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

Department of Defense Recovering Warrior Task Force

2010-2011 Annual Report

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Executive Summary

The Recovering Warrior Task Force (RWTF) found many excellent practices emerging from every level serving Recovering Warriors (RWs), from individual staff at installations to Service-level and Department-level offices. The RWTF also noted several challenges, barriers, and opportunities for improvement of programs and policies and formulated recommendations to address them. These recommendations and associated findings are organized in Chapter 2 of the report under five headings: Overall Effectiveness of Department of Defense (DoD) Recovering Warrior Policies and Programs, Restoring Wellness and Function, Restoring into Society, Optimizing Ability, and Enabling a Better Future.

The RWTF observed several consistent themes in RW programs and policies. Disparities exist across RW programs and policies in the Headquarters or Department vision and in the way in which those programs and policies are implemented in the field and experienced by RWs and their families. Clear, consistent, and accurate information does not reliably reach RWs about the programs and policies intended to support them. Also, parity of care across the Services has not been achieved. From language used to services offered, eligibility criteria, and staffing requirements, the Services implement policies and programs differently. Some of these differences disadvantage subpopulations of the RW community. There also are significant differences in the experiences of Active Component (AC) RWs, Reserve Component (RC) RWs healing at Active Duty installations, and RC RWs receiving community-based care.

In light of these findings, the RWTF makes the following recommendations:

Overall Effectiveness of DoD Recovering Warrior Policies and Programs

- DoD should define "Recovering Warrior" and adopt common standards and nomenclature for RWs, programs, and policies.
- DoD must specify population-based standards and criteria to drive decisions about location, establishment, or expansion of transition units/RW services, with consideration for housing, family support, medical and non medical case management, and rehabilitation needs of RWs.
- Develop standardized, data-driven protocols for condition-specific recovery care—to include medical decision points, related milestones, and well-defined outcomes. The DoD and Department of Veterans Affairs (VA) should utilize population-based data to project probable outcomes for RWs based on their specific condition(s). Ensure that RWs have accurate, consistent, and timely information about options for returning to duty and transitioning out of uniform across all Services.
- DoD should create standards, and provide oversight and guidance, for the implementation of the comprehensive recovery plan and comprehensive transition plan (CRP/CTP). DoD should clarify which member of the recovery team is responsible for engaging the RW and family and ensuring they actively participate throughout the entire CRP/CTP process. Ensure the plan is a

meaningful tool that is utilized to foster meaningful dialogue and make well-planned decisions among the RWs, family caregivers, and providers (medical and non medical case managers (NMCMs), counselors, and so forth).

Restoring Wellness and Function

- Warrior Transition Command (WTC) and Wounded Warrior Regiment (WWR) must define appropriate transition unit command climate and disseminate corresponding standards for achieving it.
- Enforce the existing policy guidance regarding transition unit entrance criteria. Establish clear criteria and a case manager appeal process for transfer to the Warrior Transition Unit (WTU)/WWR when the successful recovery, rehabilitation, and reintegration of a RW are not occurring at unit level.
- DoD must ensure that there are sufficient numbers of medical care case managers (MCCMs) available at WTUs, WWRs, and Community Based Warrior Transition Units (CBWTUs). DoD should establish and implement acuity-based staffing standards. In addition, care should be taken when transitioning MCCMs among RWs to ensure continuity of care within the DoD and between the VA and DoD.
- Shape strategic solutions that address the unique needs of RC RWs. Care for these RWs must meet Active Duty standards.
- Provide the needed support for the Centers of Excellence (CoEs) to enable full operational capability.
- DoD and VA must ensure timely access to routine posttraumatic stress disorder (PTSD) care across the continuum of Service to avoid exacerbation and crisis.

Restoring into Society

- Standardize and clearly define the roles and responsibilities of the Recovery Care Coordinator (RCC), Federal Recovery Coordinator (FRC), NMCM, VA Liaison for Healthcare, and VA Polytrauma Case Managers serving a RW and his or her family. Standardize the criteria for who is eligible to be assigned to a RCC (or Army Wounded Warrior (AW2) Advocate) and FRC.
- Develop minimum qualifications, ongoing training, and skill identifiers specializing in recovery and transition for transition unit personnel, with emphasis on the small group leaders who play a pivotal role within these organizations.
- As part of the intake process, and on a regular and recurring basis, review available resources for support, to include the National Resource Directory (NRD) and Keeping It All Together from Military OneSource, with the RW and the family caregiver. Tailor a plan that facilitates and ensures effective communication between caregivers, support personnel, family, and the RW.
- Empower family caregivers with the resources they need to fulfill their roles in the successful recovery of RWs. Establish the congressionally mandated database of family caregivers, to ensure information on resources may be easily disseminated. These resources include, but are not limited to: lodging, orders, support groups, child care, liaison officers, and appropriate credentialing as needed.

- The DoD should expedite policy to provide special compensation for members of the uniformed services with catastrophic injuries or illnesses requiring assistance in everyday living, as directed by Section 603 of the National Defense Authorization Act (NDAA) 2010.
- Continue to support the Soldier and Family Assistance Centers (SFACs) and take steps to increase utilization.

Optimizing Ability

- Make Transition Assistance Program (TAP) (all five TAP components) attendance mandatory for RWs within the 12 months prior to separation.
- Ensure that the VA Vocational Rehabilitation and Employment (VR&E) Program is available and accessible to RWs before their separation from the Services. Congress should extend or remove the sunset provision that currently allows pre-DD214 access to the VA program, set to expire in December 2012. DoD should issue policy to encourage Service member participation in VR&E.

Enabling a Better Future

- Develop a uniform DoD manpower and staffing model for Physical Evaluation Board Liaison Officers (PEBLOs) and legal support. Ensure adequate PEBLO and legal staffing levels to provide appropriate Integrated Disability Evaluation System (IDES) education and advocacy to RWs and family caregivers throughout the IDES process.
- Pending the implementation of a common electronic health record (EHR), find interim solutions to grant access to EHR for disability assessment. Achieve information technology interoperability between DoD, VA, and disparate civilian medical information systems. These record systems include electronic, paper, and other legacy medical information systems.
- Consolidate the Senior Oversight Committee (SOC) functions into the Joint Executive Council (JEC). The JEC will be co-chaired by the Deputy Secretaries of DoD and VA. Congressional action is required to establish the Deputy Secretaries as Co-Chairs of the JEC.

In subsequent years of operation, the RWTF will continue to assess the effectiveness of RW programs and policies, supplementing and refining the findings, recommendations, and best practices identified to date.

Introduction

CHAPTER 1

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

> (a) assess the effectiveness of the policies and programs developed and implemented by the Department of Defense, and by each of the Military Departments to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces; and (b) make recommendations for the continuous improvements of such policies and programs.[1]

The military operations in Afghanistan and Iraq brought new focus to the needs of all wounded, ill, and injured Service members and their families. The system for medical and non medical care that, in some cases, had not changed since the Vietnam War was under stress in 2007, when shortfalls in the management of Service members at Walter Reed Army Medical Center gained national attention. Since 2007, a number of commissions have made recommendations to address the needs of the wounded, ill, and injured community; among the most influential commissions was the President's Commission on Care for America's Returning Wounded Warriors.[2] With legislative assistance and a national mandate, DoD, the Military Departments, and the Department of Veterans Affairs (VA) put in place policies and programs to provide a seamless continuum of care. While the proportion of combat injured Service members assigned to wounded warrior units and programs varies, Congress and DoD have designed many of these programs for the benefit of *all* wounded, ill, and injured Service members.[3]

With the passage of four years since the revelations at Walter Reed, lawmakers have sought to understand how well this continuum of care is working. The independent DoD Recovering Warrior Task Force is the means through which Congress intends to answer this question. The RWTF will draw upon the experience and expertise of its Members to assess how effectively DoD and the Military Departments are meeting the needs of the Recovering Warrior (RW) community and to provide recommendations for the improvement of RW policies and programs.[4]

Each year, the RWTF will review and assess more than a dozen diverse matters that Congress has specified.[5] The RWTF has grouped these matters into four domains, as shown below, that reflect a holistic and patient-centered approach for the recovery, rehabilitation, and reintegration of Service members.

RESTORING WELLNESS AND FUNCTION

- RW unit/program staffing
- RW unit/program performance measurement
- Services for posttraumatic stress disorder (PTSD)/traumatic brain injury (TBI)
- Defense Centers of Excellence (CoEs)
- Medical care case management

RESTORING INTO SOCIETY

- Non medical case management
- Information resources
- Support for family caregivers

OPTIMIZING ABILITY

- Vocational programs and services including:
- Systems to ease DoD/VA transition (such as the Transition Assistance Program (TAP))

ENABLING A BETTER FUTURE

- Senior Oversight Committee (SOC) effectiveness
- Interagency Program Office (IPO) effectiveness
- Integrated Disability Evaluation System (IDES)
- Support for progressing through IDES
- Legal support for RWs and families
- Interagency matters of transition to civilian life
- Overall coordination between DoD and VA

The RWTF *Reference Handbook of Key Topics and Terms* (Appendix D) includes an overview of most of these matters. Although the RWTF is not addressing programs and services for veterans (post-DD214), Congress did mandate the assessment of interagency programs, including the DoD/VA Federal Recovery Coordination Program (FRCP), the DoD/VA SOC, and transition assistance.

Appendices at the end of the report contain supporting documentation. Among these, Appendix I lists the information sources used to assess each of the congressionally mandated topics, and Appendix M identifies the topics addressed in each RWTF recommendation.

Recommendations and Findings

CHAPTER 2

DoD's largest surveys of Active Component (AC) and Reserve Component (RC) Service members suggest that Service members are confident that they and their families will receive DoD/Department of Veterans Affairs (VA) benefits, programs, and services—should they become wounded, ill, or injured.[6] In the course of its research, the Recovering Warrior Task Force (RWTF) has found best practices and other successes that suggest that this confidence is well placed. The RWTF also has identified opportunities for improvement in programs and policies for Recovering Warriors (RWs).

Overall Effectiveness of DoD Recovering Warrior Policies and Programs

Following are the RWTF's recommendations and findings, beginning with four recommendations targeting overarching issues. These recommendations address variability across the Department in standards, nomenclature, process times, and the RW comprehensive recovery/transition plans (CRP/CTP). Best practices are highlighted at the end of the chapter.

RECOMMENDATION 1

DoD should define "Recovering Warrior" and adopt common standards and nomenclature for RWs, programs, and policies.

Finding: The RWTF's visits to Army, Air Force, Navy, Marine Corps, and National Guard sites revealed noteworthy practices, described separately in this chapter. At the same time, visits confirmed noteworthy differences from site to site and across the Services—for example, resources available to RWs differ, as do definitions of target populations and terminology.[7]

Some RWs are located near critical resources such as major medical centers and federal jobs programs, while others are not.[8] The number and types of non medical case managers (NMCMs) assigned to RWs vary, and access to a DoD-trained Recovery Care Coordinator (RCC) differs by Service.[9] The Army and the Marine Corps garrison their RWs in transition units, while the Air Force and Navy do not,[10] and the process and criteria for entering transition units vary across the Services and between the AC and the RC.[11] At some locations, transition units serve only a minority of identified RWs.[12] At the conclusion of 12 site visits, the RWTF was left with the impression that many of the successes encountered were the work of a handful of dedicated individuals rather than the products of standardized and enduring programs and processes.

While the RWTF understands that these disparities reflect the choices of unique and autonomous organizations, it is concerned about parity of care. Common standards and nomenclature—beyond the definitions established in the National Defense Authorization Act

(NDAA) of 2008[13] and the 33 standard terms and definitions approved by the Overarching Integrated Product Team (OIPT)[14]— are needed to promote consistent levels of RW care among the Services, better enable DoD to compare Services' programs, and identify and promulgate best practices.

RECOMMENDATION 2

DoD must specify population-based standards and criteria to drive decisions about location, establishment, or expansion of transition units/RW services, with consideration for housing, family support, medical and non medical case management, and rehabilitation needs of RWs.

Finding: Army and Marine Corps transition units provide vital services to RWs and families. One cannot underestimate the value of an environment that makes healing of RWs the number one priority and assigns each RW a recovery team to help him or her achieve medical and non medical goals. The Army Inspector General (IG) found that Soldiers undergoing disability evaluation who were not in a Warrior Transition Unit (WTU) were disadvantaged by less information, less access to care, and a lengthier evaluation process.[15] Many of the Soldiers, Marines, and family caregivers who participated in the RWTF focus groups expressed great appreciation for the transition unit, particularly in comparison to the alternative of remaining in the line unit.[16]

Over the course of 12 site visits, the RWTF saw how location influences RWs' access to transition units and other RW resources. At 29 Palms, for example, only 10 percent of RWs are assigned to the Wounded Warrior Detachment, although many more were eligible.[17] DoD must resource transition units and other RW services at a level commensurate with the demand for them. Such a demand-driven resourcing model will not only better serve RWs but also will guide right-sizing of transition units and other RW services.

RECOMMENDATION 3

Develop standardized, data-driven protocols for condition-specific recovery care—to include medical decision points, related milestones, and well-defined outcomes. The DoD and VA should utilize population-based data to project probable outcomes for RWs based on their specific condition(s). Ensure that RWs have accurate, consistent, and timely information about options for returning to duty and transitioning out of uniform across all Services.

Finding: The redesigned Integrated Disability Evaluation System (IDES) will be fully implemented October 1, 2011. Better information on prognosis and retention allows completion of the IDES earlier and concurrently with Service members reaching maximal medical benefit. Concurrent IDES documentation development during rehabilitation allows the Service members to focus on the future. RWs, their families, and their providers reported needing better guidance on anticipated courses of care, progress, timelines, and milestones throughout the care process.[18] Medical care case managers (MCCMs) must be able to provide patients and their families the most complete, accurate, and up-to-date information about what to expect throughout the recovery, rehabilitation, and transition processes. The sometimes protracted timeframe for recovery and rehabilitation, coupled with a lack of clarity regarding next steps and processes, can

make it difficult for a RW to determine his or her next steps and plan for the future. Standardized, data-driven guidance that provides reasonable expectations for the case managers, the RW, and the family—while allowing for flexibility and individual variation—can improve communication, facilitate planning in case management, and focus the RW and family on milestones and goal attainment.

Although some Services made available to the RWTF clear policies that are in place about opportunities for the return to duty of RWs,[19] focus group participants indicated that such information was not provided, was unclear, or was inconsistent across different sources. For example, one participant indicated that he was informed that his injury type prohibited return to duty, even though that is inconsistent with the available policy from his Service.[20]

Based on the lessons learned by military medicine over the last 10 years of caring for the wounded, the Assistant Secretary of Defense for Health Affairs (ASD(HA)), the Services, and the Centers of Excellence (CoEs) have an available database of population data to guide medical case management and better inform Members and IDES. Clear and evidence-based information regarding the anticipated course of care across a spectrum of conditions leading up to the medical retention determination point would allow earlier vocational rehabilitation, timely entry into the IDES, and efficient transition overall.

Several of the sites the RWTF visited noted that IDES was taking longer than expected and that there was wide variability across installations regarding lengths of stays in WTUs for similar conditions.[21] Focus group participants emphasized that the slowness of the IDES process and requirements to complete each step in succession make the transition out of the military a protracted, encumbered, and frustrating process. In general, focus group participants lacked confidence in the transition process and questioned whether their transition from DoD to VA would be successful.[22] The RWTF favors a more transparent process during which opportunities are afforded to RWs to begin preparing for the future as early as feasible (see Optimizing Ability, Recommendations 17 and 18 on the Transition Assistance Program (TAP) and vocational rehabilitation, respectively).

RECOMMENDATION 4

DoD should create standards, and provide oversight and guidance, for the implementation of the CRP/CTP. DoD should clarify which member of the recovery team is responsible for engaging the RW and family and ensuring they actively participate throughout the entire CRP/CTP process. Ensure the plan is a meaningful tool that is utilized to foster meaningful dialogue and make well-planned decisions among the RWs, family caregivers, and providers (medical and NMCMs, counselors, and so forth).

Finding: Focus group participants shared misgivings about the transition process. They identified impediments they believe jeopardize their ability to plan and transition effectively, such as a lack of authoritative and timely information and guidance. Some voiced grave concern about how they would make ends meet if they were forced to leave the military.[23] DoD envisioned the CRP (referred to by the Army and Marine Corps as the CTP) as an important resource to help RWs and their recovery teams navigate the recovery, rehabilitation, and reintegration processes,[24] but few if any focus group participants experienced it this way.[25]

The RWTF found that the CTP was clearly in use at the AC Army sites they visited, although they noted discrepancies between Headquarters- and site-level perceptions of the use and usefulness of the CTP. While DoD views the CRP/CTP as a cornerstone resource and key step for RW recovery and transition,[26] many RWs, Army cadre, and other providers perceive it as a "check the block" exercise. Some Recovering Soldiers recognize its value, but many described the CTP as burdensome to review weekly and said Common Access Card (CAC) access is a barrier.[27] The RWTF also noted inconsistencies between the online version and the Warrior Transition Command (WTC) six-domain version of the CTP.[28] In focus groups, RWs at venues other than AC Army installations—that is, at Community Based Warrior Transition Units (CBWTUs) and Air Force, Navy, and Marine Corps sites—were noticeably less aware of the CRP/CTP.[29]

The RWTF noted that, to facilitate continuity of care for RWs who leave the Service, it is important to include VA MCCMs and NMCMs involved in RW care in the development of the CRP/CTP.

Restoring Wellness and Function

The topics included in Restoring Wellness and Function focus centrally on the restoration of the physical and mental health of the RW. In the trajectory toward recovery, rehabilitation, and reintegration, these are foundational matters that set the stage for subsequent steps. These topics include units and programs for RWs; medical care case management; programs and services for RC RWs; the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE PH & TBI) as well as the Vision, Hearing, and Traumatic Extremity Injury and Amputation Centers of Excellence (VCE, HCE, EACE); and posttraumatic stress disorder (PTSD). The RWTF notes that DoD is making significant strides in its response to TBIs, including a new DoD instruction and best practices captured at the end of this chapter.

RECOMMENDATION 5

WTC and Wounded Warrior Regiment (WWR) must define appropriate transition unit command climate and disseminate corresponding standards for achieving it.

Finding: Transition units were established by the Army and Marine Corps to promote the restoration of RW health and wellness by providing support to them and their families throughout recovery, rehabilitation, and transition. As of May 2011, 9,973 Soldiers were assigned to 38 Army WTUs (including nine CBWTUs).[30] As of June 2011, 405 Marines were assigned to 16 units of the Marine Corps WWR.[31] Eighty-six percent of Soldiers[32] and 87 percent of Marines[33] assigned to the transition units had deployed one or more times. More than one-fourth of Army RWs[34] and more than two-thirds of Marine RWs[35] sustained their conditions while deployed, to include those wounded in action (nine percent of Soldiers;[36] 52 percent of Marines[37]) and those who became ill or injured while in theatre (20 percent of Soldiers;[38] 16 percent of Marines[39]). In July 2011, the Marine Corps reported a total of 771 Marines assigned to the WWR.[40]

During site visits, the RWTF observed that the transition units have not yet succeeded in creating a unit climate that effectively balances the dual imperatives of healing on one hand and military discipline on the other. The Army WTC and the Marine Corps WWR must cultivate an environment within the transition unit that promotes healing, maintains esprit de corps, and provides comparable treatment regardless of whether the RW is combat wounded, ill, or injured.

I think the focus with the Wounded Warrior Battalion…. We know we are Marines, but going through the process, trying to get better—those small things are what we are focusing on, not what we are wearing or haircuts. (Recovering Warrior)

The 11-Bravos—those guys…all they know is to keep going, keep going…when you feel like a zombie in the morning and they are like "keep going." (Recovering Warrior)

Here's how it should work. Just like any other Army unit. I've got one formation in the morning; I've got one in the evening. You're all adults here. Now, if you don't do the right thing—much like I tell my young privates—if you want to be treated like an adult, act like an adult. If you begin to act like young privates that can't make a decision, you've pretty much forced my hand. But there needs to be accountability on both sides of this issue. I'm accountable for my care. I need to make sure that I am doing what I need to do to…heal. But that chain of command also has to be accountable…you know, are we making sure these systems are in place for this Soldier to receive that care?... It's when it becomes, well, you know, you didn't make your appointment here, here, and here, okay now [what] we're going to do is have four formations a day and we're going to keep that until 2400. (Recovering Warrior [41])

RECOMMENDATION 6

Enforce the existing policy guidance regarding transition unit entrance criteria. Establish clear criteria and a case manager appeal process for transfer to the WTU/WWR when the successful recovery, rehabilitation, and reintegration of a RW are not occurring at unit level.

Finding: Although the Army and the Marine Corps both have transition unit assignment policies (Headquarters Department of Army Fragmentary Order (FRAGO) 4 to Executive Order (EXORD) 118-07[42] and WWR Order (WWRO) 6300.1[43]), entry criteria seemed to be interpreted differently.[44] This was true for AC as well as RC transition units. The Marine Corps indicated that Recovering Marines are assigned to the WWR by battalion commanders on a case-by-case basis, in accordance with WWRO 6300.1.[45] Visits to two CBWTUs revealed that all CBWTU assignments are direct referrals from WTUs, but the process for triggering the transfer was not transparent.[46] The RWTF is concerned about the absence of consistent transition unit entrance criteria—a position echoed by the 2011 Wounded Warrior Care Coordination Summit, which identified a need to better define entrance criteria for all RW programs, including transition units.[47]

While the RWTF recognizes that line unit leaders are not trained to manage RWs and are focused on mission requirements, the RWTF is concerned about the welfare of RWs under line unit chains of command. The RWTF encountered high proportions of Recovering Marines

assigned to operational units at the two Marine Corps bases visited. At one base, the RWTF was told that only 10 percent of the Recovering Marines were assigned to the local Wounded Warrior Detachment.[48] In focus groups, Recovering Marines suggested they do not receive adequate support from the units and that the units are insensitive to legitimate needs—to include the need to transfer to the Wounded Warrior Detachment. Recovering Marines further stated that operational units sometimes actively impede recovery—for example, by requiring limited-duty Marines to go to the field or by assigning duties that interfere with therapy appointments. They suggested operational units are not sufficiently familiar with RW programs and processes,[49] although, to its credit, the WWR has incorporated training about the WWR into the Marine Corps' enlisted professional military education curricula.[50] Family members similarly perceived an unsympathetic attitude toward RWs within line units. It should be noted that although these negative perceptions of the line units were strongest at one Marine base, they were not limited to this base or to the Marine Corps.[51]

…I actually see that a lot of the battalions out here don't care. Even if you're hurt, they just throw you off to the side and bring someone else in. And you're pretty much on your own….The best thing that happened to me was getting picked up [by the Wounded Warrior Battalion]. (Recovering Warrior)

RECOMMENDATION 7

DoD must ensure that there are sufficient numbers of MCCMs available at WTUs, WWRs, and CBWTUs. DoD should establish and implement acuity-based staffing standards. In addition, care should be taken when transitioning MCCMs among RWs to ensure continuity of care within the DoD and between the VA and DoD.

Finding: MCCMs also are integral to restoring wellness and function. RW and family member focus group participants considered MCCMs, specifically nurse case managers, important members of the recovery team.[52] MCCMs come to the job with prior training and experience, certification, and licensure, and have access to ongoing training through a variety of venues.[53] Systematic processes are in place across most Services and facilities for evaluating medical care case management and the performance and effectiveness of individuals according to core competencies.[54]

MCCM caseloads vary but tend to range from 1:12 to 1:20, according to the most recent figures provided by the Services.[55] Many focus group participants indicated that their MCCM was often busy, which sometimes impeded communication with the MCCM and limited the MCCM's responsiveness.[56] The RWTF noted that MCCM staffing ratios should take into account the level of assistance needed by the RW at different junctures, which generally is not static throughout the recovery/rehabilitation/transition process.[57]

Some RWs and family members report frustration with care discontinuity created by frequent turnover or rotation of MCCMs. Because the MCCM can be a key member of the recovery team, the loss of a MCCM can be particularly difficult for the Service member and his or her family, especially in the absence of a smooth handoff to another MCCM. [58]

The nurse case manager is the one who knows the system, works the system, and knows things. (Recovering Warrior)

I know also that every single one is way over worked, but they do a good job because they're dedicated to their job. (Recovering Warrior)

RECOMMENDATION 8

Shape strategic solutions that address the unique needs of RC RWs. Care for these RWs must meet Active Duty standards. Specifically:

- Establish a process to ensure communication between sending physician, receiving CBWTU physician, and community-based care provider.
- Ensure communication technology for those in CBWTUs is equal to the technology available to those in WTUs and appropriate to their available technological infrastructure.
- Evaluate the adequacy of civilian health care delivery systems to ensure RWs will receive appropriate care before transfer to remote locations.
- Enforce consistent application of policy on CBWTU assignment.
- Train nurse case managers who support RC RWs in applicable TRICARE benefits.
- RC must develop policy and processes to effectively manage RWs not in transition units.

Finding: RWs in the RC face unique challenges in recovery, rehabilitation, and transition that can lead to gaps in services and supports compared to what is provided to their AC peers. The RWTF focused its initial exploration of RC RW issues on access to appropriate community-based health care, transfer to and support from CBWTUs, and management of those who remain with their line units.

The receiving physicians in CBWTUs visited by the RWTF noted that contact between the sending physicians, receiving physicians, and community-based providers to ensure smooth transition and adequacy of care was not systematic and is at present a time-consuming effort.[59] The RWs at both CBWTUs that the RWTF visited had transferred from installation-based WTUs. CBWTU personnel did not clearly articulate the criteria for transfer, although there was some indication that the Post-Deployment Health Assessment (PDHA) or the Post-Deployment Health Reassessment (PDHRA) is influential. Focus group participants at one CBWTU stated that a diagnosis of PTSD or TBI could disqualify RWs from being assigned to a CBWTU. Such a policy, whether real or perceived, could discourage RC RWs from pursuing evaluation for their conditions.[60]

Concerns about access to technology and medical care were echoed in briefings from site staff and in focus groups. The RWTF was surprised to discover that at least one CBWTU did not ensure laptops or cell phones were available to RWs despite being remotely located from the Army cadre and the treatment facility.[61] CBWTU focus group participants described issues with access to medical care, noting they were tasked with providing evidence of available care before they could be transferred and then faced barriers in accessing the level of care they needed,

including limitations with TRICARE coverage. They also voiced concerns about their nurse case managers' knowledge of available TRICARE benefits related to their care needs and expressed appreciation when nurse case managers pursued more information and advocated for treatments that might not otherwise be covered by TRICARE.[62] Nurse case managers at CBWTUs visited by the RWTF corroborated that TRICARE was a challenge for them. Those who were more familiar with TRICARE benefits and those with more experience reported more success helping RWs access available programs and benefits.[63]

The state Joint Force Headquarters (JFHQs) and CBWTUs seemed to be fairly uninvolved, which struck the RWTF as a missed opportunity for resource sharing and coordination. It became apparent that the Guard members assigned to CBWTUs represent only a fraction of those who are classified as wounded, ill, or injured. Recovering Guard members not assigned to CBWTUs are managed by a case manager within the JFHQ Surgeon General's Office.[64]

RECOMMENDATION 9

Provide the needed support for the CoEs to enable full operational capability. Specifically:

- Align the DCoE PH & TBI to the Army as the Executive Agent to promote more aggressive dissemination of clinical practice guidelines and develop point-of-care decision tools for providers that are based on guidelines and integrated into the existing delivery systems.
- Resolve the following concerns of the VCE, HCE, and EACE:
  - Provide funding for the VCE, HCE, and EACE.
  - Proceed immediately on the headquarters placement decision and concept of operation decision for the EACE.
  - Proceed immediately on the concept of operation decision for the HCE.

Finding: Four centers of excellence have been established to ensure advancements in the wellness and function of RWs with particular conditions. In 2007, the DCoE PH & TBI was established to lead DoD's efforts to prevent and treat TBIs as well as PTSD and other psychological health issues.[65] In subsequent years, the VCE, HCE, and EACE were established to provide leadership on prevention and treatment in their respective injury types.[66]

Site-level evidence suggests that providers are gradually becoming aware of the DCoE PH & TBI tools and resources.[67] Increasingly, the DCoE PH & TBI is perceived as a potential clearinghouse for identifying and promoting evidence-based practices for the recovery and rehabilitation processes. However, the products of the DCoE PH & TBI are not immediately usable and often require additional development for integration by the Services into existing delivery systems.[68] Aligning the DCoE PH & TBI with an Executive Agency will ensure that the products can immediately be integrated into existing delivery systems.

Unlike DCoE PH & TBI, the other DoD CoEs did not receive dedicated funds from Congress with which to meet their mandates. As a result, full operational capability has been delayed by pending decisions on staffing, site selection, and the development of a full array of programs despite the well-documented need for these centers and their potential impact on RWs.[69]

RECOMMENDATION 10

DoD and VA must ensure timely access to routine PTSD care across the continuum of Service to avoid exacerbation and crisis.

Finding: PTSD is a signature wound of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND); PTSD and TBI affect as many as one in five OEF/OIF/OND veterans .[70] In focus groups and mini-surveys, RWs and family members generally reported that PTSD services are helpful.[71] At the same time, it was apparent from the focus groups that the units lack a sense of urgency about responding to behavioral health concerns.[72] Many focus group participants further noted that those who are not categorized as critical or high risk may face waits for care that exceed TRICARE access standards and implied that even the TRICARE standard is too long of a wait for those seeking PTSD care.[73] Other barriers to care remain as well, including delayed onset of symptoms and diagnoses[74] (which can occur after Reservists' orders have expired, particularly in the Army), stigma and fear of discrimination in career paths,[75] and bias in favor of visible wounds.[76] The RWTF finds that current service delivery modalities are insufficient and that other modalities and outlets need to be leveraged in the absence of timely individual counseling for all who seek PTSD care. For example, the U.S. Special Operations Command (USSOCOM) Care Coalition actively uses the Military Family Life Consultant (MFLC) program.[77]

PTSD is a roller coaster. It'll go up and down, but you don't always need therapy…. But there's moments—unless you say you want to kill yourself, you will not see a doc for 9-12 weeks. I'm waiting on my first appointment after nine weeks. There was kind of an interim…and I've been seen here over the last several weeks [to make sure I won't kill myself]. But the psych world is overwhelmed and they don't have enough manpower to deal with PTSD and other issues…. (Recovering Warrior)

Restoring into Society

Restoring into society is the theme uniting the topics that follow. These topics focus on needs beyond medical care by addressing recovery, rehabilitation, and the process of reintegrating into families and communities. The topics include care coordination, non medical case management, information resources, and support to family caregivers.

RECOMMENDATION 11

Standardize and clearly define the roles and responsibilities of the RCC, the Federal Recovery Coordinator (FRC), NMCM, VA Liaison for Healthcare, and VA Polytrauma Case Managers serving a RW and his or her family. Standardize the criteria for who is eligible to be assigned to a RCC (or Army Wounded Warrior (AW2) Advocate) and FRC.

Finding: Care coordinators, including FRCs and RCCs, perform an overall coordination role, linking medical and non medical case management and other RW programs and services to

ensure the needs of RWs and families are met. There are a variety of NMCMs, from squad leaders and platoon sergeants (PSGs) in the Army transition units and section leaders in the Marine Corps transition units to USSOCOM's advocates and liaisons to the Air Force's family liaison officers.

RWTF mini-survey results suggest high RW regard for RCCs, FRCs, and NMCMs (for example, 87 percent of RW participants with first-hand experience with non medical case management rated it as very or extremely helpful).[78] In RWTF focus groups, although some family members and RWs noted that their NMCM/care coordinator was overworked and a few RWs reported never having met their case manager/care coordinator, many participants expressed appreciation for their NMCMs'/care coordinators' tenacity, accessibility, helpfulness, and interest in them.[79] The RWTF identified several concerns related to parity and delivery of NMCM and care coordination services.

I guess out of everyone I've experienced since my accident—the RCCs both from [another installation] and here—have been simply amazing. Very helpful, kept in touch, questions how I'm doing. Even if I just need to talk—she's there; she'll talk to me and just listen. She'll make time for me no matter what. She's been the most wonderful person I've come across. (Recovering Warrior)

I don't even know why I have an RCC. I've never had a problem I brought to her that got fixed. Every promise she'd made to me has never got through, and she's the hardest person to get a meeting with her…. (Recovering Warrior)

Each program defines its role, as well as its eligible population, differently.[80] Non medical case management is intended as a complement to medical care case management to address non medical needs, while the Recovery Coordination Program (RCP) and the Federal Recovery Coordination Program (FRCP) provide care coordination to augment and coordinate with case management and other RW services. All Services send at least some of their RCCs (or equivalents) to RCC training provided by the DoD Office of Wounded Warrior Care and Transition Policy (WWCTP). The Navy sends all NMCMs to this training.[81] Within some Services, there are multiple NMCMs/RCCs; for example, Army cadre function as NMCMs, and AW2 Advocates function as RCCs for those who qualify.[82] The Air Force offers a RCC to all RWs, an Air Force Wounded Warrior (AFW2) Advocate to combat-related injured/ill[83] identified as going through the Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) process,[84] and a family liaison officer from the RW's unit to assist the families of all RWs.[85]

RWs who participated in RWTF focus groups said they are unsure of who does what and why they have so many case managers contacting them. More than one of these case management/care coordination programs state that they serve as a single point of contact for the RW and family,[86] yet these programs are not serving mutually exclusive populations. It is unclear, for example, whom the RW with both an AW2 Advocate and an FRC should utilize as the single point of contact.[87]

What I have a problem with is when lines get blurred. Sometimes the FRC will cross roles with the RCC and vice versa…. To me, the first two months I was here, I had to ask each coordinator what their role was. (Recovering Warrior)

Standardized roles and eligibility criteria will not only help RWs and family members better understand and use their recovery team but also will help the programs better address staffing shortages. Staffing shortages were common at most of the installations that the RWTF visited[88] and were a topic of discussion at the recent DoD Wounded Warrior Care Coordination Summit, which noted that caseloads must be determined based on what is manageable for NMCMs/care coordinators.[89]

RECOMMENDATION 12

Develop minimum qualifications, ongoing training, and skill identifiers specializing in recovery and transition for transition unit personnel, with emphasis on the small group leaders who play a pivotal role within these organizations. The approach must address the following:

- Resourcing. Allocate resources to create additional unit personnel positions, and remove obstacles preventing positions from being filled in a timely manner. Continue to develop institutional knowledge and promote continuity of care within the transition unit.
- Recruitment and retention. To attract high-caliber transition unit personnel, make the positions prestigious and career-enhancing opportunities.
- Training. Continue to refine training curricula for transition unit staff and make participation mandatory for all members. Ensure parity across Army and Marine Corps programs of instruction (POIs).

