; and computer rooms.^{171, 172} The Army has 32 SFACs (29 locations within the continental U.S. (CONUS) and three major locations outside of CONUS).¹⁷³ As of July 18, 2011, six of 18 CONUS SFAC construction locations were open and operating in centrally located, campus-like RW settings.^{174, 175} Twelve (12) more new construction projects were underway or in the planning stages.^{176, 177} Army-wide, the SFACs employ a staff of 208.¹⁷⁸ Sister Services and Army Reserve Component sites provide information to RWs and their families, but most do not have dedicated site-level facilities comparable to the Army's.^{179, 180}

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

- Army Wounded Soldier and Family Hotline (800-984-8523) is designed to allow Soldiers and their families to seek information and share concerns about medical care. Concerns also can be shared anonymously through the website: <http://www.armymedicine.army.mil/wsfh/index.html>.¹⁸¹
- Marine Corps Sergeant Merlin German Wounded Warrior Call Center (877-487-6299) is for wounded Marines, their families, and eligible Sailors and is also used for outreach.¹⁸²

The Navy and Air Force wounded warrior websites provide key links and telephone numbers.^{183, 184} However, their programs do not operate Service-specific wounded warrior hotlines.^{185, 186}



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When the DoD Wounded Warrior Care and Transition Policy office held its 2011 Wounded Warrior Care Coordination Summit, many recommendations were made regarding family resilience through increased information flow and improved access to information resources, suggesting that the subject of information resources for RWs and family members is a top priority.¹⁸⁷



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Topic: Support for family caregivers

Background:

The financial burden experienced by caregivers and families has been well documented.^{188, 189,}
¹⁹⁰ Several pieces of legislation have been written to address this burden and to support caregivers as they, in turn, support their Recovering Warriors (RWs).

Special compensation for members of the uniformed Services with catastrophic injuries or illnesses requiring assistance in everyday living. Catastrophic injury or illness is defined as “a permanent, severely disabling injury, disorder, or illness that the Secretary [of the military Service] ... determines compromises the ability of the afflicted person to carry out the activities of daily living to such a degree that the person requires personal or mechanical assistance to leave home or bed, or constant supervision to avoid physical harm to self or others.”¹⁹¹ Section 603 of Public Law 111-84, the 2010 National Defense Authorization Act (NDAA)¹⁹² amends federal law¹⁹³ to authorize monthly compensation to RWs to pay for aid and attendance care without which they would require hospitalization, nursing home care, or other residential institutional care. Eligibility expires on the earliest of the following dates: after a 90-day period following the date of separation or retirement; when a Service member dies or is determined to no longer be afflicted with the catastrophic injury or illness; or when the Service member begins receiving comparable veteran’s compensation under Title 38.¹⁹⁴ Section 634 of Public Law 111-383, the NDAA 2011, modified the criterion for the amount of special compensation paid to Service members with injuries or illnesses requiring assistance in everyday living.¹⁹⁵ This standard was to be changed from the amount established by the Veterans Administration Schedule for Rating Disabilities (VASRD) to personal caregiver stipends established under 38 U.S. Code (U.S.C.) section 1720G.¹⁹⁶

On August 31, 2011, this law was promulgated through the initiation of Special Compensation for Assistance with Activities of Daily Living (SCAADL); SCAADL pays Service members for the time and assistance their caregivers provide them at home.¹⁹⁷ In order to be eligible for this stipend, a Service member must have a catastrophic illness or injury incurred in the line of duty and be certified by a licensed physician as requiring assistance from another person in order to perform activities of daily living and requiring some form of institutional care if such assistance was not available.¹⁹⁸ As of January 31, 2012, the Air Force received 11 applications and 10 individuals are receiving the stipend¹⁹⁹, the Navy received 24 applications and 20 individuals are receiving the stipend²⁰⁰, and the Marine Corps processed 194 applications and 178 are rated for benefits.^{201, 202}

Expanded authority for family member travel. Section 632 of NDAA 2010 expanded the authorized coverage for families of a seriously ill or injured Service member who has been hospitalized to roundtrip travel and per diem once every 60 days and extended the benefit to individuals other than family members chosen by the Service member.²⁰³ Eligible Service



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members may be hospitalized due to combat injury or other serious illness or injury.²⁰⁴ This requirement is implemented in the current Joint Federal Travel Regulation (JFTR).²⁰⁵

Authorized travel and transportation allowances for non-medical attendants for very seriously and seriously wounded, ill, or injured members. A qualified non-medical attendant (NMA) is defined as a person whose presence, in the judgment of the attending physician or surgeon and commander or head of the military medical facility, “may contribute to the health and welfare of the [Service] member” while hospitalized for treatment of the wound, illness, or injury or during continuing outpatient treatment.²⁰⁶ Section 633 of NDAA 2010 amended federal law by authorizing round-trip transportation for NMAs between their home and the location at which the member is receiving treatment, as well as additional transportation while accompanying the member for further treatment.²⁰⁷ NMAs are also authorized a per diem allowance or reimbursement for actual and necessary travel expenses.²⁰⁸ This requirement is implemented in the current JFTR.²⁰⁹

Respite care for seriously ill or injured active duty members. Respite care is defined as “short-term care for a patient to provide rest and change for the primary caregivers who have been caring for the patient at home,” to include assisting the Service member with activities of daily living (e.g., dressing, feeding, hygiene).²¹⁰ Respite care is available if the Service member’s care includes more than two “interventions during the eight-hour period per day that the primary caregiver would normally be sleeping.”²¹¹ Respite care is limited to eight hours per day, five days per week, and must be provided by a TRICARE-authorized home health agency.²¹² Federal law authorizing respite for TRICARE ECHO participants—family members of Service members—was amended to allow this benefit for Service members.²¹³ Respite care for seriously ill or injured active duty members is currently available through DoD.²¹⁴

VA support for caregivers of RWs. On May 5, 2010, the President signed Public Law No. 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010.²¹⁵ This law expanded Department of Veterans Affairs (VA) support for family caregivers of active duty (i.e., still serving) RWs.²¹⁶ Sections 101 through 104 provided for a program of comprehensive assistance, including: 1) instruction, preparation, and training in providing personal care services; 2) ongoing technical support; 3) counseling; 4) lodging and subsistence; 5) mental health services; 6) respite care of not less than 30 days annually, including 24 hours per day; 7) medical care; and 8) a monthly stipend.²¹⁷ The VA launched this comprehensive caregiver program in May 2011 and began the first care-giving training in June 2011.²¹⁸

