PART I. DoD/VA Healthcare Symposium: Total Force Care

Highlights of major issues and gaps in Total Force Care, focusing on the eligibility for healthcare and availability of healthcare access and delivery.

November 19, 2008

PART II. Mental Healthcare Delivery to the Armed Forces

Highlights the major issues related to transition, Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD), how DoD/ VA and the Services are reacting, and the hope provided by new forms of treatment.

March 23, 2009

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SPONSOR RECOGNITION

We wish to express our special thanks and appreciation to the McCormick Foundation of Chicago, Illinois for their most generous support of the Defense Education Forum programs on Delivery of Healthcare to the Total Force and Mental Healthcare Delivery to the Reserve Components. They have enabled the Reserve Officers Association and its educational arm, the Defense Education Forum, to produce two outstanding programs on key issues relating to the medical well-being and care of our Service Members. These programs have both identified issues and suggested solutions for enhancement of both the DoD and VA healthcare systems.

MEMBER RECOGNITION

We wish to express our appreciation to the Members and staff of the Reserve Officers Association who made these programs a reality. Of special note, are the efforts of the program Chairpersons for the two programs covered by this report. MG (Ret) Donna Barbisch and her Steering Committee worked creatively and at length to design and execute a program on Total Force Care that is reflected in Part I of this report. MG Robert Kasulke was largely responsible for the design and execution of the program on Mental Healthcare Delivery to the Reserve Components which is reflected in Part II of this report. They are examples of the outstanding men and women of ROA, both serving and retired, who devote themselves tirelessly to well-being of our Service Members.

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Preface

The Defense Education Forum (DEF) is the education arm of the Reserve Officers Association (ROA). Education and advocacy make up the twin pillars of ROA. In January, 2007, DEF conducted a Continuum of Service Forum to explore this concept and to identify specific topics under the concept which should be explored in greater depth. It was determined that DEF would do a series of programs on the continuum of health care for the Total Force with special emphasis on the unique challenges of the reserve components. We have now completed three of these programs, all held at the Minuteman Memorial Building, the headquarters of the Reserve Officers Association located across from the United States Capitol. This report covers the findings of the second and third programs in the series. We gratefully acknowledge the support of the McCormick Foundation in making these programs possible.

The first of the healthcare educational programs took place in August 2007, addressing the "Continuum of Health care for the Reserve Components." The program identified the top four goals for an optimal continuum of health care system: 1) enhance readiness, 2) improve portability that would eliminate the most prevalent access issues for members and their families, 3) health care as a recruiting and retention tool, and 4) cost effectiveness. Recommendations of the forum included a streamlined system for medical support that could include, but was not limited to, a more comprehensive TRICARE system, stipends to support civilian health care independent of TRICARE, or a combination of both. The program also addressed cost, noting that the current cost of existing Reserve Component efforts to promote medical readiness or the cost of NOT being medically ready are not known. Additionally, the cost of transitioning in and out of the TRICARE system has not been measured. It concluded that more research was needed to identify a cost effective Reserve Component medical support system.

The second in the series was the "DoD/VA Healthcare Symposium: Total Force Care" held on November 19, 2008. This Symposium focused on the crosswalk of medical support between the Department of Defense and the Department of Veteran Affairs for the Total Force with special emphasis on the unique challenges of the reserve components. The symposium was not intended to address clinical care, but rather, the interconnected links and gaps in the complex process of transitioning between military medical support and VA medical support. The program addressed the myriad of existing programs targeted toward different groups within the military and the eligibility and access for those programs, the existing efforts in education and outreach, and the critical gaps as well as redundancies that exist in our efforts to take care of the men and women who serve our country in uniform. In addressing the issues and barriers related to the smooth transition from military medical care to Department of Veteran Affairs (VA) medical care, these DEF programs have added to the body of knowledge that will lead to breaking down those barriers and optimizing a program of comprehensive health care for the Total Force.

The third in the series of programs was entitled "Delivery of Mental Healthcare to the Reserve Components." The signature injuries of the Global War on Terrorism have been Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). The cost to Service members and their families and to the military has been enormous both on the personal and financial levels. The good news is that substantial strides have been made in treatment and research over the past six years. This program focused on mental healthcare delivery and recent research developments especially as they related to TBI and PTSD. The program featured leading physicians and mental health specialists from both the military and civilian worlds as well as from the Veterans Administration.

All of the above programs featured national leaders in their fields ranging from Assistant Secretaries from DoD and VA, to the Surgeon General of the Air Force, and Reserve Component and civilian leaders in a variety of fields. The audiences were also reflective of a broad diversity of providers in the healthcare field. It is our belief that these forums have enhanced the body of knowledge in the field, served as a focal point for sharing information, and stimulated creative thinking. We most appreciate the efforts of all the faculty members, the participation by the audience through their comments and in breakout sessions, and the substantial role played by ROA leaders and members in the development and support for these programs. A special appreciation is also extended to LTC Donna R. Van Derveer and to SGT James Taulbee, wounded warriors who shared their personal stories with us which greatly added to the program.

A special thank you is also due to MG (Ret) Donna Barbisch who chaired the first two programs, and to MG Robert Kasulke who chaired the Mental Healthcare related program, the third in the series (and who in the fall will become the Commanding General of the Army Reserve Medical Command). DEF expects to continue its far reaching strategic defense education programs in 2009 and periodically return to host programs related to major healthcare issues.

Bob Feidler
Director, Strategic Defense Education

Part I

Executive Summary – DoD/VA Delivery of Total Force Healthcare Symposium

Secretary of Defense Robert Gates assigned a very high priority to the provision of healthcare services to Service Members who have a service related injury "They deserve the very best facilities and care to recuperate from their injuries and ample assistance to navigate the next step in their lives, and that is what we intend to give them. Apart from the war itself, this department and I have no higher priority." Within that context, the *DoD/VA Health care Symposium: Total Force Care* was convened to address DoD/VA Total Force health care management. The symposium was designed to review the DoD/VA health care programs, identify the gaps with emphasis on inequities between components, and to identify next steps to facilitate comprehensive health care for the Total Force.

The primary objectives of the symposium included:

- Review the current DoD / VA health care programs and their applicability across components;
- Identify the requirements for a comprehensive DoD / VA health care program;
- Assess gaps and redundancies; and

Recommend next steps to facilitate a program of comprehensive health care for the Total Force.The symposium brought together the senior leaders in DoD health care and VA health care to present the vision and objectives in synchronizing care for the Total Force. We engaged Congressional input to identify their perspective on the issues of managing Total Force health care. The symposium then set the stage with a panel of senior subject matter experts who presented an overview of the existing programs aimed at facilitating DoD/VA health care transition. A keynote presentation by Kim Dozier, a war correspondent with CBS news, severely injured in an IED incident in Baghdad, highlighted the need for health systems that embraced a continuum of care. The final panel moved to the warfighting commander's perspectives to further identify mission needs from the DoD VA health care continuum. A working session building on the participants' knowledge engaged participants in a facilitated discussion to define the underlying issues affecting the DoD/VA continuum of care: the continued challenges; gaps and redundancies; and recommendations for next steps to address the critical issues in optimizing Service Member continuum of care from DoD to VA health support.

The key findings focused on two main issues and the enablers to support the continuum of care: **Eligibility** (component specific), and **Availability** of services. Key recommendations for further study relative to eligibility were based on consistency and simplification of the benefits determination process between DoD and VA across and between all components and services. Recommendations for further study relative to availability were based on capacity to provide services within DoD and VA for service and outreach. A similar recommendation for further study relates to TRICARE's ability to have sufficient providers and services, especially in more rural areas of the country.