Finding: The transition unit personnel who have the most frequent and direct contact with the RWs—and thus the greatest influence on RWs' transition unit experience—are the squad leaders (Army WTUs), PSGs (Army WTUs and CBWTUs), and section leaders (Marine Corps Detachments).[90] Army WTUs have a total of 936 squad leaders, of whom approximately one-quarter are mobilized RC Soldiers.[91] Army WTUs and CBWTUs also have 400 PSGs, of whom 40 percent are mobilized RC Soldiers. As of May 2011, the Marine Corps reported a total of 46 section leaders, all mobilized Reservists.[92] The Army and Marine Corps reported caseloads of 1:10 for squad leaders and section leaders, respectively.[93] The Army also reported a 1:40 caseload for PSGs.[94] During site visits, unit staff, RWs, and family caregivers often suggested that transition units are understaffed, particularly the Army CBWTUs.[95]

I think these people do a wonderful job overall, everyone appreciates them. I think they need help, they need squad leaders to help them out for the quality we need, so that we can get taken care of. But one platoon sergeant for 50 people—things are gonna get missed. (Recovering Warrior)

RWTF mini-survey results suggest that RWs find the chain of command quite helpful, although less helpful than other types of NMCMs. Soldiers were much more likely than Marines to rate

the chain of command favorably. Among mini-survey respondents, 86 percent of Soldiers rated the chain of command as very or extremely helpful, as compared to 33 percent of Marines.[96] This discrepancy may be related to the high proportion of Marine focus group participants who were assigned to line units rather than Wounded Warrior Detachments.

Various stakeholders have raised concerns regarding quality of unit staff. RWs in several Army focus groups expressed concern about Army cadre qualifications, and a RW spouse independently suggested that Army WTU cadre lack sufficient knowledge about TBIs and their ramifications.[97] The quality of the transition unit staff has been associated with shortfalls in both personnel processes and training.

Transition units contend with significant recruitment, selection, and retention challenges. They have difficulty attracting high-caliber personnel because the positions are not viewed as career enhancing. Furthermore, the use of mobilized Reservists can be administratively complex and result in protracted position vacancies and high position turnover.[98] According to the Army IG report, selection of Army WTU cadre has shifted from "best qualified" to "good and first available."[99]

My squad leader actually comes to me to ask how to do stuff. I found that I don't go to him with any issues, since he's not really versed enough to know how to navigate the waters…that's my one take-away, I dunno—if we're gonna put people in this position, maybe there should be training. (Recovering Warrior)

The Army WTU/CBWTU cadre training is fairly extensive; the Army Medical Department (AMEDD) runs a two-week resident course for WTU/CBWTU triad members in San Antonio, Texas, that includes at least 15 hours of Army cadre-specific content and is preceded by mandatory online training. It appears that AMEDD is continuing to expand and refine the WTU training curriculum.[100] However extensive the Army's training may be, the Army IG study determined that current training does not adequately prepare Army cadre to fulfill their duties.[101] Army focus group participants implicitly echoed this perspective by recommending more Army cadre training.[102]

The Marine Corps WWR holds a one-week resident course for section leaders, which is followed by on-the-job training. The course addresses WWR *Section Leader Handbook* content, such as the role of the section leader as a complement to the RCC, how section leaders interact with unit leadership, and administrative matters. It also includes training on the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Personally Identifiable Information (PII), and the Marine Corps Wounded, Ill, and Injured Tracking System (MCWIITS).[103]

RECOMMENDATION 13

As part of the intake process, and on a regular and recurring basis, review available resources for support, to include the National Resource Directory (NRD) and Keeping It All Together from Military OneSource, with the RW and the family caregiver. Tailor a plan that facilitates and ensures effective communication between caregivers, support personnel, family, and the RW.

Finding: Several information resources, websites, and hotlines are available to RWs and their families in order to access services for reintegration into society. Additionally, websites and hotlines for all military members and families have developed targeted resources and information for RWs and their families. Congress specifically instructed the RWTF to explore the effectiveness of the NRD, the Wounded Warrior Resource Center (WWRC), Military OneSource, Family Assistance Centers, and Service hotlines.

Although sites reported successful strategies for delivering information to RWs and their families,[104] only 36 percent of Service member mini-survey respondents and 50 percent of family member mini-survey respondents reported having used information resources.[105] Less than 33 percent of RWs surveyed by the RWTF had used the WWRC, and 44 percent had used Military OneSource. Although utilization of the WWRC was higher among family members (77 percent), less than 30 percent had used Military OneSource.[106] In focus groups, Service members noted their need for quality, timely, and digestible information.[107] Others have noted the need for more effective communication with RWs and families. Recommendations for the Army include designing improved family education presentations with continuing assessments of family understanding and tailoring the education programs to individual learning capabilities of Soldiers with TBI and PTSD.[108]

I know that the intentions are good, but we're not being properly informed or we don't have a proper way of getting the information… (Recovering Warrior)

WWCTP has indicated its commitment to investing in the NRD as a central source of information for RWs and families and has noted that use of the website is growing.[109] A recent advance in this area is the expansion of the NRD to a mobile version.[110] However, RWTF mini-survey data indicated low use of the NRD; less than seven percent of RWs and none of the family members had utilized the NRD.[111] In site-level briefings to the RWTF, one site reported that the staff prefers local resources and does not use the NRD.[112] However, the NRD has the potential to fill a valuable role in getting information to RWs and families, and more must be done to raise awareness about its availability and utility.

The Keeping It All Together binder from Military OneSource consolidates information across a range of websites, hotlines, and programs. It is a valuable tool for family members, filling a need identified in other studies.[113] The Marine Corps WWR has had particular success customizing and distributing the binder to its families.[114] Units and programs need to be able to obtain this resource in bulk, rather than requesting it one RW and family at a time.

Finally, from what the RWTF has observed, little infrastructure exists for family members of RC RWs. Army National Guard (ARNG) RW family members lack access to traditional base-centric resources such as brick and mortar Soldier and Family Assistance Centers (SFACs) and WTU Family Readiness Groups. Although state JFHQs have developed robust systems to support Guard members and families during reintegration and the other phases of the deployment cycle, there seems to be no cohesive RC RW family support program. The RWTF heard that units and programs have difficulty identifying, much less reaching, National Guard and Reserve RW

families.[115] These circumstances heighten both the challenge and the importance of communicating with RC RW families about available resources.

RECOMMENDATION 14

Empower family caregivers with the resources they need to fulfill their roles in the successful recovery of RWs. Establish the congressionally mandated database of family caregivers to ensure information on resources may be easily disseminated. These resources include, but are not limited to: lodging, orders, support groups, child care, liaison officers, and appropriate credentialing as needed.

So you can see as a caregiver, I have many roles. I am his chauffeur, his cook, his personal shopper, his case manager, his secretary, his social activities coordinator, his therapist, his advocate, his nurse, his navigator, his legal aide, and his job coach. I am his eyes, his ears, his voice, and on really good days, I am his wife. (Family Caregiver[116])

Finding: The support received from family caregivers is essential to many RWs and is an important element in their recovery, rehabilitation, and transition. Most family caregivers are spouses; some are parents or other non-beneficiary caregivers who may or may not be legally considered family to the RW (friends, girlfriends/boyfriends, siblings). Their sacrifice can be significant—a 2009 study found that family caregivers of seriously injured Service members lost an average of $60,300 in income and benefits over a 19-month period.[117] The emotional toll on the family caregiver is equally profound. Family caregivers are expected to assume myriad new roles for which they are likely ill prepared, all the while dealing with an abiding sense of loss.[118]

Recovery Coordination Program guidance (DoDI 1300.24) explicitly applies to recovering Service members and their eligible family members and identifies family support as one of five major activities of the recovery coordination process.[119] Numerous DoD- and Service-level initiatives exist for family caregivers—on-campus lodging during RW hospitalization, non medical attendant (NMA) orders, Military OneSource information resources, Army SFACs, Marine Corps family support group meetings, Navy free child care, and Air Force family liaison officers are just a few examples.[120] See the end of this chapter for best practices in family caregiver support that the RWTF has identified. Significant shortfalls remain, however, in support for RW family caregivers.

Survey results regarding satisfaction with available support for RW family caregivers are mixed. As an example, the Marine Corps WWR found that 50 percent of wounded, ill, and injured Marines and family members were satisfied/very satisfied with family support received during the acute phase of recovery.[121] (The WWR did not provide separate results for RWs and family members.) Navy Safe Harbor reported that 63 percent of Sailors and 46 percent of family members were satisfied with the program overall.[122]

Too many family caregivers are unconnected or barely connected to support systems and personnel. When the RWTF presented family member focus group participants a list of relevant programs and asked whether they had first-hand experience with them, many indicated they did not (e.g., 7 of 15 lacked experience with information resources, and 6 of 16 lacked experience

with support for family caregivers). When the same question was posed to RW focus group participants, 90 out of 123—nearly 75 percent—indicated that they, too, lacked first-hand experience with support for family caregivers.[123]

What is more, there is a gap between the scope of the military's expectations and the level of support that the military provides. The RWTF applauds DoD and other governmental and nongovernmental agencies for the growing menu of resources that can help caregivers in their new roles and circumstances—Families Overcoming Under Stress (FOCUS), MFLC, Keeping It All Together, and America's Heroes at Work, to name just a few. Work remains, however, particularly in the systematic communication and delivery of resources to the caregiver population. This position was reinforced by preliminary recommendations from the spring 2011 DoD Wounded Warrior Care Coordination Summit, including a) integrate and embed family support across continuum of care coordination and b) communicate resources to families.[124]

I'm not a spouse, so I don't get help. I have an eight-year-old and they won't give me that SFAC child care or get a sticker for my car if there's an emergency… I was with my son for two-and-a-half months and he was in a coma and then the polytrauma unit. There are financial stressors… (Family Caregiver)

Family caregivers include ID card holders (e.g., spouses) and non-ID card holders (e.g., most parents, fiancés, or other relatives of single Service members, who comprise roughly 50 percent of the total force[125]). All make significant sacrifices to support their RW, but their efforts on behalf of their RW can be hindered by logistical challenges stemming from a lack of DoD credentials.[126] For example, even if legally authorized, family caregivers may be unable to register their vehicle on base, view or modify their RW's medical appointment schedule, or access their RW's eBenefits page. ID cards and NMA orders are gateways to these credentials. Thus, the large proportion of caregivers who lack ID cards, who are not on NMA orders, or whose NMA orders have expired are disenfranchised, and their efforts to effectively support their RW are thwarted.

Congress directed the establishment of a centralized DoD database of family caregivers several years ago. The Defense Manpower Data Center (DMDC)/Defense Enrollment Eligibility Reporting System (DEERS) successfully implemented a database for nonbeneficiary family caregivers within VA.[127] This single-source self-service log-on credential links veterans' caregivers to key information, tools, and benefits, sparing them unnecessary logistical obstacles to provide care to their RW. If implemented in DoD, this database will help to empower family caregivers with the resources they need to successfully partner with DoD and their RWs in the recovery, rehabilitation, and reintegration processes.

RECOMMENDATION 15

The DoD should expedite policy to provide special compensation for members of the uniformed services with catastrophic injuries or illnesses requiring assistance in everyday living, as directed by Section 603 of the NDAA 2010.

Finding: DoD has not yet implemented special compensation for catastrophically injured or ill Service members as directed by Section 603 of the NDAA 2010.[128] This legislation amends federal law to authorize monthly compensation to recovering Service members to pay for aid and attendant care, without which they would require hospitalization, nursing home care, or other residential institutional care. The delay in providing this benefit profoundly burdens affected family caregivers.[129]

While family caregivers may be put on NMA orders, which can help to defray some costs, NMA status is no substitute for the special compensation directed by Congress. Furthermore, NMA status is not available to families that are permanently assigned to the treatment site. The RWTF notes that VA already has launched its benefits program for the caregivers of severely disabled Iraq- and Afghanistan-era veterans, in response to Public Law No. 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010.[130]

RECOMMENDATION 16

Continue to support the SFACs and take steps to increase utilization.

Finding: Among the information resources Congress directed the RWTF to assess were family assistance centers. Army SFACs are co-located with WTUs and offer a wide slate of services, including information and referral; human resources/military benefits; education counseling; financial counseling/Army Emergency Relief; social services; outreach services; transition support; child, youth, and school services; and a computer room. When asked to brief on caregiver support, the Army focused its presentation on SFACs, demonstrating the centrality of this resource to the Army's caregiver support strategy.[131] The Army has 32 SFACs (29 locations within the continental U.S. (CONUS) and three major locations outside CONUS (OCONUS)). Of 18 CONUS SFAC construction locations, six were open as of July 2011 and operating in centrally situated, campus-like RW settings. Twelve more new construction projects were under way or in the planning stages. Army-wide, the SFACs employ 208 staff.[132]

In focus groups, RWs and family members spoke highly of SFACs and the subject matter expertise, information, and wide range of services available there.[133] According to the RWTF mini-survey, 40 percent of Recovering Soldiers at Army WTUs had used the SFAC and, of those, 72 percent rated it as very or extremely helpful.[134] The recent Army IG report noted the strong capabilities of SFACs. Still, according to both the Army IG and the WTC Commanding General, and as illustrated by the mini-survey results, SFAC utilization remains uneven across the Army.[135]

Optimizing Ability

Optimizing ability is the theme uniting vocational and transition programs and policies. RWs need to be able to envision a future that includes a career—whether continuing in military service or transitioning to civilian life. Some programs and policies are in place in the individual Services and DoD, and some are offered to RWs by other Departments. Many of these programs have been beneficial to those who have been able to access them, but enhancements are needed to improve access and ensure success.

RECOMMENDATION 17

Make TAP (all five TAP components) attendance mandatory for RWs within the 12 months prior to separation.

Finding: TAP is a program delivered through a partnership between WWCTP at DoD and the Services, the Department of Labor (DOL), and VA. DOL offers workshops over two-and-a-half days, the Services provide pre-separation counseling (three hours), and VA provides a general VA benefits briefing (four hours) as well as a Disabled Transition Assistance Program (DTAP) two-hour session specifically for RWs.

I actually went through the whole task, resume writing, interview….it helped a lot with the different types of resume[s]. It helped to understand the different styles that were acceptable. (Recovering Warrior)

RWs in RWTF focus groups praised TAP;[136] 41 percent of those who responded to the RWTF mini-survey had participated in DTAP already, and, of those, nearly 52 percent rated DTAP very or extremely helpful.[137] Some Services already mandate TAP participation for some or all of their separating Service members,[138] and WWCTP, which administers funds to the Services to provide TAP, has a current goal of 85 percent participation overall.[139] Many sites the RWTF visited cited TAP as one of two programs (along with the VA Vocational Rehabilitation and Employment (VR&E) Service) that are *the* vocational programs to ease transition, noting the presence of a VA counselor and/or DOL staffer at the installation as evidence of successful collaboration. However, co-location alone is not enough to ensure that the programs and services are reaching RWs, which is evident by the 17 percent who indicated during RWTF site visits that they were unsure if they had attended TAP and the 41 percent who had not yet participated.[140] Additionally, some providers at the site level did note that there are additional barriers to TAP for Reservists. Specifically, TAP may not be high on the priority list as Reservists demobilize, and they may demobilize at one site and then be sent to another site for medical care and rehabilitation where the availability or delivery of TAP is different. Providers also noted that limited availability of information about TAP and limited command support of TAP participation prohibit full participation.[141]

As TAP shifts to a military career lifecycle approach,[142] ensuring that the content is current and retained by RWs near the time of separation will be essential. TAP attendance close to the time of separation will also benefit RWs who are overloaded by a deluge of information or challenged by memory issues related to their medical conditions in the early phases of their recoveries. The RWTF heard from many focus group participants that transition information and TAP were presented in ways or at times that they could not understand and/or retain,[143] and more than 17 percent of RWTF mini-survey respondents were unsure if they had been to DTAP, indicating that if they had participated, the experience had not provided them with useful information in a way in which they could retain it.[144]

To address these and other TAP access issues and to ensure that the program effectively reaches all who can benefit, the RWTF supports making TAP mandatory across all Services, as proposed in the Hiring Heroes Act of 2011.[145]

RECOMMENDATION 18

Ensure that the VA VR&E Program is available and accessible to RWs before their separation from the Services. Congress should extend or remove the sunset provision that currently allows pre-DD214 access to the VA program, set to expire in December 2012. DoD should issue policy to encourage Service member participation in VR&E.

Finding: A broad range of vocational policies and programs provides RWs an array of services, such as resume writing, education and training, adaptive equipment to facilitate employment, internships, and vocational rehabilitation counseling. For RWs with the most severe injuries, services may begin with independent living skills, which they may need before they can explore employment options. Some RWs preparing to separate from the military begin participation in VR&E before they transition, initiating their access to the variety of vocational services available.

In the last three years, over one percent of VR&E participants were currently serving, averaging 1,349 in-Service VR&E participants each year. Of these participants, 31 to 43 were rehabilitated each year, i.e. were successfully employed or completed the independent living program, before separating from the military. The remainder of those who started VR&E while in Service either completed after separation or did not complete. VR&E conducts outreach during the transition process and attributed increases in applicants of 13 percent in FY2009 and 14 percent in FY2010 to those outreach efforts.

During site visits, program staff cited VR&E and TAP as *the* programs primarily providing vocational services and touted strong collaboration between unit/program staff and onsite or local VA and/or DOL personnel.[146] Without guidance from DoD, consistent and accurate information on how to utilize the service pre-separation is not available. A recent summit of subject matter experts convened by WWCTP noted similar inconsistencies in the availability of vocational information and services. The summit participants recommended that DoD define all employment and education core services available at all Military Treatment Facilities (MTFs) to ensure RWs have clear and accurate information and to facilitate uniform implementation of programs.[147]

RWs in focus groups with the RWTF indicated that the information about VR&E was not consistent, available, accessible, and/or understandable and noted that some RCCs in particular are able to relay program information and assist with applying for services, although not all RCCs do this.[148] This limited availability of information is supported by the RWTF mini-survey findings; only 19 percent of RWTF mini-survey respondents participated in VR&E.[149] Yet those who participated in VR&E generally were satisfied with the program; 67 percent of RWTF mini-survey respondents who were in the program found it very or extremely helpful.[150] The Marine Corps' reintegration phase survey saw similar results; only 20 percent of respondents were participants in VR&E, but among those who were participants, 59 percent found it helpful.[151] Because it is valued by RWs and is one of few programs available for RWs who will transition from military service, it is critically important that VR&E remains available to RWs and that DoD takes steps to ensure that clear and accurate information about VR&E reaches RWs.

I went to the DTAP and was told they won't get you in a program until you have a rating. I'm still in limbo and don't know how much time I have left…. I went home and found the Voc Rehab back home. And [I'll] do it that way. (Recovering Warrior)

Enabling a Better Future

The IDES, the Interagency Program Office (IPO), and the Senior Oversight Committee (SOC) are interagency efforts of DoD and VA to improve collaboration and enable a better future for RWs.

RECOMMENDATION 19

Develop a uniform DoD manpower and staffing model for Physical Evaluation Board Liaison Officers (PEBLOs) and legal support. Ensure adequate PEBLO and legal staffing levels to provide appropriate IDES education and advocacy to RWs and family caregivers throughout the IDES process.

Finding: The Disability Evaluation System (DES) was redesigned in 2007 to better meet the needs of RWs. Through the SOC, the IDES began first as a pilot program and is nearing worldwide implementation. In the course of its research, the RWTF learned of lingering DES issues that impede the transition process of some RWs. The RWTF also heard from supporters and opponents of the IDES about IDES benefits and challenges.

Service members going through the IDES process often do not have a clear idea about where they are going and what their futures hold.[152] In focus groups, Service members reported the absence of adequate explanation and information about the process. The perception that information is lacking was not unique to junior personnel. For those with TBI, difficulty reading and absorbing the IDES packet proved an additional barrier to satisfaction with the IDES process.

PEBLOs work to inform RWs and to assist with the preparation of paperwork for the different phases of the DES process. The Congressional Research Service recently found that Service-imposed limitations on when PEBLOs can intervene and inadequacy of training are barriers to PEBLO effectiveness.[153] The Government Accountability Office (GAO) recently found that the Services do not agree on a maximum caseload ratio and are currently using two different staffing targets. Twenty-seven IDES sites are not meeting the 1:30 staffing target, and 23 are not meeting the 1:20 target.[154] RWTF site visits corroborated challenges in when PEBLOs can assist in the DES process, training, and caseloads. PEBLOs suggested the caseload target should be 1:20, including RWs on Temporary Disability Retired List (TDRL). Some PEBLOs noted minimal training, on-the-job training, or complete lack of training available to them.[155]

Focus group participants' knowledge of the PEBLO role was limited. Some had not heard of PEBLOs. At four sites, many participants stated that they did not have a PEBLO or had not met their PEBLO.[156] Although several individuals spoke favorably about their PEBLOs, more often comments about the PEBLOs were negative. RWs seemed to expect advocacy from their PEBLO but experienced them instead as part of the system.[157] Twenty-eight percent of RWs

responding to the RWTF mini-survey indicated that the PEBLO was very or extremely helpful, while 32 percent indicated the PEBLO was moderately helpful.[158] The RWTF mini-survey results contrast with more positive WWCTP survey findings that PEBLO customer service earned 79 percent to 88 percent satisfaction ratings across the Services. WWCTP also found that 65 percent of RW survey respondents indicated that the PEBLO managing their case was helpful or very helpful to them.[159]

I've met my PEBLO once and I've been here [for more than 10 months]… I was the one who found out about everything, I got the paper work…I meet her one time and it was only for one minute… I've seen my PEBLO once and she's always busy, on a call, or away. She cancelled twice on me for a going-away parties and things…that shouldn't have been done. I go through my nurse case manager. I gave up with my PEBLO... (Recovering Warrior)

Subject to the availability of resources, all Service members have access to routine legal support on a broad range of legal issues, including advice and advocacy related to the IDES process. In addition to the routine services available through the legal assistance office at individual installations, each Service has dedicated legal resources to support RWs proceeding through the IDES process (i.e., MEB and PEB). The Army has 24 MEB Outreach Counsel attorney/paraprofessional teams for approximately 8,000 RWs enrolled in the DES.[160] The Marine Corps, Navy, and Air Force have fewer assets devoted to MEB support.[161] During onsite briefings, legal personnel indicated to the RWTF that they are greatly understaffed.[162]

The Army, Navy, and Marine Corps provide legal counsel for both MEB and PEB.[163] The Air Force provides specific legal counsel only for PEB.[164] Air Force installation level legal counsel can address DES issues prior to PEB. However, the Air Force is the Service with the lowest satisfaction with legal counsel and the only Service whose IDES participants were not more satisfied than their legacy DES participants.[165] These survey results reinforce the importance of providing legal counsel for MEB as well as PEB.

Despite survey results demonstrating the value of having legal counsel available throughout the disability evaluation process, the majority of RWTF focus group participants lacked personal experience with, or knowledge of, these specialized legal resources. Additionally, the Services are not systematically capturing the metrics necessary to justify resource requirements or shape improvements.[166]

RECOMMENDATION 20

Pending the implementation of a common electronic health record (EHR), find interim solutions to grant access to EHR for disability assessment. Achieve information technology interoperability between DoD, VA, and disparate civilian medical information systems. These record systems include electronic, paper, and other legacy medical information systems.

Finding: The IPO exists to expedite the exchange of health care information between DoD and VA. Other policy shifts and initiatives have further advanced the goals of interoperable

EHR, and the IPO remains accountable for DoD and VA collaboration on health information exchange.

Despite movement toward interoperable EHR, the disability assessment process still requires that one or more paper copies be made of the RW's comprehensive health records.[167] This copying process is very costly in terms of the man-hours and paper involved. Accessing hard copies of health records can be particularly challenging for RC members who are assigned to transition units but must obtain some of their health records from the home unit.[168]

DoD and VA continue to pursue advancements in EHR sharing. DoD is developing two new solutions to align information technology systems. One is targeted at MTF management of their cases, and the other would integrate the Services' case tracking systems and the Veterans Tracking Application to reduce multiple data entry.[169] VA reports specific efforts under way to improve the interoperability of the Veterans Health Information System and Technology Architecture (VistA) and the Armed Forces Health Longitudinal Technology Application (AHLTA) such as Single Sign On, laboratory and radiology portability, and the joint registration capability.[170]

The IPO continues to work toward the goal of full image sharing by early 2012. Initial efforts to scan documents have been successful, but it was reported that a significant percentage of records are generated and maintained in the civilian health care system, which requires an aggressive effort to scan, store, and mine those records.[171] The ability to mine scanned documents for data is essential to both care and research.

RECOMMENDATION 21

Consolidate the SOC functions into the Joint Executive Council (JEC). The JEC will be co-chaired by the Deputy Secretaries of DoD and VA. Congressional action is required to establish the Deputy Secretaries as Co-Chairs of the JEC.

Finding: The SOC was formed in 2007 to bring DoD and VA to the same table to address RW issues following the discovery and publicizing of substandard facilities and case management at Walter Reed Army Medical Center.[172] Over the last four years, the SOC has taken on a variety of topics, from the redesign of the DES to the RCP and many others. The SOC initially was envisioned as relatively short in duration. The JEC was created by congressional action in 2004 to increase resource sharing between VA and DoD.[173] While the SOC focuses on issues affecting RWs, the JEC more broadly addresses issues facing all military members.

There is general agreement that a standing/ongoing joint DoD/VA coordinating body is needed to ensure that Service members and veterans are receiving care and services in a seamless manner.[174] The SOC was an effective mechanism for sharing information between DoD and VA and for identifying obstacles and opportunities for coordination. However, the current role of the SOC is not well-defined.[175] It is not always clear how strategies are identified and handed off for tactical implementation, and there are questions about whether the SOC at this time is able to provide sustained attention at the highest levels to the issues facing RWs and to seek accountability across both departments.[176] There has been no formal mechanism for assessing

whether SOC initiatives and goals have been partially or formally implemented and met. The initial issues driving its formation have been reduced to action items that no longer reach the "strategic" level of senior leadership. Other issues that are "strategic" in nature fall within the purview of the JEC. Duplication of effort by the SOC and the JEC addressing similar issues is not cost-effective and can lead to unnecessary competition for resources and direction.

Consolidation of the two bodies would continue to engage the power residing in the offices of the Deputy Secretary of Defense and the Deputy Secretary of VA. Those issues that are confined strictly to the RW population would be addressed within an appropriate working group or team within the consolidated council.

Summary

The final section of this chapter offers suggestions for the appropriate agencies to address the RWTF recommendations. Promising practices also are highlighted.

SUGGESTED AGENCIES TO ADDRESS RWTF RECOMMENDATIONS

Recommendations	Congress	DoD	VA	Army	Navy	USMC	Air Force	RC
Overall Effectiveness of DoD Recovering Warrior Policies and Programs								
1		●	●					
2		●						
3		●	●	●	●	●	●	
4		●		●	●	●	●	
Restoring Wellness and Function								
5				●		●		
6				●		●		●
7		●	●	●	●			
8				●	●	●	●	●
9		●						
10		●	●	●	●	●	●	●
Restoring into Society								
11		●	●					
12				●	●	●	●	●
13		●		●	●	●	●	●
14		●	●	●	●	●	●	●
15		●						
16				●				
Optimizing Ability								
17		●						
18	●	●	●	●	●	●	●	●
Enabling a Better Future								
19		●		●	●	●	●	
20		●	●					
21	●	●	●					

BEST PRACTICES

Best practices identified by the RWTF during Year One are listed below, by topic. For purposes of this report, the RWTF defines best practices inclusively—as models, innovations, and initiatives that are believed to promote effective services for the RW community and that potentially could be replicated more broadly but that have not necessarily been vetted or validated. In this regard, some of these practices might more aptly be described as "promising" rather than "best." The RWTF learned of these practices through Headquarters-level briefings as well as site visits and will explore some of them further over the coming year.

Units and Programs

At Fort Benning and Fort Campbell, command sergeants major of the Warrior Transition Battalions (WTBs) work with the command sergeants major of the line commands to identify Soldiers who may be good candidates for Army cadre positions within the WTUs.[177]

USSOCOM Care Coalition attaches most Special Operations Soldiers and Marines to the transition unit for medical care only. Thus, the Recovering Special Operator remains under the command and control of the operational unit but has access to a primary care manager and nurse case manager through the transition unit. USSOCOM accomplishes this arrangement through a memorandum of agreement with Medical Command (MEDCOM).[178]

Fort Campbell established a motivational program for RWs called HOOAH (Healing Outside of a Hospital).[179]

Fort Benning closed the road in their warrior transition battalion area to make the campus pedestrian friendly.[180]

The Air Force opened an Air Force Warrior and Family Operations Center May 2011 at Randolph Air Force Base. This 7,000-square-foot facility houses the Air Force Wounded Warrior Program (along with generic services such as Airman and Family Readiness, Retiree Services, and Sexual Assault Prevention and Response).[181]

The Marine Corps WWR will open Hope and Care Centers, with the Camp Pendleton center opening summer 2011. The Regimental Commander sometimes refers to these centers as "extreme fitness facilities."[182]

At one CBWTU, Regional PSGs are responsible for RWs who live within their geographic region, which increases the PSGs' opportunity to meet face-to-face with their RWs and their capacity to cultivate knowledge of local resources. One CBWTU also assigns female PSGs to female RWs. [183]

Medical Care Case Management

The Fort Campbell WTB developed an improved air evacuation triage guideline that has reduced unnecessary utilization of medical care case management resources by more than 20 percent, has improved the return to duty rate, and was recognized as a best practice on a recent MEDCOM IG

inspection. Based on injury severity, this triage screens and "sorts" Soldiers immediately upon redeployment or medical evacuation, keeping mildly injured with the line unit while sending complex cases to the WTU. Previously, many Soldiers not needing the WTU were sent there by default.[184]

At Balboa, the Naval Medical Center San Diego (NMCSD) is seeking certification from the Commission on Accreditation of Rehabilitation Facilities (CARF).[185] This effort drives comprehensive data collection and establishes a standard for measuring and tracking progress and outcomes.

In response to a need to enhance amputee care, NMCSD developed the Comprehensive Combat and Complex Casualty Care (C5) Program for severely wounded, ill, or injured patients. It includes trauma care; orthopedic care; amputee care; physical, occupational, and recreational therapy; mental health assessments and care; TBI care; pastoral care and counseling; family support; and career transition services.[186]

Several sites and Services co-locate providers. At Balboa NMCSD, the Army, Navy, and Marine Corps each clusters its services in the same building, if not on the same floor, in order to provide Soldiers, Sailors, and Marines a "one-stop shop." This is convenient for customers and greatly improves communication among service providers.[187] The California CBWTU noted that co-locating nurse case managers and platoon sergeants not only improves their communication with one another but increases their accessibility to RWs.[188] The Army identified placing a dedicated pharmacist with each WTU as a best practice during an initial review of commendable practices by the Army Organizational Inspection Program (OIP).[189] The Army also noted that co-locating VA Military Services Coordinators (MSCs) and Army Outreach Counselors with the Army PEBLOs greatly improves process workflow and communications between VA and DoD.[190]

Defense Centers of Excellence

The DCoE PH & TBI facilitated the development of DoD/VA clinical practice guidelines for treating moderate to severe TBI via a 2009 consensus conference. Sites frequently noted the clinical practice guidelines and meta-analyses as a basis for standardizing TBI care.[191]

The Center for Deployment Psychology (CDP), a component center of the DCoE PH & TBI, collaborated on development of the October 2010 *VA/DoD Clinical Practice Guidelines for Management of Post-traumatic Stress*. Sites mentioned the resulting practice guidelines and treatment modalities as important resources.[192] The DCoE PH & TBI is facilitating companion VA/DoD clinical support tools for PTSD.

Services for Traumatic Brain Injury and Posttraumatic Stress Disorder

In order to enhance the return to duty validation process, Fort Campbell utilizes a military-specific field exercise for Soldiers exiting treatment. Fort Campbell operationally defines the return to duty standard as "demonstrated competence" at these field tasks, which is a higher standard than "medically acceptable." The field tasks involve Soldiers using familiar equipment and demonstrating success in a controlled, exposure therapy environment, including first aid tasks, chemical drills, combat driving, map reading, "shoot versus don't shoot" scenarios, and land navigation.[193] Fort Campbell's return to duty validation process helps to ensure RWs are mission-ready before being

sent downrange again. (The exposure therapy component of this program reports a return to duty rate of 80 percent.)

Balboa's NMCSD has an inpatient PTSD program called Overcoming Adversity and Stress Injury Support (OASIS). OASIS serves Active Duty Service members with combat-related PTSD who have not experienced improvements in their condition through outpatient care.[194]

NMCSD and Fort Campbell both offer Intensive Outpatient Programs (IOPs). The NMCSD program serves Active Duty Service members with combat-related PTSD diagnosis/symptoms that impair functioning and/or create distress.[195] The IOP at Fort Campbell serves a similar population; it provides treatment for multiple diagnoses sharing the common denominator of a combat-related traumatic event resulting in difficulties with daily functioning.[196]

The Battlemind Clinic at Fort Benning provides an outpatient resource for RWs facing posttraumatic stress symptoms, which allows them to receive services without the stigma associated with going to a hospital.[197]

The California National Guard utilizes the Peer-to-Peer program. As a "first line" approach to dealing with stress, the goal is to provide Service members "…the opportunity to receive emotional and tangible peer support through times of personal or professional crises and to help anticipate and address potential difficulties."[198]

Non Medical Case Management

Several programs devised staffing models that front-load human resource allocations for the initial and acute phases of the recovery process. Navy Safe Harbor developed a process for balancing caseloads based on where Service members are in the care trajectory. This system assumes that the NMCM workload will be higher for new patients.[199] Brooke Army Medical Center (BAMC) assists in managing family caregiver needs during the inpatient stage by assigning a nurse case manager to serve as each family's initial point of contact and information source. BAMC has three nurse case managers who function in this capacity.[200] The USSOCOM non medical case management program, Care Coalition, uses two types of NMCMs—liaisons for newly identified RWs (1:10) and advocates for sustained support (1:300).[201]

Navy Safe Harbor established a Reserve Surge Support Team. This is a scalable rapid response of additional manpower to support NMCMs as needed. This team comprises 17 trained Reserve NMCMs who can mobilize within 72 hours.[202]

Navy Safe Harbor holds an annual awards ceremony, including an "NMCM of the Year" award.[203] BAMC presents "care and companion awards" to deserving transition unit staff.[204] These are two examples of efforts to recognize and promote excellence in non medical case management.

