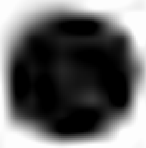

OFFICE OF
WOUNDED WARRIOR
CARE & TRANSITION POLICY

SERVE › SUPPORT › EMPOWER

WEST COAST TRIP REPORT
8-17 February 2010

Site Visits:

HAWAII:
1) Tripler Army Medical Center (TAMC)
2) Schofield Warrior Transition Unit (WTU)
3) Makalapa Naval Clinic, Navy Fleet and Family Support Center
4) Kaneohe Marine Corps Base, Wounded Warrior Battalion West-Detachment Hawaii

CALIFORNIA:

5) Palo Alto Polytrauma Rehabilitation Center
6) Menlo Park VA Center
7) West Los Angeles VA Healthcare Center

WASHINGTON STATE

8) Madigan Army Medical Center (MAMC)
9) Ft Lewis WTU

Host Organization Points of Contact:

- (b)(6) Protocol Officer, Pacific Regional Command - TAMC & Schofield WTU, Marine Corps Wounded Warrior Battalion West-Det Hawaii
- Ms. Margaret Scurfield, Regional Director, Pearl Harbor Fleet and Family Support Program
- Ms. Lisa Freeman, Director - VA Palo Alto Health Care System
- (b)(6) Commander - Madigan Army Medical Center (MAMC), Ft Lewis WTU
- (b)(6) Public Affairs Officer - West Los Angeles VA Healthcare Center

General Overview:

- Command overview of programs and services for Wounded, Ill and Injured Service members. This included:

  Tripler Army Medical Center (TAMC)
  - Command Brief
  - Behavioral Health Program Brief
  - Tour of Hospital
  - Tour of Veterans Affairs PTSD Residential Recovery Program

  Schofield WTU
  - Command Brief
  - Tour of WTU (Headquarters, Company Areas, Soldier and Family Assistance Center, Grant Hall Billeting, Warrior Transition Clinic)
  - Sensing Session with 12 Warriors in Transition (WTs) Soldiers
  - Sensing Session with 12 members of WTU Cadre

  Makalapa Naval Health Clinic – Hawaii
  - Navy Warrior Transition Program Brief
  - Command Brief

Navy Fleet and Family Support Center, Joint Service Transition Assistance Program Roundtable

- USAF Transition Assistance Program Brief
- USMC Transition Assistance Management Program Brief
- Army ACAP Brief
- Navy Transition Assistance Management Program Brief

USMC Wounded Warrior Battalion West-Det Hawaii

- Command Brief
- Tour

Veterans Affairs Palo Alto Health Care Center

- Introductory Brief
- Tour Regional Amputation Center, Facilities, Spinal Cord Injury Unit and Polytrauma Rehabilitation Units

VA Menlo Park Center

- Women's Prevention, Education and Outreach Program
- Men's and Women's Trauma Recovery Program
- Outpatient Mental Health Program

Greater L.A. Veterans Affairs Healthcare Center

- Leadership brief
- OEF/OIF Transition Care Management Program
- Polytrauma Exercise Pad
- Domiciliary tour (with Sensing Session)
- Strawberry Flag

Madigan Army Medical Center (MAMC)

- Courtesy call with (b)(6) CDR of MAMC
- Command Brief
- Sensing Session with WTU Nurse Case Managers and VA Liaisons
- Tour and visit patients in Patient Care Units
- Lunch with MAMC Medical Evaluation Board (MEB) and Ft. Lewis Physical Evaluation Board (PEB) staff
- Courtesy call with BG Jeff Mathis, Acting CG, I Corps and Joint Base Lewis-McChord
- WTU Command Brief
- Sensing Session with 20 WTS
- Sensing Session with 20 WTU Cadre and staff
- Exit call with COL Penner

TRIPLER ARMY MEDICAL CENTER (TAMC) OVERVIEW
Command Brief provided by (b)(6) CDR

Overview

- TAMC provides 95% of care to beneficiaries on Hawaii and the Pacific Islands, including most VA inpatient care.
- VA providers embedded at TAMC
- TAMC is in the top three DoD Military Treatment Facilities for caseload, leading to space constraints.