Enablers to improving DoD/VA Total Force health care included leadership emphasis on the process, access to electronic health records, a streamlined process for determining eligibility, educational programs on the process, and a focus on preventive health. The participants recommended further, more in-depth review of the Total Force impact of the changing requirements and interoperability of DoD/VA health care services and the total cost of those services.

Background

Embedded in DoD's mission is a priority to provide for the medical needs of Service Members and their families. Delivering comprehensive care to Service Members as they move across different components, from combat casualty to civilian status, from military facilities to civilian care, and making the transition into Veteran status, creates many challenges for a smooth transition. Eligibility for military health care varies depending upon the Service Member's status. Active component and some reservists on active duty, depending upon the time and status of active duty, are eligible for all services available throughout the military health care system. Some reservists in ready reserve status have the ability to purchase military health care coverage. Others in the ready reserve, inactive, or retired reserve are not eligible for military health care although they are subject to recall and mobilization (see Annex A).

Eligibility for VA health care benefits is dependent upon many factors related to length and type of service, level of disability, and economic means. When a Service Member becomes ill or injured on active duty, DoD and VA policies and programs are intended to support a seamless transition throughout their medical care. However, the process is often difficult and laborious with regard to the establishment of eligibility, the capacity and capability to provide care, and the geographic capability for critical medical care (i.e. rehabilitation, traumatic brain injury, etc.). The result is that the provision of critical medical care too often falls between the cracks. The objective of the DoD/VA health care continuum is to ensure those in need and eligible for care are quickly and effectively identified and validated, and to provide for a smooth transition of care for our Service Members.

The Changing Face of DoD/VA Health care

The ongoing wars in Iraq and Afghanistan have created tremendous challenges in providing the continuum of health care for Service Members. With the increased employment of the reserve components, gaps in the system have been identified, and initiatives are underway to address the gaps in eligibility and services. Compounding these challenges are the changing nature of the casualties and demographics. The nature of injuries has driven development of improved protective gear, resulting in increased survivability. The survivability rate, while an outstanding achievement, has in turn created a growing category of injuries requiring specialized treatment such as traumatic brain injury, complex eye injuries, limb amputations, and stress management. Policies have been implemented to improve care based on the changing environment, however, significant gaps remain. Our greatest challenge is to synchronize policies and streamline processes to optimize the continuum of health care from DoD through VA that will provide the Service Member the quality of care and the assistance to navigate through the next steps of their lives.

Vision and Challenges of the DoD/VA Continuum of Health care

The Assistant Secretary of Defense for Health Affairs, the Honorable S. Ward Casscells presented an overview of DoD Health Affairs' (HA) health care vision and the challenges in achieving a smooth transition across the DoD / VA continuum of health care for the Total Force. Dr Casscells highlighted the challenges in cutting red tape and managing bureaucracy. He focused on the need for leadership, both line and uniform to address the issues. He acknowledged the inconsistency and accessibility of treatment, and the need for standardization of health care benefit across DoD. A priority in Health Affairs is the measurement of quality of care, and the integrated health information systems. Other DoD health management challenges included enhance warrior care, deployment, transition, rehabilitation and reintegration into the community, and the issues of patient choice. A particular challenge is created in that 70% of care that is rendered is in the private sector.

The Department of Veterans Affairs, Assistant Secretary of Health, the Honorable Michael Kussman presented an overview of Veterans Health Administration's (VHA) vision and challenges in achieving a smooth transition across the DoD / VA continuum of health care for the Total Force. Dr Kussman focused on the vision and mission of the VHA.

VHA vision is to provide a continuum of high quality health care in a convenient, responsive, caring manner and at a reasonable cost. The mission of the Veterans health care system is to serve the needs of America's Veterans by providing primary care, specialized care, and related medical and social support services. To accomplish this mission, VHA needs to be a comprehensive, integrated health care system that provides excellence in health care value, excellence in service as defined by its customers, and excellence in education and research, and needs to be an organization characterized by exceptional accountability as well as being an employer of choice.

A Congressional perspective was presented by Mr. Gary Leeling, Lead Counsel of the Senate Armed Services Personnel Subcommittee. Mr Leeling discussed the effort to address the continuum contained within the Wounded Warrior Act of 2007. The complexity of the Act creates additional challenges in implementation. The overall growth of health care needs, and especially the growing needs of retirees, are concerns for Congress. Mr Leeling also addressed the continuing need to recruit more providers into the TRICARE managed care program, with a specific emphasis on the rural environments. In his final comments, he addressed concerns over the impact of the US financial crisis and challenges for the new administration relative to the future of military health care.

Existing Health care Programs

A distinguished panel of experts outlined existing programs to provide for a smooth transition of care from injury or incident throughout the continuum of care. It was determined that the access to health care services was dependent upon two main issues: **Eligibility** (component specific), and **Availability**. Availability was further identified as system capacity (were there enough providers), specific clinical service (was the clinical service and expertise available), and geographic challenges (was the service available in the Service Members location).

Eligibility criteria are dependent upon component specific length and type of service. DoD health care and VA health care have different criteria. The documentation and justification for eligibility and the limited availability of services became the focal point of discussion for a smooth continuum of care between DoD and VA health care.

The panel highlighted programs geared toward outreach and education to assist in identifying and notifying returning Service Members of their health care benefits. It was noted that the active component is eligible for all available DoD health care services; eligibility for the reserve components is dependent upon the numerous classifications as well as types of active duty orders under which a member serves. (see Annex A) Depending on the status they are serving in, the Service Member may be eligible to purchase DoD health care. Family member access and availability for DoD services was noted as a continued challenge for the Reserve Component (RC). The RC Service Member moves into and out of TRICARE and continually faces the challenge of the geographic availability of TRICARE providers.

Eligibility for VA services is based on length of service, percent of disability, and economic need. Whereas Active Component (AC) members are maintained on DoD health care throughout the transition period, RC members have often left active duty status before determination of eligibility and need. This exacerbates the challenge in providing services. Early identification of a problem is critical. Education and outreach, as well as screening programs, need to target the RC to a greater extent.

As a result of the conflicts in Iraq and Afghanistan, the VA has expanded its support of Total Force health care needs. In May 2008, the VA began an aggressive outreach campaign at Army demobilization stations. Mandatory briefings include VA health and dental benefits. The role of Veteran Centers and the Veterans Benefits Administration (VBA) benefits for combat Veterans. Briefings at the demobilization sites facilitate enrollment before the Service Members separate from Active Duty. The briefings are conducted by local VA medical center (VAMC) staff. VA has programs for the Reserve Component at 15 Army sites, four Navy, three Marine and 20 Air Force Reserve sites. This has initiated collaboration with the Army National Guard and Coast Guard Reserve. Presently, over 12,000 Reserve Component members have demobilized; over 11,000 have enrolled in VA health care.

The outreach efforts also included contacting recent combat Veterans to ensure they know about VA's medical services and other benefits. A contractor-operated "Combat Veteran Call Center" telephoned two distinct populations of Veterans of the Iraq and Afghanistan conflicts. In Phase One: VA targeted combat Veterans who were identified as sick or injured while serving in Iraq or Afghanistan. In Phase Two: VA targeted combat Veterans discharged from Active Duty, but who have not contacted VA for services. In Phase Three, which started in December 2008, the VA were to call 51,000 additional services members who returned from theater since January 2008.

One of VA's most mature programs, initiated in 2005, is its support to DoD's Post Deployment Health Reassessment Program (PDHRA). DoD provides screening teams to assist Service Members 90 to 180 days post-deployment. This screening exam identifies physical health, mental health and readjustment concerns. The program facilitates access to VA health care to further evaluate these concerns. VA has supported over 1,600 On-Site and Call Center PDHRA events as well as accepted referrals from DoD's 24/7 Call Center.