The WWR uses a Rapid Action Poll (RAP) as a tool for WWR leadership to quickly yet accurately pulse Recovering Marine and family caregiver opinion on specific issues. One of the outreach capabilities of the Marine Corps' Sergeant Merlin German Wounded Warrior Call

Center, this tool helps the WWR to proactively identify needs and challenges within the Recovering Marine community.[205]

Information Resources

The Keeping It All Together binder from Military OneSource consolidates information across a range of websites, hotlines, and programs. It is a valuable tool for family members, filling a need identified in other studies.[206] The Marine Corps routinely distributes Keeping It All Together to families.[207]

WWCTP is committed to investing in the NRD and reported that the use of the website is growing.[208] A recent advance in this area is the expansion of the NRD to a mobile version.[209]

Support for Family Caregivers

The Army Warrior Transition Command represents a collaboration of the Army MEDCOM and the Army Installation Command.[210] One of the products of this collaboration is the SFAC, which offers a wide slate of services (see Recommendation 16).[211] Among the Army's 32 SFACs are six state-of-the-art facilities (new construction) that are situated in RW campus settings. Twelve more such facilities are under construction or in the planning stages. [212]

In order to support NMAs, BAMC holds a monthly NMA forum (i.e., town hall meeting) to identify and address NMA concerns. Additionally, NMA coordinators initiate and prepare NMA orders in Defense Travel Services (DTS), process and distribute NMA orders, prepare NMA travel vouchers, and help with DTS issues.[213]

All Safe Harbor couples/families are eligible to participate in FOCUS, a resiliency building program. FOCUS was developed at the University of California Los Angeles Semel Institute for Neuroscience and Human Behavior in collaboration with National Child Traumatic Stress Network and Children's Hospital Boston/Harvard Medical School, and it was adapted to address needs of RWs and their families.[214] As of 2010, FOCUS was offered at 18 installations, including 10 Marine Corps installations and eight Navy installations, and the Army and Air Force were running pilot programs.[215]

29 Palms instituted new policy that requires Marines to provide family member contact information unless they can provide a good reason not to and that reason must be approved by the chain of command.[216]

Utilization of video teleconferencing for RWs and family members can facilitate continuity of care during transfers from one location to another. For example, a family caregiver participated in a video-teleconference with providers at the new care location while the caregiver and RW were still at National Naval Medical Center in Bethesda, Maryland.[217]

Transition Assistance Program

Two Services regulate TAP attendance: the Marine Corps requires all Marines to attend, while the Army requires all RWs assigned to a WTU to attend.[218]

Fort Campbell encourages Soldiers to return for repeat TAP briefings closer to when they are scheduled to leave the military. This practice acknowledges the denial about leaving that can be characteristic earlier in the transition process, which inhibits the RW's interest in planning. By also sending RWs to "just in time" TAP briefings closer to their departure, they should be more ready to internalize and use the information provided. (In the Army, TAP is known as the Army Career and Alumni Program, or ACAP.)[219]

Vocational Services

Balboa Navy makes good use of VA's Coming Home to Work Program. This nonpaid work experience that RWs can obtain while in a medical hold/rehabilitation status is a part of the VA's VR&E Service. It allows VR&E-eligible Service members to gain civilian skills and work experience in federal agencies, and it affords federal agencies an opportunity to review and recruit some very talented job candidates before hiring them as full-time civilian employees. A distinguishing feature of Coming Home to Work is the extensiveness of the assessment of the RW's capabilities, which in turn facilitates optimal placements. The Balboa Navy program serves more than 600 people per year, currently has approximately 100 active cases, and places Service members in 25 different federal agencies. The program works in close collaboration with other local Navy RW resources, such as the C5 and OASIS programs.[220]

Disability Evaluation System

The Army MEB Outreach (MEBOC) program was formed to introduce legal support earlier in the disability evaluation process. The Army has 24 two-person attorney/paraprofessional teams assigned to Army locations with battalion-sized or larger WTUs. The MEBOC teams educate and counsel RWs one-on-one before and during the MEB. According to the Army, the MEBOC teams also conduct regular outreach briefings at WTUs, SFACs, and town hall meetings.[221]

The Army MEBOC program promotes MEBOC team success through an annual national certification training event, monthly teleconferences conducted by the National Coordinating Counsel at Army MEDCOM, and regional conference calls conducted monthly with MEBOC offices and Offices of Soldiers Counsel. (The Offices of Soldiers Counsel pre-date the MEBOC program and provide legal support for the PEB only.) [222]

The Marine Corps WWR created an IDES Pocket Guide in order to educate RW Marines and families.[223]

Senior Oversight Committee

The SOC regularly convenes senior leadership from DoD and VA around issues central to providing a seamless transition from one department to the other.[224]

Planned Activities in 2011/2012

CHAPTER 3

The Recovering Warrior Task Force (RWTF) is chartered for five years, from 2010 through 2014, to assess the effectiveness of DoD programs and policies for Recovering Warriors (RWs).[225] Each year, the RWTF is charged with examining more than a dozen RW matters specified in the founding legislation.[226] The methods that the RWTF established in Year One, and the results that these methods yielded, will serve as a foundation for the activities in upcoming years. As required by the legislation, this chapter highlights major activities planned for the RWTF's second year of operations. These plans encompass decisions about how the RWTF will gather the information—that is, methodology—and what kinds of information, or content, the RWTF will seek.

2011/2012 Methodology

In its inaugural year, the RWTF employed a variety of methods to gather information from diverse sources. Briefings by Headquarters-level proponents and other stakeholders during RWTF business meetings; Headquarters-level data calls; key informant interviews; reviews of major reports, congressional testimony, and peer-reviewed journal articles; site-level briefings; and focus groups formed the core of the RWTF's data collection efforts. See Appendix E for further detail regarding the RWTF's Year One methodology. The RWTF will continue this rich mix of data collection methods in Year Two.

The RWTF will continue to hold bimonthly business meetings, solicit briefings by select proponents, and invite public comment. Examples of proponents from whom the RWTF has not yet heard include Reserve Affairs (RA), Military Community and Family Policy (MC&FP), the National Military Family Association (NMFA), and several offices of the Department of Veterans Affairs (VA). Some proponents who briefed the RWTF last year will be asked to return for a more focused presentation and discussion. To increase the visibility of the RWTF and the accessibility of the business meetings, the RWTF will hold at least one meeting outside the Washington, DC, area (most likely in San Antonio, Texas). The RWTF will continue to monitor congressional testimony, the release of relevant reports by federal and other agencies, and the academic literature. Additionally, through data calls the RWTF will solicit updates from the Services and DoD for metrics gathered during the first year.

In recognition of the invaluable role of site visits in assessing the ground-level implementation of RW programs and policies, particularly from the end-user perspective, the RWTF plans a total of 14 site visits in 2011/2012. Among these sites will be visits to the following:

- Two Joint Force Headquarters (JFHQs) and two Community Based Warrior Transition Units (CBWTUs), each for a two-day period, to further understanding of Reserve Component (RC) issues
- Camp Lejeune, headquarters of Marine Corps Wounded Warrior Battalion-East (the RWTF visited Wounded Warrior Battalion West entities in 2010/2011)
- 29 Palms, to assess progress made in areas of concern identified in 2010/2011

- Joint Base San Antonio, to gather further information about Air Force RW programs and the Army Medical Department's cadre training program
- Landstuhl Regional Medical Center, to which RW Service members are medically evacuated from Iraq and Afghanistan for stabilization, and other RW programs in the vicinity.

To augment RTWF focus group results and available Service-level survey results, the RWTF is pursuing DoD-level survey options in collaboration with the Defense Manpower Data Center (DMDC). Large-scale surveys can sample a larger and more representative slice of the RW community than can focus groups and can give a greater voice to subpopulations such as remotely located personnel and family caregivers. Specifically, the RWTF will employ the DMDC QuickCompass tool (a short turnaround survey that likely will be administered to the census of RWs and family caregivers for whom viable e-mail addresses are available) and/or submit questions for incorporation into the recurring DMDC Status of Forces Surveys (SOFS) (which are administered to a sample of the total force).

2011/2012 Content

In Year Two, the RWTF will again address all RW matters outlined in the legislation, as noted. The RWTF will take particular interest in the implementation of direct services to the RW community (e.g., non medical case management, vocational services, dissemination of information resources, and legal and other support during the Disability Evaluation System (DES) process). They will scrutinize, for example, the fidelity of these services to DoD and Service-level vision and guidance; the RW community's awareness of, access to, and satisfaction with these services; and the parity of service quality and scope across sites and Services. As they assess the services available to RWs and family caregivers, the RWTF will be vigilant in identifying gaps, as well as duplications, in the support system as a whole.

Additionally, the RWTF will delve more deeply into certain matters, based on the findings from the first year of effort. Examples of such matters may include:

- The training of transition unit staff, with attention to the parity of Army and Marine Corps programs of instruction (POIs)
- The parity of Recovery Care Coordinator (RCC) resources and processes across the Services and the contractual vehicles through which RCCs are hired and managed
- The practices of the Care Coalition, the non medical case management program of the U.S. Special Operations Command (USSOCOM), and the high return to duty rate among USSOCOM RWs
- The Education and Employment Initiative (E2I) and Operation Warfighter, two opportunities to engage RWs early in the recovery process and match skills to career-enhancing opportunities while Service members are still on Active Duty, and the availability of these opportunities to RWs in locations with fewer federal employment opportunities
- The adequacy of RW programs and policies for RC and family caregivers, including psychological health resources
- The tracking of, and support provided to, RC RWs assigned to line units

- Opportunities to standardize RW care through existing accreditation and certification, such as the accreditation available through the Commission on Accreditation of Rehabilitation Facilities (CARF)[227]
- The availability and adequacy of family assistance centers or similar services for Navy, Air Force, and Marine Corps RWs and families
- The role of VA in supporting the needs of RWs and family caregivers pre-DD214
- The relationship of recruiting standards to RW resilience
- Further detail regarding select best practices identified during Year One.

Through data calls to the Services, the DoD TRICARE Management Activity (TMA), and the DoD Office of Wounded Warrior Care and Transition Policy (WWCTP), the RWTF will obtain Year Two updates on key metrics related to the composition of the transition units, non medical case management staffing, and customer satisfaction. In addition to tracking specific metrics, the RWTF intends to monitor areas such as:

- RW return to duty rates
- Interagency Program Office (IPO) compliance with U.S. Government Accountability Office (GAO) recommendations
- The scheduled worldwide implementation of the Integrated Disability Evaluation System (IDES)
- The actionable results of the DoD Wounded Warrior Care Coordination Summit.

The RWTF will continue to identify emerging and best practices with the intent that these can be promulgated across DoD.

Notes

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

[2] President's Commission on Care for America's Returning Wounded Warriors. (July 2007). *Serve, support, simplify*. Washington, DC: President's Commission on Care for America's Returning Warriors.

[3] Air Force response to the RWTF data call: Medical Care Case Management. July 1, 2011; Air Force response to the RWTF data call: Non Medical Case Management. July 12, 2011; Army WTC response to the RWTF data call. July 1, 2011; Federal Recovery Coordination Program response to the RWTF data call. April 5, 2011; Marine Corps Wounded Warrior Regiment response to the RWTF data call. July 8, 2011; Navy response to the RWTF data call: Medical Care Case Management. April 11, 2011; Navy response to the RWTF data call: Non Medical Case Management. April 8, 2011.

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

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

[6] DoD, DMDC. (July 2010). *December 2009 Status of Forces Survey of Reserve Component Members*. DMDC Report No. 2010-002; DoD, DMDC. (April 2011). *June 2010 Status of Forces Survey of Active Duty Members*. DMDC Report No. 2011-001.

[7] Wounded Warrior Care & Transition Policy (WWCTP). (September 30, 2010). *WII RCC NMCM Study Report*. Washington, DC: Author.

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

[9] Air Force Warrior and Survivor Care briefing to the RWTF. February 23, 2011; Army WTC briefing to the RWTF. February 22, 2011; Col Mayer, J.L. Briefing to the RWTF. *U.S. Marine Corps Wounded Warrior Regiment*. March 30, 2011; Navy Safe Harbor briefing to the RWTF. March 31, 2011.

[10] Air Force Warrior and Survivor Care briefing to the RWTF. February 23, 2011; Army WTC briefing to the RWTF. February 22, 2011; Col Mayer, J.L. Briefing to the RWTF. *U.S. Marine Corps Wounded Warrior Regiment*. March 30, 2011; Navy Safe Harbor briefing to the RWTF. March 31, 2011; Headquarters Department of Army (HQDA) Fragmentary Order (FRAGO) 4 to Executive Order (EXORD) 118-07. *Healing Warriors*. May 19, 2009; Wounded Warrior Regiment Order (WWRO) 6300.1. *Acceptance of Wounded, Ill and Injured Personnel to the Wounded Warrior* Regiment. October 14, 2010.

[11] Army WTC briefing to the RWTF. February 22, 2011; Col Mayer, J.L. Briefing to the RWTF. *U.S. Marine Corps Wounded Warrior Regiment*. March 30, 2011.

[12] Site-level briefings to the RWTF. March/April 2011; RWTF Service member focus group results. March/April 2011.

[13] NDAA for FY2008, Pub. L. No. 110-181, §1602 (2008). Serious injury or illness is defined as "an injury or illness incurred by the member in line of duty on Active Duty in the Armed Forces that

may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating," p. 122, §1602, subsection 8.

[14] Dunne, P.W., and Dominguez, M.I. (December 10, 2008). VA and DoD Co-Chairs, Wounded, Ill and Injured OIPT. *Memorandum for Secretaries of the Military Departments, VA Undersecretaries for Health and for Benefits, Chairman of the Joint Chiefs of Staff, and DoD General Counsel. Implementation of Wounded, Ill and Injured-Related Standard Definitions*.

[15] U.S. Army Office of the Inspector General Agency (USAIG). (September 22, 2010). *Inspection of the Warrior Care and Transition Program, Department of the Army*. Washington, DC: Author.

[16] RWTF family member focus group results. March/April 2011; RWTF Service member focus group results. March/April 2011.

[17] Site-level briefings to the RWTF. March/April 2011; RWTF Service member focus group results. March/April 2011.

[18] RWTF family member focus group results. March/April 2011; RWTF Service member focus group results. March/April 2011.

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

[65] Kilpatrick, M.E., Helmick, K.M., and Col Robinson, C. Briefing to the RWTF. January 7, 2011.

[66] COL Gagliano, D.A. Briefing to the RWTF. *Traumatic Extremity Injuries and Amputation Center of Excellence.* May 18, 2011; COL Gagliano, D.A., and Lawrence, M.G. Briefing to the RWTF. *Vision Center of Excellence.* May 18, 2011; Col Gates, K. Briefing to the RWTF. *Hearing Center of Excellence.* May 18, 2011.

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[78] RWTF Service member mini-survey results. March/April 2011.

[79] RWTF family member focus group results. March/April 2011; RWTF Service member focus group results. March/April 2011.

[80] Air Force Warrior and Survivor Care briefing to the RWTF. February 23, 2011; Army WTC briefing to the RWTF. February 22, 2011; Campbell, J.R., and Carrington, R. WWCTP Briefing to the RWTF. May 18, 2011; LTC Deary, K. Briefing to the RWTF. *USSOCOM Care Coalition.* May 19, 2011; Guice, K. Briefing to the RWTF. *2010 Federal Recovery Coordination Program Survey Results*. May 18, 2011; Col Mayer, J.L. Briefing to the RWTF. *U.S. Marine Corps Wounded Warrior Regiment*. March 30, 2011; Navy Safe Harbor briefing to the RWTF. March 31, 2011.

[81] Campbell, J.R. and Carrington, R. Briefing to the RWTF. May 18, 2011; Air Force Warrior and Survivor Care briefing to the RWTF. February 23, 2011; Navy Safe Harbor briefing to the RWTF. March 31, 2011.

[82] Army WTC briefing to the RWTF. February 22, 2011. Army Wounded Warrior Advocates (RCC equivalents) are available only to RWs with a disability rating of 30% for any single injury since 9/11 or a combined rating of 50%.

[83] Air Force Warrior and Survivor Care briefing to the RWTF. February 23, 2011. The Air Force specified eligibility for an AFW2 Advocate as "combat-related injured/ill (slide 14)."

[84] Maj Wyatt, M., Warrior and Survivor Care, personal communication, August 11, 2011. Maj Wyatt specified eligibility for an AFW2 Advocate as "injured in combat and identified as going through the MEB/PEB process."

[85] Air Force Warrior and Survivor Care briefing to the RWTF. February 23, 2011.

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[91] Army WTC response to the RWTF data call. July 1, 2011.

[92] Marine Corps Wounded Warrior Regiment response to the RWTF data call. May 2, 2011.

[93] Army WTC response to the RWTF data call. July 1, 2011; Marine Corps Wounded Warrior Regiment response to the RWTF data call. May 2, 2011.

[94] Army WTC response to the RWTF data call. July 1, 2011.

[95] RWTF Service member focus group results. March/April 2011; RWTF family member focus group results. March/April 2011; Site-level briefings to the RWTF. March/April 2011.

[96] RWTF Service member mini-survey results. March/April 2011.

[97] RWTF Service member focus group results. March/April 2011; Horan, P. CounterPoint presentation to the RWTF. *Personal experiences of the spouse of a Recovering Warrior*. May 19, 2011.

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[106] RWTF family member mini-survey results. March/April 2011; RWTF Service member mini-survey results. March/April 2011.

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[132] Army Family and Morale, Welfare and Recreation Command (Family Programs, Wounded & Fallen Division) briefing to the RWTF. *Soldier & Family Assistance Center.* February 22, 2011; LTC Pasek, G., U.S. Army WTC, personal communication, July 6, 2011.

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[139] Campbell, J.R. WWCTP Briefing to the RWTF. May 18, 2011.

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[155] Site-level briefings to the RWTF. March/April 2011. Some Services limit assistance to the PEB phase, while others offer assistance during the MEB phase as well. Some site-level providers noted that being able to assist in the MEB would help them better serve RWs. One site reported a 1:86 caseload; if TDRLs are excluded, caseload drops to 1:46.

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Outreach Counsel, Walter Reed Army Medical Center, personal communication, October, 19 2010; WWCTP (May 23, 2011). *IDES monthly report for May 2011*. Washington, DC: Author.

[161]LtCol Faerber, P., Disability Evaluation System Advisor/Wounded Warrior Attorney, personal communication, November 5, 2010; WWCTP (May 23, 2011). *IDES monthly report for May 2011*. Washington, DC: Author; CDR Moores, E., Wounded Warrior Disability Attorney/Navy Regional PEB Advice and Assistance Counsel, Naval Legal Service Office North Central, personal communication, November 2, 2010; CDR O'Neil, R., Director, Legal Assistance Policy Division, Office of the Judge Advocate General, U.S. Navy, personal communication, November 5, 2010; Becker, R., Chief Disability Counsel, Formal Physical Evaluation Board, personal communication, November 5, 2010. In November 2010 personal communications, the Services reported the following legal resources dedicated to MEB support: The Marine Corps had 4 attorneys for Wounded Warrior Battalions East and West, which included approximately 2,300 RWs; the Navy had 10 attorneys for approximately 1,600 RWs; and the Air Force had 4 attorneys for approximately 800 RWs. The RWTF estimated the size of each Service's DES population based on a chart included in the following report: WWCTP. (May 23, 2011). *IDES monthly report for May 2011*. Washington, DC: Author.

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[164] Becker, R., Chief Disability Counsel, Formal Physical Evaluation Board, personal communication, November 5, 2010.

[165] WWCTP. (March 15, 2011). *Integrated disability evaluation system (IDES) program: Report prepared for the Recovering Warrior Task Force.* Washington, DC: Author. Survey question: "How well did your legal counsel represent you during the DES process?"

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

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[174] Office of the Deputy Secretary, Veterans Affairs. *Senior Oversight Committee: Interview with the RWTF.* May 31, 2011; Office of the Joint Staff Surgeon, Joint Chiefs of Staff. *Senior Oversight Committee: Interview with the RWTF.* May 23, 2011; Office of the Assistant Secretary of the Navy, Manpower & Reserve Affairs. *Senior Oversight Committee: Interview with the RWTF.* June 8, 2011; Office of the Assistant Secretary of the Air Force, Manpower & Reserve Affairs. *Senior Oversight Committee: Interview with the RWTF.* June 6, 2011; *Military associations' legislative priorities: Hearing before the Subcommittee on Military Personnel, House Committee on Armed Services,* 111th Cong. (March 23, 2010) (prepared statement of Col Steven P. Strobridge, USAF (Ret.), Director, Government Relations, Military Officers Association of America, and Co-chairman, The Military Coalition).

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

[178] LTC Deary, K. Briefing to the RWTF. *USSOCOM Care Coalition.* May 19, 2011.

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

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APPENDIX A: LEGISLATION

111 P.L. 84, *; 123 Stat. 2190; 2009 Enacted H.R. 2647

[*724] Sec. 724. Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces.

(a) Establishment.--

(1) In general.-- The Secretary of Defense shall establish within the Department of Defense a task force to be known as the "Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces" (in this section referred to as the "Task Force").

(2) Purpose.-- The purpose of the Task Force shall be to assess the effectiveness of the policies and programs developed and implemented by the Department of Defense, and by each of the military departments, to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces, and to make recommendations for the continuous improvement of such policies and programs.

(3) Relation to senior oversight committee.-- The Secretary shall ensure that the Task Force is independent of the Senior Oversight Committee (as defined in section 726(c) of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110-417; 122 Stat. 4509)).

(b) Composition.--

(1) Members.-- The Task Force shall consist of not more than 14 members, appointed by the Secretary of Defense from among the individuals as described in paragraph (2).

(2) Covered individuals.-- The individuals appointed to the Task Force shall include the following:

(A) At least one member of each of the regular components of the Army, the Navy, the Air Force, and the Marine Corps.

(B) One member of the National Guard.

(C) One member of a reserve component of the Armed Forces other than National Guard.

(D) A number of persons from outside the Department of Defense equal to the total number of personnel from within the Department of Defense (whether members of the Armed Forces or civilian personnel) who are appointed to the Task Force.

(E) Persons who have experience in--

(i) medical care and coordination for wounded, ill, and injured members of the Armed Forces;

(ii) medical case management;

(iii) non-medical case management;

(iv) the disability evaluation process for members of the Armed Forces;

(v) veterans benefits;

(vi) treatment of traumatic brain injury and post-traumatic stress disorder;

(vii) family support;

(viii) medical research;

(ix) vocational rehabilitation; or

(x) disability benefits.

(F) At least one family member of a wounded, ill, or injured member of the Armed Forces or veteran who has experience working with wounded, ill, and injured members of the Armed Forces or their families.

(3) Individuals appointed from within department of defense.-- At least one of the individuals appointed to the Task Force from within the Department of Defense shall be the surgeon general of an Armed Force.

(4) Individuals appointed from outside department of defense.-- The individuals appointed to the Task Force from outside the Department of Defense--

(A) with the concurrence of the Secretary of Veterans Affairs, shall include an officer or employee of the Department of Veterans Affairs; and

(B) may include individuals from other departments or agencies of the Federal Government, from State and local agencies, or from the private sector.

(5) Deadline for appointments.-- All original appointments to the Task Force shall be made not later than 120 days after the date of the enactment of this Act.

(6) Co-chairs.-- There shall be two co-chairs of the Task Force. One of the co-chairs shall be designated by the Secretary of Defense at the time of appointment from among the individuals appointed to the Task Force from within the Department of Defense. The other co-chair shall be selected from among the individuals appointed from outside the Department of Defense by those individuals.

(c) Annual Report.--

(1) In general.-- Not later than 12 months after the date on which all members of the Task Force have been appointed, and each year thereafter for the life of the Task Force, the Task Force shall submit to the Secretary of Defense a report on the activities of the Task Force and the activities of the Department of Defense and the military departments to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces. The report shall include the following:

(A) The findings and conclusions of the Task Force as a result of its assessment of the effectiveness of the policies and programs developed and implemented by the Department of Defense, and by each of the military departments, to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces.

(B) A description of best practices and various ways in which the Department of Defense and the military departments could more effectively address matters relating to the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces, including members of the regular components, and members of the reserve components, and support for their families.

(C) A plan for the activities of the Task Force in the year following the year covered by the report.

(D) Such recommendations for other legislative or administrative action as the Task Force considers appropriate for measures to improve the policies and programs described in subparagraph (A).

(2) Methodology.-- For purposes of the reports, the Task Force--

(A) shall conduct site visits and interviews as the Task Force considers appropriate;

(B) may consider the findings and recommendations of previous reviews and evaluations of the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces; and

(C) may use such other means for directly obtaining information relating to the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces as the Task Force considers appropriate.

(3) Matters to be reviewed and assessed.-- For purposes of the reports, the Task Force shall review and assess the following:

(A) Case management, including the numbers and types of medical and non-medical case managers (including Federal Recovery Coordinators, Recovery Care Coordinators, National Guard or Reserve case managers, and other case managers) assigned to recovering wounded, ill, and injured members of the Armed Forces, the training provided such case mangers, and the effectiveness of such case mangers in providing care and support to recovering wounded, ill, and injured members of the Armed Forces.

(B) Staffing of Army Warrior Transition Units, Marine Corps Wounded Warrior Regiments, Navy and Air Force Medical Hold or Medical Holdover Units, and other service-related programs or units for recovering wounded, ill, and injured members of the Armed Forces, including the use of applicable hiring authorities to ensure the proper staffing of such programs and units.

(C) The establishment and effectiveness of performance and accountability standards for warrior transition units and programs.

(D) The availability of services for traumatic brain injury and post traumatic stress disorder.

(E) The establishment and effectiveness of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, and the centers of excellence for military eye injuries, hearing loss and auditory system injuries, and traumatic extremity injuries and amputations.

(F) The effectiveness of the Interagency Program Office in achieving fully interoperable electronic health records by September 30, 2009, in accordance with section 1635 of the Wounded Warrior Act (title XVI of Public Law 110-181; 122 Stat. 460; 10 U.S.C. 1071 note).

(G) The effectiveness of wounded warrior information resources, including the Wounded Warrior Resource Center, the National Resource Directory, Military OneSource, Family Assistance Centers, and Service hotlines, in providing meaningful information for recovering wounded, ill, and injured members of the Armed Forces.

(H) The support available to family caregivers of recovering wounded, ill, and injured members of the Armed Forces.

(I) The legal support available to recovering wounded, ill, and injured members of the Armed Forces and their families.

(J) The availability of vocational training for recovering wounded, ill, and injured members of the Armed Forces seeking to transition to civilian life.

(K) The effectiveness of any measures under pilot programs to improve or enhance the military disability evaluation system.

(L) The support and assistance provided to recovering wounded, ill, and injured members of the Armed Forces as they progress through the military disability evaluation system.

(M) The support systems in place to ease the transition of recovering wounded, ill, and injured members of the Armed Forces from the Department of Defense to the Department of Veterans Affairs.

(N) Interagency matters affecting recovering wounded, ill, and injured members of the Armed Forces in their transition to civilian life.

(O) The effectiveness of the Senior Oversight Committee in facilitating and overseeing collaboration between the Department of Defense and the Department of Veterans Affairs on matters relating to the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces.

(P) Overall coordination between the Department of Defense and the Department of Veterans Affairs on the matters specified in this paragraph.

(Q) Such other matters as the Task Force considers appropriate in connection with the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces.

(4) Transmittal.-- Not later than 90 days after receipt of a report required by paragraph (1), the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives the report and the Secretary's evaluation of the report.

(d) Plan Required.--Not later than six months after the receipt of a report under subsection (c), the Secretary of Defense shall, in consultation with the Secretaries of the military departments, submit to the Committees on Armed Services of the Senate and the House of Representatives a plan to implement the recommendations of the Task Force included in the report.

(e) Administrative Matters.--

(1) Compensation.-- Each member of the Task Force who is a member of the Armed Forces or a civilian officer or employee of the United States shall serve on the Task Force without compensation (other than compensation to which entitled as a member of the Armed Forces or an officer or employee of the United States, as the case may be). Other members of the Task Force shall be appointed in accordance with, and subject to, the provisions of section 3161 of title 5, United States Code.

(2) Oversight.-- The Under Secretary of Defense for Personnel and Readiness shall oversee the Task Force. The Washington Headquarters Services of the Department of Defense shall provide the Task Force with personnel, facilities, and other administrative support as necessary for the performance of the duties of the Task Force.

(3) Visits to military facilities.-- Any visit by the Task Force to a military installation or facility shall be undertaken through the Deputy Under Secretary of Defense for Personnel and Readiness, in coordination with the Secretaries of the military departments.

(f) Termination.--The Task Force shall terminate on the date that is five years after the date of the enactment of this Act.

APPENDIX B: MEMBER BIOGRAPHIES

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

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

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

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

Mrs. Suzanne Crockett-Jones

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

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

Commander Timothy A. Coakley, MD, Medical Corps
United States Navy

Commander (CDR) Timothy A. Coakley, MD, Medical Corps, U.S. Navy, has been deployed several times, during the course of which he was wounded by improvised explosive device blasts. He is recognized by U.S. and foreign government agencies as a subject matter expert for these types of injuries.

Born in Aurora, Illinois, he enlisted in the Navy in 1982 as a hospital corpsman. Initially stationed in Orlando and Jacksonville, Florida, in 1986 he transferred to the Reserves and completed his bachelor's degree in biology at the University of Northern Illinois in 1990. He then attended medical school at the Finch University of Health Sciences/The Chicago Medical School in 1991 after serving in Operations Desert Shield and Storm. He graduated with his commission in June 1995.

Following an internship in family practice, he attended undersea medical officer training in Groton, Connecticut, and then reported to Commander, Explosive Ordnance Disposal Group Two (COMEODGRU TWO). After being transferred to the Naval Medical Center Portsmouth's emergency medicine residency, he graduated as the chief resident and honor graduate in 2002. CDR Coakley stayed on as a staff physician in the emergency room and deployed as the Officer in Charge of Shock Trauma Platoon-1, 2nd Force Service Support Group, Camp Lejeune, North Carolina, to Iraq in support of OIF. He currently serves as the Deputy Force Surgeon assigned to the Navy Expeditionary Combat Command in Norfolk, Virginia. CDR Coakley is a diving medical officer and is the recipient of numerous military awards.

Justin Constantine, JD

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

Mr. Constantine left active duty in 2004, and worked for the U.S. Immigration and Customs Enforcement (ICE) for two years. As a Marine Reservist, he volunteered for deployment to Iraq in 2006 and served in the Al-Anbar Province as a Team Leader of a group of Marines performing civil affairs work while attached to an infantry battalion. While on a routine combat patrol six weeks into his deployment, Mr. Constantine was shot in the head by a sniper. Thanks to his fellow Marines and the courage and skill of a U.S. Navy Corpsman, he survived.

Upon recovering from his injuries, Mr. Constantine started a new job with the U.S. Department of Justice, working in their Office of Immigration Litigation, primarily writing appellate briefs defending the lower immigration court decisions. In November of 2008, Mr. Constantine was invited to serve as Counsel for the Senate Veterans' Affairs Committee. At the same time, Mr. Constantine and his wife Dahlia also started Iraq and Back, a small business which featured different apparel items they designed, honoring those who had deployed to Iraq and Afghanistan.

Most recently, Mr. Constantine started a new position with the FBI working on a counterterrorism team. He recently was an honor graduate of the Marine Corps Command and Staff College and aims to pursue a graduate degree in National Security Studies. As a Major in the Marine Corps Reserve, Major Constantine is the Reserve Staff Judge Advocate for Marine Forces South in Miami, Florida. Mr. Constantine currently serves on the Board of Directors of the Wounded Warrior Project, a nonprofit organization whose mission is to "honor and empower wounded warriors."

Mr. Constantine also enjoys public speaking opportunities, and over the last several years has spoken to numerous military, business and school groups about the value of a positive attitude, teamwork and community values in overcoming adversity. He has been featured in magazines and programs such as CNN, Men's Health, James Madison University's *Madison Magazine*, the Wounded Warrior Project's *After Action Report*, the Verizon FIOS Channel 1 magazine show "Push-Pause," the Department of Labor's America's Heroes at Work Success Stories and the Department of Defense's Office of Wounded Warrior Care and Transition Policy *Square Deal* magazine. Mr. Constantine is the recipient of numerous military and other awards.

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

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

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

Upon his return to theatre, then Sergeant First Class DeJong was assigned to the 38th Infantry Division G3 Operations, where he was the assistant operations Non-Commissioned Officer (NCO). He was promoted to first sergeant and assigned to C Company, 1/151st Infantry Battalion, as the company first sergeant. He and his company deployed in 2007 in support of OIF, 2007–2009, performing convoy security operations in northern Iraq. After returning from Iraq, CSM DeJong was assigned as the First Sergeant of Headquarters, Headquarters Troop 2/152 Reconnaissance and Surveillance Squadron.

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

Mr. Ronald Drach

A Vietnam veteran, Ronald Drach medically retired from the U.S. Army in 1967 after losing his leg in combat. He currently serves on the Board of Directors and is immediate past President of the Wounded Warrior Project (WWP), a nonprofit organization whose mission is to "honor and empower wounded warriors."

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

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

Major General Karl R. Horst, MPA
United States Army

Major General Karl R. Horst assumed duties as Chief of Staff U.S. Central Command (CENTCOM) on 18 July 2011. He reported to CENTCOM following a successful tour as the Commanding General of the U.S. Army Military District of Washington and Joint Force Headquarters National Capital Region on June 23, 2009.

MG Horst received his bachelor's degree and commission in the Infantry from the United States Military Academy in 1978, after enlisting in the Army June 22, 1973 and attending the United States Military Academy Preparatory School at Ft. Belvoir, VA. He started his career with the 3d Infantry Division in the Federal Republic of Germany, where he served as a platoon leader. He went on to company command in the 9th Infantry Division, Fort Lewis, WA. Later, MG Horst commanded both a battalion and a brigade in the 82d Airborne Division, Fort Bragg, NC. In July 2004, he became the 3d Infantry Division's Assistant Division Commander (Maneuver) and in September 2006, he assumed the duties as the Deputy Commanding General, XVIII Airborne Corps and Fort Bragg.

MG Horst's important staff assignments include an assignment on the Army staff as aide-de-camp to the Army Chief of Staff, and a joint and NATO assignment as special assistant to the Supreme Allied Commander, Europe. He served as the Chief of Staff, 82d Airborne Division; then as the Chief of Staff, XVIII Airborne Corps and Fort Bragg. In his last joint assignment, he served as the Director for Operations, Plans, Logistics and Engineering (J3/J4), United States Joint Forces Command, Norfolk, VA. MG Horst's military education includes the infantry officer basic and advanced courses, the Armed Forces Staff College, and the Army War College. His civilian study includes a master's degree in Public Administration from Shippensburg University of Pennsylvania. MG Horst is the recipient of numerous military awards.

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

Lieutenant Colonel (LtCol) Keane currently serves as the Marine Corps/Veterans Affairs Liaison Officer for Wounded Warrior issues and is co-located in VA offices to facilitate operations. LtCol Keane graduated from the University of Massachusetts with a degree in sports medicine in 1990. He was commissioned as a second lieutenant in January 1991 aboard the USS Constitution at the Old Boston Navy Yard. Upon completion of the Basic School, he attended the Adjutant's course at Camp Johnson, North Carolina, and reported to the 1st Radio Battalion, at Kaneohe Bay, Hawaii, for duty as the Battalion Adjutant. He was promoted to first lieutenant in January 1993 and transferred to 3d Battalion, 3d Marines in June 1994, where he served as the Battalion Adjutant and Personnel Officer.

In June 1995, he was promoted to Captain. Capt Keane served with Marine Aviation Support Squadron - 6, attended the Air Support Control Officers' Course in 29 Palms, California, and became a Direct Air Support Control officer. He was the last Marine Corps officer assigned to Naval Air Station (NAS) South Weymouth, while serving as Officer in Charge (OIC) Marine Site Support Element (Rear) during the Base Realignment and Closure of 1996. Capt Keane also served in Marine Wing Support Squadron - 474 Det B as the personnel officer for the detachment. In December 1999, Capt Keane transferred to 1st Battalion, 25th Marines, to serve as the battalion adjutant and personnel officer. He was promoted to Major in August 2000. As a Major, he served as the Adjutant to the Deputy Commandant for Plans, Policies and Operations Department, Headquarters Marine Corps (HQMC). In April 2004, Maj Keane transferred to Intelligence Department, HQMC, Signals Intelligence (SIGINT) Branch, as the assistant Branch Head. In November 2004, he was assigned as the Branch Head for the SIGINT Branch. In September, 2005 Maj Keane was reassigned to the National Security Agency as the Marine Cryptologic Support Battalion's Cryptologic Augmentee Program Manager.

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

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

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

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

He was called upon to be an Air Force family liaison officer for a critically wounded airman at Walter Reed Army Medical Center. Through his tenacity and compassion for caring for the Service member and family, he received recognition from the U.S. Special Operations Command casualty assistance liaison chief.