Caregivers will receive an average of \$1,600 per month.²¹⁹ The total amount of the stipend is calculated based on the Veteran’s condition, the amount of care the Veteran requires, and where the Veteran lives.²²⁰ Under the program of comprehensive assistance, caregivers must complete caregiver training developed by Easter Seals in collaboration with the VA.²²¹ As of January 10, 2012, 4,575 applications had been filed with 2,671 approved (1,250 Tier 3 (highest level); 869 Tier 2; and 552 Tier 1 (lowest level)), 692 were disapproved, 449 were withdrawn by caregivers, and 763 were still in process.²²² Reasons for applications being disapproved include



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Veteran ineligibility (e.g., clinically ineligible or served pre-9/11), administrative issues, (e.g., application lacking date of veteran's discharge), and caregiver ineligibility.²²³

Inclusion in preseparation counseling. Section 529 of Public Law 112-81, the 2012 National Defense Authorization Act (NDAA), authorizes the inclusion of a spouse in portions of preseparation counseling and added more content areas to that counseling.²²⁴ Preseparation counseling is required for transitioning Service members (see also information paper on the *Transition Assistance Program*).²²⁵



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Topic: Legal support

Background:

Subject to availability of resources, the military is authorized by statute to provide “legal assistance in connection with personal civil legal affairs” to active duty Service members.²²⁶ This legal assistance includes routine legal support to Service members—including wounded warriors, retirees, and their families—on a broad range of legal issues (e.g., bankruptcy, credit issues, identity theft, landlord-tenant disputes, and general estate planning). In addition, each Service provides legal support for wounded, ill, and injured (WII) Service members that focuses on the process for determining medical fitness for continued duty (i.e., the Disability Evaluation System (DES)).^{227, 228, 229} Generally, this process involves two boards: the Medical Evaluation Board (MEB) and the Physical Evaluation Board (PEB) (both informal and formal PEBs).²³⁰

Directive-Type Memorandum (DTM) 11-015, Integrated Disability Evaluation System (IDES), issued guidance for providing legal support during the IDES process.²³¹ Each Military Department must provide uniformed or civilian legal counsel at no cost to the Service member. In addition, each Military Department must establish procedures to inform Service members—upon referral to the IDES—of available Government legal counsel and the alternative options of retaining private counsel at their own expense or using the services of a representative of a service organization recognized by the Department of Veterans Affairs (VA).

The Services historically assign attorneys to PEB locations where they offer legal counsel and representation to Service members undergoing formal PEB (FPEB) hearings. The Army has more than 17 Soldiers’ Counsel—mostly mobilized Reservists on one-year tours—assigned to support three PEB sites in the continental United States (CONUS), and to provide legal support for overseas FPEBs via video teleconference.²³² The Navy provides legal support for the FPEB process at the Navy Yard in Washington, DC, which is the sole PEB site for Sailors and Marines. The Air Force provides legal support for the FPEB process at Lackland Air Force Base, which is the sole PEB site for Airmen.^{233, 234, 235, 236} Apart from their consistent support for FPEB hearings, the Services vary in their legal support to WII Service members in the disability evaluation system, including the legal resources the Services have allocated and where these resources are housed organizationally. In addition, the Services vary in how early in the process they seek to engage Service members.

Army. In 2008, the Army initiated the Soldiers’ MEB Counsel (SMEBC) program to introduce legal support earlier in the disability evaluation process. The Army has 24 attorney/paraprofessional teams—mostly permanent civilian employees—at Army locations worldwide. SMEBC teams also assist severely injured Soldiers receiving care at VA polytrauma centers. In late 2011, the Army authorized the hiring of additional SMEBC attorney/paralegal teams, which will increase the total to 38 SMEBC teams Army-wide.²³⁷

The SMEBC teams are available to educate and advise WII Soldiers one-on-one before and during the MEB process, and to help them formulate—and optimize the likelihood of



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attaining—their goals. SMEBC teams also prepare MEB appeals, requests for impartial provider reviews, requests for reconsideration, requests for formal hearings, and requests for rating reconsiderations. In addition, SMEBC teams conduct regular outreach briefings at Warrior Transition Units (WTUs), Soldier and Family Assistance Centers (SFACs), MEB in-processing briefings, and town hall meetings, and they coordinate with PEB Liaison Officers (PEBLOs).^{238, 239, 240, 241} WII Soldiers should be referred to the servicing SMEBC office for an informational briefing on the DES and their rights in the process within 14 days of initiation of the MEB process.

Navy. The Navy has designed a program specifically to address the legal needs of WII shipmates. The DES Outreach Attorney Program is staffed with 12 civilian attorneys, including a Program Manager, who provide legal counsel to Sailors and Marines as they navigate the DES process. The Program is expanding an outreach campaign that will ensure that those Sailors and Marines pending review by the PEB are made aware of, and have access to, Navy DES Outreach Attorney Program services at the earliest opportunity, including the limited duty and referral phases. The early use of Outreach Attorney services will help ensure that the most complete and accurate medical information is submitted to the PEB, assisting in expediting Sailors and Marines through the DES process. The Program also seeks to bridge the transition between the informal and formal PEB phases (IPEB and FPEB respectively) of the DES process, allowing for an efficient overall evolution that instills confidence in Service members and their families. Navy DES Outreach Attorneys are located at the major medical treatment facilities (MTFs) that process Navy and Marine Corps DES cases.²⁴²

Marine Corps. The Marine Corps provides legal counsel to assist and advise Marines and Sailors as soon as they are referred to the MEB. Currently, the Marine Corps has mobilized six Reserve judge advocates within the Wounded Warrior Regiment and Judge Advocate Division who provide legal support on the East and West coasts, as well as at Quantico, Virginia, and Bethesda, Maryland. The Program Manager, one of the six mobilized Reservists, is located at Marine Corps Headquarters. In addition, two Reserve judge advocates were mobilized to provide legal support for the FPEB process at the Navy Yard in Washington, DC. The Judge Advocate Division is evaluating use of active duty judge advocates in future years.²⁴³

Air Force. The Air Force provides disability evaluation legal support through the Office of Airmen’s Counsel (OAC), at Lackland AFB, Texas. Formerly under the Air Force Personnel Center, this program was moved to the Air Force Trial Defense Division in April 2011 to best serve the interests of Recovering Airmen.²⁴⁴

In August 2011, the Air Force began supplementing its staffing with Reserve support of three attorneys and two paralegals. As of December 2011, the Air Force had six attorneys and three paralegals providing Airmen legal support after the IPEB decision and, on a space available basis, during the IPEB and MEB stage. To provide Recovering Airmen legal support at the MEB, IPEB, FPEB, and appellate stages of the DES, the OAC staffing will increase to 13 attorneys and 10 paralegals as newly authorized active duty positions are filled in the summer of



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2012. The staffing increase will also enable the OAC to conduct outreach briefings and increase its educational support to affiliated service providers, such as PEBLOs, Military Service Coordinators (MSCs), and Transition Assistance Program (TAP) and family support personnel.