- Active duty, Reserve Component and National Guard make up two-thirds of the inpatient population.
- Veteran population includes OEF/OIF, Korean, Vietnam, Gulf War and WWII.
- TAMC considering creating a facility near Barbers Point to ease traffic congestion and provide additional space.
- Inpatient and high-tech cases would stay at TAMC. Outpatient DOD/VA facility would be housed at Barbers Point.
- Remote island healthcare is a challenge:
    - Currently spending $2M for healthcare to Pacific Islanders, much of this is airfare to bring patients to TAMC
- Current resources are adequate. MEDCOM supports expansion plan to include additional space for Behavioral Health treatment programs.
- Peacetime staffing and facilities will likely be inadequate during wartime.

Training

- 3rd largest training program in the Army.
- Staff members at TAMC provide humanitarian assistance by setting up clinics throughout the Pacific Command.
- Strong research elements at TAMC are result of:
    - Interest from DoD leadership and Congress
    - "Command climate" is strong and nurturing
- TAMC has extensive Graduate Professional Health Education programs.
- Leads the Army Addiction Training Program.
- Patient satisfaction is gathered through Interactive Customer Evaluation (ICE) surveys and Army service provider-level surveys. TAMC scores in the 90th percentile in patient satisfaction.

Substance Abuse

- Significant abuse of methamphetamine on the island.
- Leadership asked Army Criminal Investigation Division to educate staff on trends in the drug trade on Hawaii.
- TAMC offers intense outpatient substance abuse program.

Homelessness

- VA currently runs a homeless facility at Barbers Point. It has been in operation for over two years.
- Long term housing is also provided for Veterans.

Telemedicine Initiatives

- e-ICU allows patients to talk to staff by using cameras and monitors.
- Tele-TBI/Behavioral Health
    - This includes the Virtual Behavioral Health Pilot Project
- Web-based store and forward technology
- Tele-Radiology

TAMC support of Warriors in Transition (WTs)

- Family members expressed concern about unclear lines of communication when Service members were medevaced from Landstuhl.
- TAMC established access to a web-based patient record from Landstuhl so providers at TAMC can view medical care and inform family.

- This information provided includes the initial entries into the Comprehensive Transition Plan (CTP).
- Providers meet monthly to assess high-risk patients. Low-risk patient cases are reviewed every 90 days.

Population:

WT Population Total: 265
US Army Reserves: 59
Army National Guard: 50
Active Duty: 156
WT Status
Receiving Treatment: 186
Medical Evaluation Board: 77
MOS Medical Retention Board: 0
Civilian-Based Healthcare Initiative: 2
REFRAD/Clearing: 0

Comprehensive Behavioral Health System

- Emphasizes prevention, assesses risky behavior, and provides early identification by targeting intervention, continuity of care, and evidence-based treatment.
- Behavioral Health screening at TAMC is for all Service members not just WTs.
- Each Service member has a 15-20 minute assessment 2-3 weeks after returning home. The goal is to create the relationship so the Service member is encouraged to return later if challenges arise
- Numerous Behavioral Health treatment modalities are used.
- Mandatory screening for TBI while in theater when exposed to an IED. The Military Acute Concussion Assessment (MACE) test is used by Army. The purpose of the MACE is to evaluate a person in whom a concussion is suspected. The MACE is used to confirm the diagnosis and assess the current clinical status. TAMC leadership reported that Soldiers memorize the answers to the MACE test while in theatre in order to return to their combat unit. This eliminates the utility of the MACE test and raises likelihood for long term symptom associated with TBI in Soldiers. **

(b)(5)

Virtual Behavioral Health Pilot Program

- Telemedicine counseling via Internet.
- TAMC is pilot site, partnering with Ft. Richardson, Alaska. The project is funded by the Defense Centers of Excellence.
- Teleconferences follow a pre-set protocol:
    - Soldier is escorted by a Medic.
    - Solider and Behavioral Health professional have virtual conversation via Internet/webcam regarding post-deployment and adjustment to life at home.
    - Prior to session, soldier completes online questionnaire.
    - The first screening is 15-20 minutes.
    - Soldiers can receive referrals as needed.
    - Approximately 20-30% of Soldiers are referred to professionals at their base.