VA expanded and enhanced its mental health services during the past year by hiring 4,000 mental health workers, for a total staff of 17,000. Its Suicide Prevention Hot Line is staffed by professionals and is linked to the national suicide hot line. The staff is able to access the electronic health record of the VA member and call for local help to provide service. The program has been credited with assisting more than 2,000 callers since the program was implemented.

The VA supports the National Guard Transition Assistance Advisors (TAAs) by training them as VA and TRICARE Advisors. This has expanded to 60 TAAs, serving 54 states and territories. Their role is to facilitate access to VA services and benefits. As a result, this model for coordination of VA and community services has led to the formation of state coalitions. The VA Office of Outreach supports the TAAs efforts and provides monthly conference calls, newsletters, and the identification of best practices.

Other VA initiatives include: Wounded Warrior Resource Center (call-in); VA's Welcome Home Events in the community; Outreach Efforts to those in the Disability Evaluation System; Linkages to the Warrior Transition Units and Wounded Warrior Regiments; Yellow Ribbon Reintegration Program (30-60-90 days) and 21st Century INTERNET for Returning Service Members. The VA has built its fifth Traumatic Brain Injury Center in San Antonio, Texas; and established 50 mobile counseling centers for rural health, offering readjustment counseling, pharmacy, and communication services for rural health issues.

Discussion on VA services commended the effort of the VA in outreach but questioned underlying issues related to consistency across the Total Force. Service and component specific programs (Table 1) resulted in different levels of success.

Table 1 Active Duty, Reserve Component and Veterans New or Updated Programs

Program	Type of Service/Business Process	Active Duty	Reserve Comp.	National Guard	Army Only	Air Force Only	Navy Only	Veterans
Yellow Ribbon Integration Program	Information, referrals, outreach			x				
Warrior Transition Units	Treatment, rehabilitation, reintegration	x	x					
Reserve Health Readiness Program	Medical & Dental services		x					
Post Deployment Health Reassessment	Medical Services	x	x					
Army Selected Reserve Dental Readiness System (ASRDRS)	Dental Services				x			
Full active duty healthcare access benefits (90 days prior to deployment)	Medical Benefits		x					
Transitional Assistance Management Program (TAMP) for healthcare coverage 180 days post mobilization	Medical Benefits		limited					
VA Outreach Programs	Medical and Dental benefits information		limited				x	
Combat Veteran Call Center	Outreach	limited to OEF/OIF	limited to OEF/OIF					
VA National Guard Transition Assistance Advisors				x				
Case Management	Seriously ill and injured OEF/OIF service members	x					x	
Expansion of VA services to 5 years for combat related injuries	combat related injuries	x	x					x
Suicide Hotline	staffed by clinicians; links to VA EHR	x	x					x
VA Women's Care	Women's health centers	x	x					x
Linkages between DoD and VA EHRs	Clinical record interoperability	x	x					x
Rural Health Care Vans	serves veterans							x
Completion of DD215	VA enrolls AD and RC at centers	x	x					x
Disability Pilot	MEB completed then VA does exam for PEB to determine disability and benefits	x	x					x
HERO pilot program	Medical services							x

Total Force Continuum Issues

The faculty and participants identified the various challenges and efforts being undertaken to address the issues. Assuring the individual medical readiness of members of the Reserve Components continues as a major challenge. For example, individual Mobilization Augmentees (IMAs) and gray area retirees are eligible for mobilization and deployment but are not included in medical readiness programs.

Facilitated discussion engaged the audience in reviewing the information presented. The issues were categorized into two primary categories and the enablers for those categories. The Enablers are those technical capabilities that support interoperability of the systems. The two main categories were: **Eligibility** (component specific), and **Availability** of services. See Table 2. It was noted that the Total Force impact of the changing requirements and total cost of those services was an unknown.

Availability Issues:	
	Coordination of services with community based organizations
	Ensure follow-up of positive Post Deployment Health Assessments and Reassessments
	Lack of availability and preference of combat injured Service Members to receive treatment and rehabilitate closer to home
	Limited access to adequate dental care
	Limited dental services; need preventive dental services
	Limited National Guard capability for case management
	Limited number of providers within TRICARE managed care programs
	Variation in services among TRICARE managed care support contracts
	Variations in the disability rating processes of DoD and VA
	Clinicians available to conduct Post Deployment Health Assessment and Reassessment tools
Eligibility Issues:	
	Consistency in benefits for National Guard whether performing state or military services
	Consistency in benefits whether deployment or training mission
	Consistently offer TRICARE to Total Force, including Reserve Component and

	National Guard and gray area members
	Inconsistency in requirements to secure retirement benefits
	IMAs and gray area retirees are eligible for mobilization and deployment but are not included in medical readiness programs
Enablers:	
	Access to and incorporate electronic and personal health records by VA, DoD and/or private sector
	Complexity of the VA benefit application process and length of time for approvals
	Educate the family on benefits, entitlements and services
	Leadership to support Service Members' compliance and access to health and dental services
	Need to focus on preventive health care
	Provide consistency in communications and training of staff
	Simple language and work flow processes for application processes

Conclusion

The symposium provided a forum to identify and discuss the issues, challenges, and opportunities related to DoD/VA Total Force health care. It addressed gaps in the system, as well as redundancies that if addressed in a more comprehensive approach, could result in enhanced interoperability, improved outcomes, and a more cost effective system. The discussion identified the impact of health care challenges related to readiness, recruitment, retention, and retirement. Medical and dental readiness is critical in Total Force preparedness. Increasing deployments in the Iraq and Afghanistan campaigns along with additional engagement of the reserve components present challenges in how to meet personnel needs. Furthermore, the shift to a strategic reserve elevates the health and dental needs of the Reserve and National Guard.

Discussion focused on two main issues, eligibility and availability, that would provide the enablers to support the continuum of care. **Eligibility** (component specific) and **Availability** of services were further identified as system capacity (were there enough providers), specific clinical service (was the clinical service and expertise available), and geographic challenges (was the service available in the Service Members location), and were the topics throughout the symposium. The participants recommended an in-depth review of the Total Force impact of the changing requirements and interoperability of DoD/VA health care services and the total cost of those services. Recommendations for further study relative to eligibility were based on consistency and simplification of the benefits determination process between DoD and VA, across and between all components and services.

Recommendations for further study relative to the enhancement of healthcare services were based on the capacity to provide services within DoD and VA for service and outreach. This also applies to TRICARE and its ability to have sufficient providers and services. **Enablers** to improving DoD/VA Total Force health care included leadership emphasis on the process, access to electronic health records, a streamlined process for determining eligibility, educational programs on the process, and a focus on preventive health.

The increase in deployments has presented challenges while enabling DoD and the VA to expand, enhance, initiate, and develop health care services, and benefits. Ongoing research efforts have been designed to benefit the medical and dental needs of the Total Force. The unique challenges of the Reserve and National Guard have driven component specific programs. DoD and VA acknowledge many challenges exist in developing a smooth transition and interoperability of health care programs from point of injury or incident throughout the continuum of care to VA health care.

Part II

Executive Summary-Mental Healthcare Delivery Symposium

The signature injuries of the Global War on Terrorism have been Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). The cost to Service members and their families and to the military has been enormous both on the personal and financial levels. The good news is that substantial strides have been made in treatment and research over the past six years. As part of a continuing series of programs on healthcare delivery to the Armed Forces, sponsored by the Reserve Officers Association (ROA) and its educational arm, the Defense Education Forum (DEF), a special program was conducted on mental healthcare delivery and recent developments especially as they related to TBI and PTSD. The program was conducted on March 23, 2009 at the ROA headquarters facilities, the Minuteman Memorial Building located on Capitol Hill in Washington D.C… The program featured leading physicians and mental health specialists from both the military and civilian worlds as well as from the Veterans Administration. Please see the ROA website at www.roa.org under Education and DEF Programs to view a number of the slide presentations given at the program as well as video of portions of the program.