In September 2007, MSgt MacKenzie was selected by the Commander, Air Force Special Operations Command, for a full-time position with the U.S. Special Operations Command Care Coalition as a liaison for the wounded, ill, and injured Special Operations Forces and their families in the National Capital Region. As of 2010, MSgt MacKenzie is now assigned to HQ USSOCOM Care Coalition in Tampa, FL. MSgt MacKenzie is the recipient of numerous military awards.

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

Dr. Phillips was on active duty from 1968 to 1970. He served in Vietnam with the 101st Airborne, the 27th Surgical Hospital, and then at the Walter Reed Army Institute of Research. In 1970, he returned to Vietnam with a research team to study the effects of altitude on the wounded being flown from Vietnam to the Philippines and Japan. He remained a Reserve officer until his retirement as a Lieutenant Colonel in 1993. He is a life member of the 101st Airborne Association and an invited Associate Life Member of the UDT/SEAL Association. Dr. Phillips is on the board of the Vietnam Wall Memorial Reception Center.

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

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

In 1997, Dr. Phillips was interviewed by the White House search committee for the position of Commissioner, of the Food and Drug Administration, and in 1998 he testified before the Full Committee on Commerce as a witness on the implementation of the Food and Drug Administration Modernization Act of 1997. Dr. Phillips has received numerous military, scientific, and humanitarian awards. He serves and has served on numerous corporate and medical society boards and as president of national and international medical societies. He has approximately 125 peer-reviewed medical publications and has been granted 6 patents.

David K. Rehbein, MS

David K. Rehbein has served a dual career, with his professional life spent in the research field specializing in solid state physics and materials science and his personal life spent heavily involved in veterans service and issues through The American Legion. Mr. Rehbein is a U.S. Army veteran with service in Germany from 1970–1971, with separation at the rank of sergeant, E-5.

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

In Iowa, Mr. Rehbein received gubernatorial appointments to two terms on the Iowa Commission of Veterans Affairs overseeing the Department of Veterans Affairs (VA) and the 650-resident Iowa Veterans Home. He holds a bachelor of science degree in physics and a master of science degree in metallurgy from Iowa State University and spent 30 years as a research scientist at the Ames Laboratory, U.S. Department of Energy. He is the author of 75 published scientific papers and 1 patent. His career has included work on many unique problems, including aging aircraft, nuclear waste storage, space shuttle fuel tanks, high-strength bonds for aircraft turbine blades, and robotic inspection. Mr. Rehbein brings a unique blend of knowledge of veterans and military health issues and a set of problem-solving and evaluation skills developed through spending years in a scientific research environment.

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

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

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

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

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

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

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

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

Karen S. Guice, MD, MPP
Department of Veterans Affairs
(Co-Chair from January 2011–May 2011)

Dr. Karen Guice was the Executive Director of the Federal Recovery Coordination Program, a joint program of the DoD and VA. Dr. Guice also serves as the VA lead for the tri-agency National Resource Directory (NRD) initiative. She has recently completed a six-month detail to the Office of Wounded Warrior Care and Transition Policy (WWCTP) at DoD.

Dr. Guice graduated from the University of New Mexico School of Medicine and completed her general surgery training at the University of Washington. She has been a member of the surgical faculties at the University of Texas Medical Branch at Galveston, the University of Michigan, Duke University, and the Medical College of Wisconsin. She was promoted to professor of surgery during her tenure at Duke University. Dr. Guice received a master's degree in public policy from Duke University and was selected as a 1997–1998 Robert Wood Johnson Health Policy Fellow. Dr. Guice served as a staff member of the Senate Committee on Labor (1998–1999) and as the director of fellowship services at the American College of Surgeons (1999–2001). She was deputy director for the President's Commission on Care for America's Returning Wounded Warriors (Senator Bob Dole and Secretary Donna Shalala, co-chairs, 2007).

Dr. Guice has been a funded investigator for more than 10 years, receiving grants from the NIH and the Emergency Medical Services for Children (EMSC) Program. Her basic science research has included the scientific investigation of pancreatitis related respiratory failure, and her health services research focused on the development of a national trauma registry for children and an outcome evaluation of children's trauma-related care. She has served on NIH study sections and EMSC grant review panels. She has authored or coauthored more than 60 peer-reviewed publications and 9 book chapters. Dr. Guice is a member of several professional societies and was elected president of the Association of Academic Surgery in 1993. She is the recipient of numerous awards.

APPENDIX C: CHARTER

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

1. Committee's Official Designation: The Committee shall be known as the Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces (hereafter referred to as "the Task Force").

2. Authority: The Secretary of Defense, under the provisions of section 724 of Public Law 111-84, the Federal Advisory Committee Act of 1972 (5 U.S.C., Appendix 2), and 41 CFR § 102-3.50(a), established the Task Force.

   Pursuant to section 724(a)(3), the Secretary of Defense shall ensure that the Task Force's work is independent of the Senior Oversight Committee, as defined by section 726(c) of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110-417; 122 Stat. 4509).

3. Objectives and Scope of Activities: The Task Force shall: (a) assess the effectiveness of the policies and programs developed and implemented by the Department of Defense, and by each of the Military Departments to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces; and (b) make recommendations for the continuous improvements of such policies and programs.

4. Description of Duties: The Task Force, pursuant to section 724(c) of Public Law 111-84, shall no later than 12 months after the date on which all Task Force members have been appointed, and each year thereafter for the life of the Task Force, shall submit a report to the Secretary of Defense.

   The Task Force shall submit to the Secretary of Defense a report on the activities of the Task Force, and on the activities of the Department of Defense, to include the Military Departments, to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces. As a minimum, the Task Force's report shall include the following:

   a. The Task Force's findings and conclusions as a result of its assessment of the effectiveness of developed and implemented DoD policies and programs, to include those by the Military Departments, to assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces.
   b. A description of best practices and various ways in which the Department of Defense, to include the Military Departments, could more effectively address matters relating to the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces, including members of the Regular and Reserve Components and support for their families.
   c. A plan listing and describing the Task Force's activities for the upcoming year.
   d. Such recommendations for other legislative or administrative action that the Task Force considers appropriate for measures to improve DoD-wide policies and programs that assist and support the care, management, and transition of recovering wounded, ill, and injured members of the Armed Forces.

The Task Force, for the purposes of its reports, shall fully comply with sections 724(c)(2) and (3) of Public Law 111-84 in all matters dealing with the report's: (a) methodology; and (b) matters to be reviewed and assessed.

No later than 90 days after receiving the Task Force's report, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives the report and the Secretary's evaluation of the report.

No later than six months after receiving the Task Force's report, the Secretary of Defense, in consultation with the Secretaries of the Military Departments, shall submit to the Committees on Armed Services of the Senate and the House of Representatives a plan to implement the recommendations of the Task Force's annual report.

5. Agency or Official to Whom the Committee Reports: Pursuant to section 724(c) of Public Law 111-84, the Task Force reports its independent findings, advice and recommendations to the Secretary of Defense.

6. Support: The Department of Defense, through the Office of the Under Secretary of Defense for Personnel and Readiness and the Office of the Director of Administration and Management, shall provide support as deemed necessary for the performance of the Task Force's functions, and shall ensure compliance with the requirements of the Federal Advisory Committee Act.

   Upon request by the Task Force's co-chairs and in consultation with the Deputy Under Secretary of Defense for Personnel and Readiness, any department or agency of the Federal Government, to include DoD Federally Funded Research and Development Centers, may provide information that the Task Force considers necessary to carry out its duties.

   Any Task Force visit to a military installation or facility shall be undertaken through the Deputy Under Secretary of Defense for Personnel and Readiness, in consultation with the appropriate the Secretary of the Military Departments.

7. Estimated Annual Operating Costs and Staff Years: It is estimated that the annual operating costs, to include travel and contract support is approximately $5,000,000.00. The estimated annual DoD personnel costs are 25.0 full-time equivalents (FTE).

8. Designated Federal Officer: The Designated Federal Officer, pursuant to DoD policy, shall be a full-time or permanent part-time DoD employee, and shall be appointed in accordance with established DoD policies and procedures.

   In addition, the Designated Federal Officer is required to be in attendance at all Task Force and subcommittee meetings; however, in the absence of the Designated Federal Officer, the Alternate Designated Federal Officer shall attend the meeting.

9. Estimated Number and Frequency of Meetings: The Task Force shall meet at the call of the Task Force's Designated Federal Officer, in consultation with the co-chairs. The estimated number of Panel meetings is five (5) per year.

10. Duration: The need for this advisory function, unless extended by Act of Congress, is for five years; however this Charter is subject to renewal every two years.

11. Termination: Unless otherwise extended by Act of Congress, the Task Force, pursuant to section 724(f) of Public Law 111-84, terminates no later than October 27, 2014.

12. Membership and Designation: The Task Force, pursuant to section 724(b) of Public Law 111-84, shall be comprised of not more than 14 members appointed by the Secretary of Defense.

    Pursuant to 724(b)(2) of Public Law 111-84, the Secretary of Defense shall appoint:

    a. At least one member of each of the Regular Components of the Army, the Navy, the Air Force and the Marine Corps;
    b. One member of the National Guard;
    c. One member of a Reserve Component of the Armed Forces other than the National Guard;
    d. At least one family member of a wounded, ill, or injured member of the Armed Forces or veteran who has experience working with wounded, ill, and injured members of the Armed Forces or their families; and
    e. A number of person from outside the Department o Defense equal to the total number of personnel from within the Department of Defense (whether members of the Armed Forces or civilian personnel) who are appointed to the Task Force.

    Sections 724(b)(2) through (4) of Public Law 111-84, further stipulate the following Task Force appointment requirements:

    a. At least one individual appointed to the Task Force from within the Department of Defense shall be the Surgeon General of an Armed Force.
    b. The individuals appointed to the Task Force from outside the Department of Defense –
        i. With the concurrence of the Secretary of Veterans Affairs, shall include an officer or employee of the Department of Veterans Affairs; and
        ii. May include individuals from other departments or agencies of the Federal Government, from State and local agencies, or from the private sector.
    c. Persons appointed to the Task Force shall have experience in –
        i. Medical care and coordination for wounded, ill, and injured members of the Armed Forces;
        ii. Medical case management;
        iii. Non-medical case management;
        iv. The disability evaluation process for members of the Armed Forces;
        v. Veterans benefits;
        vi. Treatment of traumatic brain injury and post-traumatic stress disorder;
        vii. Family support;
        viii. Medical research;
        ix. Vocational rehabilitation; or
        x. Disability benefits.

    There shall be two co-chairs of the Task Force. One of the co-chairs shall be designated by the Secretary of Defense at the time of appointment from among the individuals appointed to the Task Force from within the Department of Defense. The other co-chair shall be selected from among the individuals appointed from outside the Department of Defense by those individuals.

Pursuant to sections 724(e)(1) of Public Law 111-84, Task Force members who are members of the Armed Forces or a civilian officer or employee of the United States shall serve on the Task Force without compensation (other than compensation to which entitled as a member of the Armed Forces or an officer or employee of the United States, as the case may be).

Other Task Force members shall be appointed in accordance with, and subject to, the provisions of 5 U.S.C. § 3161 and shall be compensated. These individuals shall serve as special government employees, and they shall not be considered full-time or permanent part-time officers or employees of the Federal Government for the purpose of determining the applicability of the Federal Advisory Committee Act of 1972.

All Task Force members shall be appointed for the duration of the Task Force. In the event of a vacancy on the Task Force the individual appointed to fill that vacancy shall be appointed by the same officer (or the officer's successor) who made the appointment to the seat when the Task Force was first established.

All Task Force members shall receive travel and per diem for official Task Force travel.

13. Subcommittees: With DoD approval, the Task Force is authorized to establish subcommittees, as necessary and consistent with its mission. These subcommittees or working groups shall operate under the provisions of the Federal Advisory Committee Act of 1972, the Government in the Sunshine Act of 1976 (5 U.S.C. § 552b), and other governing Federal regulations.

    Such subcommittees or workgroups shall not work independently of the chartered Task Force, and shall report all their recommendations and advice to the Task Force for full deliberation and discussion. Subcommittees or workgroups have no authority to make decisions on behalf of the chartered Task Force; nor can they report directly to the Department of Defense or any Federal officers or employees who are not Task Force members.

    Subcommittee members, who are not Task Force members, shall be appointed in the same manner as Task Force members.

14. Recordkeeping: The records of the Task Force and its subcommittees shall be handled according to section 2, General Record Schedule 26 and governing Department of Defense policies and procedures. These records shall be available for public inspection and copying, subject to the Freedom of Information Act of 1966 (5 U.S.C. § 552, as amended).

15. Filing Date: 18 November 2010

APPENDIX D: REFERENCE HANDBOOK OF KEY TOPICS AND TERMS

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

December 22, 2010

Including updates from NDAA 2011

Recovering Warrior Task Force
200 Stovall Street Alexandria, VA 22332-0021
703-325-6640

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

As directed by the 2010 National Defense Authorization Act (NDAA, Section 724), the Recovering Warrior Task Force 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 (subsequently referred to as the Department) to assist and support the care, management, and transition of recovering wounded, ill, and injured(WII) members of the Armed Forces, and to make recommendations for the continuous improvement of corresponding policies and programs. The Task Force provides an invaluable service to the Department as an independent body of advisors and has been formed to evaluate, provide expert advice, and give recommendations on the policies and programs within the Department that affect wounded warriors. The Task Force's objective is to provide a report with legislative and administrative recommendations to the Department at the end of each year of effort, over the course of four years.

Prepared by Recovering Warrior Task Force staff, including:

COL (Ret) Denise Dailey, Executive Director
Suzanne Lederer, Ph.D.—ICF International
Jessica Jagger, Ph.D.—ICF International
Allen Bediako—ICF International
Bradford Booth, Ph.D.—ICF International
COL (Ret) Charles Ciccolella—ICF International
Diane Boyd, Ph.D.—ICF International
Sara Maddox, MA—AECOM

ICF International is under sub-contract to AECOM Federal Services Group, National Security Program, holder of Prime Contract HQ0034-09-A-3000

Reference Handbook of Key Topics and Terms

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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).*

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[i]. Congress prioritized case management for wounded warriors through the creation of the Recovery Coordination Program (RCP); the Department of Defense (DoD) followed with RCP implementation guidance in 2009[ii, iii].

The RCP includes: 1) a comprehensive recovery plan (CRP) developed and implemented for each recovering Service member (RSM), encompassing medical/non-medical needs and short-/long-term goals, to include transition to 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 with the RCC develop the CRP and deliver or facilitate services and resources. The RT includes a non-medical case manager (NMCM) who works closely with the RSM and family to ensure they "get needed non-medical support" and assist in "resolving non-medical issues"[iv].

The assignment of an RCC is based on the RSM's care category: CAT I (a mild injury or illness, likely to return to duty in less than 180 days); CAT II (a serious injury or illness, unlikely to return to duty in less than 180 days); or CAT III (a severe/catastrophic injury or illness, likely to be medically separated from the military)[v]. RSMs rated CAT II are assigned a DoD RCC; RSMs rated CAT III are assigned a VA federal recovery coordinator (FRC).

RCCs are to be hired and jointly trained by DoD and the Services' wounded warrior programs. Currently, 97 RCCs (42 Marine Corps, 18 Air Force, 15 Army, 10 Army Reserve, 8 Special Operations Command, and 4 Navy) are assigned to 41 locations[vi]. According to DoD guidance, the Services' wounded warrior programs are to assign RCCs and NMCMs caseloads of 40 RSMs or fewer, depending on condition acuity and complexity of non-medical needs. Waivers are required for exceptions[vii].

The Services' wounded warrior programs differ in their use of—and nomenclature for—RCCs and NMCMs. Army Warrior Transition Units (WTUs) assign RSMs a Squad Leader who functions as the primary NMCM (caseload 1:20); more severely injured RSMs are assigned an Army Wounded Warrior (AW2) Advocate who fulfills the RCC role (13 of the 160 AW2 Advocates are DoD-funded RCCs). The Marine Corps uses RCCs and Wounded Warrior Battalion Squad Leaders as the primary NMCM (caseload 1:10). The Navy uses RCCs and 13 NMCMs (1:20).

The Air Force uses RCCs, NMCMs, Air Force Wounded Warrior (AFW2) Program Consultants, local Community Readiness Consultants (1:40), and Family Liaison Officers. The Special Operations Command uses Wounded Warrior Advocates (1:30) and Liaison Officers (LNOs) (1:10), including eight DoD-trained RCCs, and Care Coalition Recovery Plan (CCRP) Advocates (1:15)[viii].

References for non-medical case management:

[i] Government Accountability Office (2007, September 26). *GAO 07-1256T: DoD and VA: Preliminary observations on efforts to improve health care and disability evaluations for returning service members.* Washington, DC: Author.

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

[iii] Department of Defense (2009, December 1). *DoD instruction 1300.24: Recovery coordination program.*

[iv] Department of Defense (2009, December 1). *DoD instruction 1300.24: Recovery coordination program.*

[v] Department of Defense (2009, December 1). *DoD instruction 1300.24: Recovery coordination program.*

[vi] Mencl, P., Roberts, S., & Stevens, B. (2010, June 10). *Wounded warrior care & transition policy programs overview.* Presentation to DoD Inspector General Office.

[vii] Mencl, P., Roberts, S., & Stevens, B. (2010, June 10). *Wounded warrior care & transition policy programs overview.* Presentation to DoD Inspector General Office.

[viii] CALIBRE (2010, May 24). *Wounded, ill, and injured recovery care coordinator non-medical case manager (WII RCC NMCM) study—Interim report*. Alexandria, VA: Author. Office of Wounded Warrior Care and Transition Policy.

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)[i]. The MCCM works as a part of the recovery team with the recovering Service member (RSM), the RSM's commander, a recovery care coordinator (RCC) or federal recovery coordinator (FRC), and a non-medical case manager (NMCM)[ii]. In addition, RSMs receive primary care management from a physician[iii].

In the National Defense Authorization Act (NDAA) of 2008, section 1611, subsection e, paragraph 3, Congress specified that the duties of the MCCM 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 care during care, recovery, and transition; and
- Conducting periodic review of the Service member's medical status with the service member, or with a manager's approval if the service member cannot participate [iv].

Congress tasked the Departments of Defense (DoD) and Veterans Affairs (VA) to develop policies on the caseloads as well as training requirements for the MCCMs and 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 the DoD and VA must provide the necessary resources to operate the medical case management program [v]. DoD Instruction (DoDI) 1300.24 tasks the Assistant Secretary of Defense for Health Affairs (ASD(HA)), under the Under Secretary of Defense for Personnel and Readiness (USD(PR)), with ensuring the development and consistent implementation across military departments of policies and procedures for MCCMs, including training, qualifications, and caseloads [vi]. Also, DoDI 1300.24 requires that as RSMs transition to veteran status, MCCMs communicate directly with the accepting physician/facility [vii].

At Walter Reed Army Medical Center Warrior Transition Unit (WRAMC WTU), for example, MCCMs operate at a ratio of one case manager per 18 Service members, while the ratio for primary care managers (physicians) is one per 200 Service members. Other Army WTUs have a 1:20 ratio for MCCMs, except Fort Hood, which has a ratio of 1:25. These differences in MCCM caseloads are due to the intensity of need among the Service members at each WTU [viii].

Also in NDAA 2008, section 1611, Congress mandated uniform standards for the training and skills of MCCMs as well as non-medical case managers (NMCMs) and care coordinators

(RCCs or FRCs) working with wounded, ill, and injured Service members to detect and report signs of post-traumatic stress disorder (PTSD), suicidal or homicidal thoughts, and other behavioral health concerns [ix].

References for medical care case management:

[i] Office of the Under Secretary of Defense. (2009, August 26). *Directive-type memorandum (DTM) 08-033: Interim guidance for clinical case management for the wounded, ill, and injured service member in the military health system.*

[ii] Department of Defense. (2009, December 1). *DoD instruction 1300.24: Recovery coordination program.*

[iii] Government Accountability Office. (2009, April). *Army health care: Progress made in staffing and monitoring units that provide outpatient case management, but additional steps needed (GAO 09-357).* Washington, DC: Author.

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

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

[vi] Department of Defense. (2009, December 1). *DoD instruction 1300.24: Recovery coordination program.*

[vii] Department of Defense. (2009, December 1). *DoD instruction 1300.24: Recovery coordination program.*

[viii] Government Accountability Office. (2009, April). *Army health care: Progress made in staffing and monitoring units that provide outpatient case management, but additional steps needed (GAO 09-357).* Washington, DC: Author.

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

Additional references for medical care case management:

Assistant Secretary of Defense for Health Affairs. (2008, March). *ASD (HA) policy 08-001: Implementation of new medical expense and performance reporting system codes to track case management associated with global war on terror heroes.*

Department of Defense. (2006, January 5). *DoD instruction 6025.20: Medical management (MM) programs in the direct care system (DCS) and remote areas.*

Government Accountability Office (2007, September 26). *GAO 07-1256T: DoD and VA: Preliminary observations on efforts to improve health care and disability evaluations for returning service members.* Washington, DC: Author.

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

Background:

These units and programs are the vehicles through which the Services execute the Recovery Coordination Program (RCP) and manage the transition of recovering Service members (RSMs), per the 2008 National Defense Authorization Act (NDAA) and Department of Defense Instruction (DoDI) 1300.24.

Army. The Army Warrior Transition Command (WTC) oversees two mutually dependent programs—the Warrior Transition Unit (WTU) and Army Wounded Warrior (AW2) Program. WTUs are brigade-, battalion-, or company-level units to which RSMs 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" [i]. Today, approximately 9,300 Soldiers are assigned to 38 WTUs (including 9 community-based WTUs (CBWTUs) for reservists). The most severely disabled (approximately 66% of WTU members) are concurrently enrolled in the AW2 Program, which assigns RSMs and their families an AW2 Advocate "for life." AW2 rolls include approximately 1,200 currently serving RSMs[ii].

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 Marine-connected Sailors (i.e., Corpsman), including active-duty, reserve, separated, and retired. The WWR comprises a battalion at Camp Lejeune (WWBn-East) and at Camp Pendleton (WWBn-West), which have detachments at 12 principal MTFs and 4 Department of Veterans Affairs (VA) polytrauma rehabilitation centers. Fifteen to 20 RSMs are assigned to each detachment. The USMC program emphasizes outreach and reintegration, through such resources as Battalion Contact Centers, the Sergeant Merlin German Call Center, District Injured Support Cells (DISCs) located at 21 VA sites, and the Marine For Life (M4L) Program. The WWR has supported approximately 18,000 WII Marines and Sailors [iii].

Navy. The Navy Safe Harbor Program provides non-medical case management for severely (and high-risk non-severely) WII Sailors, Coast Guardsmen, and their families. Enrollees remain assigned to their parent unit. The Safe Harbor Operations Department consists of non-medical case managers (NMCMs) geographically dispersed at major MTFs and VA polytrauma hospitals. A Strategic Support Department of subject matter experts assists the NMCMs. Safe Harbor partners with voluntary and community organizations to offer the Anchor Program, which facilitates Veterans' transitions to civilian life and extends their contact with Safe Harbor[iv]. (Navy Medical Hold is a program that allows reservists to be retained beyond the expiration of their orders in order to obtain medical treatment[v].)

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 RSMs, and the Air Force Survivor Assistance Program (AFSAP). AFW2 is for Airmen with conditions that are "combat/hostile related requiring long-term care and …a Medical Evaluation Board/Physical Evaluation Board (MEB/PEB) to determine fitness for duty." AFW2 leverages existing resources such as AFSAP and installation Airman and Family Readiness Centers (A&FRCs) to provide services such as expanded transition assistance, extended case management, follow-up, and advocacy through no less than five years following separation or retirement. As part of AFSAP, families of personnel who are medically evacuated from overseas are assigned a Family Liaison Officer[vi]. (Under Air Force Medical Hold, Airmen who are recovering and undergoing disability evaluations remain in their home units and receive comprehensive case management, both by the home unit and major command case managers[vii].)

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." While all SOF RSMs 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 (currently 135 SOF members). The Care Coalition partners with governmental and non-governmental agencies to optimize RSMs' access to services (particularly cutting-edge care) and works closely with unit leadership to facilitate swift return of SOF members to duty, as appropriate. It serves as a liaison with, and complements, the Services' wounded warrior programs by advocating that standards be met or exceeded and promoting equality of benefits across the Services[viii].

References for wounded warrior units and programs:

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Topic: Services for post-traumatic stress disorder and traumatic brain injury

Background:

Post-traumatic 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"[i]. The Department of Defense (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"[ii]. Approximately 18.5 percent of Service members return from Afghanistan or Iraq with PTSD or depression, and approximately 19.5 percent experienced a TBI[iii]. PTSD and TBI frequently co-occur and affect moods, thoughts, and behavior, "yet these wounds often go unrecognized and unacknowledged"[iv].

The National Intrepid Center of Excellence (NICoE), a new facility on the campus of Bethesda Naval Hospital, offers cutting-edge diagnosis, treatment, rehabilitation, and follow-up for warriors with PTSD, TBI, and related conditions[v]. Interest in military mental health has expanded beyond DoD, as evidenced by the Substance Abuse and Mental Health Services Administration's (SAMHSA) adoption of military mental well-being as one of its 10 strategic initiatives[vi].

Treatment of PTSD. Treatment options include individual, couples, and group counseling (also known as "talk" therapy or psychotherapy), medication, and/or complementary and alternative approaches such as acupuncture, yoga nidra, and herbal/dietary supplements. Psychotherapeutic approaches include, for example, cognitive and cognitive-behavioral therapies (CBTs), prolonged exposure therapy, and stress inoculation therapy. Eye movement desensitization and reprocessing (EMDR) also may be used[vii]. Combat veterans can access direct or indirect support from such sources as the National Center for PTSD, the DCoE for PH and TBI, Military OneSource, and installation resources such as chaplains, mental health services, and Military Family Life Consultants (MFLCs), among others.

Screening, prevention, and early intervention of PTSD. CBT, exposure-based therapies, and "psychological first aid" have been found to be effective early intervention and prevention approaches[viii]. Noteworthy additional tools include the Army's *Comprehensive Fitness Program*, which trains Soldiers in order to improve resilience, decrease stress, and promote success[ix], and *Battlemind*, which is a training curriculum that facilitates transition from combat zone to "home zone" largely through expectations management[x]. According to DoD Instruction 6490.03, Deployment Health, all re-deploying Service members must participate in a post-deployment health assessment (PDHA)[xi] and a post-deployment health reassessment (PDHRA)[xii], both of which include PTSD screening.

Section 712 of Public Law 111-383, the National Defense Authorization Act for FY 2011, advances the DoD's ability to detect and treat psychological changes in deployed personnel by mandating predeployment medical examinations, postdeployment medical examinations

(including the assessment of mental health), and postdeployment health reassessments. The language specifies that the postdeployment medical examination shall be conducted when the member is redeployed or otherwise leaves an area in which the system is in operation (or as soon as possible thereafter); the postdeployment health reassessment shall be conducted at an appropriate time during the period beginning 90 days after the member is redeployed and ending 180 days after the member is redeployed.[xiii]

Section 722 of the same Act requires the Secretary of Defense to develop and implement a comprehensive policy on consistent neurological cognitive assessments of members of the Armed Forces before and after deployment no later than January 31, 2011. The Secretary is also required to revise the policy on a periodic basis in accordance with experience and evolving best practice guidelines. Section 723 requires the Secretaries of the military departments to each conduct an assessment of post-traumatic stress disorder incidence by military occupation, including identification of military occupations with a high incidence of such disorder. Within one year of the passage of the Act, the Secretaries shall each submit to the congressional defense committees a report on this assessment.[xiv]

Screening and treatment of TBI. Screening occurs in-theatre, at Landstuhl Regional Medical Center (LRMC), during PDHA and PDHRA, and at Department of Veterans Affairs (VA) Medical Centers. Mild TBI (mTBI), or concussion, is particularly difficult to diagnose because symptoms are not obvious. Military Acute Concussion Evaluation (MACE) is a tool that helps to systematize the diagnosis process[xv]. DoD TBI programs have been established throughout the continental United States (CONUS) and overseas, and evidence-based treatment protocols have been tailored to treatment location (in-theatre, CONUS), acuity of condition (acute, sub-acute, chronic), and severity of condition (mild, moderate, severe, penetrating). DoD and VA collaboratively address the screening and treatment of TBI through the Defense and Veterans Brain Injury Center (DVBIC), which was established by Congress in 1992 and is now a part of DCoE[xvi].

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Topic: Defense 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 stood up in November 2007 and is a part of the Department of Defense (DoD) Military Health System (MHS). DCoE serves as DoD's "open front door" for the needs associated with PH and TBI that are experienced by our Armed Forces. The DCoE is structured as a "center of centers," to increase collaboration and information sharing among its component centers, which are:

- Center for Deployment Psychology (CDP)
- Center for the Study of Traumatic Stress (CSTS)
- Defense and Veterans Brain Injury Center (DVBIC)
- Deployment Health Clinical Center (DHCC)
- National Center for Telehealth and Technology (T2)

Established by Congressional mandate, the DCoE mission is multifaceted: "to assess, validate, oversee and facilitate prevention, resilience, identification, treatment, outreach, rehabilitation and reintegration programs for PH and TBI to ensure DoD meets the needs of service members, veterans, military families and communities"[i]. Through its component centers, DCoE brings together and coordinates the work of scientific researchers, clinicians, and other health professionals from DoD, the Services, the Department of Veterans Affairs (VA) and other federal agencies, academic institutions, state and local agencies, and the non-profit and private sectors to expand the state of knowledge about PH and TBI. The DCoE also works to move research to practice in the areas of PH, TBI, and suicide prevention, and ensure 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 interim director is Dr. Michael E. Kilpatrick.

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 post-traumatic stress disorder (PTSD), TBI, and promising treatments; create and disseminate guidelines to military and civilian practitioners; develop outreach programs for military and veteran communities as well as 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.

It is likely that DCOE will play a role in supporting compliance with Section 716 of Public Law 111-383, the National Defense Authorization Act for FY 2011, which requires the Secretary of

Defense to develop and implement training, available through the Internet or other means, on the use of pharmaceuticals in rehabilitation programs for seriously ill or injured members of the Armed Forces. The Act specifies that training shall be provided to: patients in or transitioning to a wounded warrior unit, with special accommodation in such training for such patients with cognitive disabilities; nonmedical case managers; military leaders; and family members. Additionally, the Secretary shall review all policies and procedures of the DoD regarding the use of pharmaceuticals in rehabilitation programs for seriously ill or injured members of the Armed Forces and no later than September 20, 2011, submit to the congressional defense committees any recommendations for administrative or legislative action with respect to the review as the Secretary considers appropriate.[ii]

In addition to the DCoE, Congress has directed the establishment of three other centers: the Vision Center of Excellence, mandated by the National Defense Authorization Act (NDAA) of 2008, and the Hearing Center of Excellence and Traumatic Extremity Injuries and Amputation Center of Excellence, both mandated by the NDAA of 2009. Like the DCoE, these other Centers of Excellence share a common purpose of addressing the results of blasts, described as the signature weapon of the current wars in Afghanistan and Iraq[iii]. These other centers are not yet operational, although the Vision Center of Excellence has established a public-facing website, http://vce.health.mil/, which features some early accomplishments.

In April 2010, the Military Personnel Subcommittee of the House Committee on Armed Services held a hearing on the progress made by these centers and the timeline for their stand-up and operation. The Subcommittee heard testimony from Lt. Gen. Charles Bruce Green, U.S. Air Force Surgeon General; Dr. Charles Rice, President, Uniformed Services University of Health Sciences, performing the duties of the Assistant Secretary of Defense for Health Affairs; Vice Adm. Adam Robinson, U.S. Navy Surgeon General; and Lt. Gen. Eric Schoomaker, U.S. Army Surgeon General. These proponents described challenges that have both delayed and informed the establishment of the centers; e.g., reaching a common vision; infrastructure; governance and controls; duplication; leveraging existing efforts, interagency partners, and the academic community; integration across centers; and reconciling operational and policy development responsibilities[iv].

Section 704 of Public Law 111-383, the National Defense Authorization Act for FY 2011, mandates actions relevant to the Hearing Center of Excellence. Under this mandate, the Secretary of Defense is to identify the best tests currently available to screen members of the Armed Forces for tinnitus, to develop a plan to ensure that all members of the Armed Forces are screened for tinnitus prior to and after a deployment to a combat zone, and to report to the congressional defense committees on these actions no later than December 31, 2011. Additionally, the Secretary of Defense is required to examine methods to improve the aural protection for members of the Armed Forces in combat and to submit a report on these methods to the congressional defense committees no later than one year following the date of enactment of the Act. All results of these activities are to be transmitted to the Hearing Center of Excellence as well.[v]

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Topic: Interagency Program Office

Background:

The Interagency Program Office (IPO) was established by Congress in Section 1635 of the National Defense Authorization Act (NDAA) of 2008[i]. In this section of the NDAA, Congress mandated that the Department of Defense (DoD) and the Department of Veterans Affairs (VA) 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 the DoD and VA.

The IPO was formed by DoD and VA on April 17, 2008 and staffed initially with temporary personnel from both departments[ii]. The IPO was chartered by January 2009[iii]. The charter specified that the IPO would develop a plan and a schedule, as well as performance measures for assessing achievements toward the goal of interoperability. The permanent staffing structure included seven government service (GS) civilian positions from DoD and seven GS positions from VA, led by a DoD Director (Senior Executive Service (SES) 2) and a VA Deputy Director (SES 1)[iv]. The GS positions are GS-14 and GS-15, with the exception of one GS-13[v]. In Fiscal Year (FY) 2009, IPO staff began analyzing weekly data reports from DoD and VA for missed milestones, assessed the impact of those missed milestones, reported them to senior leadership, and monitored efforts to resolve them[vi]. Additionally, the IPO is responsible for the DoD/VA Information Interoperability Plan (IIP), which was published in September 2008 and revised in FY 2009[vii].

In April 2009, at the direction of the Senior Oversight Committee (SOC), the charter was changed to include coordinating and overseeing the development of the Virtual Lifetime Electronic Record (VLER), which is supposed to enable access to all electronic records for Service members through their transition from military to veteran status[viii].

Since 2008, the Government Accountability Office (GAO) [ix, x, xi, xii] has issued four reports on the interoperability of DoD and VA health information systems and the IPO. In January 2010, the GAO report concluded that the mandate to develop interoperability capabilities were met, but that the IPO was not able to assume accountability for the interoperability of health information systems of DoD and VA. At the time of the GAO‟s January 2010 report, GAO noted the IPO was “nearly fully staffed” after having previously reported that staffing of leadership positions was often done on an interim basis[xiii, xiv]. The report concluded that because the IPO did not implement the changes recommended by previous GAO reports [xv, xvi], such as

having a fully developed schedule, project plan, and measurable goals and objectives for interoperability, it was not able to manage and oversee the interoperability efforts.