  - Online screenings are voluntary. Soldiers report that they like the system because it is impersonal.
- The goal is to track the soldier in areas such as:
  - family challenges
  - who seeks counseling
  - who receives misconduct warnings
  - substance abuse problems
- The data is reviewed to look for trends and thus create a predictive model for behavioral health screening.
- Replaces Post-Deployment Health Reassessment Program (PDHRA) for these returning Soldiers.
- There is a challenge in recruiting volunteers for pilot because soldiers become concerned about how this data "follows" them through their recovery and reintegration.

Wellness Program Clinic

- Mission is to provide high risk WTs with the necessary tools that will lower risk level and increase safety.
- 60% of WTs have Behavioral Health issues.
- WTs treated for depression, anxiety, suicidal thoughts. The program is not designed to be PTSD-specific.
- Program began July 2009 as a local pilot.
- 6-week program where high-risk WTs engage in a fully-structured program of mind-body activities:
  - Psych-educational classes, self-regulation/mindfulness
  - Group therapy, alternative therapies (art, yoga, tai chi)
  - Therapeutic outings (e.g. water activities)
  - Individualized goal setting plan – CTP
- Demographic: 18-24 year old WTs.
- Program takes 10 WTs per rotation and has treated 40 Soldiers since inception.
- All Soldiers enrolled in the Wellness Program are residing at Schofield, and some are part of the Army Wounded Warrior Program (AW2).
- The program is designed to help Squad Leaders and Nurse Case Managers with their caseload of high-risk patients. The goal is to minimize "idle time."
- Objectives include:
  - Enhancing defenses
  - Instilling resiliency: asking for help, preparing for unexpected changes, recognizing the "trigger"
  - Increasing coping strategies
  - Promoting successful progress towards their next transition
- Not a "cookie-cutter" program.
- There is an open door policy to return to the program.
- 1/3 of the 40 who have graduated from the program have returned to duty.
- Cadre in Wellness Program:
  - 1 Psychologist
  - 3 Psychological Nurses
  - 2 Social Workers

- 1 Administrative Assistant
- Current MWR staff handles therapeutic activities such as tai chai, yoga and water activities
- Full Time Employees (FTEs) taken out of hide

- Army chaplains are now co-located at the WTU along with a Psychological Technician who observes the WTs following therapy sessions to ensure safety.

PTSD & Suicide

- Discussion on diagnosis of PTSD. If diagnosed with PTSD and found unfit for duty, WT can receive a 6-month, 50% disability rating from DoD/VA. Seeing trend in Wounded Warriors "gaming the system" in order to receive this diagnosis. **

(b)(5)

- Suicide rate low in Hawaii (5 per 100,000).
- ARMY-STARRS (Study to Assess Risk and Resilience in Service members) funding $50M study on suicide conducted by the National Institute of Mental Health.

Veterans Affairs PTSD Residential Recovery Program (PRRP)
Brief provided by (b)(6) MD, PhD

- Residential VA outpatient facility located inside TAMC hospital.
- Only residential PTSD program established by Congress.
- Opened in 1993 in response to concerns about more than 2,000 homeless Vietnam Veterans living in the mountains of Hawaii.
- Facility renovated in 2006 and re-opened to accommodate Veterans from OEF/OIF and the Gulf War. Two thirds of the patient population is Active Duty or Guard/Reserves.
- Program still services Vietnam-era Veterans. These Vets provide mentorship to younger OEF/OIF patients.
- Patient limit is 12 due to space constraints. Larger building being constructed which will house 16 patients.
- Program is cohort-based so patients start and finish the program together.
- The facility provides evidence-based treatment:
  - Cognitive processing therapy
  - Prolonged exposure
  - Eye movement de-sensitization
- Soldiers attend therapy sessions from 0800 to 1630 plus evening classes as well as weekend and group activities.
- The program is designed to teach Soldiers coping mechanisms for anger management, parenting, and interactive skills. Treatment modified based on individual needs.
- Currently, the patient population is 70% OEF/OIF, with 75% Active Duty.
- Co-located near DoD facilities benefits patients.
- Staff at PTSD clinic has military background which helps integrate DoD and VA care.
- Strong Command leadership support.
- The clinic does not conduct formal research to support their evidence-based approaches because velocity of learning process makes it impossible to freeze the treatment in place. Marine Corps Wounded Warrior Battalion West-Detachment Hawaii Commander commends the program and sends Marine Wounded Warriors to participate.