The program began with a briefing on a new Transitional Support Program ("TSP") that the Department of Defense is initiating in April 2009. An overview was then conducted relating to TBI, the classifications of the injury and the clinical spectrum of the injury. It was followed by a segment on PTSD. It was clear from both presentations that leadership by unit commanders and peer support are crucial to early identification and treatment.

Leading physicians briefed on the latest developments in the treatment of TBI and some remarkable breakthroughs that have recently occurred. Some of these treatments revolved around the use of neuromarkers to guide treatment, and the concept of neuromodulation to normalize and regulate or even reprogram the brain. Numerous case studies were discussed which concluded with substantial patient improvement after a series of treatments in the hyperbaric chambers.

The Army Reserves and the ARNG have aggressive medical readiness efforts but face several challenges that also apply to other RC components: identifying Soldiers in need of mental health care; encouraging Soldiers who are receiving mental health care to identify themselves; and caring for Soldiers who are often geographically widely dispersed and who are not seen by their units for weeks at a time. The Navy also has an aggressive psychological health outreach program that is designed to provide early identification and clinical assessment of stress injuries to returning Naval Reservists. The Surgeon General of the Air Force who both described the Air Force programs and also emphasized leadership in identifying and then seeking care for those who may be in need of mutual healthcare. He especially praised those who were working so diligently with the Wounded Warriors.

Substantial research still needs to be done concerning mild TBI and PTSD and the incidence of these disorders among returning Service Members. Numbers vary widely as to the number of affected Service Members, but exposure to concussive events might be as high as 20% in some ground combat units. A portion of the program dealt with Comprehensive Soldier Fitness (CSF). The essence of CSF is to provide "resilience training" prior to the Soldier encountering an adverse event to better prepare that Soldier for how to cope with PTSD. The hope is that the event might even prove to be a "growth" event for the injured Service Member.

Another portion of the program engaged individuals who had suffered from mTBI and/or PTSD and continued to have to deal with these issues. It reinforced the need for unit leaders to demonstrate leadership, knowledge and sensitivity in dealing with their unit members who may be suffering from mTBI or PTSD. The program concluded with a briefing on services being offered by the VA and their emphasis on adding mobile units to cover rural areas.

Introduction

The following addresses the highlights of presentations. This report reflects the content of the symposium, and not necessarily positions of ROA or DEF.

Five Principles have guided recent decisions by DoD regarding healthcare for Service Members:

1. Furnish strong, visible leadership and the necessary resources
2. Create, disseminate, and maintain excellent standards of care
3. If best practices are unavailable, conduct pilot or demonstration projects to better inform quality standards
4. Monitor and revise access, quality, and program implementation to ensure standards and consistent quality are executed, and
5. Construct a system where each individual can expect and receive the same level of service and quality of service regardless of Service, Component, status, or geographic location

These have led to seven goals:

1. Expand access to care
2. Improve quality of care
3. Support transition
4. Improve screening and surveillance
5. Build resilience
6. Conduct research, and
7. Build a strong culture of leadership and advocacy

Transitional Support

The program began with a briefing on a new Transitional Support Program (TSP) that the Department of Defense is initiating in April 2009. The program is designed to bridge gaps in psychological health services that can occur during periods of transfer that are typical for Service members. Transitional Support Facilitators (TSF) will be made available to offer coaching services, provide support and education, and otherwise encourage the utilization of behavioral health services by Service members. The TSP was developed in response to the DoD Mental Health Task Force recommendation to "Maintain Continuity of Care Across Transitions."

Both AC and RC Members are eligible for the service to include:

- Active and Reserve Duty Service members with post traumatic stress disorders, mild TBI, depression, anxiety, and other mental health conditions
- Subsets of the patient population to be served include: wounded warriors returning home from a Warrior Transition Unit (WTU) or other treatment environment, between Medical Treatment Facilities (MTF), or moving to a community-based provider

- Service Members who received or are receiving care in a MTF and are scheduled for a permanent change of station (PCS) or an extended temporary duty station
- Service Members who are transitioning from a MTF to a Department of Veterans Affairs (DVA) or TRICARE system of care
- Service members who are transitioning from a DVA facility back to active duty where they will receive treatment from an MTF-based or TRICARE provider system

The TSP will draw facilitators from an established behavioral health network with national networking capability,the Magellan Group. The facilitators, or coaches, will be licensed health experts trained in motivational interviewing and coaching techniques. A facilitator will be assigned to a Service member by their current health care provider, and will remain with them until a transfer is completed to the gaining provider of mental health management. The facilitator will provide crisis intervention until a transfer is complete. The program is expecting 25,000 – 35,000 calls a month.

One drawback for RC members is that the TSP program only applies to those Service members who are in the system. It will not cover an RC member who has been discharged and for whom the malady arises after they have left the system.

Traumatic Brain Injury

An overview was conducted relating to TBI, the classifications of the injury and the clinical spectrum of the injury. Two conditions must be met to suspect/diagnose a TBI:

1. An injury event must occur AND
2. The person must have experienced an alteration of consciousness (ranging from dazed or confused to amnesia to loss of consciousness).
3. In the absence of documentation, both of these are based on self reporting

The experience in OIF and OEF was reviewed which demonstrated the prevalence and severity of TBI injuries which were overwhelmingly caused as a result of a blast. Approximately 56% of TBI injuries are from blasts. And, if a person should suffer 3 previous concussive injuries the repeat risk of injury is dramatically increased – up to three fold. Most TBI injuries result in being classified as “mild” or “mTBI”. It was pointed out that sustaining any type of injury in theater may also serve to increase the risk for PTSD. The injuries can be physical, emotional and cognitive with symptoms such as: headaches, dizziness, balance problems, anxiety, depression, irritability, slow processing, poor concentration, and memory problems.

The Defense Centers of Excellence for Psychological Health and TBI (DCoE) includes at least six entities devoted to the study of TBI and PTSD and its treatment. They include the:

1. Defense and Veterans Brain Injury Center
2. Center for Deployment Psychology
3. Deployment Health Clinical Center
4. Center for the Study of Traumatic Stress

5. Telehealth and Technology Center, and
6. National Intrepid Center of Excellence

A number of activities are underway throughout DoD and the Services to address TBI and PTSD, these include: TBI Training Conferences (2007 and 2008); MACE (Military Acute Concussion Evaluation); a 15 year Longitudinal Study; TBI Surveillance; Deployed and DoD/VA Clinical Practice Guidelines (CPG); Family Caregiver Panels; JIEDDO and DVBIC/MIT Collaboration, the Yellow Ribbon Reintegration Program, and the Senior Oversight Committee's Line of Action 3: Case Management.

DoD/DCoE Research includes: HBO2 in TBI Clinical Trials; National Intrepid Center of Excellence (NICoE) research, and other research endeavors such as

1. Neuroimaging (DTI, SWI)
2. Biomarkers
3. Neuroprotective agents (progesterone, NAC)
4. Several complimentary/alternative therapies
5. Improved helmet technology/blast sensors, and
6. Neurocognitive Assessment Test (NCAT) evaluations

It was noted that there are 1.4 million TBIs annually in USA, 750,000 strokes, and 75,000 new cases of multiple sclerosis. The hope was expressed that given the magnitude of the TBI issue not only for the military but also for the civilian population, that greater funding for current TBI research efforts will translate into better care of all TBI patients.