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Topic: Vocational Services

Background:

DoD and the Services collaborate with other federal agencies, Veteran Service Organizations (VSOs), private entities, and non-profit organizations to provide job training, counseling, referral, placement, and other assistance.

The Department of Veterans Affairs (VA) Vocational Rehabilitation and Employment (VR&E) Program. Congress passed the Soldiers and Sailors Relief Act in 1918 to provide employment and vocational rehabilitation for disabled veterans. As of 2004,²⁴⁵ VA maintains a five-track system that provides a more focused, individualized approach to employment—as opposed to the previous, single-track, long-term path toward academic degrees.²⁴⁶ The five-track system includes: (1) self-employment for those interested in entrepreneurship;(2) reemployment for those returning to a previous or similar job or occupation; (3) rapid access to employment for those who need short term assistance with resume, job search, accommodations, and post-employment follow-up; (4) employment through long-term services for the more than 80 percent of VR&E participants seeking education or vocational training; and (5) independent living for those who need assistive technologies, adaptive housing grants, training, support services, and/or financial aid to increase their independence in activities of daily living.²⁴⁷

The VR&E program can include free tuition at any institution of higher learning or vocational training where the Veteran is accepted, academic counseling, special tutoring if needed, dental care, job referrals, job placement, and other benefits.²⁴⁸ VR&E is available to Veterans with a combined disability rating of 20 percent or more and to some Service members awaiting discharge.^{249, 250} Access to VR&E for active duty Service members was mandated by NDAA 2011 which had a sunset provision ending their access by December 31, 2012.²⁵¹ The VOW to Hire Heroes Act of 2011 extended this sunset provision by an additional two years, until December 31, 2014.²⁵² In Fiscal Year (FY) 2012, VR&E began placing its counselors at all Integrated Disability Evaluation System (IDES) sites; Service members referred to the Physical Evaluation Board (PEB) were mandated to meet with a VR&E counselor for information, evaluation, and to begin VR&E services where appropriate.²⁵³

DoD Operation Warfighter (OWF) Program. OWF is a federal internship program for RWs who are convalescing at medical treatment facilities (MTFs).²⁵⁴ The program provides RWs an opportunity to build their resumes, explore federal employment, develop job skills, and gain valuable federal government work experience.²⁵⁵ While there is no promise of permanent employment with a federal agency upon completion of the OWF assignment, the program helps federal agencies experience the talent and skills of transitioning Service members. Many employers participating in the OWF program hire transitioning Service members.²⁵⁶

DOL Recovery and Employment Assistance Lifelines (REALifelines). DOL's Veterans Employment and Training Service (VETS)—in partnership with DoD, VA, and the State



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Workforce Agencies—collaborate with public and private employers to provide job training and employment services to RWs.²⁵⁷ Using dedicated Disabled Veterans’ Outreach Program Specialists (DVOPS) and Local Veterans’ Employment Representatives (LVERs) located in One-Stop Career Centers throughout the nation, REALifelines creates a seamless, personalized assistance network to provide RSMs training for careers in the private sector.²⁵⁸

Additional Initiatives. Vocational services are often included in the annual National Defense Authorization Acts (NDAA), to pilot new services, or expand availability of existing services. Section 2805 of NDAA 2011 instructed the Secretary of Defense (SecDef) to establish a program to allow Veterans to work on military construction projects.²⁵⁹ NDAA 2012 contained three provisions related to vocational services for RWs. Section 555 of NDAA 2012 allowed the Secretary of the Air Force to permit certain post-9/11 RWs to enroll in degree programs of the Community College of the Air Force.²⁶⁰ Section 558 of NDAA 2012 required the SecDef to conduct a pilot program assessing feasibility and advisability of permitting Service members to obtain civilian credentialing or licensing for skills required in a Military Occupational Specialty (MOS). Congress included a statement in its NDAA report encouraging the SecDef to include Commercial Driver’s Licenses (CDLs) as one of the civilian credentials/licenses to be included in the pilot.²⁶¹ Section 551 of NDA 2012 allows the Secretaries of the Services to offer job skills training programs, including apprenticeships, for Service members preparing to transition to civilian employment and civilian life.²⁶²



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Topic: Disability Evaluation System

Background:

Under the Legacy Disability Evaluation System (LDES), Service members are separately evaluated by DoD to determine fitness for duty and compensation for injury or disease incurred in the line of duty that inhibits a Service member's ability to perform the duties of her or his office, grade, rank, or rating.^{263, 264} In LDES, the Department of Veterans Affairs (VA) evaluates the Service member separately to determine VA benefits, factoring in "all disabilities incurred or aggravated during military service" warranting a disability rating of 10 percent or higher.^{265, 266, 267} This difference in what was considered by DoD and VA evaluations accounted for differences in ratings that transitioning Service members received from DoD and VA. Implementation of a new process has been underway since at least 2002 to address these discrepancies and other shortcomings in the Disability Evaluation System (DES).^{268, 269}

The Senior Oversight Committee (SOC) (see also information paper on *Senior Oversight Committee*) called for pilot testing of an Integrated Disability Evaluation System (IDES) in 2007 as an alternative to the LDES; pilots began November 2007²⁷⁰ at three military installations, and Congress included the pilots in the 2008 National Defense Authorization Act (NDAA).²⁷¹ The pilots were intended to provide a singular evaluation—using VA protocols and rating—in lieu of the separate DoD and VA evaluations. Specifically, the SOC called for increased consistency in ratings for Service members and veterans, protecting appellate procedures, ensuring direct hand-off from DoD case managers to VA case managers when a Service member transitions, and a reduction in the time from referral to DES to receipt of VA benefits.²⁷² At the direction of the SOC co-chairs, IDES was expanded worldwide.²⁷³ Full DoD-wide implementation—replacing LDES—was achieved by the end of September 2011.²⁷⁴ In December 2011, DoD published the first comprehensive Directive-Type Memorandum, DTM 11-015, Integrated Disability Evaluation System.²⁷⁵ This DTM compiles numerous previous letters and guidelines published by the SOC and established in work groups.²⁷⁶ This is the first comprehensive policy document on the DES since DoD Directive 1332.18, Separation or Retirement for Physical Disability, in 1996.²⁷⁷