- Staff provides 24 hour coverage:
  - One part-time Psychiatrist and Psychologist
  - Two Psychological Advanced Practice RNS
  - One RN
  - Two Licensed Clinical Social Workers
  - One Re-adjustment counselor

SCHOFIELD WARRIOR TRANSITION UNIT

Briefing provided by (b)(6) WTU Commander

- 265 Warriors in Transition (WTs).
- (b)(6) outlined his "battlefield plan:"
  - Decisive Operation: Development and execution of the Comprehensive Transition Plan (CTP) ("the most important thing we do"- currently executing 250 CTPs)
  - "Decisive Point:" WT Transition
  - Main Effort: WTs- Triad of Care
  - Center of Gravity: Access to Care
  - No inpatient PTSD program for women. WT females must go to Palo Alto for treatment
- Command does not control access to all care because Schofield WTU doesn't oversee TAMC. Leadership at TAMC is sensitive to the needs of WTs.
- WTs have priority at TAMC over Active Duty Service members.
- WTs go through 30-day medical assessment. If the Soldier meets entry requirement their needs are initially coordinated through the Intake Platoon.
- "Shaping Operations":
  - Quality of Life
  - Wellness Program
  - Town Hall Meetings (each month, mandatory attendance)
  - Team Building/MWR Events
  - Reception Operations
  - Work Plans – Civilian Education
    - Encourage 9/11 Post GI Bill
  - Soldier and Family Assistance Center (SFAC)
  - Special Events
- WT demographics:
  - Hawaii: 68, American Samoa: 31,Guam: 14,Saipan: 1,CONUS: 1

Command's Comments on WTU Cadre

- Cadre Population: 144, Officer: 21, NCO: 61,Civilian: 62
  - This doesn't include staff at SFAC
- Cadre training formally conducted at Fort Sam Houston; however there are members of the Cadre who are "grand-fathered" into the system and are not formally trained.
- Nurse Case Managers receive weekly training but would like additional training and ability to attend more conferences.
- Members of the Cadre may lose "combat skills" during tour at WTU.

- Cadre may need to be screened for their own possible PTSD and how to recognize symptoms of "compassion fatigue."

- Have slots for 46 squad leaders at Tripler and only staffed with 27. Recommend that leadership assess staffing and fill these spots.COL SAUM INPUT
- Squad Leader to WT ratio is 1:10
- Primary Care Manager ratio is 1:200
- Nurse Case Manager ratio is 1:20
- Behavioral Health ratio is 1:100
    - Although Schofield is meeting ratios based on current population there are plans to lower the Behavioral Health ratios by hiring more staff
    - 10 WTs per squad leader is challenging if several soldiers are high-risk and require more oversight and care
    - Currently, there is one 68X (Mental Health specialist) for the WTU. Current ratio of 68X to WT is 1:265
    - This billet can 68X can provide support and treatment for both WTs and Cadre. Recommended that the ratio at Schofield be 2:100.
    - It is required that Squad leaders monitor any WT who is in Intensive Care at TAMC.
    - Members of the Cadre also perform collateral duties such as Staff Duty Officer hours like 24 hour desk duty. Following these collateral duties, the Cadre will then be required to report for Cadre duty at the WTU the following morning. This "double" duty puts strain on members of the Cadre and divides their attention between two sets of responsibilities.
    - Commander would welcome additional staff for the Cadre.