Post Traumatic Stress Disorder

Several speakers addressed Post Traumatic Stress Disorder in the U.S. military reflected that the disorder can occur after either experiencing or witnessing a traumatic event such as might occur in military combat although numerous other stressors can be cause of the disorder as well. PTSD is characterized by repeated re-experiencing of the event, avoidance, and arousal. The disorder can manifest itself immediately or even years later.

PTSD is a relatively new diagnosis for a disorder, having been recognized as such in 1980. However, under whatever name, the symptoms and the disorder have existed since the beginning of wars but have gone under other names: "shellshock" "battle fatigue" "combat exhaustion" etc. Combat is not the only stressor that can lead to PTSD. Other stressors include:

- Sexual assault
- Physical assault
- Natural disasters
- Witnessing horrors
- Industrial accidents
- Transportation accidents

Trauma exposure is extremely common - PTSD is much less common. Many people recover from PTSD, but a minority develop chronic and persistent symptoms. Other

psychiatric disorders may develop or co-occur with PTSD. Research indicates that women are more likely to develop PTSD, although data from war are not consistent.

Evidence based risk factors related to getting PTSD include:
- Severity of the traumatic event
- Absence of social support post event
- Additional life stressors
- Adverse childhood events
- Low SES, Intelligence, Education
- Prior traumatic exposure, and
- Gender

People with PTSD may also have other problems, including:
- Drinking or drug problems
- Feelings of hopelessness, shame, or despair
- Suicidal behaviors
- Employment problems
- Legal problems
- Relationship problems including divorce and violence
- Physical symptoms
- Traumatic Brain Injury

Prevalence estimates of PTSD for Service members varies. Estimates range from 4 - 9%. Among combat units such as infantry units, anecdotal evidence suggests that upwards of 20% of members of such units might be subjected to a concussive event.

It was stated by one speaker that mild TBI and concussions were similar, but concussions and moderate and severe TBI are not comparative. Mild TBI may lead to persistent post-concussive symptoms / syndrome (PCS) in a unknown percentage of service members. Several studies have shown that "post-concussion syndrome" & "cognitive impairment" are just as frequent after non-head injuries as after concussions.
A concussion/mTBI does <u>not</u> "overlap" with PTSD. <u>Post-concussive symptoms (PCS)</u> are what overlap with PTSD, but also with hundreds of other medical & post-war conditions. Mild TBI is often misused to refer to PCS.

Treatment suggestions included:

1. <u>The most important</u> (and only evidence-based) treatment for mTBI is providing reassurance and expectation for full recovery.
2. Use the term "concussion" to reduce the stigma & negative impact of the "brain injury" label and clearly distinguish this from mod/severe TBI.
3. Minimize speculation regarding blast effects.
4. Develop a collaborative treatment plan with each patient to evaluate & treat symptoms in a stepped manner, as well as address each health concern.
5. Trust your clinical judgment. Consult as appropriate. Protect patients from unnecessary evaluations.

6. Routine neuropsychology exams may reinforce negative expectations.
7. Screen for and treat underlying mental health problems. These are physiological/neurobiological not "psychological" disorders.
8. Modify post-deployment screening for mTBI (PDHA, PDHRA, PHA) to minimize risk of misattributing symptoms to mTBI.

Websites of interest relating to family and reintegration support include:

- Sesame Street DVDs
- www.AfterDeployment.org
- www.MilitaryOneSource.com
- www.MilitaryHomeFront.dod.mil
- www.MilitaryMentalHealth.org

New Developments in Treatment

Leading physicians briefed on the latest developments in the treatment of TBI and some remarkable breakthroughs that have recently occurred. Some of these treatments revolved around the use of neuromarkers to guide treatment, and the concept of neuromodulation to normalize and regulate or even reprogram the brain. To make these treatments effective and available it will be necessary to standardize and operationalize the new tools of science for successful interventions. The International Brain Research Foundation and Louisiana State University have been in the forefront of innovative treatments to include hyperbaric oxygen chamber sessions which show great promise. Numerous case studies were discussed which concluded with substantial patient improvement after a series of treatments in the hyperbaric chambers. The point was made that it was not the number of the functioning neurons in the brain that was important – but their organization. This becomes especially important in TBI. The cases seemed to discredit other medical theories and showed a range of disorders that had been helped by the treatments with resulting cost saving and improvement in the life style of the patients.

Service Initiatives

Service program initiatives to deal with behavioral health issues, among others, include: Army Battlemind; Navy Operational Stress Control; Marine Corps Combat Operational Stress Control; and Air Force Landing Gear.
Early intervention initiatives reflecting behavioral health integration in primary care are the:

- Army's RESPECT-Mil
- Air Force's Behavioral Health Optimization Program, and the
- Navy's Deployment Health Clinics.

Providers also embedded in line units such as in the Marine Corps Operational Stress Control and Readiness program.

In FY 2008, 1178 providers were trained by the Center for Deployment Psychology in deployment care, including Prolonged Exposure and/or Cognitive Processing Therapy for PTSD.

The Services have developed many measures revolving around periodic health assessments to identify the disorder and begin early treatment. Leadership and peer support are crucial and there must be no stigmatization of those who are afflicted by the disorder or who seek assistance. Family support is essential as is the need for more research into various aspects of PTSD. Finally, it was acknowledged that the Guard and Reserve have unique issues given that their members are often in rural areas, distant from peer and medical support, and may not have the safety net in their civilian lives that active component members have.

- **Army Reserve Component Programs**

The Army National Guard ("ARNG") is the largest in size of the Reserve Components – about 360,000 Service members. It is also the component of the RC that due to the nature of its units, which are primarily combat and combat support, is exposed most frequently to events that might cause TBI or PTSD. The ARNG has an aggressive medical readiness team but faces several challenges that also apply to other RC components: identifying Soldiers in need of mental healthcare; encouraging Soldiers who are receiving Mental HealthCare to identify themselves to the ARNG; 31 States do not have a Behavioral Health Officer; ARNG Soldiers are part-time, but the expectation on the Guard is for full accountability; and geographic dispersion of ARNG Soldiers. To meet these challenges a variety of programs have developed such as Yellow Ribbon and Strong Bonds; community partnerships with health care providers; Warrior Family Assistance Program and connection with other Federal programs, especially with the Department of Health and Human Services and VA.

The Army Reserve (AR) has a Deputy Surgeon General for Behavioral Health and four behavioral health officers who serve as Regional Directors for Psychological Health. Their job is to operationalize the AR behavioral health plan. They will focus on command consultation, outreach, surveillance, resilience promotion, liaison, intervention and care coordination, and caregiver support. They also expect to embed behavioral health personnel into the AR well-being programs and perhaps to embed similar personnel into the Operational and Functional Command staffs.

- **Navy Programs**

The Navy also has an aggressive psychological health outreach program that is designed to provide early identification and clinical assessment of stress injuries to returning Naval Reservists. It has established psychological health outreach coordinators and psychological health support teams at each of its five Reserve Component Commands. In addition, it is conducting Returning Warrior Workshops for its Service members and their families.

- **Air Force Programs**

The Air Force has several initiatives to address needed care at home. Air Force Medical Service officials released a prevention education program that provides focused education specifically targeted at Airmen at risk for PTSD and other deployment-related mental health problems in October, 2008. Entitled Landing Gear, the training fulfills existing requirements for pre-exposure preparation training and reintegration education. A key feature of Landing Gear is that it provides a standardized approach to mental health requirements for pre-exposure preparation training for deploying Airmen and reintegration education for redeploying Airmen. The course offers a standardized but flexible lesson plan that can be expanded or contracted to meet audience needs.

The largest effort to date is the Traumatic Brain Injury Clinic at Elmendorf AFB, Alaska, located there in support of the Army's 4th Airborne Brigade Combat Team. Officials at Fort Wainwright in Fairbanks like the concept so much, they have planned to open up a similar TBI clinic near the post hospital.