The IDES features a single set of disability medical examinations designed for determining both fitness and ability to return to duty, and disability. Evaluation of a Service members' fitness for duty by DoD runs concurrently with VA determination of a disability rating, and has led to a streamlined process that reduces the amount of time it takes for Recovering Warriors (RWs) to receive benefits.²⁷⁸ While the Physical Evaluation Board Liaison Officer (PEBLO) is assigned to assist the Service member through the process in both LDES and IDES, the assistance of a Military Service Coordinator (MSC) is a new support available in IDES (see also information paper on *legal support*).²⁷⁹

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



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the Defense Manpower Data Center. As of the November 2011 IDES monthly report, enrollment was 20,656 and steadily increased at a rate of seven percent per month between May 2011 and October 2011—an overall increase of 40 percent, or 5,880 cases. Average IDES processing time was 361 days compared to the LDES average of 540 days^{280, 281}—the goal is 295 days. In addition, the Medical Examination stage is meeting the 45-day goal with an average processing time of 42 days. However, the Medical Evaluation Board (MEB) stage continues to exceed the goals for number of days (35) with Active Component (AC) Service members at 75 days, Reserve at 86 days, and National Guard at 83 days. The goal for Service member satisfaction—calculated by averaging the combined satisfaction with MEB, PEB, and/or Transition and defined as greater than 3.0 on a five-point Likert scale is 80 percent. As of the November 2011 IDES monthly report, satisfaction of the total DoD was 76 percent, with the Army reporting the highest level of satisfaction (78 percent) and the Marine Corps reporting the lowest (69 percent).

Surveys on IDES revealed a steady decrease in overall satisfaction. Service member satisfaction with the IDES experience DoD-wide,—determined by the sum of four items from each of the three phases (MEB, PEB, and Transition)—decreased from 83 percent in July-September 2009 to 70 percent in April-June 2011. The Air Force reported the highest level of satisfaction at 78 percent and the Marine Corps reported the lowest satisfaction at 62 percent. However, the overall percentage satisfied has remained relatively stable during the past year—July 2010 through June 2011.²⁸²

Several sections of Public Law 111-383 of NDAA 2011 addressed disability benefits and the disability process, including Sections 533, 534, 631, 632, and 633. Section 533 introduced a modification of the PEB process, expanding the rights of Service members by broadening the criteria for those eligible to request a review of their retirement or separation without pay for physical disability—this eligibility was formerly restricted to officers.²⁸³ In an additional step, Section 534 prohibited a Service branch from authorizing an involuntary administrative separation of a Service member because of that member's unsuitability for deployment or worldwide assignment, when the unsuitability is because of a medical condition already assessed by a PEB.²⁸⁴ Sections 631, 632, and 633 modified the criteria for calculating disability retirement pay. Section 631 allowed benefits to exceed the 75 percent cap on disability retirement for members who served on active duty for more than 30 years while retaining the retired pay multiplier based on years of service.²⁸⁵ Section 632 specified that disability pay will be paid on the first day of each month, beginning after the month in which the right to such pay accrues.²⁸⁶ Section 633 amended the method by which eligibility for receiving retired pay is calculated for Reserve Component (RC) Service members; the new method awards credit for time receiving medical care to be counted toward years of service.²⁸⁷

In NDAA 2012, additional provisions regarding disability evaluation were introduced. Section 527 prohibited Services from administratively separating a Service member based on medical conditions for which s/he was found fit for duty by a PEB²⁸⁸. Section 596 required



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the SecDef to report on the feasibility and advisability of an expedited disability determination process for RWs with certain specific diseases or conditions.²⁸⁹



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

Background:

Section 502 of Public Law 101-510, the 1991 National Defense Authorization Act (NDAA), as codified in 10 USC §1141-1143 and 1144-1150, authorized comprehensive transition assistance benefits and services for military personnel and their spouses separating or retiring from the Armed Forces within the last 180 days of service and beginning no fewer than 90 days prior to separation.^{290, 291, 292} By November 21, 2012, the Transition Assistance Program (TAP) will be mandatory for all Service members unless waived by the Secretary of Defense (or Secretary of the Department of Homeland Security (DHS)), as specified in Section 221 of the Veterans Opportunity to Work (VOW) to Hire Heroes Act of 2011.²⁹³ Currently, TAP is authorized for all active duty Service members and their spouses without regard to geographic location and is conducted at most military installations in the United States and overseas. Prior to the VOW to Hire Heroes Act, the Marine Corps and Army's Warrior Transition Command had already mandated TAP participation.²⁹⁴

The scope of TAP encompasses all Active Component (AC) separations and retirements, all Reserve Component (RC) deactivations, and all wounded, ill, and injured (WII), and their families.²⁹⁵ However, the timeline for TAP participation does vary between AC and RC. Public Law 107-103, the Veterans Education and Benefits Expansion Act of 2001, changed the timeline in which separating Service members are to commence the transition process so that pre-separation counseling can now begin up to 12 months prior to separation for those who are not retiring and, in the case of Service members anticipating retirement, 24 months prior to retirement.²⁹⁶ Prior to release from active duty, demobilizing Reserve Component (RC) Service members are required to receive transition counseling equivalent to the pre-separation counseling provided to their AC counterparts. In the NDAA 2012, Congress authorized an exception to the 90-day rule for demobilizing Reservists; transition assistance can begin fewer than 90 days prior to separation if duties related to demobilization interfere with starting earlier.²⁹⁷ RC members are eligible to utilize their transition assistance counselors for up to 180 days after release from active duty.²⁹⁸

TAP is a mutual responsibility of DoD, the Department of Labor (DOL), Department of Veterans Affairs (VA), and DHS.^{299, 300} The Departments collaborate to provide a program that furnishes counseling, assistance in identifying and obtaining employment and training opportunities, information about veterans' benefits programs, and related information and services to separating Service members and their spouses. Specifically, the Departments' responsibilities are:

- DoD and DHS: Individual pre-separation counseling through the Army, Navy, Air Force, Marines, and Coast Guard to inform Service members about educational assistance benefits, financial planning, and other benefits to which they are entitled under the law. Section 529 of Public Law 112-81, NDAA 2012, authorized the inclusion



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of a spouse in portions of pre-separation counseling and added more content areas to that counseling.³⁰¹

- DOL: Conducts two-and-a-half day (20-hour) TAP Employment Workshops that provide employment information, training opportunities, and vocational guidance to allow separating Service members make informed career choices. DOL is currently collaborating with DoD and VA to update the TAP program.³⁰² For the RC, DOL focuses primarily on the Uniformed Services Employment and Reemployment Rights Act (USERRA).³⁰³
- VA: Conducts half-day, four-hour VA Benefits Briefings (usually in conjunction with the DOL TAP Employment Workshop). For separating members who are injured and/or disabled, VA conducts an additional two-hour Disabled TAP (DTAP) briefing that provides extensive information regarding VA's Vocational Rehabilitation and Employment (VR&E) benefits and assistance with VR&E application.³⁰⁴

For those without easy access to an installation's Transition Assistance Office, DoD has established a TAP web portal—www.TurboTAP.org—that provides a series of resources.³⁰⁵ These resources include guidebooks and checklists, materials for transitioning personnel to help prepare for mandatory counseling, resources for TAP counselors and state transition assistance providers, links to partner websites, and other tools and information to help facilitate successful transition. The “Pre-separation Guide for the AC” and “Transition Guide for the RC” are available through TurboTAP.³⁰⁶ DoD is expanding its offerings through TurboTAP.³⁰⁷



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Topic: Senior Oversight Committee

Background:

The President's Commission on Care for America's Returning Wounded Warriors released the Dole/Shalala Report in 2007.³⁰⁸ To address the hundreds of recommendations made by this commission and other review groups convened before and after the deficiencies at Walter Reed Army Medical Center (WRAMC) were made public, the 2008 National Defense Authorization Act (NDAA) directed DoD and the Department of Veterans Affairs (VA) to "jointly develop and implement comprehensive policies on the care, management, and transition of Recovering Service Members (RSMs)."^{309, 310} The Senior Oversight Committee (SOC) for the Wounded, Ill, and Injured (WII)—a team of senior DoD and VA officials co-chaired by the respective Deputy Secretaries—was formed to execute this requirement. Since its inception, the SOC has targeted many issues facing RWs, including some also identified for action by the DoD and VA Joint Executive Council (JEC).

As of February 2012, and consistent with the 2011 recommendation by RWTF, the SOC has been folded into the JEC.³¹¹ As of March 2012, the JEC was restructured to include the new Wounded, Ill, and Injured Committee (WIIC) along with the existing Construction Planning Committee (CPC), Health Executive Council (HEC), Benefits Executive Council (BEC), and Interagency Program Office (IPO).³¹² The eight lines of action from the SOC were assigned to appropriate working groups (WG) within the JEC, and two new working groups were added (the James A Lovell Federal Health Care Center WG under the HEC and the Case Management/Care Coordination WG under the BEC).³¹³ The following paragraphs summarize the evolution of the SOC from inception through this incorporation into JEC in 2011.

In its initial stages, the committee members were organized into eight work groups or lines of action (LOAs): 1) disability system; 2) traumatic brain injury (TBI) and posttraumatic stress disorder (PTSD); 3) case management; 4) DoD/VA data sharing; 5) facilities; 6) clean sheet design (for thinking outside the box); 7) legislative and public affairs; and 8) personnel, pay, and financial support.³¹⁴ Among the most visible initiatives of the SOC are the Defense Centers of Excellence (DCoE) for Psychological Health (PH) and TBI, the National Resource Directory, the Federal Recovery Coordination Program (FRCP), and the pilot and full implementation of the Integrated Disability Evaluation System (IDES).^{315, 316}

The NDAA 2008 called for the Government Accountability Office (GAO) to examine the Departments' progress in developing and implementing joint policy reforms on behalf of the wounded warrior community, which GAO did in a July 2009 report.³¹⁷ This report indicated that the majority of the policy requirements identified by the SOC (60 of 76) had been completed and those remaining were in progress. The report also identified challenges faced by the SOC, such as standardizing key terminology across the Services, concerns about changes in SOC leadership and reporting chains, and unclear differentiation of the responsibilities of the SOC and the JEC, which since 2002 has provided senior leadership for collaboration and resource sharing between VA and DoD. In an October 5, 2011, GAO report on the subject of



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the integration of DoD and VA health care coordination and case management programs, GAO recommended the Secretaries of Defense and VA direct the SOC to address redundancy and overlap with a plan to strengthen functional integration across all DoD and VA care coordination and case management programs.³¹⁸ On September 12, 2011, the SOC co-chairs issued a joint letter stating the departments were considering options to maximize care coordination resources. The options were not finalized, identified, or outlined in this letter.

Conceived as a one-year committee, the SOC was to expire May 2008, but was extended to January 2009. The NDAA 2009 then extended it through December 2009. In August 2009, the Deputy Secretaries of DoD and VA cosigned a series of letters to the House leadership to request that the SOC be allowed to continue its work implementing and overseeing “program and process enhancements” serving the WII.³¹⁹ “In order to improve the integration of DoD and VA into a single team to address wounded warrior needs as well as the integration of these issues into the management framework of the Under Secretary for Personnel Readiness, the Department created two new offices in late 2008, the Transition Policy and Care Coordination Office and the Office of Strategic Planning and Performance/Executive Secretariat to the SOC/JEC”.³²⁰ In November 2008, Lines of Action (LOAs) one, three, and eight were incorporated into the Transition Policy and Care Coordination Office, whose mission was to “ensure equitable, consistent, high-quality care coordination and transition support for Service members, including wounded warriors and their families, through appropriate interagency collaboration, responsive policy and effective program oversight.” This was the forerunner of today’s DoD Office for Wounded Warrior Care and Transition Policy (WWCTP). Four LOAs were incorporated into existing DoD organizations and one—LOA six—was deemed completed.³²¹

As of May 2011, efforts of the SOC continued to focus on four main areas: 1) Service accomplishments; 2) DoD and VA Continuity of Care initiatives to form a coordinated team approach; 3) new approaches to psychological health and the anti-stigma campaign for TBI and posttraumatic stress disorder (PTSD); and 4) the revolution in customer care.³²²



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

Background:

As early as 2002, Congress recognized the need for interagency collaboration on health care through the establishment of the Joint Executive Council (JEC), which “provides senior leadership for collaboration and resource sharing between VA and DoD.”³²³ Federal law describes the purpose of the JEC as follows:

“The Secretary of Veterans Affairs and the Secretary of Defense shall enter into agreements and contracts for the mutually beneficial coordination, use, or exchange of use of the health care resources of the Department of Veterans Affairs (VA) and the Department of Defense (DoD) with the goal of improving the access to, and quality and cost effectiveness of, the health care provided by the Veterans Health Administration and the Military Health System to the beneficiaries of both Departments.”³²⁴

The JEC’s charter encompasses four areas: 1) overseeing development and implementation of the VA/DoD Joint Strategic Plan (JSP); 2) overseeing the Health Executive Council (HEC) and Benefits Executive Council (BEC); 3) identifying opportunities to enhance mutually beneficial services and resources; and 4) submitting an annual report to Department Secretaries and Congress, including progress on the JSP.^{325, 326} The JEC laid a foundation of interagency collaboration for the newer Senior Oversight Committee (SOC), which was convened specifically to address the needs of the wounded, ill, and injured (WII). As of February 2012 and consistent with the 2011 recommendation by the Recovering Warrior Task Force (RWTF), the SOC has been folded into the JEC (see also information paper on *Senior Oversight Committee*).

JEC’s Fiscal Year (FY) 2010 Annual Report summarizes JEC accomplishments under six goal areas.³²⁷ Below is a sampling of accomplishments related to Recovering Warriors (RWs), many of which are also under the purview of federal entities other than the JEC.

- Goal 1: Leadership, Commitment, and Accountability
- Goal 2: High-Quality Health Care
 - Virtual Grand Rounds training program focusing on health issues of returning Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF, OIF, and OND) forces was implemented, generating two to four episodes of training each month focused on high priority clinical topics, such as posttraumatic stress disorder (PTSD), integrated care of pain, and traumatic brain injury (TBI).
 - VA/DoD Deployment Health Working Group (DHWG) was established to ensure coordination and collaboration between the Departments to maintain, protect, and



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- preserve the health of Armed Forces personnel, with an emphasis on those returning from OEF/OIF/OND, including health surveillance information, research initiatives related to deployment health, and health risk communication.
- VA/DoD DHWG coordinated DoD's identification of major environmental and occupational exposure incidents during the conflicts in Iraq and Afghanistan; included identification of exposed cohorts, provision of data to VA, and development of appropriate follow-up activities.
 - DoD funded \$30.5 million to VA researchers in Fiscal Year (FY) 2010 to investigate high-priority topics, such as secondary prevention of PTSD in at-risk Service members from OEF/OIF/OND, mild TBI (mTBI) following exposure to explosive devices, and effects of deployment to Iraq on psychological health (PH) of Veterans after returning home.
 - DoD developed supplemental psychological health screening questions in FY 2010 for the post-deployment health assessment (PDHA) and post-deployment health reassessment (PDHRA); these instruments are administered to Service members within two months prior to deployment, and 3-to-6, 7-to-12, and 16- to-24 month intervals after return from deployment.
 - VA and DoD continued to collaborate on providing Web-based public information to promote positive cultural associations with mental health (MH) treatment and care, and provide information on anonymous MH resources to Service members, Veterans, and their families. DCoE's Real Warriors Campaign website was visited by 71,913 users in FY 2010. VA/DoD Integrated Mental Health Strategy (IMHS), defined by four strategic goals designed to develop a joint VA/DoD strategy to address the range of MH needs of Services members, Veterans, and their families in the wake of contingency operations in Iraq and Afghanistan, was approved by the SOC in May 2010.
- Goal 3: Seamless Coordination of Benefits
 - VA/DoD BEC Pre-Discharge Program allows Service members to file VA disability compensation claims up to 180 days prior to separation.
 - VA/DoD expanded the BEC Communication of Benefits and Services Working Group (WG) to increase awareness of new or expanded VA/DoD benefits and services available to Service members.
 - BEC Medical Records WG updated the memorandum of agreement (MOA) between VA and DoD regarding the physical transfer of treatment records for Veterans benefits processing.



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- Goal 4. Integrated Information Sharing
 - As part of the DoD/VA Interagency Program Office (IPO) initiative to develop electronic health care records systems and accelerate the exchange of health care information:
 - Bidirectional Health Information Exchange (BHIE) completed 100 percent of FY 2010 quarterly metric milestones to enhance viewable bidirectional electronic health data sharing between DoD/VA.
 - HHS Nationwide Health Information Network developed software using a specified set of health data standards to allow interoperability between different health care organization systems to securely communicate over the Internet.
- Goal 5: Efficiency of Operations
- Goal 6: Joint Medical Contingency/Readiness Capabilities



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Topic: Other matters: Resources for Reserve Component

Background:

The Reserve Components (RC) of the Armed Forces—Army Reserve (USAR), Air Force Reserve, Navy Reserve, Marine Corps Reserve, Coast Guard Reserve, Army National Guard (ARNG), and Air National Guard (ANG)—total nearly 1.1 million Service members and comprise more than 40 percent of the total force.³²⁸ Since 9/11, more than 800,000 RC personnel have been called to active duty.³²⁹ The ARNG and USAR have deployed more than 450,000 Soldiers—many Soldiers have been deployed more than once—in support of Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND).³³⁰ The Services are required to “ensure their Recovery Coordination Programs (RCPs) are extended to include Recovering Service members (RSMs) in their RCs and incorporate all program services, to include identifying RSMs, assigning RSMs to Recovery Care Coordinators (RCCs), and preparing recovery plans.”³³¹ The Services’ wounded warrior programs do not differentiate between Active Component (AC) members and activated Reservists (see also information paper on *wounded warrior units and programs*).³³² However, certain resources are unique to the RC as a whole and to specific RCs.