Partly in response to GAO reports, Section 715 of Public Law 111-383, the National Defense Authorization Act for FY 2011, requires the Secretary of Defense to 1) conduct an enterprise risk assessment methodology study of all health information technology programs of the Department of Defense and 2) to report on the organizational structure for health information technology within the Department of Defense; both reports are due no later than 180 days after the date of enactment of the Act. The IT organizational structure report must contain an assessment of how well the health information systems of the Department of Defense interact with the health information systems of the Department of Veterans Affairs and entities other than the Federal Government, and must describe all future plans for legacy systems and new electronic health record initiatives, including the joint virtual lifetime electronic record. Additionally, no later than March 31, 2011, the Secretary of Defense was to submit to the congressional defense committees a report on the status of implementation of the recommendations made in the report by the Comptroller General of the United States titled „„Information Technology: Opportunities Exist to Improve Management of DOD‟s Electronic Health Record Initiative‟‟ (GAO-11-50).[xvii]

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Topic: Wounded warrior information resources

Background:

National Resource Directory (www.nationalresourcedirectory.org): One of four cornerstones of the Recovery Coordination Program (RCP) established through the Senior Oversight Committee (SOC) (see also information paper on *Senior Oversight Committee*), this joint venture of the Departments of Defense (DoD), Labor (DoL), and Veterans Affairs (VA) is "an online partnership for wounded, ill, and injured Service members, Veterans, their families and those who support them."The directory provides access to national, state, and local governmental and non-governmental services and resources for recovery, rehabilitation, and reintegration. Major topic areas include benefits and compensation, education and training, employment, family and caregiver support, health, homeless assistance, housing, transportation and travel, and other services and resources.

Wounded Warrior Resource Center (www.woundedwarriorresourcecenter.com): A companion to the National Resource Directory, this initiative is "a single point of contact providing help for wounded warriors, their families, and their primary caregivers to obtain health care services or benefits information, or to report deficiencies in military facilities or other difficulties getting the support they need."It is staffed 24/7 and accessible at 800-342-9647 or wwrc@militaryonesource.com. It is also accessible through the National Resource Directory.

Military OneSource (www.militaryonesource.com or 800-342-9647): Military OneSource is an all-purpose portal for Active-Component and Reserve-Component military members, spouses, families, and service providers, through which DoD's Military Community and Family Policy (MC&FP) office disseminates information to the military community. Wounded Warrior Support can be accessed from Military OneSource. In fact, Military OneSource Wounded Warrior Support and the Wounded Warrior Resource Center are the same; i.e., master's-level Military OneSource consultants staff the Wounded Warrior Resource Center.

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. SFACs can assist, for example, with entitlement and benefits counseling, travel pay for family members on invitational travel orders, stress management, translation arrangements, lodging resources, and child care referral. Sister services assist families of wounded warriors, but do not appear to have established local facilities such as the Army SFACs[i, ii].

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

- Army Wounded Soldier and Family Hotline: 800-984-8523
- Marine Corps Sergeant Merlin German Wounded Warrior Call Center (for wounded Marines, their families, and eligible Sailors): 877-487-6299 (also used for outreach)

The Navy and Air Force wounded warrior websites provide key links and telephone numbers but their programs do not operate Service-specific wounded warrior hotlines.

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Topic: Support for family caregivers

Background:

Several pieces of federal legislation have been written in an effort to offset the financial burden experienced by caregivers and families, and to support caregivers as they, in turn, support their recovering Service members[i, ii, iii].

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 concerned (e.g., Secretary of the Army) 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"[iv]. Section 603 of the National Defense Authorization Act (NDAA) of 2010[v] amends federal law[vi] to authorize monthly compensation to recovering Service members (RSMs) to pay for aid and attendance care without which they would require hospitalization, nursing home care, or other residential institutional care. Eligibility expires once members are medically retired and receiving comparable veteran's compensation under Title 38. This requirement has not yet been implemented.

Expanded authority for family member travel. Section 632 of NDAA 2010[vii] expands 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 extends the benefit to individuals other than family members chosen by the Service member. Eligible Service members may be hospitalized due to combat injury or other serious illness or injury. This requirement is implemented in the current Joint Federal Travel Regulation (JFTR)[viii].

Authorized travel and transportation allowances for non-medical attendants for very seriously and seriously wounded, ill, or injured (WII) 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 member" while hospitalized for treatment of the wound, illness, or injury or during continuing outpatient treatment. Section 633 of NDAA 2010[ix] amends 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. NMAs are also authorized a per diem allowance or reimbursement for actual and necessary travel expenses. This requirement is implemented in the current JFTR[x].

Respite care for seriously ill or injured active duty members. Respite care is defined as "short-term care for a patient in order to provide rest and change for the primary caregivers who have been caring for the patient at home," to include assisting the member with activities of daily living (e.g., dressing, feeding, hygiene). Respite care is available if the member's care

includes more than two "interventions" during the eight-hour period that the primary caregiver would normally be sleeping. Respite care is limited to eight hours per day, five days per week, and *must* be provided by a TRICARE-authorized home health agency[xi]. Federal law authorizing respite for TRICARE ECHO participants (family members of Service members) was amended to allow this benefit for Service members[xii]. Respite care for seriously ill or injured active duty members is currently available through the Department of Defense (DoD).

VA support for caregivers of recovering Service members. On May 5, 2010, the President signed Public Law No. 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010[xiii]. This bill expands Department of Veterans Affairs (VA) support for family caregivers of active duty (i.e., still serving) WII Service members. Sections 101 through 104 provide for a program of comprehensive assistance including, for example, 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-hour per day; 7) medical care; and 8) monthly stipend. The VA launched this comprehensive caregiver program in May 2011.

Section 634 of Public Law 111-383, the National Defense Authorization Act for FY 2011, modifies the criterion for the amount of special compensation paid to Service members with injuries or illnesses requiring assistance in everyday living. This standard will be changed from the amount established by the VASRD to personal caregiver stipends established under 38 USC section 1720G.[xiv]

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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 members of the armed forces on active duty"[i]. This legal assistance includes routine legal support to Service members, including wounded warriors, and families on a broad range of legal issues (e.g., bankruptcy, credit issues, identity theft, landlord-tenant disputes, and general estate planning). In addition, the military 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 process[ii, iii, iv]. Generally, this process involves two boards—the Medical Evaluation Board (MEB) and the Physical Evaluation Board (PEB) (informal and formal)[v, vi].

The Services historically assign attorneys to PEB locations where they offer legal counsel and representation to Service members undergoing formal PEB hearings. The Army has, for example, more than 20 Soldier's Counsel (mostly mobilized reservists on one-year tours) assigned to three major military treatment facilities (MTFs) and satellite locations in the continental United States (CONUS) and overseas[vii, viii]. The Navy provides legal support at the Navy Yard in Washington, DC, which is the sole PEB site for Sailors and Marines, and the Air Force provides legal support at Lackland Air Force Base, the sole PEB site for Airmen[ix, x, xi, xii]. Apart from their consistent support for formal PEB (FPEB) hearings, the Services vary in their legal support to WII Service members in the disability evaluation system, including the resources the Services have allocated and where the Services house their FPEB attorneys organizationally. In addition, the Services vary in how early in the process they seek to engage Service members.

In 2008, **the Army** initiated the MEB Outreach Counsel (MEBOC) program to introduce legal support earlier in the disability evaluation process. There are 24 MEBOC attorney/paraprofessional teams, most permanent hires, at Army locations with battalion or larger sized Warrior Transition Units (WTUs). MEBOC teams also assist severely injured Soldiers receiving care at Department of Veterans Affairs (VA) polytrauma centers.

The MEBOC teams are available to educate WII Soldiers and counsel them one-on-one before and during the MEB, and help them formulate—and optimize the likelihood of attaining—their goal, whether that is to be found fit for duty or to maximize appropriate disability compensation. MEBOC teams generally prepare appeals, requests for impartial medical reviews, requests for reconsideration, requests for formal hearings, and requests for rating reconsiderations. MEBOCs are also available to provide priority legal assistance to WII Soldiers for other legal issues.

MEBOC teams conduct regular outreach briefings at WTUs, Soldier and Family Assistance Centers (SFACs), and town hall meetings. For example, the Walter Reed Army Medical Center (WRAMC) MEBOC team conducts briefings monthly at the WRAMC WTU and quarterly at

other military installations with WII populations[xiii, xiv, xv]. As part of their outreach, MEBOCs also coordinate with PEB Liaison Officers (PEBLOs), who act as points of contact between the recovering Service members (RSMs) and the evaluation boards[xvi].

The Navy has 14 attorneys (10 Navy and 4 Marine Corps) who provide legal support to Sailors and Marines once they have received the informal PEB (IPEB) decision and must decide whether to seek a formal PEB decision or accept the informal PEB findings. These legal counselors also provide services during the MEB process on a space-available basis. While they do not travel or conduct outreach/briefings, they do participate in Disabled Transition Assistance Program (DTAP) briefings. The Navy also runs a Legal Assistance Outreach Program for wounded warriors, in coordination with the Navy Safe Harbor Program[xvii, xviii, xix, xx].

The Marine Corps has mobilized four reserve judge advocate billets to provide legal support to Marines, and Sailors attached to Marine units, undergoing disability evaluation (mentioned above in connection with the Navy program). One of these attorneys is assigned to develop a Standard Operating Procedure (SOP), leaving only three attorneys to work directly with all Marines undergoing the disability evaluation process—one with Wounded Warrior Battalion East (WWBn-East) at Camp Lejeune and two with Wounded Warrior Battalion West (WWBn-West) at Camp Pendleton. The Marine Corps is currently seeking additional reserve billets—13 attorney and 7 paraprofessional—at these two locations. Similar to the Army model, the Marine Corps approach seeks to engage Marines as early as possible, if not pre-MEB. As time permits, the Marine Corps attorneys also conduct outreach briefings on request and participate in DTAP briefings[xxi, xxii, xxiii].

Unlike the other Services, **the Air Force** provides legal support only for the formal PEB (FPEB) process. This support is provided by four attorneys (two who occupy permanent positions) and one paraprofessional[xxiv, xxv].

Grassroots. The active duty and veteran communities also benefit from grassroots support. Operation Enduring LAMP and the Military Pro Bono Project are ongoing projects of the American Bar Association (ABA) Standing Committee on Legal Assistance for Military Personnel[xxvi,xxvii]. A number of law schools have established clinics to support transitioning Service members and veterans in their regions[xxviii]. Veterans service organizations (VSOs), such as Disabled American Veterans (DAV) and the National Veterans Legal Services Program (NVLSP), which launched Lawyers Serving Warriors in 2008, also provide legal support.[xxix], [xxx], [xxxi]

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Topic: Vocational training for transitioning wounded, ill, and injured Service members

Background:

The Department of Defense (DoD) and the Services collaborate with other federal agencies, veteran service organizations (VSOs), private agencies, and non-profit organizations to provide job training, counseling, referral, placement, and other assistance:

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, 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:

- *Self-Employment* – rehabilitation includes a business plan and training as a small business owner;
- *Reemployment* – VA works with the Department of Labor (DOL) and employers to accommodate the veteran's disabilities and offers resources to facilitate the transition back to work;
- *Rapid Access to Employment* – disabled veterans with workforce skills are assisted with resume development, job search, employment accommodations, and post-employment follow-up;
- *Employment Through Long-Term Services* – academic/vocational education (e.g., college, technical school, work study, job shadowing), which is chosen by more than 80 percent of VR&E participants; and
- *Independent Living* – veterans are assisted in reducing their dependence on outside aid and in expanding their ability to accomplish activities of daily living through assistive technologies, adaptive housing grants, training, support services, and/or financial aid.

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[i]. By law[ii], members of the armed forces with severe injuries or illnesses may enroll in the VA VR&E program (without compensation) while still on active duty to facilitate their recovery, rehabilitation, and transition.

DoD Operation Warfighter (OWF) Program. OWF is an internship program for recovering Service members (RSMs) who are convalescing at military treatment facilities (MTFs). The program provides RSMs an opportunity to build their resumes, explore federal employment, develop job skills, and gain valuable federal government work experience. 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[iii].

DoL Recovery and Employment Assistance Lifelines (REALifelines). The DoL's Veterans Employment and Training Service (VETS), in partnership with DoD, and VA, and the State Workforce Agencies, collaborate with public and private employers to provide job training and employment services to RSMs. 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 [iv].

Wounded Warrior Career Demonstration Program. The Army Wounded Warrior (AW2) Program and the National Organization on Disabilities (NOD) are collaborating on a Wounded Warrior Career Demonstration Program in Colorado, North Carolina, and Texas that assists severely wounded Army soldiers in finding civilian careers. NOD career specialists provide intensive support to hundreds of wounded warriors and their families to help them discover new career paths, explore education and training opportunities, and find jobs that lead to satisfying careers[v].

Additional Initiatives. Under Title 28 of the Act, Military Construction General Provisions, Section 2805 of Public Law 111-383, the National Defense Authorization Act for FY 2011 recommends that the Secretary of Defense establish a 'Veterans to Work' program to provide an opportunity for apprentices, who are also veterans, to work on military construction projects. Within 180 days after enactment of the Act, the Secretary of Defense is to prepare a report in consultation with Secretary of Labor and the Secretary of Veterans Affairs to include an assessment of the number of individuals who might participate, an evaluation of potential benefits in terms of workforce sustainability and cost-effectiveness, and a review of any challenges, difficulties, or problems projected in recruiting apprentices who are also veterans.[vi]

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Topic: Disability Evaluation System

Background:

The Disability Evaluation System (DES) is the mechanism by which a Service member is evaluated for fitness for duty by the Department of Defense (DoD)[i, ii]. The Legacy DES is a DoD process that assesses Service members' fitness for duty and compensates 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. DES includes a medical evaluation board (MEB) (an informal process of the medical treatment facility), physical evaluation board (PEB) (informal and formal fitness-for-duty and disability determinations), appellate review process, and final disposition. A PEB Liaison Officer (PEBLO) is assigned to assist the Service member through the process[iii] (see also information paper on *legal support*). The PEB recommends that the Service member either return to duty, be placed on temporary disabled/retired list (TDRL), separate from active duty, or medically retire[iv].

When a Service member is evaluated under the Legacy DES, she or he will have to be separately evaluated by the Department of Veterans Affairs (VA) to determine VA benefits. In that benefits eligibility process, the VA takes into account "all disabilities incurred or aggravated during military service" warranting a disability rating of 10 percent or higher[v, vi, vii]. This difference in what is considered by DoD and VA evaluations accounts for differences in ratings that transitioning Service members receive from DoD and VA. Efforts have been underway since at least 2002 to address these discrepancies and other shortcomings in the DES[viii, ix].

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 Legacy DES; pilots began November 2007[x], and Congress included the pilots in the National Defense Authorization Act (NDAA) of 2008[xi]. 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[xii]. As of the November 2009 expansion of the pilots, 27 facilities were participating[xiii]. Between November 2007 and November 2009, more than 5,431 Service members participated in the DES pilot[xiv]. Active Component (AC) Service members completed the DES pilot in an average of 289 days, and Reserve Component (RC) Service members completed in an average of 270 days[xv], compared to a Legacy DES average of 540 days[xvi]. Surveys revealed significantly higher satisfaction among DES pilot participants[xvii]. On July 30, 2010, the SOC co-chairs directed that IDES expand worldwide beginning October 2010[xviii].

A modification of the PEB process was introduced by Public Law 111-383, the National Defense Authorization Act for FY 2011, which under Section 533 expanded the rights of Service members by broadening the criteria for those members eligible to request a review of their retirement or separation without pay for physical disability; this eligibility was formerly restricted to officers.[xix] In an additional step, Section 534 prohibits a Service branch from authorizing an involuntary administrative separation of a member based on that member's unsuitability for deployment or worldwide assignment, as based on a medical condition assessed by a PEB.[xx]

Three sections (631, 632, and 633) of Public Law 111-383, the National Defense Authorization Act for FY 2011 modify the criteria for calculating disability retirement pay. Section 631 allows benefits to exceed the 75% 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.[xxi] Section 632 specifies 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.[xxii] Section 633 amends the method by which eligibility for receiving retired pay is calculated for Reserve Component members; the new method awards credit for time receiving medical care to be counted toward years of service.[xxiii]

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

Background:

Section 502 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 1991, codified in Sections 1141-1143 and 1144-1150 of Title 10 U.S. Code, 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[i, ii]. 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[iii]. The scope of the Department of Defense (DoD) Transition Assistance Program (TAP) encompasses all Active Component (AC) separations and retirements, all Guard and Reserve deactivations, and all wounded, ill, and injured (WII) and their families[iv].

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 as well as overseas. Prior to their release from active duty, demobilizing Reserve Components (RC) members are required to receive transition counseling equivalent to the pre-separation counseling provided to their AC counterparts.

TAP is a mutual responsibility of DoD, the Department of Labor (DOL), Department of Veterans Affairs (VA), and Department of Homeland Security (DHS)[v, vi]. 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 members about educational assistance benefits, financial planning, and other benefits to which they are entitled under the law;
- DoL: Conducts 2 ½ day (20-hour) TAP Employment Workshops that provide employment information, training opportunities, and vocational guidance to allow separating Service members make informed career choices; and
- VA: Conducts ½ day (4-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 2-hour Disabled TAP (DTAP) briefing that provides extensive information regarding VA's Vocational Rehabilitation and Employment (VR&E) benefits.

TAP components differ somewhat for AC and RC members. For the AC, pre-separation counseling is mandatory, while the DoL Employment Workshop, VA Benefits Briefings, and DTAP workshop are voluntary. For the RC, pre-separation counseling is also mandatory, and briefings on the Uniformed Services Employment and Reemployment Rights Act (USERRA) and VA benefits, which usually includes information on DTAP, are voluntary. RC members are eligible to utilize their transition assistance counselors for up to 180 days after release from active duty[vii].

DoD has established a TAP web portal, www.TurboTAP.org, that provides a series of guidebooks and checklists, materials for transitioning personnel to help them prepare for their 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. These include a Pre-separation Guide for the AC and a Transition Guide for the RC[viii].

References for Transition Assistance Program:

[i] Pub. L. No. 101-510 (1991). Military Transition Assistance Programs. Retrieved October 28, 2010, from http://www.dtic.mil/ird/law/pl101_510.html

[ii] 10 U.S.C. Chapter 58: Benefits and Services for Members Being Separated or Recently Separated (2010).

[iii] Pub. L. No. 107-103 (2001). Veterans Education and Benefits Expansion Act of 2001. Retrieved October 28, 2010, from http://frwebgate.access.gpo.gov/cgi-bin /getdoc.cgi?dbname=107_cong_public_laws&docid=f:publ103.107.pdf

[iv] Office of the Secretary of Defense, Office of Transition Policy and Care Prevention. (2009, September 1-3). Paper presented at the DoD Joint Family Readiness Conference. Chicago, IL.

[v] Department of Defense. (1993, December 9). *DoD directive 1332.35: Transition assistance for military personnel.* Retrieved October 26, 2010, from www.dtic.mil/whs/directives/corres/pdf/133235p.pdf

[vi] Department of Defense. (1994, February 14). *DoD instruction 1332.36 Pre-separation counseling for military personnel.* Retrieved October 28, 2010, from www.dtic.mil/whs/directives/corres/pdf/133236p.pdf

[vii] Transition Assistance Program. (2007, May). *Transition guide for the guard and reserve.* Retrieved October 29, 2010, from http://www.turbotap.org/export/sites /default/transition/resources/PDF/TransitionGuide_RC.pdf

[viii] Transition Assistance Program. (2007, May). *Transition guide for the guard and reserve.* Retrieved October 29, 2010, from http://www.turbotap.org/export/sites /default/transition/resources/PDF/TransitionGuide_RC.pdf

Topic: Senior Oversight Committee

Background:

The President's Commission on Care for America's Returning Wounded Warriors released the Dole/Shalala Report in 2007[i]. 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) came to light, the National Defense Authorization Act (NDAA) of 2008 directed the Department of Defense (DoD) and Department of Veterans Affairs (VA) to "jointly develop and implement comprehensive policies on the care, management, and transition of recovering Service members." (RSMs)[ii]. 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. The committee members were organized into eight work groups or lines of action (LOAs): 1) disability system; 2) traumatic brain injury (TBI) and post-traumatic 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[iii]. 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 Disability Evaluation System (DES) pilot[iv].

Conceived as a one-year committee, the SOC was to expire May 2008 but was extended to January 2009. NDAA 2009 then extended it through December 2009. In November 2008, LOAs 1, 3, and 8 were incorporated into a new DoD organization entitled Transition Policy and Care Coordination Office, whose mission was to "ensure equitable, consistent, high-quality care coordination and transition support for members of the Armed Forces, including wounded warriors and their families, through appropriate interagency collaboration, responsive policy and effective program oversight." Four LOAs were incorporated into existing DoD organizations, and one LOA (6) was deemed completed[v]. The Under Secretary of Defense extended the SOC and it remains active. Examples of issues it has addressed recently include the expansion of the pilot DES to an additional six locations, special compensation, and expedited security clearances for wounded warriors seeking to work in the intelligence community.

The fruits of efforts of the SOC to support expedited security clearances may be seen in Section 351 of Public Law 111-383, the National Defense Authorization Act for FY 2011, which permits the Secretary of Defense to prescribe a process for performing expedited background investigations for individuals separated or expected to be retired or separated for physical disability, as well as for these individuals' spouses under certain conditions. Section 351 authorizes the Secretary of Defense to use funds appropriated to the Department of Defense for operation and maintenance to conduct these investigations.[vi]

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. This report indicated that the majority of the policy requirements (60 of 76) had been completed and the remaining required policies were in progress. The report also identified challenges faced by the SOC, such as standardizing key terminology across departments, concerns about changes in SOC leadership and reporting chains, and in certain instances, unclear differentiation of the responsibilities of the SOC and the DoD and VA Joint Executive Council (JEC). GAO will address the implementation of SOC policies in a future series of reports.

References for Senior Oversight Committee:

[i] President's Commission on Care for America's Returning Wounded Warriors (2007, July). *Serve, support, simplify*. Washington, DC: Author.

[ii] Government Accountability Office. (2009, July*). GAO 09-728: Recovering service Members: DoD and VA have jointly developed the majority of required policies but challenges remain.* Washington, DC: Author.

[iii] Defense Advisory Committee on Women in the Services. (2010, March 23). *2009 annual report.* Fairfax, VA: ICF International.

[iv] Government Accountability Office. (2009, July*). GAO 09-728: Recovering service Members: DoD and VA have jointly developed the majority of required policies but challenges remain.* Washington, DC: Author.

[v] Defense Advisory Committee on Women in the Services. (2010, March 23). *2009 annual report.* Fairfax, VA: ICF International.

[vi] National Defense Authorization Act of 2011, Pub. L. No. 111-383, §351 (2011).

Topic: Overall coordination between Department of Defense 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"[i]. 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[ii].

The JEC's charter encompasses: 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[iii, iv]. 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) (see also information paper on *Senior Oversight Committee*). The Fiscal Year (FY) 2009 Annual Report summarizes JEC accomplishments under 6 goal areas and 24 objectives. Following are several accomplishments relevant to wounded warriors, many of which are also the purview of the SOC:

<u>Goal 1. Leadership, Commitment, and Accountability</u>

<u>Goal 2. High-Quality Health Care</u>

Evidence-based clinical practice guidelines for Mild Traumatic Brain Injury (mTBI) and post-traumatic stress disorder (PTSD), clinical training policies and training of behavioral health providers, improved collaboration on post-deployment health reassessments (PDHRAs)

<u>Goal 3. Seamless Coordination of Benefits</u>

VA/DoD Disability Evaluation System (DES) pilot (initiated through the SOC, incorporated into the JEC JSP, and brought under the BEC), JEC Federal Recovery Coordination Program (FRCP), JEC Recovery Coordination Program (RCP), FRCP and RCP interoperability, Communications Outreach Program (the National Resource Directory)

Goal 4. Integrated Information Sharing

Defense Manpower Data Center developed WII tables in Defense Eligibility Enrollment Reporting System (DEERS), the DoD/VA Interagency Program Office (IPO) to develop/implement electronic health records systems and accelerate the exchange of health care information to support the delivery of health care by DoD/VA

Goal 5. Efficiency of Operations

Goal 6. Joint Medical Contingency/Readiness Capabilities [v]

References for Joint Executive Council:

[i] VA/DoD Joint Executive Council. (2009). *Annual report fiscal year 2009.* Washington, DC: Author.

[ii] 38 U.S.C. 8111.Sharing of Department of Veterans Affairs and Department of Defense Health Care Resource. Retrieved October 19, 2010, from http://www.tricare.mil/DVPCO/policy-leg.cfm

[iii] VA/DoD Joint Executive Council. (n.d.). *JEC charter.* Washington, DC: Author.

[iv] VA/DoD Joint Executive Council. (2009). *Annual report fiscal year 2009.* Washington, DC: Author.

[v] VA/DoD Joint Executive Council. (2009). *Annual report fiscal year 2009.* Washington, DC: Author.

Additional references for Joint Executive Council:

Department of Defense. (2002, August 1). *DoD instruction 6010.23 - Department of Defense and Department of Veterans Affairs Health Care Resource Sharing Program.* Retrieved October 19, 2010, from http://www.tricare.mil/DVPCO/policy-leg.cfm

TRICARE. (2002 August 1). *TRICARE policy manual, chapter 11, section 2.1 - Veterans Affairs health care facilities.* Retrieved October 19, 2010, from http://www.tricare.mil/DVPCO/policy-leg.cfm

Topic: Other matters: Resources for Reserve Components

Background:

The Reserve Components (RC) of the U.S. armed forces—the Army Reserve (USAR), Air Force Reserve, Navy Reserve, Marine Corps Reserve, Coast Guard Reserve, Army National Guard (ARNG), and Air National Guard (ANG)—total 1.1 million members and comprise roughly 43 percent of the total force. Since 9/11, more than 760,000 RC personnel have been called to active duty. The ARNG and USAR have activated the most RC members since 9/11 (326,818 and 190,435, respectively)[i]. The military departments 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"[ii]. 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).* However, certain resources are unique to the RC as a whole and to specific RCs.

Army Community-Based Warrior Transition Units (CBWTUs) allow qualified reservists (USAR and ARNG) to recover in their home communities. Nine CBWTUs serve approximately 1,770 reserve Soldiers. Reserve Soldiers also comprise more than one-third of the membership of the remaining 29 WTUs based at military treatment facilities (MTFs) throughout the country and overseas[iii].

USAR RCCs. Nineteen RCCs, trained by the Department of Defense (DoD), are located in high-density areas throughout the USAR. The USAR RCC program does not support ARNG Soldiers[iv].

The **National Guard Bureau (NGB) Transition Assistance Advisor (TAA) Program** serves *all* redeploying or separating Guard members, injured or not. TAAs are in each of the 54 states and territories, co-located with the state Adjutants General and incorporated into the Department of Veterans Affairs (VA) sectors and the CBWTUs. 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. There are 61 TAAs working caseloads of 1:80 for wounded, ill, or injured (WII) ARNG/ANG members and 1:12,000 for all separating/returning ARNG/ANG members[v].

The congressionally mandated **Yellow Ribbon Reintegration Program** (YRRP) provides information, services, referral, and proactive outreach programs to RC members and families throughout the deployment cycle[vi]. For reintegration purposes, the YRRP is organized on a 30-

60-90-day post-deployment model[vii]. While YRRP is a resource for all personnel who deploy, wounded warriors may benefit particularly from YRRP activities.

Additionally, participation in YRRP activities by undiagnosed Soldiers may lead to help seeking and/or referral. Official health screening in the form of the post-deployment health reassessment (PDHRA) (see also information paper on *services for post-traumatic stress disorder and traumatic brain injury)* is typically incorporated into 90-day YRRP activities.

Public Law 111-383, the National Defense Authorization Act for FY 2011, Section 583, introduced a set of enhancements of the Program, including expansion of partnerships to include the Department of Veterans Affairs and Service and State-based programs, which may provide access to curriculum, training, and support for services to members and families from all components. The legislation also adds a mechanism for evaluation of the effectiveness of the Program via the Center for Excellence in Reintegration, and authorizes provision of resiliency training through the Program for members of the Armed Forces to build mental and emotional resiliency for successfully meeting the demands of the deployment cycle.[viii]

In an additional step, Section 622 of Public Law 111-383, the National Defense Authorization Act for FY 2011, provides for enhanced accessibility of YRRP events by authorizing round-trip transportation and per diem allowances to a participating service member as well as a person designated by the member to accompany him or her to the event.[ix]

References for resources for Other matters: Resources for Reserve Components:

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[i] Lovejoy, K, (n.d.). *U.S. Army warrior transition command. Resourcing care for wounded warrior*. [PowerPoint presentation]. Retrieved November 18, 2010 from *www.asmcsouthsideva.com/index_files/2010MiniPDI**Lovejoy**.ppt*

[ii] Department of Defense. (2009, December 1). *DoD instruction 1300.24: Recovery coordination program.*

[iii] Office of the Assistant Secretary of Defense for Reserve Affairs.(n.d.) *Reserve affairs overview.* Retrieved on November 18, 2010 from http://ra.defense.gov/documents/Reserve%20Affairs%20Overview.pdf

[iv] CALIBRE. (2010, May 24). *Wounded, ill, and injured recovery care coordinator non-medical case manager (WII RCC NMCM) study—Interim report*. Office of Wounded Warrior Care and Transition Policy. Alexandria, VA: Author.

[v] CALIBRE. (2010, May 24). *Wounded, ill, and injured recovery care coordinator non-medical case manager (WII RCC NMCM) study—Interim report*. Office of Wounded Warrior Care and Transition Policy. Alexandria, VA: Author.

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

[vii] Office of the Under Secretary of Defense. (2009, August 26). *Directive-type memorandum (DTM) 08-033: Interim guidance for clinical case management for the wounded, ill, and injured service member in the military health system*

[viii] National Defense Authorization Act of 2011, Pub. L. No. 111-383, §583 (2011).

[ix] National Defense Authorization Act of 2011, Pub. L. No. 111-383, §622 (2011).

Additional references for resources for Other matters: Resources for Reserve Components:

Defense Advisory Committee on Women in the Services. (2010 March 23). *2009 annual report.* Fairfax, VA: ICF International.

Appendix:

Acronyms Used in Handbook

A&FRC	Airman and Family Readiness Centers
ABA	American Bar Association
AC	Active Component
AF	Air Force
AFSAP	Air Force Survivor Assistance Program
AFW2	Air Force Wounded Warrior
ANG	Air National Guard
ARNG	Army National Guard
ASD(HA)	Assistant Secretary of Defense for Health Affairs
AW2	Army Wounded Warrior
BEC	Benefits Executive Council
CBT	Cognitive-Behavioral Therapy
CBWTU	Community-Based Warrior Transition Unit
CCRP	Care Coalition Recovery Program
CDP	Center for Deployment Psychology
CONUS	Continental United States
CRP	Comprehensive Recovery Plan
CSTS	Center for the Study of Traumatic Stress
DAV	Disabled American Veterans
DCoE	Defense Center(s) of Excellence
DEERS	Defense Eligibility Enrollment Reporting System
DES	Disability Evaluation System
DHCC	Deployment Health Clinical Center
DHS	Department of Homeland Security
DISC	District Injured Support Cell
DoD	Department of Defense
DoDI	Department of Defense Instruction
DoL	Department of Labor

DTAP	Disabled Transition Assistance Program
DVBIC	Defense and Veterans Brain Injury Center
DVOPS	Disabled Veterans' Outreach Program Specialists
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
HEC	Health Executive Council
IDES	Integrated Disability Evaluation System
IIP	Information Interoperability Plan
IPEB	Informal Physical Evaluation Board
IPO	Interagency Program Office
JEC	Joint Executive Council
JFSAP	Joint Family Support Assistance Program
JFTR	Joint Federal Travel Regulation
JSP	Joint Strategic Plan
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
MEBOC	Medical Evaluation Board Outreach Counsel

MFLC	Military Family Life Consultant
MHS	Military Health System
mTBI	Mild Traumatic Brain Injury
MTF	Medical Treatment Facility
NDAA	National Defense Authorization Act
NGB	National Guard Bureau
NICoE	National Intrepid Center of Excellence
NMA	Non-Medical Attendant
NMCM	Non-Medical Case Manager
NOD	National Organization on Disabilities
NVLSP	National Veterans Legal Service Program
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
PTSD	Post-Traumatic Stress Disorder
RC	Reserve Component(s)
RCC	Recovery Care Coordinator
RCP	Recovery Coordination Program
REALifelines	Recovery and Employment Assistance Lifelines
RSM	Recovering Service Member
RT	Recovery Team
SAMHSA	Substance Abuse and Mental Health Services Administration
SES	Senior Executive Service
SFAC	Soldier and Family Assistance Center
SOC	Senior Oversight Committee

SOP	Standard Operating Procedure
SOF	Special Operations Forces
T2	National Center for Telehealth and Technology
TAA	Transition Assistance Advisor
TAP	Transition Assistance Program
TBI	Traumatic Brain Injury
TDRL	Temporary Disabled/Retired List
USAR	U.S. Army Reserve
USD(PR)	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
VETS	Veterans Employment and Training Service
VLER	Virtual Lifetime Electronic Record
VR&E	Vocational Rehabilitation and Employment
VSO	Veterans Service Organizations
WII	Wounded, Ill, and Injured
WRAMC	Walter Reed Army Medical Center
WTC	Warrior Transition Command
WTU	Warrior Transition Unit
WWBn	Wounded Warrior Battalion
WWR	Wounded Warrior Regiment
YRRP	Yellow Ribbon Reintegration Program

APPENDIX E: METHODOLOGY

RWTF 2010/2011 Methodology

This appendix provides an overview of the RWTF's research methodology during its first year of operations. The overview is organized in four parts:

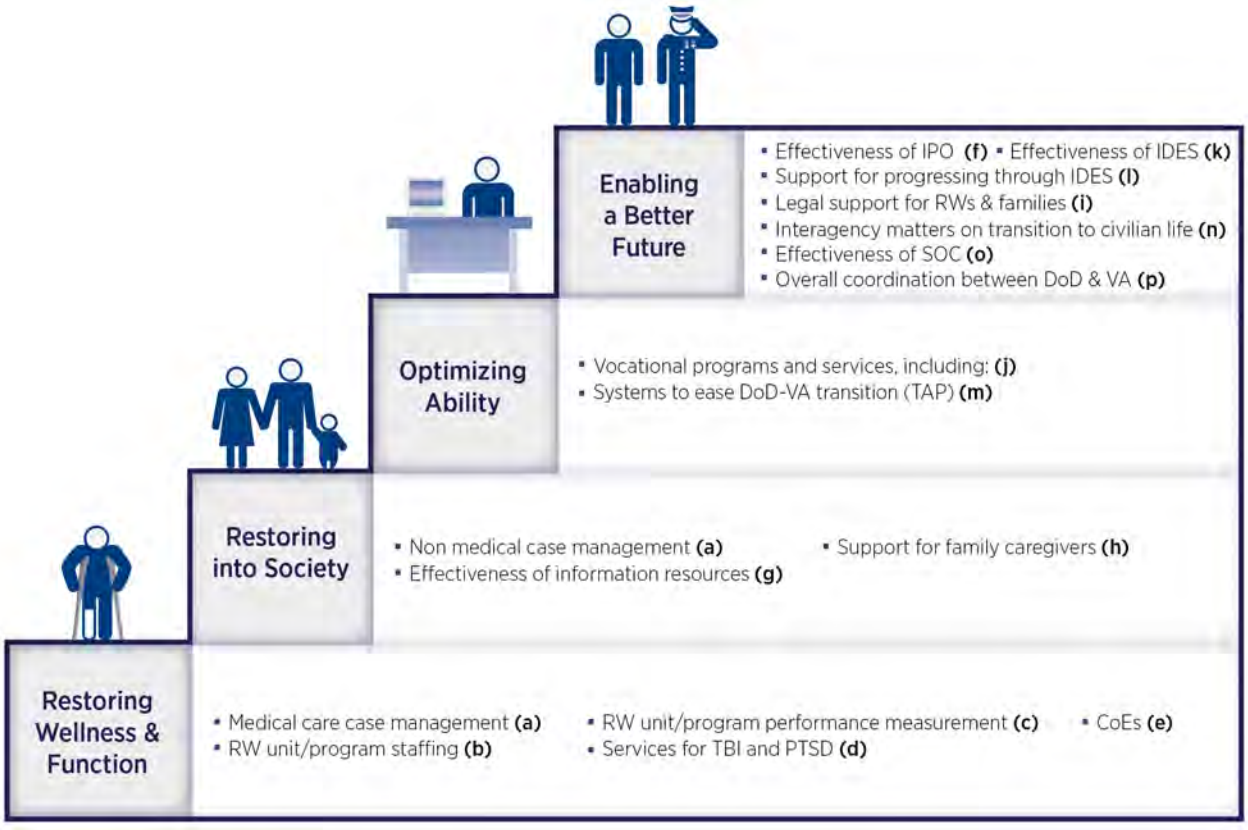
- Research topics
- Approach
- Focus groups
- Strategy for assessing effectiveness

Additional detail regarding aspects of the RWTF's methodology is contained in separate appendices and referenced below.