WTU Barracks Tour
- Currently moving to 1 + 1 (which is two Soldiers per room) which presents space challenges.
- Barracks provides "tech package" (e.g. flat panel TV, cable, laptop, cell and Internet service.
- Rooms are not officially ADA-compliant but there is sufficient room for wheelchair access.

Schofield Health Clinic
- Health clinic is for Soldiers and families (Includes TBI clinic and Wellness Program)
- 2 Primary Care Managers, 3 Nurse Case Managers.
- Majority of staff are mobilized Reservists on active duty for two years.
- Clinic houses patient information via electronic profiles.
- Provides Occupational Therapy and Counseling by Licensed Clinical Social Workers.
- Social worker caseload is 1:80. Clinic working with MEDCOM to reduce caseload to 1:40.
- Services include spouse/marriage counseling. Approximately 40% of WT Soldiers are married.

Soldier and Family Assistance Center (SFAC)
- Mission is to provide WTs, their families and caregivers with easy access to one-stop services in a home-away-from-home-environment.
- All WTs are entitled to full-time childcare at a reduced rate.
- SFAC is open 0730 to 1630 daily and two nights a week from 2300-0800.
- There are two computers, 60" TVs, video games, ping pong, quiet area, library and fitness room

- SFAC recently started a Spouse Support Group.
- Services at SFAC include:
  - ACAP (handle pre-separation counseling, 90 Days for MEB/PEB)
  - AW2 Advocate, Social services
  - Military & Family Life Consultants
  - VA OEF/OIF representatives (visit 2 times per week from TAMC)
- SFAC receives funding from several local organizations including the USO.
- Family members use the SFAC for a variety of purposes including education and financial counseling.
- Debt/credit issues are re-occurring theme in financial counseling
- Recent loss of Bright Score, a credit score tool provided by FINRA, in conjunction with the DoD Financial Readiness Program has severely impacted counselor's ability to structure credit repair techniques. Military has abolished Bright Score.

Sensing Session: 10 WTs
Observations:

- WTs separated from families who live on other islands of Hawaii or American Samoa, Guam
- Difficult to get appointments at TAMC. May take up to 30 days.
- WTs say Cadre and caseworkers are overwhelmed. Caseloads too high.
- Some believe criteria for enrollment too broad.
- Turnover of Cadre does not allow for continuous case management. 80% turnover of Nurse Case Managers in last 12 months.
- Many WTs volunteer at the WTU and help Cadre with tasks.
- WTs in Sensing Session expressed frustration that their fellow WTs are "are on "5 year plan" which no aspirations to RTD or separate. **

(b)(5)

Sensing Session: 12 WT Cadre
Observations:

- Members of the Cadre love their job because it challenges them and they have a cohesive unit that allows them "to get the job done."
- Lack of training needed to support and care for WTs particularly those that are high-risk requiring Behavioral Health support.
- One member of the Cadre noted, "We aren't trained for it. I'm not prepared. I'm an Infantry guy."
- Expressed desire for additional staff support in Behavioral Health and patient administration.
- Frequent changes and turnover in recovery team means the WT has to "re-tell" his/her story to new case managers, social workers etc.
- If a WT misses two appointments, the Squad Leader must escort them to appointments. Cadre estimates 10-12 hours per week coordinating and escorting WTs to appointments.
- Members of the Cadre also perform collateral duties such as Staff Duty Officer hours like 24 hour desk duty. Following these collateral duties, the Cadre will then be required to report for Cadre duty at the WTU the following morning. This "double" duty puts strain on members of the Cadre and divides their attention between two sets of responsibilities.
- Cadre Soldiers would like badge/recognition as members of "Cadre."