In 2009, the Air Force introduced new virtual reality-based software to help veterans combat PTSD. The software, introduced to eight bases in the Air Force, is designed to create a safe environment for redeployers with PTSD to recreate a traumatic situation they have experienced. This new technology compliments the evidence-based treatment used to treat redeployed members, called 'Prolonged Exposure Therapy' and other research proven approaches to help deployers successfully integrate their deployment experiences into their concept of themselves, the world, right and wrong and other challenges that face today's warriors.

- **Comprehensive Soldier Fitness – a Chance for Growth**

A portion of the program dealt with Comprehensive Soldier Fitness (CSF). The essence of CSF is to provide “resilience training” prior to the Soldier encountering an adverse event to better prepare that Soldier for how to cope. The traumatic event could lead to post traumatic stress, or, it could lead to post adversity growth by ones gaining self confidence, enhanced leadership abilities, personal strength, spiritual growth, and a greater appreciation for life. Those who have experienced the trauma may well be better able to relate to others, be more open to new possibilities and making choices in a conscious manner and better able to set priorities.

Individual Stories

A portion of the program engaged individuals who had suffered from mTBI and/or PTSD and continued to have to deal with these issues. Their stories were compelling and both reflected the substantial care that is available, but also exposed the almost shocking lack of sensitivity and understanding by the Soldier’s leaders about what was occurring to the Soldier and what could be done to assist. It also painted a grim picture of stigma and bureaucratic obstacles that degenerated into adversarial relationships with the services. The phrase used was that leaders were intent on accomplishing their mission and were

forgetting the second principle of leadership, taking care of your Soldiers. A compelling discussion occurred over whether the effects of the traumatic incidents that had caused their disorders would be lifelong events or whether they could be overcome in time with proper care and assistance. Both alternatives are viable.

Veterans Administration Initiatives

The conference concluded with a review of the scope of services provided by the Veterans Administration. They now have over 230 outreach centers which will grow to 270 with an increase in employees from 1000 to 1500. Over 25% of the staff at theses centers are now OIF or OEF veterans. They are also starting a program of 50 mobile vet centers to service more rural sites which will be fully operational shortly. They are based at National Guard armories but controlled by nearby Vet Centers. To date, the VA has assisted nearly 350,000 OEF-OIF veterans in their outreach and in-center facilities.

Conclusion

TBI and PTSD are the signature wounds of the GWOT, most of which are caused by blasts. Substantial research still needs to be done concerning mild TBI and PTSD and the prevalence of these disorders among returning Service members. Present funding for research is grossly low given the incidence of TBI in both the civilian and military populations. Figures were discussed that suggested that upwards of 20% of Soldiers in combat units deployed to OIF and OEF may have been exposed to a concussive incident. This does not necessarily mean that TBI or PTSD will result. The overall prevalence rate for PTSD in the military appears to be somewhere between 4 – 9%. DoD, the Services, and VA have developed numerous Centers and programs to conduct research and provide care to Service members suffering from TBI and PTSD. A new program to assist Service members transitioning in some way will be rolled out by DoD in April, 2009. Creative research into the treatment of TBI is aggressively occurring at the several leading brain research entities and universities with hyperbaric oxygen treatments showing great promise both for TBI and other non-brain related injuries.

The Surgeon General of the Air Force, Lt Gen James Raudebush captured the essence of the issue nicely when he stated “We are in this together as a family. But we must remember that the process of research and care is not quick - we must be patiently impatient.”

ANNEX A – Eligibility for DoD health care by RC classification

RC Classification	Eligible for DoD health care at no cost	Eligibility to purchase TRICARE benefit	Eligible for Recall to AD
1. Ready Reserve			
a. Selected Reserve			
i. Drilling Unit Reservists	No	Yes	Yes
ii. Full-time Reserve Unit Support Personnel (active guard reserve (AGR))	Yes	N/A	N/A
iii. Trained Individuals (Individual Mobilization Augmentees (IMAs))	No	No	Yes
iv. Training Pipeline: (Individuals who have not completed their training)	No	No	Yes
b. Individual Ready Reserve (IRR) and Inactive National Guard (ING)	No	No	Yes
i. Ready Reservists not in the Selected Reserve	No	No	Yes
2. Standby Reserve	No	No	Yes
Retired Reserve (10 USC 10141(a) < 60 yrs "gray area retirees"	No	No	Yes

ANNEX B – Health Assessments and Readiness Tools

Post Deployment Health Assessments (PDHA)	• Purpose: screening each Service Member's current health, mental health or psychosocial issues commonly associated with deployments, special medications taken during the deployment, possible deployment-related occupational/environmental exposures, and to discuss deployment-related health concerns. • Positive responses to the questionnaire require the use of supplemental assessment tools and/or referrals for medical consultation. • The medical provider will document concerns and referral needs and discuss resources available to help resolve any post-deployment issues with the Service Member.
Post-Deployment Health Reassessment (PDHRA) Program	• Designed to identify and address health concerns, with specific emphasis on mental health, that have emerged over time since deployment. • Provides for a second health assessment using DD Form 2900 during the three- to six-month time period after return from deployment, ideally at the three to four month mark. • Reassessment is scheduled for completion before the end of 180 days after return so that Reserve Component members have the option of treatment using their TRICARE health benefit.
Periodic Health Assessments (PHA)	• Annual periodic assessment is conducted to closely monitor the health status of our Active Duty and Select Reserve Components, especially changes that could impact a member's ability to perform military duties and to provide timely, evidence-based preventive health care, information, counseling, treatment or testing as appropriate.
Dental Readiness	• The Oral Health and Readiness Classification System is to help commanders estimate how many of their soldiers are likely to require treatment for dental emergencies during a deployment. • Minimize personnel losses to treatment or MEDEVAC by ensuring that as many soldiers as possible are Dental Class 1 prior to deployment.
Immunization Status	• Effectively prevent infectious diseases in the deployed as well as non-deployed environments, • Vaccines provide a safe and effective means of countering the threats to personal health and military

	readiness. • Immunizations are monitored and kept current. • Pre-deployment immunizations for all personnel include: o Hepatitis A, MMR (Measles, Mumps, Rubella), Td, influenza and typhoid. • Selected personnel may require other vaccines as dictated by appropriate medical authority.

Medical Readiness Laboratory Studies	• Required studies:
	  o are current HIV testing
	  o DNA sample on file in the Armed Forces Repository of Specimen Samples for the Identification of Remains (AFRSSIR).

Individual Medical Equipment	• Medical equipment is monitored and disseminated as appropriate for deploying Service Members to fulfill their mission, such as eyeglasses, hearing protection and protective equipment.

ANNEX C – DoD Programs

- Warrior Transition Units - An estimated 12,000 wounded Service Members are supported among all Services Warrior Transition Units. Warriors in Transition are those wounded, injured or ill soldiers in recovery, rehabilitation and preparation to either return to duty or leave the service for civilian life. They are assigned to Warrior Transition Units (WTU), where they work with a "triad of care" consisting of a primary-care medical professional, a nurse case manager and a squad leader. This triad not only ensures they receive the medical treatments they need, but also attends to details such as ensuring they make medical appointments, visiting families have housing and transportation, pay and benefits continue, and paperwork is properly completed and filed.

- Defense Center of Excellence - The Department of Defense created the Defense Center of Excellence (DOE) as part of its continued effort to improve the quality of care for wounded warrior. The goal of the Center is to become the leading international resource for all psychological health and brain injury education, training, research, treatment and prevention with a worldwide web of clinicians, researchers, educators and leaders, from the military system, private practice and academia.