Research Topics

Congress specified over a dozen diverse matters that the RWTF is to review and assess each year. These matters are shown below, in Exhibit 1, categorized by domain.

Exhibit 1: Mandated Topics Organized by Domain



Synopses of most of these matters can be found in the RWTF Reference Handbook (Appendix D).

Approach

The RWTF engaged in a broad range of data collection activities between January 2011 and May 2011 to inform its first annual assessment and recommendations. These activities were guided by a comprehensive data collection framework organized by topic, research questions, desired information sources, and corresponding data collection methods. The main sources from which the RWTF gathered information were: Headquarters-level proponents, site-level proponents, Recovering Warriors and family members, and pre-existing information sources such as reports, other literature and documents, and administrative or survey databases. The main methods the RWTF used to gather information from these sources included briefing presentations and panel discussions during monthly RWTF business meetings, key informant interviews, briefing presentations and focus groups during site visits, and analysis of existing databases, reports, or literature. Exhibit 2 identifies the types of methods used to gather various categories of information.

Exhibit 2: Information Gathering Methods by Information Source

Source of Information	Methods of Gathering Information	Example
Headquarters-level program proponents	▸ Briefings during monthly meetings ▸ Panel discussions during monthly meetings ▸ Key informant interviews	DoD and Service-level Wounded Warrior programs
Site-level program proponents	▸ Briefings during site visits	Wounded Warrior program/unit leadership and cadre
Recovering Warriors and family members	▸ Focus groups	RW assigned to RW units or line units; spouses and/or parents of RW
Existing reports, literature, and documents	▸ Search and review	GAO reports, peer reviewed literature, news articles
Administrative or survey databases	▸ Data calls	Personnel rosters, survey results

Highlights of the RWTF's 2011 data collection activities are summarized below:

- Four business meetings totaling approximately 158 RWTF person-days
- Thirty-two Headquarters-level (or other national-level) briefings, involving 44 personnel
- Four Headquarters-level (or other national-level) panel discussions, involving g 15 personnel
- Five Headquarters-level key informant interviews
- Twelve Site visits totaling 110 RWTF person-days
- Seventy site-level briefings,[1] involving 208 site-level personnel
- Twenty-three site-level focus groups[2] involving 144 participants (including 18 Recovering Warrior (RW) sessions and 5 family member sessions) (RWs assigned to RW units or line units and caregivers)
- Review of more than 100 reports, articles, and policy documents

A more detailed accounting of the RWTF's data collection activities is in Appendices F and G, including the business meeting and site visit schedules and a crosswalk of sources by topic. Further detail regarding the RWTF's focus groups follows.

Focus Groups

The on-site focus groups formed a centerpiece of the RWTF's data collection activities, capturing a real-time customer perspective. Teams of 3 to 5 members visited 12 Army, Air Force, Navy, Marine Corps, and

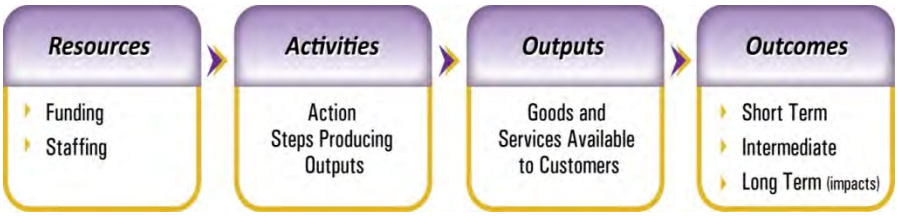
National Guard sites, where they held separate focus groups with RWs (assigned to transition units or line units) and family caregivers. The RWTF conducted 18 RW focus groups and 5 caregiver focus groups at these locations, employing a methodology and instruments approved in advance by the ICF International Institutional Review Board.

Focus group participants also completed anonymous mini-surveys, which gathered both demographic and substantive information. The mini-surveys were completed by 126 Service members, of whom more than 90 percent were male. The large majority were Active Component Soldiers and Marines and were predominantly junior enlisted personnel and junior noncommissioned officers. Half indicated that they have more than one condition. The most prevalent of these conditions was medical diagnosis, followed by psychological diagnosis, orthopedic injury, and traumatic brain injury (TBI). Eighteen family members completed mini-surveys, of whom more than two-thirds were spouses. The large majority were family members of Active Component Soldiers, Airmen, and Marines. Two-thirds of the family members indicated their Service member had more than one condition, and the most prevalent of these conditions was TBI, followed by psychological diagnosis and orthopedic injury.

Strategy for Assessing Effectiveness

"Effectiveness" may be defined as the extent to which a policy or program accomplishes its stated goals and objectives or meets the needs it was established to address. Assessing effectiveness tells what positive difference a policy or program makes. It is not a straightforward task, however, and there are myriad ways to approach it—some more formal and rigorous than others. The RWTF's approach to assessing effectiveness is a practical one that takes into account the maturity of existing RW programs and policies as well as the metrics that these initiatives are currently gathering. The RWTF approach capitalizes on the logic model—a tool that helps program developers and evaluators explicate how the elements of a program are supposed to work together to achieve intended outcomes. This model is particularly useful for illustrating the range of opportunities and various types of metrics—in addition to outcomes—that can contribute to an assessment of effectiveness. A pared-down sample logic model is presented in Exhibit 3.

Exhibit 3: Basic Logic Model



The RWTF recognized from the outset that, although outcome data provide the strongest evidence of an initiative's effectiveness, younger initiatives are more likely to be gathering resource data, activity data, and/or output data. Accordingly, the RWTF sought and used the best available metrics to inform its assessments of program and policy effectiveness.

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[1] Although most briefings were presented directly to the RWTF Members, some briefing content was imparted less formally, and other briefings and related collateral were provided to the members as take-aways.

[2] Three of these sessions included just one participant, which technically made these sessions individual interviews rather than focus groups.

APPENDIX F: BUSINESS MEETINGS AND PRESENTATIONS/PANELS

Business Meetings and Presentations/Panels

Dates	Presentations/Panels
January 6–7, 2011	**Defense Centers of Excellence Presentation** ▸ DCoE for Psychological Health and Traumatic Brain Injury (Michael Kilpatrick, MD) ▸ Traumatic Brain Injury (Katherine Helmick, MS, CNRN, CRNP) ▸ Psychological Health (Col. (S) Christopher Robinson, PhD, MPH)
February 22–23, 2011	**Army Presentations** ▸ Introduction and Overview of WII Program (BG Darryl Williams, Col. Catherine Mozden, COL Greg Gadson) ▸ Warrior Transition (WT) Command Satisfaction (Dr. Melissa Gliner) ▸ Warrior Care and Transition Program and Support for Caregivers (COL Catherine Mozden and LTC (P) Suzanne Scott) ▸ Soldier & Family Assistance Centers (Christopher Watson and Colleen Tuddenham) ▸ Clinical Aspects of the WCTP (LTC (P) Suzanne Scott) ▸ Services for TBI and PTSD (COL John Stasinos and Maj. Sarah Goldman) ▸ IDES (COL Daniel Cassidy and Col. Sheila Hobbs) ▸ Programs for Vocational Training/Reemployment as Army Civilians/Transition Assistance (Nancy Adams) (Prepared, Not presented) **Air Force Presentations** ▸ Air Force Clinical Case Management Program (Lt Col Wendy Lee) ▸ Air Force Warrior and Survivor Care (Lt Col Beth Demmons) ▸ Medical Services for PTSD (Lt Col David Dickey) ▸ Medical Services for TBI (Maj Laura Baugh) ▸ Additional comments (Col Catherine Biersack)
March 30–31, 2011	**Marine Corps Presentations** ▸ Wounded Warrior Regiment (Col John Mayer) ▸ Measures of Effectiveness and Systems of Performance and Accountability (Col John Mayer) ▸ Training (Col John Mayer) ▸ Recovery Coordination Program (Mr. Tim Clubb) ▸ Information Resources (Col John Mayer and Mr. Tim Clubb) ▸ Wounded Warrior Regiment Family and Caregiver Support (April Peterson) ▸ Wounded Warrior Regiment Transition Assistance (Col John Mayer) ▸ Integrated Disability Evaluation System (Paul Williamson) **Navy Presentations** ▸ Introduction and Safe Harbor Program Overview (CAPT Bernie Carter) ▸ Measures of Effectiveness and Systems of Accountability and Performance for Navy Safe Harbor (Merissa Larson) ▸ Training provided by Safe Harbor (LT David Noriega) ▸ Vocational Training and Re-employment (CDR Bailey) ▸ BUMED Introduction and WII/Psychological Health-TBI/PDHRA funding (CAPT Richard Begthold and Mr. Eddie Bueno) ▸ Navy Medical Case Management (CDR Moise Willis) ▸ Psychological Health and PTSD Treatment at BUMED (Dr. Makeithan) ▸ TBI Treatment at BUMED (CDR Jack Tsao) ▸ Integrated Disability Evaluation System (CDR Dave Webster) **National Guard Presentations** ▸ Introduction and Transition Assistance Advisor Program (Mr. Michael Conner, Sr.) ▸ Challenges unique to the NGB when working with psychological health issues (CPT Joan Hunter)

Dates	Presentations/Panels
May 18–19, 2011	**Presentations** ▸ DoD Wounded Warrior Care and Transition Policy (WWTCP staff, including Mr. John Campbell, Mr. Koby Langley, Mr. Philip Burdette, Mr. Brett Stevens, and Mr. Robert Carrington) ▸ Federal Recovery Care Coordination Program (Dr. Karen Guice) ▸ Clinical Decision Support for Civilian Primary Healthcare Management of PTSD (Dr. Charles Sneiderman) ▸ Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Services (Mr. Wilbert Berrios) ▸ U.S. Special Operations Command Care Coalition (LTC Katryna Deary) **Centers of Excellence Panel** ▸ DoD/VA Vision Center of Excellence (Mary G. Lawrence, MD, MPH) ▸ Traumatic Extremity Injuries and Amputation Center of Excellence (EACE) (COL Donald A. Gagliano, MD, MPH) ▸ DoD Hearing Center of Excellence (COL Kathy Gates) **Employment Panel** ▸ Able Forces (Mr. Skip Rogers) ▸ The Sentinels of Freedom Scholarship Foundation (Mr. Michael Conklin) ▸ DirectEmployers Association, Inc. (Ms. Jolene Jefferies) ▸ Army Warrior Transition Command (Ms. Nancy Adams) **Counterpoint Panel** ▸ Continuing Issues with the Defense Disability Evaluation System (DES) (Michael A. Parker, LTC, USA [Ret.]) ▸ The American Legion (Mr. Ryan Butler) ▸ Personal experiences of the spouse of a Recovering Warrior (Mrs. Patty Horan) ▸ Personal experiences as a Recovering Warrior (SSG Lanier) **Cognitive Rehabilitation Therapy and TBI Panel** ▸ Cognitive Rehabilitation In Moderate/Severe and Mild TBI (Rodney D. Vanderploeg, PhD, ABPP-CN) ▸ Cognitive Rehabilitation in mTBI: DoD Demonstration Project (CDR Michael T. Handrigan) ▸ Cognitive Rehabilitation for Service Members with TBI at WRAMC (Michael Pramuka, PhD, CRC)

APPENDIX G: SITE VISITS

Site Visits

Dates	Installation/ Location/Service	Presentations
March 8–9, 2011	Ft. Campbell; Kentucky (Army)	▸ Medical Care Case Management for Wounded Warriors (COL Wasserman ▸ Non-Medical Case Management/AW2 Advocates (Mr. Melvin Taylor) ▸ Wound Warrior Units (CPT Martin) ▸ PTSD (MAJ Singh, MD) ▸ Warrior Resiliency and Recovery Center (TBI) (Bret W. Logan, MD, David A. Twillie, MD, Marc A. Zola, PhD) ▸ Caregiver Support Briefing (Mr. Britton) ▸ PEBLO/DES ▸ Legal Support Briefing ▸ VA Vocational Rehabilitation and Employment (Tim Schoonover) ▸ Vocational Training Transition Assistance ▸ Warrior Transition Battalion (Prepared, not presented) ▸ ACS Soldier and Family Assistance Center
March 14–15, 2011	Ft. Benning; Georgia (Army)	▸ Fort Benning Warrior Transition Battalion (CSM Gregory S. Chatman) ▸ Fort Benning Warrior Transition Battalion – Transition (Mr. Kevin L. Peoples) (Prepared, Not Presented) ▸ First Sergeant's Brief (1SG Drayton) ▸ Family Support Briefing (Ms. Jenna Hughes) ▸ Warrior Transition Unit (Luzmira Torres, MD, Carolyn E. Driver, MSN) ▸ PTSD (Dr. Mellissa Mecina) ▸ TBI (Ms. Sherry Williams) ▸ Integrated Disability Evaluation System Briefing (Mr. Mark Dixon) ▸ Legal Services in the Army Physical Disability Evaluation System– MEB Outreach Counsel (Mr. Michael Cassady) (Prepared, Not Presented) ▸ IDES Briefing ▸ Medical Case Management Briefing (Carolyn E. Driver, MSN) ▸ Legal Support Briefing (Mr. Michael Cassady) ▸ Non-Medical Case Management AW2 Advocates A Co. ▸ Non-Medical Case Management AW2 Advocates B Co. ▸ Non Medical Case Management/AW2 Advocates (Ms. Carlisle/ Ms. Steplight)
March 22, 2011	Brooke Army Medical Center (BAMC); Texas (Army)	▸ Care Case Management (Army Wounded Warriors) (LTC Sonia Rivera) ▸ Care Giver Support (MAJ Finch, Ms. Dias, Ms. Markelz) ▸ Non-Medical Case Management (Army Wounded Warriors) (SFC Bryant, Mrs. Harris) ▸ Brooke Army Medical Center Army Warrior Transition Battalion
March 23, 2011	Wilford Hall Medical Center; Texas (Air Force)	▸ United States Air Force Recovery Coordination Program and the Role of the Recovery Care Coordinator ▸ Air Force Wounded Warrior (AW2) Program (Prepared, Not presented) ▸ Patient Squadron (Prepared, Not presented)
March 23, 2011	VA Polytrauma Rehabilitation Center; Texas (VA)	▸ Informal briefing and tour presented to RWTF
April 6–7, 2011	Marine Corps Air Ground Combat Center (29 Palms); California (USMC)	▸ Family and Caregiver Support (Ms. Melinda Willet, SgtMaj Templeton) ▸ Medical Care Case Management ▸ DoD Inspector General Transition Information – Vocational Rehabilitation Handout ▸ TBI/PTSD (Mr. Thomas Teleha) ▸ WWBN-W Detachment 29 Palms (LtCol Gregory Martin, SgtMaj Mark Olouglin, SgtMaj Mike Templeton) ▸ Wounded Warrior Battalion West (LtCol Gregory Martin) ▸ Robert E. Bush Naval Hospital – Marine Corps Air Ground (Prepared, Not Presented) ▸ Combat Center/Marine Air Ground Task Force Training Center (Prepared, Not presented) ▸ Planning for Success (Prepared, Not presented)

Dates	Installation/ Location/Service	Presentations
April 11, 2011	Naval Medical Center San Diego; California (Navy)	▸ Comprehensive Combat and Complex Casualty Care (C5) Program (Ms. Jennifer Town) ▸ Department of Defense. Office of the Inspector General ▸ Balboa IDES Information– Handout ▸ Legal Services – Handout ▸ DHB Case Management ▸ Oasis Program – Handout ▸ Oasis Program Welcome Aboard Package – Handout ▸ Oasis Program Pamphlet – Handout ▸ PTSD Intensive Outpatient Program Pamphlet – Handout ▸ Coming Home to Work Program – Handout ▸ Program of Wellness Education and Recovery Pamphlet – Handout
April 12, 2011	Marine Detachment; California (USMC)	▸ Wounded Warrior Detachment – NMCSD (LtCol Timothy Bleidistel) (Prepared, Not presented)
April 21, 2011	Joint Force Headquarters (JFHQ); Florida (NGB)	▸ Psychological Health (Michael McFarland, LMFT) ▸ Transition Assistance Advisor (Linda L. Cononie) ▸ Case Management ▸ Medical Care Case Management (SFC Julia Porter) ▸ Family Assistance Centers (CPT Amy Green) ▸ Family Programs ▸ PDHRA (MSG Randy Dukes, 2LT Lakiesha Roberson, SPC Michelle Fernandez)
April 22, 2011	Community Based Warrior Transition Unit (CBWTU); Florida (NGB)	▸ AW2 (Mr. Chlapowski) ▸ C2 Briefing (MAJ Charles Hansrote, 1SG Edwin Brockell) ▸ Southern Regional Medical Command CBWTU (MAJ Charles Hansrote, 1SG Edwin Brockell) ▸ M2 Briefing (LTC Jonnie Bailey) ▸ PSG Transition Service (1SG Edwin Brockell) ▸ Warriors in Transition Survey – Handout ▸ Florida CBWTU Demographics – Handout
April 26, 2011	Joint Force Headquarters (JFHQ); California (NGB)	▸ CNG In-brief (LTC Anderson) ▸ Transition Assistance Advisor (Mr. Horst Laube) ▸ Peer-to-Peer Advisor (Mr. John Wilson) ▸ WTU Medical Liaison (SSG Briley) ▸ Post-Deployment Health Reassessment (PDHRA) (SSG Shane J. Kirk) ▸ Reintegration: Medical Processing from AOR to Home Station (Col. David L. Walton) ▸ CA ARNG Health Services Support Branch (LTC Anderson) ▸ California National Guard Joint Behavioral Health Office (LTC Frye) ▸ Family Assistance Network
April 27, 2011	Community Based Warrior Transition Unit (CBWTU); California (NGB)	▸ CBWTU In-brief (MAJ Basher) ▸ Medical Care Case Manager (LTC Fox) ▸ Medical Officer (COL Siegel, CPT Flores) ▸ Platoon Sergeants (MSG Giliberto) ▸ AW2 ▸ Wounded Warriors Units Chain of Command Care (MAJ Brasher)

APPENDIX H: KEY INFORMANT INTERVIEWS

Key Informant Interviews

Date	Interview Participant(s)
May 23, 2011	Office of the Joint Staff Surgeon, Joint Chiefs of Staff
May 24, 2011	Office of the Assistant Secretary of the Army (Manpower and Reserve Affairs)
May 31, 2011	Office of the Deputy Secretary of the Department of Veterans Affairs
June 6, 2011	Office of the Assistant Secretary of the Air Force (Manpower and Reserve Affairs)
June 8, 2011	Office of the Assistant Secretary of the Navy (Manpower and Reserve Affairs)

APPENDIX I: INFORMATION SOURCES BY TOPIC

Information Sources by Topic

Recovering Warrior Units and Programs

- Air Force response to the RWTF data call: Non Medical Case Management. July 12, 2011.
- Air Force Warrior and Survivor Care briefing to the RWTF. February 23, 2011.
- Air Force Wounded Warrior Program. *Memorandum prepared for the RWTF.* March 23, 2011.
- Army Warrior Transition Command (WTC) briefing to the RWTF. February 22, 2011.
- Army WTC response to the RWTF data call. July 1, 2011.
- Buckley, B. (May 19, 2011). CounterPoint presentation to the RWTF. *Professional experiences as the American Legion MEB/PEB representative at Fort Lewis, WA.*
- Campbell, J.R. (September 7, 2010). Deputy Under-Secretary of Defense for Wounded Warrior Care and Transition Policy (WWCTP), *Memorandum for Assistant Secretaries of the Services (Manpower and Reserve Affairs), Announcement of the Warrior Transition Programs (WTP) Needs Assessment.*
- Campbell, J.R. WWCTP Briefing to the RWTF. May 18, 2011.
- COL Cassidy and COL Hobbs. Briefing to the Task Force. *US Army IDES*. February 22, 2011.
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- LTC Deary, K. Briefing to the RWTF. *Special Operations Command Care Coalition*. May 19, 2011.
- Defense Advisory Committee on Women in the Services (DACOWITS). (2009). *Report: Support for families of wounded warriors.* Retrieved June 8, 2011, from http://dacowits.defense.gov/annual_reports/DACOWITS%2009%20Final%20Report.pdf.
- Emerich, S.A. (2008). Ensuring Excellence: The Warrior Transition Unit Staff Training Program. *The Army Medical Department Journal*, January–March 2008, 17-20.
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- Horan, P. CounterPoint presentation to the RWTF. *Personal experiences of the spouse of a Recovering Warrior.* May 19, 2011.
- LtCol Knox, E., Deputy Operations Officer, US Marine Corps Wounded Warrior Regiment, personal communication, July 5, 2011.
- SSG Lanier, RW. CounterPoint presentation to the RWTF. *Personal experiences as a Recovering Warrior.* May 19, 2011.
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- Marine Corps Wounded Warrior Regiment. (n.d.). *USMC Research Fact Sheet: Recovery Care Coordinator Survey: Executive Summary.* Washington, DC: Future Initiatives and Transformation Team.
- Marine Corps Wounded Warrior Regiment. (n.d.). *USMC Research Fact Sheet: Support to WII Reserve Personnel.* Washington, DC: Future Initiatives and Transformation Team.
- Marine Corps Wounded Warrior Regiment briefing to the RWTF. March 30, 2011.
- Marine Corps Wounded Warrior Regiment. *Memorandum to the RWTF in response to March 30, 2011 briefings.* April 6, 2011.
- Marine Corps Wounded Warrior Regiment response to the RWTF data call. July 8, 2011.
- Martinez, D., and Heinbaugh, E. Briefing to the RWTF. *Air Force Wounded Warrior Program Care Managers at the Air Force Personnel Center.* March 23, 2011.
- Navy. (n.d.). *2009 Safe Harbor Annual Care Survey Executive Summary.* Washington, DC: Author.
- Navy Safe Harbor briefing to the RWTF. March 31, 2011.
- Navy response to the RWTF data call: Non Medical Case Management. April 8, 2011.
- Lt Gen Newton III, R. Air Force/A1 Memorandum. *Wounded Warrior Personnel Policies.* February 10, 2009.
- Panel on Cognitive Rehabilitation Therapy and TBI briefing to the RWTF. May 19, 2011.
- LTC Pasek, G., U.S. Army Warrior Transition Command, personal communication, June 3, 2011.

Recovering Warrior Units and Programs (cont.)

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- RWTF family member focus group results. March/April 2011.
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- RWTF Service member mini-survey results. March/April 2011.
- Site level briefings to the RWTF. March/April 2011.
- U.S. Army Office of the Inspector General (USAIG). (September 22, 2010). *Inspection of the Warrior Care and Transition Program, Department of the Army.* Washington, DC: Author.
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- Zoroya, G. (January 25, 2011). Report: 35% of warrior-unit soldiers face addiction. *USA Today.* Retrieved January 27, 2011, from www.usatoday.com/news/military/2011-01-25-wounded-care_N.htm.

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- California National Guard (n.d.) *Peer-to-Peer Support Program.* Retrieved on July 12, 2011 from www.calguard.ca.gov/j1/Pages/Peer_support.aspx
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- Jaffee, M.S., and Meyer, K.S. (2009). A brief overview of traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD) within the Department of Defense. *The Clinical Neuropsychologist*, 23, 1291-1298.
- Col Mayer, J.L. Briefing to the RWTF. *US Marine Corps Wounded Warrior Regiment*. March 30, 2011.
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Other Centers of Excellence

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- COL Gagliano, D.A., and Lawrence, M.G. Briefing to the RWTF. *Vision Center of Excellence.* May, 18 2011.
- Col Gates, K. Briefing to the RWTF. *Hearing Center of Excellence.* May 18, 2011.

Medical Care Case Management

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- Air Force response to the RWTF data call: Medical Care Case Management. July 1, 2011.
- Army briefing to the RWTF. February 22, 2011.
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- RWTF Service member focus group results. March/April 2011.

Medical Care Case Management (cont.)

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

Non Medical Case Management

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- RWTF Service member focus group results. March/April 2011.
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- *Seamless transition – Meeting the needs of Service members and veterans: Hearing before the U.S. Senate Committee on Veterans Affairs*, 112th Cong. (May 25, 2011) (statement of James R. Lorraine, Executive Director, Central Savannah River Area Wounded Warrior Care Project).
- *Seamless transition – Meeting the needs of Service members and veterans: Hearing before the U.S. Senate Committee on Veterans Affairs*, 112th Cong. (May 25, 2011) (testimony of George Taylor, Assistant Secretary of Defense, Force Health Protection and Readiness, with Philip Burdette, Principal Director, Wounded Warrior Care and Transition Policy).
- *Seamless transition – Meeting the needs of Service members and veterans: Hearing before the U.S. Senate Committee on Veterans Affairs*, 112th Cong. (May 25, 2011) (statement of Dr. Antonette Zeiss, Acting Deputy Chief Officer, Mental Health Services, Office of Patient Care Services, Veterans Health Administration, Department of Veterans Affairs).
- Site level briefings to the RWTF. March/April 2011.
- *The Federal Recovery Coordination Program: From concept to reality: Hearing before the Subcommittee on Health, House Committee on Veterans' Affairs*, 112th Cong. (May 13, 2011) (prepared statement of Robert S. Carrington, Director, Recovery Coordination, WWCTP).

Non Medical Case Management (cont.)

- *The Federal Recovery Coordination Program: From concept to reality: Hearing before the Subcommittee on Health, House Committee on Veterans' Affairs,* 112th Cong. (May 18, 2011) (prepared statement of Karen Guice, Executive Director, Federal Recovery Coordination Program, U.S. Department of Veterans Affairs).
- *The Federal Recovery Coordination Program: From concept to reality: Hearing before the Subcommittee on Health, House Committee on Veterans' Affairs,* 112th Cong. (May 13, 2011) (prepared statement of the Military Officers Association of America).
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- Campbell, J.R. Wounded Warrior Care and Transition Policy (WWCTP) Briefing to the RWTF. May 18, 2011.
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APPENDIX J-1: SERVICE MEMBER FOCUS GROUP PROTOCOL

SESSION INFORMATION

Location:
Date:
Time:
Facilitator:
Recorder:
# of Participants present for entire session:
# of Participants excused/reasons:

FOCUS GROUP KICK-OFF: KEY POINTS TO COVER

(As participants start to arrive, scribe distributes name tents and markers)

- **Welcome attendees**
  - Thank you for taking the time to join our discussion today.
  - I am ___ (insert name) and I am a member of the DoD Recovering Warrior Task Force (RWTF), and this is ___ (introduce partner), also a member of this Task Force.
  - Our scribe, ___, is part of the RWTF research staff.

- **Introduce RWTF and its purpose**
  - The 2010 National Defense Authorization Act (NDAA, Section 724) directs the Recovering Warrior Task Force (RWTF) to assess the effectiveness of the policies and programs developed and implemented by the Office of the Secretary of Defense and the military departments, and make recommendations for improving the policies and programs.
  - The RWTF is comprised of 14 active Service members, veterans, and professionals, of which we are two. All of us bring to the table highly relevant recovering warrior experience, personal and/or professional.
  - The RWTF is chartered for four years and will generate an Annual Report at the end of each year of effort.

- **Describe how focus group session will work**
  - This session is intended for recovering Service members.
  - We have scripted questions formulated to address specific topics.
  - The session will last approximately 90 minutes, and we will not take a formal break. (Restrooms are located xxxxxx)
  - Before we begin our voluntary discussion, we will pass around a short questionnaire to gather some basic background information from you. The questionnaire is voluntary and should be completed anonymously—no names please. If you need assistance filling out the questionnaire, please let us know so one of us can offer our assistance.
  - Try not to mention individuals by name in your comments to protect their confidentiality.
  - Each of us has a role to play here.

- I serve as an impartial data gatherer and discussion regulator.
- Our scribe serves as recorder—note s/he is taking no names and we are not audio- or video-taping the session.
- You serve as subject matter experts.
- My other colleagues are here to observe.

- **Emphasize that participation is voluntary**
  - Your participation in this session is voluntary.
  - While we would like to hear from everyone; feel free to answer as many or as few questions as you prefer.
  - If you would prefer to excuse yourself from the focus group at this time, you are free to do so.
  - You may also excuse yourself at any point during the focus group and, if you wish, to return.

- **Address confidentiality**
  - We treat the information you share as confidential. That means we will protect your confidentiality to the extent allowable by law. We will not reveal the names of study participants and no information will be reported that can identify you or your family. In fact, all members of the RWTF research team (members and staff) have signed confidentiality agreements pledging to safeguard the confidentiality of the information we gather in these sessions.
  - We may report data by installation, but your name will never be linked to your answers or to any comments you make during the discussion. Your answers to our questions will not affect your promotions, rights, or benefits.
  - However, there are some behaviors that we are required to report. If we learn that you are being hurt or planning on hurting yourself or others, or others are being hurt or planning on hurting themselves or others, the law requires that we share this information with someone who can help and to the appropriate authority.
  - Also, because this is a group meeting, it is important that each of you agree to respect and protect each other's privacy. We expect you to keep any information you hear today in the strictest of confidence, and not discuss it with anyone outside of this group.
  - Please be aware, however, that we cannot guarantee that other participants will honor this expectation. If this concerns you, you should limit your participation to what you are comfortable discussing, or not participate in the focus group at all.
  - We will distribute an informed consent form for you to read and sign. If you have any questions or need assistance with the form, please let us know so one of us can offer our assistance.

- **Ask scribe to distribute/collect the informed consent forms and then the mini-surveys. (After collecting the completed mini-surveys, the scribe will place the completed informed consent forms and mini-surveys in two separate folders.)**
  - Informed consent form is to be read and signed.
  - Short mini-survey is to be completed anonymously.

- **Explain ground rules**
  - Speak one at a time so that your statement can be heard by all.
  - There are no right or wrong answers.
  - We want to hear the good and the bad.
  - We respect and value differences of opinion.
  - Please avoid sidebar conversations.
  - Please note that we use the terms recovering Service member; recovering warrior; and wounded, ill, or injured Service member interchangeably.

WARM-UP/INTRODUCTIONS

To begin I'd like to go around the room and ask each of you to introduce yourselves and to share some brief background. Specifically please tell us:

1. Your branch of Service (e.g., AC Marine Corps, Army Reserve)

2. Length of time since you became wounded, ill, or injured

3. Where you are in the recovery process (e.g., inpatient, outpatient and living near hospital, outpatient and living at home)

DISCUSSION QUESTIONS

We are here to learn about your experiences and perspectives regarding the policies and programs that have been established to support the care, management, and transition of recovering Service members and their families. We are particularly interested in hearing how effectively these resources meet your needs.

We will be talking mainly about 5 topics: 1) medical care case management, 2) non-medical care case management, 3) legal support, 4) vocational training, and 5) services for traumatic brain injury (TBI) and post traumatic stress disorder (PTSD) [and, at select locations, 6) the disability evaluation system (DES)].

(**Note to moderators**: Many of the same questions are deliberately repeated across several topics. For your convenience, questions that are unique to a topic appear in bold font)

INITIAL QUESTIONS

A. Who is part of your team helping you through the recovery process?

B. Which of these "team members" is most valuable to you as you recover?

C. What is it about these individuals, or the team as a whole, that makes them valuable to you?

D. How active a part do you have in your recovery plan?

E. During this recovery process, what needs do you have that are not being met, if any?

(FOLLOW-ON QUESTIONS BELOW TO BE CHOSEN BASED ON RESPONSES TO INITIAL QUESTIONS)

I. Medical Care Case Management

INTRO:
Medical care case management is sometimes called clinical case management.
The medical care case manager is typically a registered nurse (RN) or someone with a master's degree in social work (MSW).
While we hope you are satisfied with your medical care and your medical care providers, our focus here today is on medical care *case management*.

a. What kinds of support does your medical care case manager provide you?
b. To what extent does your medical care case manager meet your needs?
c. We are interested in best practices that could be shared with other medical care case managers and other locations. What aspect of the support he/she provides you works particularly well?

(Mini-survey captures ratings of medical care case manager helpfulness)

II. Non-Medical Case Management

INTRO:
We are specifically interested in the non-medical case management provided by your *Recovery Care Coordinator (RCC)* or your *Federal Recovery Coordinator (FRC*).
If you are enrolled in the Army Wounded Warrior Program (AW2), this would be your *AW2 Advocate.*
If you are in the National Guard, this will be your *Transition Assistance Advisor (TAA)* once you separate or retire from the military.

The RCC (or FRC, AW2 Advocate or TAA) has primary responsibility for the development of the RSM's comprehensive recovery plan (CRP) and works in coordination with the other members of the recovery team.

a. What kinds of support does your RCC/FRC/AW2 Advocate/TAA provide you? (Please specify whether you are talking about an RCC, FRC, AW2 Advocate/TAA)
b. To what extent does he/she meet your needs?
c. We are interested in best practices that could be shared with other RCCs/FRCs/AW2 Advocates/TAAs and other locations. What aspect of the support he/she provides you works particularly well?

Your *unit chain of command* may also provide non-medical case management.

a. What kinds of support does your unit chain of command provide you?
b. To what extent does the unit chain of command meet your needs?
c. We are interested in best practices that could be shared with other units and other locations. What aspect of the support your unit chain of command provides you works particularly well?

(Note to moderators: For site visits to Community-based WTUs, you will receive tailored focus group protocols.)

(Mini-survey captures ratings of RCC/FRC/AW2/TAA/unit chain of command helpfulness)

III. Disability Evaluation System (DES)

(Note to moderators: Questions only to be asked at sites where Integrated DES is in place: Ft. Benning, Balboa, BAMC**)**

INTRO:
We'd like to hear about your experiences with the Disability Evaluation System (DES).

a. **Who is currently going through the DES process?** (Moderator asks for show of hands and scribe records number)
b. **Where are you in this process**? (Moderator asks for show of hands for those in 1) final decision, 2) appeal process, 3) PEB complete, and 4) MEB complete, and scribe records number)
c. What types of support and assistance are available to you, **and from whom**, as you progress through the DES process?
d. To what extent does this support meet your needs as you progress through this process?
e. If not addressed spontaneously: **What is the role of the Physical Evaluation Board Liaison Officer** (PEBLO) during this process?

f. We are interested in best practices that could be shared with others responsible for supporting recovering Service members as they progress through this process and other locations. What aspect of the support the **PEBLO provides you, or other personnel provide you**, works particularly well?
g. For those of you nearing transition from DoD to VA care and services, how confident are you about how the transition will work? Why is that? Does the combined DoD/VA rating examination affect your level of confidence about this transition?