Army Community-Based Warrior Transition Units (CBWTUs). CBWTUs allow qualified ARNG and USAR Reservists to recover in their home communities. As of September 2011, 53 per cent of the 9,825 Soldiers assigned to WTUs/CBWTUs were ARNG or USAR Soldiers, and 23 percent of the 9,825 were managed by a CBWTU.³³³

USAR RCCs. Nineteen RCCs, trained by DoD, are located in high-density areas throughout the USAR. The USAR RCC program does not support ARNG Soldiers.^{334, 335}

National Guard Bureau (NGB) Transition Assistance Advisor (TAA) Program. NGB TAA serves all redeploying or separating RC members, injured or not. TAAs are in each of the 50 states and four territories, co-located with the state Adjutants General and incorporated into the Department of Veterans Affairs (VA) sectors and the CBWTUs.³³⁶ TAAs assist Soldiers and families with reintegration into the unit or transition to civilian life by establishing one-on-one contact and educating them on federal, state, local, and community benefits and entitlements. TAAs partner extensively with entities such as the Joint Family Support Assistance Program (JFSAP), Employer Support of the Guard and Reserve (ESGR), Psychological Health (PH), Yellow Ribbon Reintegration Program (YRRP), CBWTUs, job assistance programs, veterans service organizations (VSOs), and others.³³⁷ There are 65 contracted TAAs and a handful of TAAs working as state employees or in Active Duty for Operational Support (ADOS) status. TAAs carry caseloads of approximately 1:73 for wounded, ill, or injured (WII) members and 1:5117 for all separating/returning members.³³⁸ While TAAs serve all RC members, and even some AC members, ARNG members comprise their largest clientele.³³⁹

ARNG. The ARNG has taken several steps to address gaps in RC medical care, and the management of Soldiers who are not medically ready for deployment. One such step was



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creating a process for Soldiers with low risk-low acuity conditions, who were injured or became ill during mobilization or training, to return to active duty on short-term orders to resolve those duty-related limiting conditions. The Reserve Component Managed Care (RCMC) Pilot Program involves 14 states from the ARNG with a formal application process for putting eligible Soldiers on active duty orders for up to 179 days. Soldiers participating in this program are managed through the Medical Management Processing System (MMPS). MMPS systematically monitors, manages, and facilitates authorized medical care for Soldiers who are medically non-available for deployment and focuses on facilitating a final disposition of their medical condition. This program utilizes many of the full-time medical staff that the ARNG has brought on board over the past 10 years to assist in building and maintaining medical readiness. Overseen by the Deputy State Surgeon, the staff that support the MMPS include case managers, care coordinators and medical readiness non-commissioned officers (NCOs). The RCMC Pilot will be reevaluated by the Assistant Secretary of Defense for Manpower and Reserve Affairs (ASD(M&RA)) in August 2012 to assess whether full implementation of this program across the ARNG is warranted.³⁴⁰

Another recent initiative was the implementation of the RC Soldier Medical Support Center (SMSC). Established in Pinellas Park, Florida, in January 2011 and staffed by USAR and ARNG Soldiers, it is a short-term solution to facilitate the screening of the backlog of RC Medical Evaluation Board (MEB) packets, and a gateway for RC Integrated Disability Evaluation System (IDES) medical processing support. The RC SMSC screens RC MEB packets for accuracy/completeness; validates and submits RC MEB packets to Medical Command; and provides administrative /medical subject matter expertise regarding IDES RC medical processing.³⁴¹

Marine Corps Reserve. The Marine Corps Reserve established its PH Outreach Program in 2009 to provide activated Reserve Marine forces access to appropriate PH care services, to increase resilience, and to facilitate recovery. Much like the Navy Psychological Health Outreach Program (PHOP), six teams of five licensed clinicians work throughout the country in Washington, California, Missouri, Georgia, Louisiana, and Massachusetts. They provide Marines and family members initial screenings, referrals, and telephone/email follow-up services to ensure clients have received needed information and services, whether through military, VA, or civilian community resources. In addition, PHOP provides psycho-educational briefs and consultation to command, and interfaces with civilian resources to ensure they have the background necessary to effectively serve the Marine Corps population.³⁴²

Navy Reserve. The Navy Region Mid-Atlantic (NRMA) RC Command Medical Hold Department (MEDHOLD EAST), located in Norfolk, Virginia, provides case management services for RC members who are authorized a medical hold status.³⁴³ Eligible Sailors must be unfit for duty and have “conditions incurred or aggravated after completion of continuous active duty orders for more than 30 days.”³⁴⁴ Stays in MEDHOLD do not normally exceed 12 months.³⁴⁵ MEDHOLD case management is provided by RN case managers, with an emphasis on medical matters, although non-medical case management is provided as warranted.³⁴⁶



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The Navy Reserve established a PHOP in 2008 aimed at maintaining psychological health and promoting resilience and recovery of Reserve Service members and their families.³⁴⁷ PHOP staff, including clinically licensed outreach coordinators and outreach support team members, are co-located with RC Command staff in five regions—Mid-Atlantic, Southeast, Southwest, Northwest, and Midwest. They conduct a thorough behavioral health screening to holistically assess an individual’s psychological, physical, and social functioning, and family well-being. Based on this screening, PHOP staff link individuals with appropriate military or community-based providers and provide follow-up. PHOP also conducts outreach calls with recently demobilized Sailors and provides psycho-educational briefings on a variety of topics of interest to the Navy Bureau of Medicine.³⁴⁸

YRRP. The 2008 National Defense Authorization Act (NDAA) called for the establishment of the YRRP to provide information, services, referral, and proactive outreach programs to RC members and families throughout the deployment cycle.³⁴⁹ DoD Instruction 1342.28, DoD YRRP, provides comprehensive guidance regarding YRRP policy, responsibilities, and implementation, replacing earlier departmental guidance.³⁵⁰ For reintegration purposes, the YRRP is organized on a 30-60-90-day post-deployment model.³⁵¹ Official health screening in the form of the post-deployment health reassessment (PDHRA) is to be incorporated into 90-day YRRP activities (see also information paper on *services for post-traumatic stress disorder and traumatic brain injury*).³⁵²

NDAA 2011 introduced YRRP enhancements, including expansion of partnerships with the VA and Service and state-based programs, a mechanism for evaluating the effectiveness of the YRRP via the Center for Excellence in Reintegration, authorization of resiliency training, and authorization of transportation and per diem allowances for YRRP participants.³⁵³ Section 590 of NDAA 2012 restated the function of the Center for Excellence in Reintegration to focus on lessons learned from states’ Guard/Reserve, training for state representatives, and identifying best practices in information dissemination and outreach.³⁵⁴ Section 703 of NDAA 2012 provides for mental health care and training on suicide prevention and response for un-activated Reservists during training, at no cost to the Reservists.³⁵⁵



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Appendix:

Acronyms Used in Handbook

A&FRC	Airman and Family Readiness Centers
AC	Active Component
ADOS	Active Duty for Operational Support
AF	Air Force
AFSAP	Air Force Survivor Assistance Program
AFW2	Air Force Wounded Warrior
AHLTA	Armed Forces Health Longitudinal Technology Application
ANG	Air National Guard
ARNG	Army National Guard
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASD(M&RA)	Assistant Secretary of Defense for Manpower and Reserve Affairs
AW2	Army Wounded Warrior
BEC	Benefits Executive Council
BHIE	Bidirectional Health Information Exchange
BPR	Business Process Re-engineering
BUMED	Navy Bureau of Medicine and Surgery
CAT	Category
CBT	Cognitive Behavioral Therapy
CBWTU	Community-Based Warrior Transition Unit
CCRP	Care Coalition Recovery Program
CDL	Commercial Driver's License
CONUS	Continental United States
CPC	Construction Planning Committee
CPT	Cognitive Processing Therapy
CRP	Comprehensive Recovery Plan
DCoE	Defense Centers of Excellence



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DES	Disability Evaluation System
DHCC	Deployment Health Clinical Center
DHS	Department of Homeland Security
DHWG	Deployment Health Working Group
DISC	District Injured Support Coordinator
DoD	Department of Defense
DoDI	Department of Defense Instruction
DoL	Department of Labor
DTAP	Disabled Transition Assistance Program
DTM	Directive-Type Memorandum
DVBIC	Defense and Veterans Brain Injury Center
DVOPS	Disabled Veterans' Outreach Program Specialists
EACE	Extremity Trauma and Amputation Center of Excellence
EHR	Electronic Health Record
EMDR	Eye Movement Desensitization and Reprocessing
ESGR	Employer Support of the Guard and Reserve
FPEB	Formal Physical Evaluation Board
FRC	Federal Recovery Coordinator
FRCP	Federal Recovery Coordination Program
FY	Fiscal Year
GAO	Government Accountability Office
GS	Government Service
HCE	Hearing Center of Excellence
HEC	Health Executive Council
IDES	Integrated Disability Evaluation System
iEHR	Individual Electronic Health Record
IMHS	Integrated Mental Health Strategy
IOP	Intensive Outpatient Therapy
IPEB	Informal Physical Evaluation Board
IPO	Interagency Program Office



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JEC	Joint Executive Council
JFSAP	Joint Family Support Assistance Program
JFTR	Joint Federal Travel Regulation
JSP	Joint Strategic Plan
JTTR	Joint Theatre Trauma Registry
LNO	Liaison Officer
LOA	Line of Action
LRMC	Landstuhl Regional Medical Center
LVERS	Local Veterans' Employment Representatives
M4L	Marine for Life Program
MACE	Military Acute Concussion Evaluation
MC&FP	Military Community and Family Policy
MCCM	Medical Care Case Manager
MEB	Medical Evaluation Board
MEDHOLD	Medical Hold Department
MFLC	Military Family Life Consultant
MH	Mental Health
MHS	Military Health System
MMPS	Medical Management Processing System
MOA	Memorandum of Agreement
MOS	Military Occupational Specialty
MRMC	U.S. Army Medical Research and Materiel Command
MSC	Military Service Coordinator
mTBI	Mild Traumatic Brain Injury
MTF	Medical Treatment Facility
NCO	Non-Commissioned Officer
NCPTSD	National Center for Posttraumatic Stress Disorder
NDAA	National Defense Authorization Act
NGB	National Guard Bureau
NICoE	National Intrepid Center of Excellence



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NMA	Non-Medical Attendant
NMCM	Non-Medical Case Manager
NOD	National Organization on Disabilities
NRMA	Navy Region Mid-Atlantic
OAC	Office of Airmen's Counsel
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OND	Operation New Dawn
OSD	Office of the Secretary of Defense
OWF	Operation Warfighter
PDHA	Post-Deployment Health Assessment
PDHRA	Post-Deployment Health Reassessment
PEB	Physical Evaluation Board
PEBLO	Physical Evaluation Board Liaison Officer
PH	Psychological Health
PHOP	Psychological Health Outreach Program
PTSD	Post-Traumatic Stress Disorder
RC	Reserve Component(s)
RCC	Recovery Care Coordinator
RCMC	Reserve Component Managed Care
RCP	Recovery Coordination Program
REALifelines	Recovery and Employment Assistance Lifelines
RSM	Recovering Service Member
RT	Recovery Team
RW	Recovering Warrior
RWTF	Recovering Warrior Task Force
SCAADL	Special Compensation for Assistance with Activities of Daily Living
SMSC	Soldier Medical Support Center
SecDef	Secretary of Defense



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

SES	Senior Executive Service
SFAC	Soldier and Family Assistance Center
SMEBC	Soldiers' Medical Evaluation Board Counsel
SNRI	Serotonin Norepinephrine Reuptake Inhibitors
SOC	Senior Oversight Committee
SOF	Special Operations Forces
SSRI	Selective Serotonin Reuptake Inhibitors
T2	National Center for Telehealth and Technology
TAA	Transition Assistance Advisor
TAP	Transition Assistance Program
TBI	Traumatic Brain Injury
USAR	U.S. Army Reserve
U.S.C.	U.S. Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USMC	U.S. Marine Corps
USERRA	Uniformed Services Employment and Reemployment Rights Act
USSOCOM	U.S. Special Operations Command
VA	Department of Veterans Affairs
VASRD	Veterans Administration Schedule for Rating Disabilities
VCE	Vision Center of Excellence
VETS	Veterans Employment and Training Service
VISTA	Veterans Health Information Systems and Technology Architecture
VLER	Virtual Lifetime Electronic Record
VR&E	Vocational Rehabilitation and Employment
VSO	Veterans Service Organizations
VTA	Veterans Tracking Application
WG	Working Groups
WII	Wounded, Ill, and Injured



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WIIC	Wounded, Ill, and Injured Committee
WRAMC	Walter Reed Army Medical Center
WRNMMC	Walter Reed National Military Medical Center
WTC	Warrior Transition Command
WTU	Warrior Transition Unit
WWBn	Wounded Warrior Battalion
WWBn-East	Wounded Warrior Battalion-East (Camp Lejeune)
WWBn-West	Wounded Warrior Battalion-West (Camp Pendleton)
WWCTP	Wounded Warrior Care and Transition Policy
WWR	Wounded Warrior Regiment
YRRP	Yellow Ribbon Reintegration Program