MAKALAPA NAVAL CLINIC

Brief provided by CAPT Utez, Deputy Commander

Overview

- Established in 2007 as a small clinic and has grown considerably.
- Outpatient Medical Treatment Facility but also includes outpatient services.
- Close working relationship with TAMC for specialty care.
- Staffing:
    - 1 Psychiatrist, 1 Psychiatric Nurse Practitioner, 1 Physician Assistant
    - 2 Registered Nurses, 3 Clinical Psychologists, MSW-Social Worker
- Currently providing mental health services to 72 OEF/OIF Marines (not all assigned to Wounded Warrior Battalion).
- FOCUS program is a resource for families with children dealing with combat/deployment stress
- Services available for Wounded Warriors:
    - Treatment of depression and/or anxiety
    - Evaluation of mild traumatic brain injury (TBI)
    - Evaluation and treatment of PTSD (Eye Movement Desensitization and Reprocessing, Cognitive Processing Therapy, and Prolonged Exposure)
    - Combat Stress Group at Wounded Warrior Battalion West, Det Hawaii
    - Psychological Testing (Objective Personality and Projective Testing)
- Recreation Therapy, integrated into the WW Battalion, implemented in November 2009:
    - Treatment modality designed to use leisure activities to improve functional abilities, enhance personal health, independence, and quality of life.
    - Treatment Goals:
        - Increase cognitive abilities for TBI & Memory Loss.
        - Supplement patient's physical/occupational therapy treatment plan with recreational interventions.
        - Provide leisure-based coping skills and relaxation techniques.
        - Increase self efficacy levels, empowering them to continue to participate in past recreational interests despite limitations caused by injuries.
- Disabled Sports USA will be taking several Wounded Warriors from Kaneohe to Lake Tahoe for skiing, snowboarding and hockey.

Observations:

- Need for additional funding for recreational therapy equipment like hand cycles, volleyball nets, stationary bikes and other adaptive sports equipment.
- Staff comprised of mostly contractors. BUMED working to convert to government billets

JOINT SERVICE TRANSITION ASSISTANCE PROGRAM ROUNDTABLE

OVERVIEW:

Engage in dialog and briefings by representatives of military installations to:

- Determine the degree of engagement and collaboration with joint service providers;
- Obtain a ground assessment of partner agency or VSO initiatives;

- Integration of TAP services with WII and family members;
- Integration of TAP services for demobilizing National Guard, Reserves, and family members;
- Local initiatives to advance hiring of veterans in federal sector employment
- Determine challenges in delivering TAP services

Hickham AFB, HI
Brief provided by (b)(6) - Airmen and Family Readiness Center Flight

- Approximately 550 Airmen stationed at Hickham or Tenant Units participate in TAP Employment workshops annually.
- Classroom interaction for entire TAP lasts 4 days; additional stand-alone workshops on resume writing and interviewing techniques provided routinely.
- TAP Employment Workshops and VA Benefits Brief voluntary; not mandatory attendance
- Provides 2 Executive-level (06 &E9) contracted TAP workshops annually. Contract is with for-profit company; USDOL/VETS State Director indicates same service available at no charge.
- Provided assistance to 5 Wounded Warriors and collaborates with Recovery Care Coordinators.
- Support by federal partner agencies reported as excellent.
- Disability claims preparation assistance by DAV with weekly visit; average 10 clients per visit.
- Challenges relate directly to Joint Base evolution.

Marine Corps Base Hawaii
Brief provided by: Mr. Jim Gardner, RCSS Manager

- Troop Strength: 8,500 active duty; approximately 4,000 family members.
- Mandatory attendance for DoL TAP Employment Workshop, VA Benefits and DTAP briefs.
- Entire transition workshops delivered in 4 days; includes DoL Employment workshop, VA Benefits Briefing and DTAP Briefing.
- Robust TAP services; federal employment assistance most popular.
- Targeted workshops to Wounded Warrior augment core services:
  - Job search tips for service members with disabilities
  - Beginning the job search; writing an effective resume
  - Interviewing with confidence; dress for success
  - Success on the job
- Strong partnerships with DoL and VA.
- Limited engagement with VSO's; no knowledge of Heroes to Hometown Program.
- Core services focus on employment assistance. Statutory requirement to deliver assistance in personal financial management and relocation assistance not fully developed.
- Challenge: Availability of dedicated training space to accommodate larger audience for TAP workshops.