(Mini-survey captures further detail about PEBLOs, including ratings of helpfulness)

IV. Legal Support

INTRO:
Military personnel, including recovering Service members and others, have access to legal assistance services. We are interested in the *additional* legal support that is available to you as you prepare to transition either to civilian status or back to duty.

a. What additional legal support have you used? (e.g., pre MEB, MEB, pre-PEB, PEB? Other?)
b. How did you learn of this legal support?
c. To what extent has this legal support met your needs?
d. We are interested in best practices that could be shared with other providers of legal support and other locations. What aspect of the support you have received works particularly well?
e. What has prevented you or others from taking better advantage of available legal support?
f. Are Service members diagnosed with TBI provided an opportunity to review their DES packet with legal prior to sending it off to the PEB board?

V. Vocational Support

INTRO:
Vocational support can be a critical component of a recovering Service member's rehabilitation and transition.
Many different kinds of supports can potentially fall under the umbrella of vocational support—for example: training for a specific skill (e.g., computer programming), certification (e.g., Microsoft), education (e.g., AA degree), job preparation (e.g., resume writing, interviewing skills, job coaching), internships, job vocational rehabilitation including assistive technology and adaptive equipment for the workplace, and job referral and job placement.

a. What types of vocational support have you used?
b. How did you learn of these vocational resources?
c. To what extent have these vocational resources met your needs?

d. We are interested in best practices that could be shared with other providers of vocational support and other locations. What aspect of the vocational support you have received works particularly well?
e. What has prevented you or others from taking better advantage of available vocational support resources?
f. Are you enrolled in VA Vocational Rehabilitation & Employment (VR&E)?
g. What do you know about obtaining VA reimbursement for child care while enrolled in VR&E, based on your own experience or things you've heard?
h. What has prevented you or others from taking better advantage of VR&E?

Recovering Service members may be interested in returning to duty but may need or want to change their occupational specialty. Others may be interested in continuing to work for the Federal Government but in a civilian capacity. We are interested in the resources available to help you transition to new military occupations or civilian jobs within the Federal Government.

a. What forms of assistance have you used to prepare for a new military occupational specialty or a civilian job within the Federal Government? (Please specify program by name)
b. How did you learn of these resources?
c. To what extent have these resources met your needs?
d. We are interested in best practices that could be shared with other initiatives like this. What aspect of the program has worked particularly well?
e. What has prevented you or others from taking better advantage of this program or programs like it?

Mentoring can be an invaluable source of support as you transition back to work within or outside the military. Let's call this vocational mentoring.

a. What vocational mentors or vocational mentoring programs have you used?
b. How did you learn of them?
c. What kinds of support does he/she provide you? How helpful is this support?
d. We are interested in best practices that could be shared with other vocational mentoring programs and locations. What aspect of the program has worked particularly well?
e. What has prevented you or others from taking better advantage of this program or programs like it?

(Mini-survey captures ratings of helpfulness of individual vocational resources)

VI. Services for TBI & PTSD

INTRO:
Studies show that approximately 20% of combat veterans experience traumatic brain injuries (TBI) or post-traumatic stress disorder (PTSD).

These conditions, which frequently co-occur and may be invisible to the naked eye, sometimes can be difficult to diagnose.
We recognize that some of you have been, or could be, diagnosed with TBI and/or PTSD.

(**Note to moderators**: If possible, particularly attend to participants who acknowledge first-hand experience; scribe will flag their input)

a. **What treatment options, here or at prior locations, are available?**
b. **How did you learn of these treatment options?**
c. **To what extent do available treatment options meet the needs of Service members diagnosed with TBI or PTSD?**
d. **What prevents Service members from taking better advantage of available TBI/PTSD treatment services?**

VII. Wrap Up

As we draw to a close, we have one final question.

a. What military policy or program stands as something that has been particularly helpful for you as a recovering warrior?

This concludes our discussion. Please remember not to repeat what you heard in this room. Thank you for taking the time to share your opinions and experiences with us. Your thoughts are invaluable to our efforts to inform the Secretary of Defense and Congress on these matters. Once again, thank you very much, and our sincere best wishes for your continued recovery.

(Mini-survey also captures: DTAP briefing attendance, ratings of helpfulness of individual information resources, and ratings of helpfulness of individual DoD programs)

APPENDIX J-2: FAMILY MEMBER FOCUS GROUP PROTOCOL

SESSION INFORMATION

Location:
Date:
Time:
Facilitator:
Recorder:
# of Participants present for entire session:
# of Participants excused/reasons:

FOCUS GROUP KICK-OFF: KEY POINTS TO COVER

(As participants start to arrive, scribe distributes name tents and markers)

- **Welcome attendees**
  - Thank you for taking the time to join our discussion today.
  - I am ___ (insert name) and I am a member of the DoD Recovering Warrior Task Force (RWTF), and this is ___ (introduce partner), also a member of this Task Force.
  - Our scribe, ___, is part of the RWTF research staff.

- **Introduce RWTF and its purpose**
  - The 2010 National Defense Authorization Act (NDAA, Section 724) directs the Recovering Warrior Task Force (RWTF) to assess the effectiveness of the policies and programs developed and implemented by the Office of the Secretary of Defense and the military departments, and make recommendations for improving the policies and programs.
  - The RWTF is comprised of 14 active Service members, veterans, and professionals, of which we are two. All of us bring to the table highly relevant recovering warrior experience, personal and/or professional.
  - The RWTF is chartered for four years and will generate an Annual Report at the end of each year of effort.

- **Describe how focus group session will work**
  - This session is intended for participants who are family members of recovering Service members.
  - We have scripted questions formulated to address specific topics.
  - The session will last approximately 90 minutes, and we will not take a formal break. (Restrooms are located xxxxxx)
  - Before we begin our voluntary discussion, we will pass around a short questionnaire to gather some basic background information from you. The questionnaire is voluntary and should be completed anonymously—no names please. If you need assistance filling out the questionnaire, please let us know so one of us can offer our assistance.
  - Try not to mention individuals by name in your comments to protect their confidentiality.

- Each of us has a role to play here.
  - I serve as an impartial data gatherer and discussion regulator.
  - Our scribe serves as recorder—note s/he is taking no names and we are not audio- or video-taping the session.
  - You serve as subject matter experts.
  - My other colleagues are here to observe.

- **Emphasize that participation is voluntary**
  - Your participation in this session is voluntary.
  - While we would like to hear from everyone; feel free to answer as many or as few questions as you prefer.
  - If you would prefer to excuse yourself from the focus group at this time, you are free to do so.
  - You may also excuse yourself at any point during the focus group and, if you wish, to return.

- **Address confidentiality**
  - We treat the information you share as confidential. That means we will protect your confidentiality to the extent allowable by law. We will not reveal the names of study participants and no information will be reported that can identify you or your family. In fact, all members of the RWTF research team (members and staff) have signed confidentiality agreements pledging to safeguard the confidentiality of the information we gather in these sessions.
  - We may report data by installation, but your name will never be linked to your answers or to any comments you make during the discussion. Your answers to our questions will not affect your or your Service member's promotions, rights, or benefits.
  - However, there are some behaviors that we are required to report. If we learn that you are being hurt or planning on hurting yourself or others, or others are being hurt or planning on hurting themselves or others, the law requires that we share this information with someone who can help and to the appropriate authority.
  - Also, because this is a group meeting, it is important that each of you agree to respect and protect each other's privacy. We expect you to keep any information you hear today in the strictest of confidence, and not discuss it with anyone outside of this group.
  - Please be aware, however, that we cannot guarantee that other participants will honor this expectation. If this concerns you, you should limit your participation to what you are comfortable discussing, or not participate in the focus group at all.
  - We will shortly distribute an informed consent form for you to read and sign. If you have any questions or need assistance with the form, please let us know so one of us can offer our assistance.

- **Ask scribe to distribute/collect the informed consent forms and then the mini-surveys. (After collecting the completed mini-surveys, the scribe will place the completed informed consent forms and mini-surveys in two separate folders.)**

- Informed consent form to be read and signed.
- Short mini-survey to be completed anonymously.

- **Explain ground rules**
  - Speak one at a time so that your statement can be heard by all.
  - There are no right or wrong answers.
  - We want to hear the good and the bad.
  - We respect and value differences of opinion.
  - Please avoid sidebar conversations.
  - Please note that we use the terms recovering Service member; recovering warrior; and wounded, ill, or injured Service member interchangeably.

WARM-UP/INTRODUCTIONS

To begin I'd like to go around the room and ask each of you to introduce yourselves (your first name is sufficient) and to share some brief background on your Service member and his/her injury. Specifically please tell us:

1. Your Service member's branch of Service (e.g., Marine Corps, Army) and your relationship to him or her (e.g., spouse? parent?)

2. Length of time since your Service member became wounded, ill, or injured

3. Where the Service member is in the recovery process (e.g., inpatient, outpatient and living near hospital, outpatient and living at home)

DISCUSSION QUESTIONS

We are here to learn about your experiences and perspectives regarding the policies and programs that have been established to support the care, management, and transition of recovering Service members and their families. We are particularly interested in hearing how effectively these resources meet <u>your</u> needs.

We will be talking about 3 main topics: 1) Support for family caregivers, 2) Recovering warrior information sources, and 3) Non-medical case management.

(**Note to moderators**: Many of the same questions are deliberately repeated across several topics. For your convenience, questions that are unique to a topic appear in bold font)

INITIAL QUESTIONS

A. Who is part of your Service member's team helping him or her through the recovery process?

B. Which of these "team members" is most valuable to your Service member as he/she recovers?
Which of these "team members" is most valuable **to you** as your Service member recovers?

C. What needs does your Service member have that are not being met, if any?

D. What additional skills do you wish you had, if any, to be of more help to your Service member?

(FOLLOW-ON QUESTIONS BELOW TO BE CHOSEN BASED ON RESPONSES TO INITIAL QUESTIONS)

I. Support for Family Caregivers

INTRO:
Let's start with support for you and your family. We know that the families of recovering warriors, and particularly those in the caregiver role, are profoundly impacted by their Service member's condition and the recovery process.

a. What supports and benefits have you been using? These may be through the military or other sources.
(e.g., financial, travel/lodging, respite care, caregiver training, vocational training, counseling, family readiness groups)
(**Note to moderators:** start with top of mind, then probe not only for the kinds of supports/benefits but also for the source)
b. How did you learn about these resources?
c. To what extent have these resources met your needs as the family member/caregiver of a recovering warrior?
d. We are interested in best practices that could be shared at other locations. What supports and benefits have worked particularly well for you?
e. What has prevented you from taking fuller advantage of available supports and benefits?
f. What specific resources are provided on the installation to support family caregivers of *severely wounded, ill or injured* Service members?

Does your Service member have *Recovery Care Coordinator (RCC),* or perhaps a *Federal Recovery Coordinator (FRC)?* If your Service member is enrolled in the Army Wounded Warrior Program (AW2), that might be his or her *AW2 Advocate.*

a. What kinds of support or information does your Service member's RCC/FRC/AW2 Advocate provide you? (**Note to moderators:** Ask participants to specify whether talking about RCC, FRC, or AW2 Advocate; scribe will note)
b. To what extent does he/she meet your needs as a family member/caregiver of a recovering warrior?
c. We are interested in best practices that could be shared with other RCCs/FRCs/AW2 Advocates and other locations. What aspect of the support he/she provides you works particularly well?
d. What is the protocol for communication between you and your Service member's RCC/FRC/AW2 Advocate?

Your Service member's *unit chain of command* may also provide non-medical case management.

a. What kinds of support or information does your Service member's unit chain of command provide you?
b. To what extent does the unit chain of command meet your needs as a family member/caregiver of a recovering warrior?
c. We are interested in best practices that could be shared with other units and other locations. What aspect of the support your Service member's unit chain of command provides you works particularly well?
d. What is the protocol for communication between you and your Service member's unit chain of command?

(Mini-survey captures ratings of 1) satisfaction with support for family by stage, 2) satisfaction with support for family by domain, and 3) helpfulness of RCC/FRC/AW2/unit chain of command)

II. Recovering Warrior Information Resources

We'd like to talk with you about information resources for recovering warriors and their families**.**
Please note these questions about information resources are about your experiences with these information resources, rather than your Service member's.

When your Service member was seriously wounded, ill, or injured, they and you began a treatment, recovery, and rehabilitation journey together. We're interested in hearing how you have obtained the information you needed—when you first entered the system and along the way.

a. Did you receive consolidated reference information?
b. From whom and when?
b. In what format? (e.g., website, hard copy)
c. Was this provided to you automatically or did you have to seek it out?
d. To what extent has this information met your needs?

e. We are interested in best practices that could be shared at other locations. What aspect of how this information was provided to you has worked particularly well?
f. What has prevented you from taking fuller advantage of this information that has been provided to you?

Now let me ask you some questions about specific information sources.

(**Note to moderators:** questions b-f below are intended to supplement the helpfulness ratings captured on the mini-survey; ask for show of hands for b-f; scribe will note)

a. Which information resources have you used? (**Note to moderators**: top of mind)

b. Have you consulted the *Wounded Warrior Resource Center*? This provides 24/7 assistance to recovering warriors, families, and primary caregivers.
   - How helpful is it compared with similar resources you are aware of?

c. Have you consulted the *National Resource Directory*? This is an online directory of national, state, and local governmental and non-governmental services and resources that assist with recovery, rehabilitation, and reintegration.
   - How helpful is it compared with similar resources you are aware of?

d. Have you consulted *Military OneSource*? This is an all-purpose portal for the military community, accessible online or by phone, and provides dedicated support for recovering warriors and their families.
   - How helpful is it compared with similar resources you are aware of?

e. Have you consulted a military *hotline*?
   - If so, which Service branch?
   - How helpful is it compared with similar resources you are aware of?

f. Have you consulted a military *Family Assistance Cente*r? This is an office or agency that facilitates recovering Service member and family access to information and resources.
   - If so, which Service branch?
   - In your experience, how do the warrior transition unit and the family assistance center work together on behalf of families?

(Mini-survey captures ratings of helpfulness of individual information resources)

(Note to moderators: if time permits before wrapping up, turn to final page to pose optional questions on inter-agency matters)

III. Wrap Up

As we draw to a close, we have one final question.

a. What military policy or program, if any, stands as something that has been particularly helpful for you as the family member of a recovering warrior?

This concludes our discussion. Please remember not to repeat what you heard in this room. Thank you for taking the time to share your opinions and experiences with us. Your thoughts are invaluable to our efforts to inform the Secretary of Defense and Congress on these matters. Once again, thank you very much, and our sincere best wishes for your Service member's continued recovery.

(Mini-survey captures ratings of helpfulness of individual DoD programs)

Optional Questions on Inter-Agency Matters

We would like to get a sense for the specific agencies and organizations—within and outside DoD—that are providing support during the recovery process. (Moderator: several questions below pulse participants' familiarity with resources)

a. To begin, let's consider agencies outside DoD

   - What non-DoD agencies have you met with? (e.g., Department of Veterans Affairs [VA], Social Security Administration [SSA], state agencies [e.g., Vocational Rehabilitation and Medicaid]) (Moderator: start with top of mind, ask for show of hands)
   - How do you know about these agencies?
   - What kinds of resources or support do these agencies offer recovering Service members?

b. Let's move on to agencies/organizations within DoD, apart from ones we've already touched on (e.g., WTU, TAP, FAC, etc.)

   i. Military Family Life Consultant (MFLC) program
      a) What is the MFLC program
      b) How does one access it?
      c) How do you know about MFLC?

   ii. For National Guard only: Psychological Health program
      a) What is the Psychological Health program?
      b) How does one access it?
      c) How do you know about Psychological Health?

   iii. Finally, let's consider any other entities that may be providing you support.

   iv. What additional agencies and organizations—within and outside DoD—are working with you during the recovery process?

   v. How do you know about these entities?

   vi. What kinds of resources or support do these entities offer recovering Service members?

APPENDIX J-3: SERVICE MEMBER MINI-SURVEY

RWTF Focus Groups: Demographic Sheet for Recovering Service Members

ABOUT YOU

1. Please tell us whether you are currently receiving inpatient or outpatient care. (Inpatient =staying overnight in the hospital.)

(Please check either inpatient **OR** outpatient)

O **I am currently receiving inpatient care**

☞ If you are currently receiving inpatient care, is this your first CONUS hospitalization following your injury/illness?

O Yes O No

☞ If you are currently receiving inpatient care, are you receiving rehabilitation therapy?

O Yes O No

O **I am currently receiving outpatient care**

☞ If you are currently receiving outpatient care, how many days per month are you receiving care?

- o 1 day per month or fewer
- o 2 to 4 days per month
- o 5 to 10 days per month
- o More than 10 days per month

☞ If you are currently receiving outpatient care, are you receiving rehabilitation therapy?

O Yes O No

2. Please tell us about your condition. (Mark all that apply)

O Traumatic Brain Injury
O Amputation
O Spinal Cord injury
O Burn injury
O Vision loss
O Psychological diagnosis
O Intra-abdominal injury
O Orthopedic injury
O Chest injury
O Hearing loss
O Inhalation injury
O Medical diagnosis

3. What is your marital status?

O Married
O Single, never married
O Legally separated or filing for divorce
O Divorced or widowed

4. Do you have dependent children living in the home?

O Yes
O No

5. What is your gender?

O Male
O Female

6. What is your branch of Service?

O Army O Marine Corps Reserve
O Navy O Army Reserve
O Air Force O Air Force Reserve
O Marine Corps O Army National Guard
O Coast Guard O Air Guard

7. What is your pay grade?

O E1	O E6	O WO1	O O1
O E2	O E7	O CW2	O O2
O E3	O E8	O CW3	O O3
O E4	O E9	O CW4	O O4
O E5		O CW5	O O5
			O O6

TRANSITION SUPPORT FOR YOU

8. Have you attended a Disabled Transition Assistance Program (DTAP) briefing? (An additional Transition Assistance Program briefing provided by the Department of Veterans Affairs for individuals who will be claiming disability benefits such as Vocational Rehabilitation and Employment, also known as VR&E)

O Yes
O No

O Don't know

CASE MANAGEMENT SUPPORT FOR YOU

9. How helpful is your medical care case manager to you? (also known as "clinical case manager") (Mark one**)**

O Does not apply—I do not have a medical care case manager or a clinical case manager
O Extremely helpful
O Very helpful
O Moderately helpful
O A little bit helpful
O Not at all helpful

10. Please indicate whether you are working with <u>each</u> of the following types of case managers. For each one that you are working with, please rate how helpful they are to you.

				How helpful is this person to you?				
Are you working with a…	**No**	**Not sure**	**Yes**	**Extremely helpful**	**Very helpful**	**Moderately helpful**	**A little helpful**	**Not at all helpful**
a. Recovery Care Coordinator (RCC)?	O	O	O →	O	O	O	O	O
b. Federal Recovery Coordinator (FRC)?	O	O	O →	O	O	O	O	O
c. Army Wounded Warrior Program (AW2) Advocate?	O	O	O →	O	O	O	O	O
d. Unit chain of command?	O	O	O →	O	O	O	O	O

INFORMATION RESOURCES FOR YOU

11. Please indicate whether you have used each of the following information resources. For each one that you have used, please rate how helpful it has been <u>to you</u>.

				How helpful have these information resources been to you?				
Have you used…	**No**	**Not sure**	**Yes**	**Extremely helpful**	**Very helpful**	**Moderately helpful**	**A little helpful**	**Not at all helpful**
a. Wounded Warrior Resource Center?	O	O	O →	O	O	O	O	O
b. National Resource Directory?	O	O	O →	O	O	O	O	O
c. Military OneSource?	O	O	O →	O	O	O	O	O
d. Military Hotline?	O	O	O →	O	O	O	O	O
Please specify branch:								
e. Military Family Assistance Center	O	O	O →	O	O	O	O	O
Please specify branch:								

SUPPORT FOR YOU DURING THE DES PROCESS
(only at locations where IDES is in place)

12. How many Physical Evaluation Board Liaison Officers (PEBLOs) have you had?

_____ PEBLOs

13. How long has your current PEBLO been assigned to you?

_____ months

14. How helpful is your current Physical Evaluation Board Liaison Officer (PEBLO) to you.

- O Does not apply—I do not have a PEBLO
- O Extremely helpful
- O Very helpful
- O Moderately helpful
- O A little bit helpful
- O Not at all helpful

VOCATIONAL RESOURCES FOR YOU

15. Please indicate whether you have first-hand experience with any of the following vocational programs. For each of the programs with which you have had first-hand experience, please rate how helpful it has been <u>to you.</u>

				How helpful have these vocational resources been to you?				
Have you participated in…	**No**	**Not sure**	**Yes**	**Extremely helpful**	**Very helpful**	**Moderately helpful**	**A little helpful**	**Not at all helpful**
Operation Warfighter?	O	O	O →	O	O	O	O	O
REALifelines?	O	O	O →	O	O	O	O	O
AW2 Career Demonstration Program (NOD)?	O	O	O →	O	O	O	O	O
VA Vocational Rehabilitation & Employment (VR&E)?	O	O	O →	O	O	O	O	O
Other vocational training or education program?	O	O	O →	O	O	O	O	O
Please specify the vocational program:								

DOD PROGRAMS AND SERVICES FOR YOU OVERALL

16. Please indicate whether you have first-hand experience with any of the following programs. For each of the programs with which you have had first-hand experience, please rate how helpful it has been <u>to you.</u>

				How helpful have these programs and services been to you?				
Do you have experience with…	**No**	**Not sure**	**Yes**	**Extremely helpful**	**Very helpful**	**Moderately helpful**	**A little helpful**	**Not at all helpful**
Medical care case management?	O	O	O →	O	O	O	O	O
Non-medical case management?	O	O	O →	O	O	O	O	O
Services for traumatic brain injury (TBI) & posttraumatic stress disorder (PTSD)?	O	O	O →	O	O	O	O	O
Information resources?	O	O	O →	O	O	O	O	O
Support for family caregivers?	O	O	O →	O	O	O	O	O
Legal support for recovering Service members & families?	O	O	O →	O	O	O	O	O
Vocational training for transition to civilian life?	O	O	O →	O	O	O	O	O
Disability Evaluation System (DES) ?	O	O	O →	O	O	O	O	O
Disability Transition Assistance Program (DTAP)?	O	O	O →	O	O	O	O	O

Thank you for providing this information.

APPENDIX J-4: FAMILY MEMBER MINI-SURVEY

RWTF Focus Groups: Demographic Sheet for Family Member Participants

ABOUT YOU

1. What is your relationship to the recovering Service member?

- O Parent of recovering Service member
- O Spouse of recovering Service member
- O Other (Please specify):_____

2. With whom are you attending this focus group?

- O I am attending by myself
- O I am attending with my spouse
- O I am attending with someone else (Please specify):_____

3. What is your gender?

- O Male
- O Female

ABOUT YOUR SERVICE MEMBER

4. Please tell us whether your Service member is currently receiving inpatient or outpatient care. (Inpatient = staying overnight in hospital.) (Check either inpatient **OR** outpatient)

- O **He/she is <u>currently</u> receiving inpatient care**
  - ☞ If he/she receiving inpatient care, is this the first CONUS hospitalization following their injury/illness?
    - O Yes O No
  - ☞ If he/she is receiving inpatient care, is he/she receiving rehabilitation therapy?
    - O Yes O No
- O **He/she is <u>currently</u> receiving outpatient care**
  - ☞ If he/she is receiving outpatient care, how many days per month are they receiving care?
    - o 1 day per month or fewer
    - o 2 to 4 days per month
    - o 5 to 10 days per month
    - o More than 10 days per month
  - ☞ If he/she is receiving outpatient care, is he/she receiving rehabilitation therapy?
    - O Yes O No

5. What is your Service member's marital status?

- O Married
- O Single, never married
- O Legally separated or filing for divorce
- O Divorced or widowed

6. Does your Service member have dependent children living in the home?

- O Yes
- O No

7. Please tell us about your Service member's condition. (Mark all that apply)

- O Traumatic Brain Injury
- O Amputation
- O Spinal Cord injury
- O Burn injury
- O Vision loss
- O Psychological diagnosis
- O Intra-abdominal injury
- O Orthopedic injury
- O Chest injury
- O Hearing loss
- O Inhalation injury
- O Medical diagnosis

8. What is your Service member's branch of Service?

- O Army
- O Navy
- O Air Force
- O Marine Corps
- O Coast Guard
- O Marine Corps Reserve
- O Army Reserve
- O Air Force Reserve
- O Army National Guard
- O Air Guard

9. What is your Service member's pay grade?

O E1	O E6	O WO1	O O1
O E2	O E7	O CW2	O O2
O E3	O E8	O CW3	O O3
O E4	O E9	O CW4	O O4
O E5		O CW5	O O5
			O O6

ABOUT SUPPORT YOU AND YOUR SERVICE MEMBER HAVE RECEIVED

10. Please indicate whether your Service member is working with <u>each</u> of the following types of case managers. For each one that your Service member is working with, please rate how helpful that person is <u>to you</u>.

				How helpful is this person to you?				
Is your Service member working with a…	**No**	**Not sure**	**Yes**	**Extremely helpful**	**Very helpful**	**Moderately helpful**	**A little helpful**	**Not at all helpful**
a. Recovery Care Coordinator (RCC)?	O	O	O →	O	O	O	O	O
b. Federal Recovery Coordinator (FRC)?	O	O	O →	O	O	O	O	O
c. Army Wounded Warrior Program (AW2) Advocate?	O	O	O →	O	O	O	O	O
d. Unit chain of command?	O	O	O →	O	O	O	O	O

ABOUT INFORMATION RESOURCES FOR YOU

11. Please indicate whether you have used each of the following information resources. For each one that you have used, please rate how helpful it has been <u>to you</u>.

				How helpful have these information resources been to you?				
Have you used…	**No**	**Not sure**	**Yes**	**Extremely helpful**	**Very helpful**	**Moderately helpful**	**A little helpful**	**Not at all helpful**
a. Wounded Warrior Resource Center?	O	O	O →	O	O	O	O	O
b. National Resource Directory?	O	O	O →	O	O	O	O	O
c. Military OneSource?	O	O	O →	O	O	O	O	O
d. Military Hotline?	O	O	O →	O	O	O	O	O
Please specify branch:								
e. Military Family Assistance Center	O	O	O →	O	O	O	O	O
Please specify branch:								

SUPPORT FOR YOUR FAMILY

12. For each stage of your Service member's treatment and recovery, please indicate your overall level of satisfaction or dissatisfaction with the military's support for your family.

Stages of Treatment/Recovery Process	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	Does not apply
a. Support getting you to the member's bedside after you were notified	O	O	O	O	O	O
b. Support while member undergoes inpatient care	O	O	O	O	O	O
c. Support during outpatient care or partial hospitalization	O	O	O	O	O	O
d. Support during follow up care (home, rehabilitation)	O	O	O	O	O	O

13. Please indicate your level of satisfaction or dissatisfaction with the military's support of your family in each of the following areas:

Areas of Support	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	Does not apply
a. Overall support	O	O	O	O	O	O
b. Finances (e.g., advances, reimbursements)	O	O	O	O	O	O
c. Logistics (e.g., movement to and between treatment facilities)	O	O	O	O	O	O
d. Condition of facilities	O	O	O	O	O	O
e. Information/education to help you care for your Service member	O	O	O	O	O	O
f. Information/education about available benefits and services	O	O	O	O	O	O
g. Emotions (e.g., stress management, coping with depression /grief)	O	O	O	O	O	O
h. Assistance/advocacy (e.g., reducing red-tape, case management, respite care)	O	O	O	O	O	O
i. Support helping children cope with a Service member's injuries	O	O	O	O	O	O

DOD PROGRAMS AND SERVICES FOR YOU OVERALL

14. Please indicate whether you have first-hand experience with any of the following programs. For each of the programs with which you have had first-hand experience, please rate how helpful it has been <u>to you.</u>

				How helpful have these programs and services been to you?				
Do you have experience with…	**No**	**Not sure**	**Yes**	**Extremely helpful**	**Very helpful**	**Moderately helpful**	**A little helpful**	**Not at all helpful**
Medical care case management?	O	O	O →	O	O	O	O	O
Non-medical case management?	O	O	O →	O	O	O	O	O
Services for traumatic brain injury (TBI) & posttraumatic stress disorder (PTSD)?	O	O	O →	O	O	O	O	O
Information resources?	O	O	O →	O	O	O	O	O
Support for family caregivers?	O	O	O →	O	O	O	O	O
Legal support for recovering Service members & families?	O	O	O →	O	O	O	O	O
Vocational training for transition to civilian life?	O	O	O →	O	O	O	O	O
Disability Evaluation System (DES)?	O	O	O →	O	O	O	O	O
Disability Transition Assistance Program (DTAP)?	O	O	O →	O	O	O	O	O

Thank you for providing this information.

APPENDIX K-1: SERVICE MEMBER MINI-SURVEY RESULTS

Demographic Profile (N = 126)		
Variable/Response	N*	Percent**
Gender:		
Male	113	91%
Female	11	9%
Total	124	100%
Branch of Service:		
Army	48	38%
Navy	4	3%
Air Force	10	8%
Marine Corps	27	21%
Army Reserve	18	14%
Army National Guard	19	15%
Total	126	100%
Pay Grade:		
E1 – E3	17	14%
E4 – E6	63	51%
E7 – E9	15	12%
WO	2	2%
O1 – O3	19	15%
O4 – O6	8	6%
Total	124	100%
Marital Status:		
Married	70	56%
Single, never married	29	23%
Legally separated or filing for divorce	9	7%
Divorced or widowed	17	14%
Total	125	100%
Dependent Children Living in the Home:		
Yes	64	52%
No	60	48%
Total	124	100%

* Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

Care Profile (N = 126)		
Variable/Response	N*	Percent**
Are you currently receiving inpatient or outpatient care?		
Inpatient	7	6%
Outpatient	63	50%
Both	56	44%
Total	126	100%
If you are currently receiving inpatient care, is this your first CONUS hospitalization following your injury/illness?		
No	48	76%
Yes	15	24%
Total	63	100%

* Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

Care Profile (N = 126)		
Variable/Response	N*	Percent**
If you are currently receiving inpatient care, are you receiving rehabilitation therapy?		
No	28	68%
Yes	13	32%
Total	41	100%
If you are currently receiving outpatient care, how many days per month are you receiving care?		
1 day per month or fewer	4	4%
2 – 4 days per month	27	26%
5 – 10 days per month	37	36%
More than 10 days per month	36	35%
Total	104	100%
If you are currently receiving outpatient care, are you receiving rehabilitation therapy?		
No	33	30%
Yes	78	70%
Total	111	100%
Number of Service members who endorsed each of the following conditions:		
Traumatic Brain Injury	35	28%
Amputation	12	10%
Spinal Cord Injury	25	20%
Burn Injury	4	3%
Vision Loss	9	7%
Psychological Diagnosis	40	32%
Intra-abdominal Injury	2	2%
Orthopedic Injury	38	30%
Chest Injury	6	5%
Hearing Loss	27	21%
Inhalation Injury	3	2%
Medical Diagnosis	46	37%
Total Number of conditions endorsed:		
Zero	5	4%
One	58	46%
Two	23	18%
Three	21	17%
Four	11	9%
Five	6	5%
Six	1	1%
Total	125	100%

*Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

DTAP (N = 126)		
Variable/Response	N*	Percent**
Have you attended a Disabled Transition Assistance Program (DTAP) Briefing?		
No	50	41%
Yes	50	41%
Don't know	21	17%
Total	121	100%

* Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

Case Managers (N = 126)		
Variable/Response	N*	Percent**
How helpful is your medical care case manager to you?		
Extremely helpful	54	44%
Very helpful	35	29%
Moderately helpful	19	16%
A little bit helpful	11	9%
Not at all helpful	3	3%
Total	122	100%
Please indicate whether you are working with each of the following types of case managers:		
Recovery Care Coordinator (RCC)		
No	50	43%
Yes	47	40%
Not Sure	20	17%
Total	117	100%
Federal Recovery Coordinator (FRC)		
No	79	69%
Yes	9	8%
Not Sure	26	23%
Total	114	100%
Army Wounded Warrior Program (AW2) Advocate		
No	69	58%
Yes	35	29%
Not Sure	15	13%
Total	119	100%
Unit chain of command		
No	23	19%
Yes	91	76%
Not Sure	6	5%
Total	120	100%
Please rate how helpful the following are to you:		
Recovery Care Coordinator (RCC)		
Extremely helpful	19	42%
Very helpful	17	38%
Moderately helpful	4	9%
A little helpful	3	7%
Not at all helpful	2	4%
Total	45	100%
Federal Recovery Coordinator (FRC)		
Extremely helpful	2	25%
Very helpful	3	38%
Moderately helpful	3	38%
A little helpful	0	0%
Not at all helpful	0	0%
Total	8	100%
Army Wounded Warrior Program (AW2) Advocate		
Extremely helpful	18	51%
Very helpful	14	40%
Moderately helpful	3	9%
A little helpful	0	0%
Not at all helpful	0	0%
Total	35	100%

* Not every participant answered each question.