  During its short operational history it is focused on Psychological Health (PH) and Traumatic Brain Injury (TBI). With support from the Department of Veterans Affairs (VA), the DOE is leading a national collaborative network to advance and disseminate PH/TBI knowledge, enhance clinical and management approaches, and facilitate other vital services to best serve the urgent and enduring needs of warrior families with PH and/or TBI. Integration includes the Defense and Veterans Brain Injury Center (DVBIC) as well as the DoD Center for Deployment Psychology, currently at the Uniformed Services University of the Health Sciences.

  In addition the medical readiness and medical deployment capabilities four additional Reserve Component health care programs have been established:
  - Baseline pre-deployment neurocognitive assessment
  - Mental Health Self-Assessment Program
  - Warrior support web-based programs
    - Afterdeployment.org
    - Military OneSource
  - Access to AHLTA (Armed Forces Health Longitudinal Technology Application)

ANNEX D –VHA Programs

The Veterans Benefits Administration has specific benefits for the severely injured. In addition, they initiated a program to address National Guard and Reserve specific issues. The benefits for the severely injured include:

- Case management services provided by Operation Iraqi Freedom/ Operation Enduring Freedom (OIF/OEF) coordinators to ensure utilization of all VBA benefits and services which may include:
    - Compensation and Pension Benefits (C&P)
    - Special Adapted Housing Grant
    - Adapting an Automotive
    - Traumatic Servicemembers' Group Life Insurance (TSGLI)
    - Vocational Rehabilitation and Employment (VRE)
    - Educational Assistance for Dependents
    - Federal Recovery Coordinator Program

- The monthly Welcome Home Program offers benefits information that may be available to active duty and/or Reserve Components including but not limited to:
    - Health and dental services
    - Monthly compensation for service connected disabilities incurred or aggravated during active duty and active duty training
    - Additional programs dealing with education, vocational counseling, home loans, and life insurance

- VA Transition Patient Advocates established in 2007 provides outreach and assistance to OEF/OIF Service Members and Veterans.

- Health Care Eligibility for 5 years — services members may enroll for health care at any VA Medical Center or clinic for 5 years following his/her military separation date. Upon enrollment the Service Member/Veteran may choose to immediately receive health care services at the VA. Service Members must enroll within 5 years of separation.

- VA Care for Reserve Component with OEF/OIF combat related health care needs has two years of care at VA and Priority 6 Veterans' access to care is expanded to five years.

- Dental Benefits - the VA provides dental examinations and benefits to Veterans with service related dental conditions. The Service Member may be eligible for one-time dental care but he/she must apply for a dental exam within the first 180 days of your separation date.

- OEF/OIF Programs — every VA Medical Center has a team ready to welcome and help OEF/OIF Service Members coordinate their care.

- Federal Recovery Coordination Program — assists severely wounded, ill or injured recovering Service Members, Veterans, and their families in accessing the care, services, and benefits provided through the various programs in the Departments of Defense and Veterans Affairs, other federal agencies, states, as well as the private sector.

- Project HERO Demonstration Project – the Department of Veterans Affairs (VA) Project HERO demonstration contracted with Humana Veterans Health care Services (HVHS) to support health care delivery to Veterans in four Veterans Integrated Service Networks (VISNs). HVHS will work with local VA officials to deliver timely access to high quality, cost-effective care, for the Veteran population in the affected areas. The contract is comprised of one base period and four one-year option periods. HVHS will offer an extensive array of resources and services. Among the clinical offerings will be behavioral health, diagnostic, dialysis, medical and surgical services. Availability of these services will improve the ability of VA's patient-focused health care system to care for the Department's enrolled Veterans.

- VA Rural Health Care Vans provides psychological health and other medical services to Service Members and Veterans residing in rural health areas. The project is being implemented initially in Maine and Texas.

A list of the updated and/or new programs and/or services offered to Service Members and/or Veterans presented by the symposium faculty is presented in Table 1 on page 9 of the Proceedings. A brief description of the various programs includes:

- The Yellow Ribbon Reintegration Program Act of 2007 provides National Guard members and their families with information, services, referral, and outreach opportunities throughout the entire deployment cycle. The Act requires the Program to consist of informational events and activities for such members, their families, and community members through the following phases of the deployment cycle: (1) pre-deployment; (2) deployment; (3) demobilization; and (4) post-deployment-reconstitution. It also requires the: (1) National Guard Bureau to establish the Office for Reintegration Programs to administer state National Guard reintegration programs; and (2) Bureau Chief to establish a Center for Excellence in Reintegration.

- The Reserve Health Readiness Program (RHRP) services Medical and Dental Services, including but not limited to Physical / Dental (RC only)/ Eye / Hearing Exams; On-site and Call Center Periodic Health Assessment (PHA); On-site and Call Center Post Deployment Health Reassessment (PDHRA), Onsite/Mass Immunizations, Dental Restorations (RC only), Laboratory Services, Management Support, and Logistical Support. Health care services are delivered through three models 1) In-clinic model, utilizing civilian clinics; 2) On-site model, providers are sent to unit locations to perform group services and 3) Call Center. The provider network encompasses 50 States, four Territories, 18,000 medical providers, and 6,000 dental providers.

Changes to the program include: 1) five (5) year physical exam replaced by annual Pre-deployment Health Assessment (PHA) limited to those on active duty; PHA, PDHRA, and Individual Medical Readiness (IMR) services limited to Service Members located in geographically remote areas, 2) On-Site events - PHA and PDHRA minimums reduced to give Reserve Components more flexibility in scheduling services and Readiness Systems, that include: Medical Non-Deployable Module (MND) and DENCLASS – Army and PDHRA Line of Duty (LOD) Module – Army National Guard.

- The Post Deployment Health Reassessment, implemented in 2005 for all deploying Active Duty, National Guard and Reserve Service Members who have completed DD 2796 form. The purpose is to assess the physical and psychological health of the Forces 90-180 days post deployment in order to screen for required care and facilitate his or her access to care for physical, mental health, and re-adjustment concerns.

- DoD/VA Disability Rating System Reform Pilot Project will be initiated in Texas and Maine. The pilot will reform the current disability rating system for wounded Service Members to facilitate the transition process from the Department of Defense to the Department of Veterans Affair. To simplify this process and to make it more equitable for our wounded Service Members the pilot will reform the disability compensation system by changing the roles and duties of the involved agencies. Rather than assign an actual rating, DoD would determine fitness for duty and document such a decision. If fit, the Service Member would return to duty. If unfit, three options would exist:
    1. The Service Member can appeal the fitness determination.
    2. The Service Member can be immediately placed on the Temporary Disability Retirement List if he/she qualifies for a VA Pre-Stabilization rating according to 38 CFR 4.28 until a final rating is determined.
    3. If the Service Member is unfit for duty but does not qualify for the pre-stabilization rating as their injury does not appear to be more than 50%, the Service Member's disability claim would be immediately further developed to determine a final rating.

- Army Selected Reserve Dental Readiness System (ASRDRS) clarifies authorization, appropriation, and policy used by ASRDRS to identify and fix Dental Fitness Category (DFC) 3 problems outside of alert. The programs include First Term Dental Readiness Program and utilization of RHRP. Full funding of the dental program will occur in 2010. Requests have been submitted for early funding for dental services.

- Full active duty health care access benefits under TRICARE up to 90 days prior to deployment and while mobilized.

- Eligibility for the Transitional Assistance Management Program (TAMP) for health care coverage 180 days post mobilization, as well as Continued Health Care Benefit Program on a purchased basis of TRICARE Reserve Select (TRS). TRS offers full

continuum of care for some but not all categories of non-mobilized Reserve Components and their family members.

- No limit on the length of enrollment in TRS; and
- As of January 2009 the premiums will drop 50% from $81 per member per month (pmpm) to $47.51 pmpm and member and family coverage from $253 per month to $180.17 per month.