Army ACAP Schofield Barracks, Hawaii
Brief provided by: (b)(6)

- AOR covers 9,000 miles over 16 time zones from US west coast to east coast of Africa.
- Troop Strength
  - 20,060 Active Component; 2,315 Reserve Component; 2,443 other military services; 5,177 Retirees; 15,178 family members of retirees
- FY09 Service Utilization Data: 2,763 New Clients; 9,104 repeat visits.

- Services provided to WTU personnel via outreach ACAP staff positioned at the SFAC.
- Limited understanding of ACAP by average Soldier on the street. Comments indicated most printed program advertising not intriguing to young Soldier. Rather, they prefer to communicate via social media (e.g. Facebook, text messages and Twitter).
- Young Soldiers (age 18-14) cited limited support by senior NCOs to allow participation in services outside of core TAP workshop.
- Challenges:
  - Soldiers not afforded adequate opportunities to utilize available services through ACAP
  - Un-programmed losses (admin discharges) are not referred early enough or permitted to participate beyond pre-separation counseling
  - No accountability of MEB/PEB Soldiers not assigned to WTU as to whether they completing mandatory briefings
  - Opportunity to utilize services for Soldiers returning from deployment has been reduced from 90 to 60 days.
- Meeting Challenges:
  - New local ACAP policy memo (signed 15 Jan 2010) by the CG US Army Hawaii with expectation that Army personnel will adhere to the Commander's directive to allow Soldiers to use ACAP services.
  - MILPER MSG 09-027 provides guidance for mandatory briefings for all Soldiers going through an MEB/PEB.

KANEOHE MARINE CORPS BASE, WOUNDED WARRIOR BATTALION WEST-DETACHMENT HAWAII

Brief by (b)(6) Commander

Overview

- Mission: Ensure well-being of all attached WII Marines and Sailors which includes:
  - Medical tracking and advocacy, administration and logistics
  - Family support, Personal/Professional development
- Current population small but expect surge from Afghanistan.
- Population does not include most severely injured. They receive care at stateside MTFs.
  - 31 Total WII (5-6 cancer patients, other illnesses/injuries)
  - 10 OEF/OIF Wounded (PTSD, mTBI, Shrapnel)
- Coordinated Support Network
  - Non-Medical Support:
    - Section Leader, Platoon Sergeant
    - Deputy Family Readiness Officer (FRO) and Assistant
    - Recovery Care Coordinators
    - VA OEF/OIF Counselor (2 days a week or more)
    - Mentors (Retired Colonels-promote staying on AD
  - Medical Support
    - Corpsman
    - Licensed Clinical Consultant
    - Nurse Case Manager (assigned to each Marine)
    - Primary Care Manager
    - Recreational Therapist (same person from Naval Health Clinic)

- (b)(6) emphasized the advancement in non-medical care and support as results of RCCs embedded in the WWBn-W: "The RCCs do God's work."
- NCO is with the Wounded Warriors (WWs) daily to keep communication lines open.
- Leadership emphasizes order but also compassion. Strives to maintain this balance.
- Family Support:
  - Deputy FRO and RCC meets with family within 7 days of check-in.
  - Within one week of returning home, the RCC meets with WW and family to develop a needs assessment. This is used to develop a Family Care Plan.
  - The Family Care Plan differs from the WW's Comprehensive Transition Plan in that it is more specific to the needs of the family.
  - Commander conducts "Family Readiness Stand Downs" to encourage family members to interact with each other and leadership.
- RCC Support
  - Command very supportive of RCCs
  - Encourage Return to Full Duty (RFD)
  - Establish Comprehensive Transition Plan (CTP) (referred to as "Comprehensive Transition Plan" by Marine Corps and Army)
  - Involved in Employment preparation/job fairs and internships
  - Ensure hand off to VA is smooth
- Operation Warfighter Program (examples of job placement sites):
  - National Geospatial Agency Wounded Warrior Program
  - Pearl Harbor Naval Shipyard
  - WYOTECH (18 month automotive vocational training and placement)
  - PACOM internships
  - Sentinels of Freedom
  - BAE, Northrop Grumman (Operation Impact)
- WWTUn-W Barracks:
  - 20 rooms total with 37 beds
  - Currently have 3 ADA rooms and building 2 more

Observations:

- (b)(6) likes the Schofield WTU Intake Program and Medical Support provided by the Army. Would like to see multi-disciplinary approach expanded as a model for BUMED.
- Command Family Support personnel involvement with WWs and families resulting in positive outcomes.