**Percentages may not sum to 100% due to rounding.

Case Managers (N = 126)		
Variable/Response	N*	Percent**
Please rate how helpful the following are to you:		
Unit chain of command		
Extremely helpful	31	34%
Very helpful	36	40%
Moderately helpful	15	17%
A little helpful	7	8%
Not at all helpful	2	2%
Total	91	100%

* Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

Information Resources (N = 126)		
Variable/Response	N*	Percent**
Please indicate whether you have used each of the following information resources:		
Wounded Warrior Resource Center		
No	57	47%
Yes	40	33%
Not Sure	25	21%
Total	122	100%
National Resource Directory		
No	93	76%
Yes	8	7%
Not Sure	22	18%
Total	123	100%
Military OneSource		
No	61	49%
Yes	55	44%
Not Sure	8	7%
Total	124	100%
Military Hotline		
No	113	91%
Yes	7	6%
Not Sure	4	3%
Total	124	100%
Military Family Assistance Center		
No	75	62%
Yes	36	30%
Not Sure	10	8%
Total	121	100%
How helpful have these information resources been to you?		
Wounded Warrior Resouce Center		
Extremely helpful	20	50%
Very helpful	10	25%
Moderately helpful	8	20%
A little helpful	2	5%
Not at all helpful	0	0%
Total	40	100%

* Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

Information Resources (N = 126)		
Variable/Response	N*	Percent**
How helpful have these information resources been to you?		
National Resource Directory		
Extremely helpful	3	38%
Very helpful	2	25%
Moderately helpful	1	13%
A little helpful	2	25%
Not at all helpful	0	0%
Total	8	100%
Military OneSource		
Extremely helpful	14	26%
Very helpful	13	25%
Moderately helpful	15	28%
A little helpful	9	17%
Not at all helpful	2	4%
Total	53	100%
Military Hotline		
Extremely helpful	1	14%
Very helpful	2	29%
Moderately helpful	2	29%
A little helpful	1	14%
Not at all helpful	1	14%
Total	7	100%
Military Family Assistance Center		
Extremely helpful	14	41%
Very helpful	10	29%
Moderately helpful	8	24%
A little helpful	1	3%
Not at all helpful	1	3%
Total	34	100%

DES (N = 126)		
Variable/Response	N*	Percent**
How long has your current Physical Evaluation Board Liaison Officer (PEBLO) been assigned to you?		
Up to 3 months	19	42%
4 – 6 months	8	17%
7 – 9 months	8	18%
10 – 12 months	4	9%
More than 12 months	6	13%
Total	45	100%
How many PEBLOs have you had?		
Zero	65	58%
One	41	37%
Two	5	5%
Three	0	0%
Four	1	1%
Total	112	100%

* Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

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DES (N = 126)		
Variable/Response	N*	Percent**
How helpful is your current Physical Evaluation Board Liaision Officer (PEBLO) to you?		
Extremely helpful	6	13%
Very helpful	7	15%
Moderately helpful	15	32%
A little bit helpful	13	28%
Not at all helpful	6	13%
Total	47	100%

* Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

Vocational Resources (N = 126)		
Variable/Response	N*	Percent**
Please indicate whether you have first-hand experience with any of the following vocational programs:		
Operation Warfighter		
No	102	84%
Yes	9	7%
Not Sure	10	8%
Total	121	100%
REALifelines		
No	107	89%
Yes	2	2%
Not Sure	11	9%
Total	120	100%
AW2 Career Demonstration Program (NOD)		
No	107	90%
Yes	6	5%
Not Sure	6	5%
Total	119	100%
VA Vocational Rehabilitation and Employment (VR&E)		
No	91	76%
Yes	23	19%
Not Sure	6	5%
Total	120	100%
Other vocational training or education program		
No	86	72%
Yes	23	19%
Not Sure	10	8%
Total	119	100%
How helpful have these vocational programs been to you?:		
Operational Warfighter		
Extremely helpful	3	43%
Very helpful	1	14%
Moderately helpful	2	29%
A little helpful	1	14%
Not at all helpful	0	0%
Total	7	100%

* Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

Vocational Resources (N = 126)		
Variable/Response	N*	Percent**
How helpful have these vocational programs been to you?:		
REALifelines		
Extremely helpful	1	50%
Very helpful	1	50%
Moderately helpful	0	0%
A little helpful	0	0%
Not at all helpful	0	0%
Total	2	100%
AW2 Career Demonstration Program (NOD)		
Extremely helpful	0	0%
Very helpful	4	80%
Moderately helpful	1	20%
A little helpful	0	0%
Not at all helpful	0	0%
Total	5	100%
VA Vocational Rehabilitation and Employment (VR&E)		
Extremely helpful	9	43%
Very helpful	5	24%
Moderately helpful	6	29%
A little helpful	1	5%
Not at all helpful	0	0%
Total	21	100%
Other vocational training or education program		
Extremely helpful	10	50%
Very helpful	10	50%
Moderately helpful	0	0%
A little helpful	0	0%
Not at all helpful	0	0%
Total	20	100%

* Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

Experience Across Resources (N = 126)		
Variable/Response	N*	Percent**
Please indicate whether you have first-hand experience with any of the following programs:		
Medical care case management		
No	14	11%
Yes	102	82%
Not Sure	9	7%
Total	125	100%
Non medical case management		
No	71	57%
Yes	30	24%
Not Sure	23	19%
Total	124	100%
Services for traumatic brain injury (TBI) & post traumatic stress disorder (PTSD)		
No	72	58%
Yes	50	40%
Not Sure	2	2%
Total	124	100%

* Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

Experience Across Resources (N = 126)		
Variable/Response	N*	Percent**
Please indicate whether you have first-hand experience with any of the following programs:		
Information resources		
No	58	48%
Yes	44	36%
Not Sure	20	16%
Total	122	100%
Support for family caregivers		
No	90	73%
Yes	21	17%
Not Sure	12	10%
Total	123	100%
Legal support for recovering Service members & families		
No	91	73%
Yes	20	16%
Not Sure	14	11%
Total	125	100%
Vocational training for transition to civilian life		
No	87	71%
Yes	28	23%
Not Sure	8	7%
Total	123	100%
Disability Evaluation System (DES)		
No	88	72%
Yes	22	18%
Not Sure	13	11%
Total	123	100%
Disability Transition Assistance Program (DTAP)		
No	80	65%
Yes	29	23%
Not Sure	15	12%
Total	124	100%
How helpful have these programs and services been to you?		
Medical care case management		
Extremely helpful	46	47%
Very helpful	34	34%
Moderately helpful	10	10%
A little helpful	7	7%
Not at all helpful	2	2%
Total	99	100%
Non medical case management		
Extremely helpful	14	47%
Very helpful	12	40%
Moderately helpful	3	10%
A little helpful	1	3%
Not at all helpful	0	0%
Total	30	100%

* Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

Experience Across Resources (N = 126)		
Variable/Response	N*	Percent**
How helpful have these programs and services been to you?		
Services for traumatic brain injury (TBI) & post traumatic stress disorder (PTSD)		
Extremely helpful	16	33%
Very helpful	14	29%
Moderately helpful	9	19%
A little helpful	6	13%
Not at all helpful	3	6%
Total	48	100%
Information resources		
Extremely helpful	16	35%
Very helpful	13	28%
Moderately helpful	15	33%
A little helpful	1	2%
Not at all helpful	1	2%
Total	46	100%
Support for family caregivers		
Extremely helpful	9	43%
Very helpful	3	14%
Moderately helpful	5	24%
A little helpful	3	14%
Not at all helpful	1	5%
Total	21	100%
Legal support for recovering Service members and families		
Extremely helpful	8	40%
Very helpful	6	30%
Moderately helpful	5	25%
A little helpful	0	0%
Not at all helpful	1	5%
Total	20	100%
Vocational training for transitionto civilian life		
Extremely helpful	8	30%
Very helpful	10	37%
Moderately helpful	7	26%
A little helpful	1	4%
Not at all helpful	1	4%
Total	27	100%
Disability Evaluation System (DES)		
Extremely helpful	3	14%
Very helpful	5	23%
Moderately helpful	8	36%
A little helpful	2	9%
Not at all helpful	4	18%
Total	22	100%
Disability Transition Assistance Program (DTAP)		
Extremely helpful	10	35%
Very helpful	5	17%
Moderately helpful	7	24%
A little helpful	5	17%
Not at all helpful	2	7%
Total	29	100%

* Not every participant answered each question.
**Percentages may not sum to 100% due to rounding.

APPENDIX K-2: FAMILY MEMBER MINI-SURVEY RESULTS

Demographic Profile (N = 18)	
Variable/Response	N*
Gender of Family Member:	
Male	2
Female	16
Total	18
Family Member relationship to the recovering Service member:	
Parent of recovering Service member	2
Spouse of recovering Service member	14
Sibling	1
Cousin	1
Total	18
With whom Family Member attended the focus group:	
I am attending by myself	13
I am attending with my spouse	5
Total	18
Branch of Service:	
Army	6
Navy	1
Air Force	5
Marine Corps	4
Army Reserve	1
Army National Guard	1
Total	18
Service Member Pay Grade:	
E1 – E3	2
E4 – E6	11
E7 – E9	0
WO	1
O1 – O3	1
O4 – O6	1
Total	16
What is your Service member's marital status?	
Married	15
Single, never married	2
Legally separarted or filing for divorce	0
Divorced or widowed	1
Total	18
Does your Service member have dependent children living in the home?	
No	7
Yes	11
Total	18

* Not every participant answered each question. Percentages are not provided due to sample size.

Care Profile (N = 18)	
Variable/Response	N*
Is your Service member currently receiving inpatient or outpatient care?	
Inpatient	0
Outpatient	10
Both	8
Total	18
If your Service member is currently receiving inpatient care, is this the first CONUS hospitalization following their injury/illness?	
No	8
Yes	0
Total	8
If your Service member is currently receiving inpatient care, is he/she receiving rehabilitation therapy?	
No	5
Yes	0
Total	5
If your Service member is currently receiving outpatient care, how many days per month are they receiving care?	
1 day per month or fewer	1
2 – 4 days per month	1
5 – 10 days per month	2
More than 10 days per month	11
Total	15
If your Service member is currently receiving outpatient care, is he/she receiving rehabilitation therapy?	
No	5
Yes	12
Total	17
Number of Service members with each of the following conditions:	
Traumatic Brain Injury	9
Amputation	4
Spinal Cord Injury	3
Burn Injury	1
Vision Loss	3
Psychological Diagnosis	6
Intra-abdominal Injury	0
Orthopedic Injury	6
Chest Injury	0
Hearing Loss	4
Inhalation Injury	0
Medical Diagnosis	5
Total Number of conditions endorsed:	
Zero	0
One	6
Two	5
Three	4
Four	2
Five	1
Total	18

* Not every participant answered each question. Percentages are not provided due to sample size.

Case Managers (N = 18)	
Variable/Response	N*
Please indicate whether your Service member is working with each of the following types of case managers:	
Recovery Care Coordinator (RCC)	
No	1
Yes	10
Not Sure	7
Total	18
Federal Recovery Coordinator (FRC)	
No	6
Yes	1
Not Sure	11
Total	18
Army Wounded Warrior Program (AW2) Advocate	
No	8
Yes	7
Not Sure	2
Total	17
Unit chain of command	
No	1
Yes	13
Not Sure	3
Total	17
Please rate how helpful the following are to you:	
Recovery Care Coordinator (RCC)	
Extremely helpful	8
Very helpful	2
Moderately helpful	0
A little helpful	0
Not at all helpful	0
Total	10
Federal Recovery Coordinator (FRC)	
Extremely helpful	0
Very helpful	1
Moderately helpful	0
A little helpful	0
Not at all helpful	0
Total	1
Army Wounded Warrior Program (AW2) Advocate	
Extremely helpful	2
Very helpful	3
Moderately helpful	0
A little helpful	0
Not at all helpful	1
Total	6
Unit chain of command	
Extremely helpful	4
Very helpful	5
Moderately helpful	1
A little helpful	1
Not at all helpful	1
Total	12

* Not every participant answered each question. Percentages are not provided due to sample size.

Information Resources (N = 18)	
Variable/Response	N*
Please indicate whether you have used each of the following information resources:	
Wounded Warrior Resource Center	
No	3
Yes	13
Not Sure	1
Total	17
National Resource Directory	
No	13
Yes	0
Not Sure	4
Total	17
Military OneSource	
No	11
Yes	5
Not Sure	1
Total	17
Military Hotline	
No	14
Yes	1
Not Sure	2
Total	17
Military Family Assistance Center	
No	6
Yes	7
Not Sure	3
Total	16
How helpful have these information resources been to you?	
Wounded Warrior Resouce Center	
Extremely helpful	7
Very helpful	6
Moderately helpful	0
A little helpful	0
Not at all helpful	0
Total	13
National Resource Directory	
Extremely helpful	0
Very helpful	0
Moderately helpful	0
A little helpful	0
Not at all helpful	0
Total	0
Military OneSource	
Extremely helpful	2
Very helpful	2
Moderately helpful	1
A little helpful	0
Not at all helpful	0
Total	5

* Not every participant answered each question. Percentages are not provided due to sample size.

Information Resources (N = 18)	
Variable/Response	N*
How helpful have these information resources been to you?	
Military Hotline	
Extremely helpful	0
Very helpful	0
Moderately helpful	0
A little helpful	0
Not at all helpful	0
Total	0
Military Family Assistance Center	
Extremely helpful	1
Very helpful	6
Moderately helpful	0
A little helpful	0
Not at all helpful	0
Total	7

* Not every participant answered each question. Percentages are not provided due to sample size.

Family Support (N = 18)	
Variable/Response	N
Please indicate your overall level of satisfaction or dissatisfaction with the military's support for your family:	
Support getting you to the member's bedside after you were notified	
Very satisfied	2
Satisfied	4
Neither satisfied or dissatisfied	1
Dissatisfied	1
Very dissatisfied	2
Total	10
Support while member undergoes inpatient care	
Very satisfied	4
Satisfied	8
Neither satisfied or dissatisfied	2
Dissatisfied	1
Very dissatisfied	2
Total	17
Support during outpatient care or partial hospitalization	
Very satisfied	3
Satisfied	10
Neither satisfied or dissatisfied	2
Dissatisfied	2
Very dissatisfied	1
Total	18
Support during follow-up care (home, rehabilitation)	
Very satisfied	3
Satisfied	9
Neither satisfied or dissatisfied	0
Dissatisfied	0
Very dissatisfied	3
Total	15

* Not every participant answered each question. Percentages are not provided due to sample size.

Family Support (N = 18)	
Variable/Response	N*
Please indicate your level of satisfaction or dissatisfaction with the military's support of your family in each of the following areas:	
Overall support	
Very satisfied	1
Satisfied	12
Neither satisfied or dissatisfied	1
Dissatisfied	3
Very dissatisfied	1
Total	18
Finances (e.g., advances, reimbursements)	
Very satisfied	0
Satisfied	10
Neither satisfied or dissatisfied	2
Dissatisfied	0
Very dissatisfied	3
Total	15
Logistics (e.g., movement to and between treatment facilities)	
Very satisfied	2
Satisfied	8
Neither satisfied or dissatisfied	2
Dissatisfied	2
Very dissatisfied	3
Total	17
Condition of facilities	
Very satisfied	5
Satisfied	9
Neither satisfied or dissatisfied	2
Dissatisfied	0
Very dissatisfied	2
Total	18
Information/education to help you care for your Service member	
Very satisfied	2
Satisfied	10
Neither satisfied or dissatisfied	1
Dissatisfied	2
Very dissatisfied	2
Total	17
Information/education about available benefits and services	
Very satisfied	1
Satisfied	9
Neither satisfied or dissatisfied	4
Dissatisfied	2
Very dissatisfied	2
Total	18
Emotions (e.g., stress management, coping with depression/grief	
Very satisfied	2
Satisfied	9
Neither satisfied or dissatisfied	4
Dissatisfied	1
Very dissatisfied	1
Total	17

* Not every participant answered each question. Percentages are not provided due to sample size.

Family Support (N = 18)	
Variable/Response	N*
Please indicate your level of satisfaction or dissatisfaction with the military's support of your family in each of the following areas:	
Assistance/advocacy (e.g., reducing red-tape, case management, respite care)	
Very satisfied	3
Satisfied	4
Neither satisfied or dissatisfied	4
Dissatisfied	5
Very dissatisfied	1
Total	17
Support helping children cope with a Service member's injuries	
Very satisfied	0
Satisfied	3
Neither satisfied or dissatisfied	9
Dissatisfied	0
Very dissatisfied	2
Total	14

* Not every participant answered each question. Percentages are not provided due to sample size.

Experience Across Resources (N = 18)	
Variable/Response	N*
Please indicate whether you have first-hand experience with any of the following programs:	
Medical care case management	
No	3
Yes	12
Not Sure	2
Total	17
Non medical case management	
No	5
Yes	6
Not Sure	5
Total	16
Services for traumatic brain injury (TBI) and post traumatic stress disorder (PTSD)	
No	7
Yes	9
Not Sure	0
Total	16
Information resources	
No	7
Yes	8
Not Sure	1
Total	16
Support for family caregivers	
No	6
Yes	10
Not Sure	1
Total	17

* Not every participant answered each question. Percentages are not provided due to sample size.

Experience Across Resources (N = 18)	
Variable/Response	N*
Please indicate whether you have first-hand experience with any of the following programs:	
Legal support for recovering Service members and families	
No	10
Yes	4
Not Sure	2
Total	16
Vocational training for transition to civilian life	
No	12
Yes	0
Not Sure	4
Total	16
Disability Evaluation System (DES)	
No	11
Yes	2
Not Sure	3
Total	16
Disability Transition Assistance Program	
No	10
Yes	2
Not Sure	4
Total	16
How helpful have these resources been to you?	
Medical care case management	
Extremely helpful	5
Very helpful	4
Moderately helpful	3
A little helpful	0
Not at all helpful	0
Total	12
Non medical case management	
Extremely helpful	3
Very helpful	2
Moderately helpful	1
A little helpful	0
Not at all helpful	0
Total	6
Services for traumatic brain injury (TBI) and post traumatic stress disorder (PTSD)	
Extremely helpful	2
Very helpful	3
Moderately helpful	3
A little helpful	0
Not at all helpful	1
Total	9
Information resources	
Extremely helpful	3
Very helpful	3
Moderately helpful	2
A little helpful	0
Not at all helpful	0
Total	8

* Not every participant answered each question. Percentages are not provided due to sample size.

Experience Across Resources (N = 18)	
Variable/Response	N*
How helpful have these resources been to you?	
Support for family caregivers	
Extremely helpful	2
Very helpful	4
Moderately helpful	2
A little helpful	2
Not at all helpful	0
Total	10
Legal support for recovering Service members and families	
Extremely helpful	0
Very helpful	2
Moderately helpful	1
A little helpful	1
Not at all helpful	0
Total	4
Vocational training for transition to civilian life	
Extremely helpful	0
Very helpful	0
Moderately helpful	0
A little helpful	0
Not at all helpful	0
Total	0
Disability Evaluation System (DES)	
Extremely helpful	0
Very helpful	1
Moderately helpful	0
A little helpful	1
Not at all helpful	0
Total	2
Disability Transition Assistance Program	
Extremely helpful	0
Very helpful	1
Moderately helpful	0
A little helpful	1
Not at all helpful	0
Total	2

* Not every participant answered each question. Percentages are not provided due to sample size.

APPENDIX L: DATA CALL RESULTS – POPULATION AND STAFFING OF PROGRAMS

Recovering Warrior Medical Care Case Management (MCCM) Staffing

Each organization listed below responded to data calls from the RWTF. Some organizations provided data on multiple occasions and as of multiple dates.

Air Force Clinical Medical Management (As of June 2011)

Number of Wounded, Ill, or Injured Currently Assigned to Wounded Warrior Unit or Program:			**782**[a]
Number of Combat injured within that population (if known):			**447**[b]
	Number of MCCMs:		
Status	RNs	MSWs	Total
Uniformed			
AC			
Mobilized reservist			
Government civilian			
Contractor	Baseline: 110[c] WW CM: 26[d]		136
Total number MCCMs	**136**		**136**
MCCM: Recovering Warrior staffing ratio: 1:20[e]			

[a] Data as of March 2011.
[b] Ibid.
[c] Baseline MCCMs serve Recovering Warriors (RWs) and other active duty personnel.
[d] WW CMs serve only RWs.
[e] AF RWs are not assigned to transition units. Instead, the majority remain assigned to their base unit and get follow-on care at the base MTF. 50 out of 75 MTFs have less than 20 RWs as a monthly average. MTFs with more than 20 RWs are given a WW funded CM to manage that additional workload. MTFs with less than 20 RWs are cared for by the Baseline CMs.

US Army Warrior Transition Command (As of March 2011)

Number of Wounded, Ill, or Injured Currently Assigned to Wounded Warrior Unit or Program:			**9858**
Number of Combat injured within that population (if known):			**1201**
	Number of MCCMs:		
Status	NCMs	MSWs	Total
Uniformed			
AC	77	3	80
Mobilized reservist	232	1	233
Government civilian	330	162	492
Contractor	18	18	36
Total number MCCMs	**657**	**184**	**841**
MCCM: Recovering Warrior staffing ratio: 1:12			

Navy Case Management
(As of March 2011)

Number of Wounded, Ill, or Injured Currently Assigned to Wounded Warrior Unit or Program:			**4011**[f]
Number of Combat injured within that population (if known):			**1785**
	Number of MCCMs:		
Status	RNs	MSWs	Total
Uniformed			
AC	16	3	19
Mobilized reservist	0	0	0
Government civilian	104	10	114
Contractor	88	15	103
Total number MCCMs	**208**	**28**	**236**
MCCM: Recovering Warrior staffing ratio: 1:17			

[f]Data as of April 11, 2011.

Federal Recovery Coordination Program (FRCP) Staffing

Federal Recovery Coordination Program
(As of April 2011)

Number of Wounded, Ill, or Injured Currently Assigned to Wounded Warrior Unit or Program:			**704 Active Cases**[g]
Number of Combat injured within that population (if known):			**225 AD, 153 Vet.**
	Number of MCCMs:		
Status	RNs	Licensed SWs	Total
Government civilian	12	10	22
Mobilized reservist	0	0	0
Other (specify)	0	0	0
Total number MCCMs	**12**	**10**	**22**
MCCM: Recovering Warrior staffing ratio: 1:32 for Active Cases			

[g] There are also 276 “Assist”, 79 “Evaluate”, 343 “Inactive”, and 200 “Redirect” additional cases.

Recovering Warrior Non-Medical Care Case Management (NMCM) Staffing

Each organization listed below responded to data calls from the RWTF. Some organizations provided data on multiple occasions and as of multiple dates.

Air Force Warrior and Survivor Care (As of March 2011)

Number of Wounded, Ill, or Injured Currently Assigned to Wounded Warrior Unit or Program:	**2060**[h]
Number of Combat injured within that population (if known):	**1008**

	Number of NMCMs:							
	RCC & RCC Equivalents			Other NMCMs				
Status	RCCs	AFW2 Adv.	TAAs	PSGs	Squad Ldrs	Family Liaison Officers	Other NMCM	Total
Uniformed								
AC		1						
Mobilized reservist		1						
Government civilian		22						
Contractor	33[i]	6						
Total number NMCMs	**33**[j]	**28**[k]				**As needed**		**61**

Staffing ratio: RCCs (& equivalent) to eligible Recovering Warriors: 29:1[l] **(RCCs) and 52:1**[m] **(AFW2 Advocates)**	
Staffing ratio: NMCMs (excl. RCCs & equiv.) to Recovering Warriors assigned to unit/program: N/A	

[h] 908 of these are active duty wounded, ill, and injured who are working with RCCs; 1152 are AFW2 enrollees (combat wounded and are at the MEB phase of DES or later, including those who have separated). Data as of June 30, 2011.
[i] Data as of June 30, 2011.
[j] Two of these are Program Managers (do not impact caseload). Data as of June 30, 2011.
[k] Six of these do not impact caseload.
[l] Data as of June 30, 2011.
[m] Ibid.

US Army Warrior Transition Command (As of March 2011)

Number of Wounded, Ill, or Injured Currently Assigned to Wounded Warrior Unit or Program:	**9858**
Number of Combat injured within that population (if known):	**1201**

	Number of NMCMs:							
	RCC & RCC Equivalents			Other NMCMs				
Status	RCCs	AW2 Adv.	TAAs	PSGs	Squad Ldrs	Family Liaison Officers	Other NMCM	Total
Uniformed								
AC	0	0	1	241	696	0	0	938
Mobilized reservist	0	0	0	159	240	0	0	399
Government civilian	0	19	13	0	0	22	7	61
Contractor	0	15	0	0	0	1	1	17
Total number NMCMs	**0**	**34**	**14**	**400**	**936**	**23**	**8**	**1415**

Staffing ratio: RCCs (& equivalent) to eligible Recovering Warriors: 1:205	
Staffing ratio: NMCMs (excl. RCCs & equiv.) to Recovering Warriors assigned to unit/program: 1:7	

Marine Corps Wounded Warrior Regiment
(Data received on May 2, 2011)

Number of Wounded, Ill, or Injured Currently Assigned to Wounded Warrior Unit or Program:	**751[n]**
Number of Combat injured within that population (if known):	**507[o]**

	Number of NMCMs:							
	RCC & RCC Equivalents			Other NMCMs				
Status	RCCs	AW2 Adv.	TAAs	PSGs	Section Ldrs	Family Liaison Officers	Other NMCM	Total
Uniformed								
AC								
Mobilized reservist					46			46
Government civilian	2		2					4
Contractor	49						7	49
Total number NMCMs	**52[p]**		**2**		**46**		**10[q]**	**110[r]**

Staffing ratio: RCCs (& equivalent) to eligible Recovering Warriors: 1:26[s]	
Staffing ratio: NMCMs (excl. RCCs & equiv.) to Recovering Warriors assigned to unit/program: N/A[t]	

[n] Data received on July 8, 2011.
[o] This includes 406 combat wounded and 101 ill/injured in combat zone. Data received on July 8, 2011.
[p] One individual was not identified as either Government civilian or Contractor. Data received on July 8, 2011.
[q] 7 are contractor NMCMs who work in the Wounded Warrior Contact Centers, 3 are current billets for Family Readiness Coordinators. Data received on July 13, 2011.
[r] Total includes one individual who was not identified as either Government civilian or Contractor and ten other NMCMs.
[s] Currently, there are 1, 243 individuals that have an RCC: these RWs may or may not be assigned to the WWR. Data received on July 8, 2011.
[t] NMCMs include NMCMs who work in the Wounded Warrior Contact Centers. They are not assigned specific cases, rather, the population they serve is wounded, ill, and injured active duty Marines across the Marines Corps and not just those attached to the WWR. Data received on July 13, 2011.

Navy Safe Harbor
(As of March 2011)

Number of Wounded, Ill, or Injured Currently Assigned to Wounded Warrior Unit or Program:	**631**
Number of Combat injured within that population (if known):	**61**

	Number of NMCMs:							
	RCC & RCC Equivalents			Other NMCMs				
Status	RCCs	AW2 Adv.	TAAs	PSGs	Squad Ldrs	Family Liaison Officers	Other NMCM	Total
Uniformed								
AC	3							3
Mobilized reservist	8							8
Government civilian	5							5
Contractor	2							12
Total number NMCMs	**18**							**18**

Staffing ratio: RCCs (& equivalent) to eligible Recovering Warriors: 1:35	
Staffing ratio: NMCMs (excl. RCCs & equiv.) to Recovering Warriors assigned to unit/program: N/A	

APPENDIX M: RECOMMENDATIONS FOR CONGRESSIONALLY MANDATED TOPICS

Recommendations for Congressionally Mandated Topics

Topics Listed in 111 Pub. L. 111-84, 123 Stat 2190, Section 724, subsection c, paragraph 3:	Recommendation	Page
a. Case management	1	3
	3	4
	4	5
	6	7
	7	8
	8	9
	11	11
	12	13
	14	16
b. Staffing of units and programs	1	3
	2	4
	4	5
	5	6
	11	11
	12	13
c. Performance and accountability standards for units and programs	1	3
	2	4
	3	4
	4	5
	5	6
	6	7
	8	9
	12	13
d. Services for TBI and PTSD	10	11
e. Centers of Excellence	9	10
f. Interagency Program Office	20	22
g. Wounded warrior information resources	13	14
	14	16
	16	18
h. Support to family caregivers	13	14
	14	16
	15	17
	16	18
i. Legal support	19	21
j. Vocational training	18	20
k. Enhancements to the DES (IDES)	3	4
l. Support for RWs in the DES	3	4
	19	21
	20	22
m. Support systems to ease transition from DoD to VA	3	4
	17	19
	18	20

Topics Listed in 111 Pub. L. 111-84, 123 Stat 2190, Section 724, subsection c, paragraph 3:	Recommendation	Page
n. Interagency matters affecting transition to civilian life	3	4
	17	19
	18	20
	20	22
o. SOC	21	23
p. Overall coordination between DoD and VA	1	3
	3	4
	7	8
	10	11
	11	11
	14	16
	20	22
	21	23
q. Other matters selected by the RWTF- Reserve Component	1	3
	6	7
	7	8
	8	9
	10	11
	12	13
	13	14
	14	16
	18	20

APPENDIX N: ACRONYM LISTING

Acronyms Used in Report

Acronym	Meaning of Acronym
1SG	First Sergeant
AA	Associate in Arts Degree
ABPP-CN	American Board of Professional Psychology – Clinical Neuropsychology
AC	Active Component
ACAP	Army Career and Alumni Program
ACS	Army Community Service
AD	Active Duty
AFB	Air Force Base
AFMS	Air Force Medical Service
AFPS	American Forces Press Service
AFW2	Air Force Wounded Warrior (Program)
AHLTA	Armed Forces Health Longitudinal Technology Application
AMEDD	Army Medical Department
AMVETS	American Veterans
AOR	Area of Responsibility
ARNG	Army National Guard
ASD(HA)	Assistant Secretary of Defense for Health Affairs
AW2	Army Wounded Warrior (Program)
BAMC	Brooke Army Medical Center
BG	Brigadier General
BUMED	Bureau of Navy Medicine
C2	Command and Control
C5	Comprehensive Combat and Complex Casualty Care
CA ARNG	California Army National Guard
CAC	Common Access Card
CAPT,Capt, CPT	Captain
CARF	Commission on Accreditaton of Rehabilitation Facilities
CBWTU(s)	Community Based Warrior Transition Unit(s)
CDP	Center for Deployment Psychology
CDR	Commander
CENTCOM	Central Command
CNA	Center for Naval Analyses
CNG	California National Guard
CNN	Cable News Network
CNRN	Certified Neuroscience Registered Nurse
CoE(s)	Center(s) of Excellence

Acronym	Meaning of Acronym
COL, Col, Col.	Colonel
COMEODGRU TWO	Commander, Explosive Ordnance Group Two
CONUS	Continental United States
CRC	Certified Rehabilitation Counselor
CRNP	Certified Registered Nurse Practitioner
CRP	Comprehensive Recovery Plan
CRS	Congressional Research Service
CSAF	Chief of Staff of the United States Air Force
CSM	Command Sergeant Major
CSTC	Combined Security Transition Command
CTP	Comprehensive Transition Plan
DACOWITS	Defense Advisory Committee on Women in the Services
DAV	Disabled American Veterans
DCoE	Defense Centers of Excellence
DCoE PH & TBI	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DEERS	Defense Enrollment Eligibility Reporting System
DES	Disability Evalutation System
DHB	Department of Healthcare Business
DMDC	Defense Manpower Data Center
DoD	Department of Defense
DOL	Department of Labor
DTAP	Disabled Transition Assistance Program
DTS	Defense Travel Services (DTS)
DVBIC	Defense and Veterans Brain Injury Center
E2I	Education and Employment Initiative
EACE	Traumatic Extremity Injury and Amputation Center of Excellence
EHR	Electronic Health Record(s)
EMSC	Emergency Medical Services for Children
ETT	Embedded Tactical Trainer
EXORD	Executive Order
FAC	Family Assistance Center
FACA	Federal Advisory Committee Act
FOCUS	Families Overcoming Under Stress
FRAGO	Fragmentary Order
FRC(s)	Federal Recovery Coordinator(s)
FRCP	Federal Recovery Coordination Program
FY	Fiscal Year
GAO	Government Accountability Office
GEN	General

Acronym	Meaning of Acronym
HCE	Hearing Center of Excellence
HIPAA	Health Insurance Portability and Accountability Act
HOOAH	Healing Outside of a Hospital
HQDA	Headquarters Department of Army
HQMC	Headquarters Marine Corps
H.R.	House Resolution
ICE	Immigration and Customs Enforcement
IDES	Integrated Disability Evaluation System
IG	Inspector General
IOP(s)	Intensive Outpatient Program(s)
IPO	Interagency Program Office
JAG	Judge Advocate General
JAMA	Journal of the American Medical Association
JCS	Joint Chiefs of Staff
JD	Juris Doctor
JEC	Joint Executive Council
JFHQ	Joint Force Headquarters
LMFT	Licensed Marriage and Family Therapist
LT	Lieutenant
LTC, LtCol, Lt Col	Lieutenant Colonel
Lt Gen	Lieutenant General
LRS-D	Long Range Surveillance Detachment
MA	Master of Arts
MAJ, Maj, Maj.	Major
MC&FP	MIlitary Community and Family Policy
MCCM(s)	Medical Care Case Manager(s)
MCWIITS	Marine Corps Wounded, Ill, and Injured Tracking System
MD	Medical Doctor
MEB	Medical Evaluation Board
MEBOC	Medical Evaluation Board Outreach
MEDCOM	Medical Command
MFLC	Military Family Life Consultant
MG	Major General
MOAA	Military Officers Association of America
MPA	Master of Public Administration
MPH	Master of Public Health
MPP	Master of Public Policy
MS	Master of Science
MSC	Military Services Coordinators

Acronym	Meaning of Acronym
MSG, MSgt	Master Sergeant
MSN	Master of Science in Nursing
MSW	Master of Social Work
mTBI	Mild Traumatic Brain Injury
MTF	Military Treatment Facility
MWR	Morale, Welfare, and Recreation
NAS	Naval Air Station
NATO	North Atlantic Treaty Organization
NCM(s)	Nurse Case Manager(s)
NCO	Non-Commissioned Officer
NCOIC	Non-Commissioned Officer in Charge
NDAA	National Defense Authorization Act
NEJM	New England Journal of Medicine
NGB	National Guard Bureau
NIH	National Institutes of Health
NLM	National Library of Medicine
NMA(s)	Non-Medical Attendant(s)
NMCM(s)	Non Medical Case Manager(s)
NMCSD	Naval Medical Center San Diego
NMFA	National Military Family Association
NOD	National Organization on Disability
NPRST	Navy Personnel Research Studies and Technology
NRD	National Resource Directory
OASD(HA)/TMA/TPOD	Office of the Assistant Secretary of Defense (Health Affairs), TRICARE Management Activity, TRICARE Policy and Operations Directorate
OASIS	Overcoming Adversity and Stress Injury Suport
OCONUS	Outside the Continental United States
OEF	Operation Enduring Freedom
OIC	Officer In Charge
OIF	Operation Iraqi Freedom
OIP	Organizational Inspection Program
OIPT	Overarching Integrated Product Team
OND	Operation New Dawn
PDHA	Post-Deployment Health Assessment
PDHRA	Post-Deployment Health Reassessment
PEB	Physical Evaluation Board
PEBLO(s)	Physical Evaluation Board Liaison Officer(s)
PhD	Doctor of Philosophy
PII	Personally Identifiable Information
P.L., Pub. L.	Public Law

Acronym	Meaning of Acronym
POI(s)	Program(s) of Instruction
PSG(s)	Platoon Sergeant(s)
PTSD	Posttraumatic stress disorder
RA	Reserve Affairs
RAP	Rapid Action Poll
RC	Reserve Component
RCC(s)	Recovery Care Coordinator(s)
RCP	Recovery Coordination Program
REALifelines	Recovery & Employment Assistance Lifelines
Ret	Retired
RN(s)	Registered Nurse(s)
RSM(s)	Recovering Service Member(s)
RW(s)	Recovering Warrior(s)
RWTF	Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces, also referred to as the Recovering Warrior Task Force
SECAF	Secretary of the Air Force
SFAC(s)	Soldier and Family Assistance Center(s)
SFC	Sergeant First Class
SgtMaj	Sergeant Major
SIGINT	Signals Intelligence
Stat.	Statute
SOC	Senior Oversight Committee
SOFS	Status of Forces Survey(s)
SPC	Specialist
SSA	Social Security Administration
SSG	Staff Sergeant
TAA	Transition Assistance Advisor
TAP	Transition Assistance Program
TBI	Traumatic Brain Injury
TDRL	Temporary Disability Retired List
TMA	TRICARE Management Activity
USA	United States Army
USAF	United States Air Force
USAIG	United States Army Office of the Inspector General
USAR	United States Army Reserve
USMC	United States Marine Corps
USN	United States Navy
USSOCOM	U.S. Special Operations Command
VA	Department of Veterans Affairs

Acronym	Meaning of Acronym
VBA	Veterans Benefits Administration
VCE	Vision Center of Excellence
VETS	Veterans' Employment & Training Service
VHA	Veterans Health Administration
VistA	Veterans Health Information System and Technology Architecture
VR&E	Vocational Rehabilitation and Employment
WCTP	Warrior Care and Transition Program
WII	Wounded, Ill, and Injured
WRAMC	Walter Reed Army Medical Center
WTB(s)	Warrior Transition Battalion(s)
WTC	Warrior Transition Command
WTP	Warrior Tranistion Programs
WTU(s)	Warrior Transition Unit(s)
WWBN-W	Wounded Warrior Battalion West Detachment
WW CM	Wounded Warrior Case Managers
WWCTP	Office of Wounded Warrior Care and Transition Policy
WWP	Wounded Warrior Project
WWR	Wounded Warrior Regiment
WWRC	Wounded Warrior Resource Center
WWRO	Wounded Warrior Regiment Order