ANNEX E – Symposium Agenda

DOD / VA Healthcare Symposium

Total Force Care

A Conference Sponsored by the:

Defense Education Forum of the Reserve Officers Association

November 19, 2008

8:00 a.m. **Welcome:** LTG (Ret) Dennis McCarthy

8:05 a.m. **Opening Remarks:** MG (Ret) Donna Barbisch, Program Chair; President, Global Deterrence Alternatives, LLC, Washington, DC

8:15 a.m. **Congressional Perspective:** Gary Leeling, Senior Counsel to the Personnel Subcommittee of the Senate Armed Services Committee

8:30 a.m. **DoD Vision for Comprehensive Health care in the RC:** Dr. S. Ward Casscells, ASD HA

9:00 a.m. **VA Vision for Comprehensive Health care in the RC**: Michael Kussman, Undersecretary for Health at the Department of Veterans Affairs

9:30 a.m. **Break**

10:00 a.m. **Panel: Existing Health care Programs**

MG Robert Kasulke (moderator)
Army Deputy Surgeon General for Reserve Affairs

MG (Ret) Marianne Mathewson-Chapman
VHA Outreach to Guard/Reserve and Families

MG Deborah C. Wheeling
Deputy Surgeon General for National Guard Affairs

BG Margaret Wilmoth
Assistant for Mobilization and Reserve Affairs, Force Health Protection and Readiness

CMSgt Manuel Sarmina
Senior Enlisted Advisor for OSD/HA/TMA

11:30 a.m. **Lunch / Networking**

Keynote Speaker, Kimberly Dozier, CBS News Correspondent

1:00 p.m. **Panel: Operational Issues (requirements) Related to Health Readiness**

MG (Ret) Donna Barbisch (moderator)

MG James Graves,
Assistant to the Chairman, JCS for Reserve Matters

MG "Marty" Mazick,
Commander, 22nd Air Force, Dobbins Air Reserve Base, GA

2:00 p.m. **Working Session**

Capacity and Capability of Existing Programs:
What should DoD–VA RC Health care Support Encompass

3:30 p.m. **Break**

4:00 p.m **Brief-back and Next Steps** Lead MG (Ret) Donna Barbisch

5:30 p.m. **Adjournment**

ANNEX F – DoD/VA Healthcare Symposium Organizing Committee

MG (Ret) Donna Barbisch	Program Chair; President, Global Deterrence Alternatives, LLC, Washington, DC
MG Robert Kasulke	Deputy Surgeon General for Reserve Affairs, US Army
MG (Ret) Marianne Mathewson-Chapman	VHA Outreach to Guard/Reserve and Families
BG Margaret Wilmoth	Assistant for Mobilization and Reserve Affairs, Force Health Protection and Readiness, Office of Assistant Secretary of Defense for Health Affairs
MG Deborah C. Wheeling	Deputy Surgeon General for National Guard Affairs, US Army
COL Corinne Ritter	Deputy Surgeon, Office of the Chief, Army Reserve
CMS John Vallario	Former Senior Enlisted Advisor for OSD/HA/TMA
Col Arnyce Pock	Director, AF Medical Corps/Chief, Medical Force Management
Debra Irwin	AF/SG POC for DoD-VA sharing arrangements
LTC Paige Sikes	Surgeon-Fwd, Office of the Chief, Army Reserve
Helen A. White	Contract support
Bob Feidler	ROA, Director, Strategic Defense Education

ANNEX G – Symposium Agenda

Mental Healthcare Delivery to the Reserve Components:
An Update on Research and Care

A Conference Sponsored by the:
Defense Education Forum of the Reserve Officers Association
MARCH 23, 2009

0830	**Welcome**	**Bob Feidler, Director of DEF**
0835	**Introduction to Program**	**MG Robert Kasulke Deputy Surgeon General, Mobilization Readiness Reserve Affairs**
0840	**DOD Initiatives**	**CDR Guy Mahoney, Ph.D., LCSW, BCD** Senior Program Analyst Psychological Health Strategic Operations Force Health Protection and Readiness Office of the Assistant Secretary of Defense (Health Affairs)
0900	**Latest developments in TBI care**	**Col. Christopher S. Williams** Senior Executive Director for Traumatic Brain injury, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
0930	**Novel Treatments for Severe Brain Injury and Disorders of Consciousness**	**Philip A. De Fina, Ph.D.** Founder & Chairman, Board of Directors Chief Executive Officer Chief Scientific Officer International Brain Research Foundation, Inc. **Paul G. Harch, M.D., Clinical Associate Professor**, Director of the Albert Lauro, Jr., Hyperbaric Medicine Department, LSU School of Medicine, New Orleans
1000	**Addressing PTSD In the U.S. Military**	**Lt Col JAY M. STONE, USAF, BSC, Ph.D.** Director, PH Clinical Standards of Care Defense Centers of Excellence for PH/TBI
1030	**BREAK**	
1045	**Update re National Guard**	**CAPT Joan Hunter Director of Psychological Health for the NGB** MAJ Clifford Trott Chief Mental Health Officer for the Army National Guard LTC Laura Wheeler -- Mental Health Officer for State of Hawaii
1130	**Mild TBI and post concussive Symptoms: what does PTSD have to do with these?**	**COL Charles W. Hoge, M.D.,** Director of the Division of Psychiatry and Neuroscience, Walter Reed Army Institute of Research
1140	**Psychological Health**	**RDML Karen A. Flaherty**

	Outreach Program	Director for Navy Wounded Ill-Injured Warrior Support at Navy's Bureau of Medicine
1150	**Air Force Update**	**Lt Gen James Roudebush, Air Force Surgeon General**
1200	**LUNCH**	
1310	**Overview re PTSD**	**BG Rhonda Cornum, Ph.D., M.D.** Director, Comprehensive Soldier Fitness HQDA, DCS G-3/5/7
1400	**Patient/Client Perspectives**	**LTC Donna R. Van Derveer, USAR** **SGT James Taulbee, USAR**
1515	**PTSD and Mild TBI**	**Paul G. Harch, M.D., Clinical Associate** Professor, Director of the Albert Lauro, Jr., Hyperbaric Medicine Department, LSU School of Medicine, New Orleans **Philip A. De Fina, Ph.D.** Founder & Chairman, Board of Directors Chief Executive Officer Chief Scientific Officer International Brain Research Foundation, Inc.
1600	**Leave No One Behind: Readjustment Services for Returning Warriors and Their Families**	**Alfonso R. Batres, Ph.D., MSSW** Department of Veterans Affairs Veterans Health Administration Chief Officer, Readjustment Counseling Service Dr. Robert T. Frame, Colonel USAR (ret), National OEF/OIF Returning Warriors Liaison, Department of Veterans Affairs, Vet Center Program
1645	**Adjournment**	**MG Robert Kasulke Deputy Surgeon** General, Mobilization Readiness Reserve Affairs

ANNEX H- Military Healthcare Sites & POC's

The following sites are a culmination of web-based resource tools for current or prior military personnel interested in mental healthcare related questions such as PTSD/TBI.

www.dcoe.health.mil/default.aspx -The Defense Centers of Excellence-Outreach, Advocacy, and Clearinghouse Directorate. Call center (703-696-9460)
http://tricare.mil/tma/CCS.aspx-Tricare management comm's and customer service page
http://www1.va.gov/health/index.asp
http://www.health.mil/
www.MilitaryOneSource.com
http://www.myarmyonesource.com/HealthCare/default.aspx
http://www.behavioralhealth.army.mil/
http://www.behavioralhealth.army.mil/ptsd/index.html
http://www.hooah4health.com/mind/combatstress/default.htm
http://www.cs.amedd.army.mil/
http://www.defense.gov/