PALO ALTO HEALTHCARE SYSTEM-Menlo Park, California
Briefed by Ms. Lisa Freeman, Director

Overview

- VAPAHCS is a major tertiary care center encompassing large catchment area.
- Special Emphasis Programs include:
  - Acute Psychiatry
  - Polytrauma Rehabilitation Center (includes TBI Center)
  - Hospice/Palliative Care
  - PTSD Center (at Menlo Park)
  - Spinal Cord Injury, Western Blind Rehabilitation, Regional Amputation Center
  - War Related Injury and Illness Study Center
- 250,000 + Veterans reside in catchment area (from Sonora in North to Monterey in South).
- 30% of this population use VAPAHCS.
- 837 operating beds, 8 inpatient beds, 364 community-living center or nursing home beds.
- Strong relationship with Stanford University, 4th largest research program in the VA.
- Majority of patients are Vietnam Veterans with less than 3% OEF/OIF Veterans.
- Vietnam Veteran population mentors OEF/OIF patients.
- Polytrauma Transitional Rehabilitation Program:
  - 12 beds
  - Most patients are Active Duty, 40% OEF/OIF
  - Program focuses on living independently, attending school and achieving successful reintegration

Family Support

- Even though the VA is not chartered to provide support to families, the VAPAHCS addresses needs of families by employing two full time Military liaisons (Marine & Army) to assist Wounded Warriors and families.
- Modeled their family support programs after those of Travis AFB. Currently have two full time staff members (one is a recreational therapist) providing emotional support, coordinating activities and ensuring that the family's needs are being met.
- Fisher House on campus.
- Established a NAF "family fund" that allows the VAPAHCS to support un-planned family needs.

Staffing

- Adequately resourced, although high cost of living in Palo Alto. Over 70% of staff receives special salary rates to compensate.

Facility Tour

- Included tour of lab which uses robotic blood samples, ICU and demo of the VAPAHCS electronic health records system.
  - No standardization of electronic health records in the 21 Veteran Integrated Support Networks (VISNs).
  - Overview of "PISCES" Electronic Health Records:
    - Bedside medical records visible in some Veterans Hospitals ICUs, operating room and patient's bedside.
    - Reads CT Scans, EEGs; shows all medications.

- Recovery Team reads during rounds and can discuss with patient at bedside, establishing medical plan.
- Allows for trend analysis of OEF/OIF Veterans.
- Not yet standardized within VA system.

  - Regional Amputation Center:
    - "Flagship" facility for Amputation System of Care. Provides high level of expertise in clinical and state-of-the-art prosthetic concepts.
    - Program available to all Veterans with upper or lower extremity limb amputations.
- Spinal Cord Injury Center:
  - 43-bed unit provides coverage for much of California and catchment area (HI, Guam)
  - Provides initial rehabilitation and then "follows" the Veteran as long as needed.
  - 700 patients currently being followed.
  - Seeing pattern of amputees requiring spinal cord rehabilitation particularly in OEF/OIF Veterans.
  - Challenges in rehabilitation for patients with both physical and cognitive injuries.
  - Focused on wellness including outdoor exercise and maintaining long term health life choices.

VA Center Sensing Session: 8 Active Duty and Veterans

Observations

- Four Active Duty and 4 Veterans
- All speak highly of care and support at VAPAHCS
- The OEF/OIF Veterans were injured prior to Wounded Warrior programs and agreed the services and support available now would have been beneficial

Observations

- VAPAHCS uses Veterans as volunteers in programs, instilling sense of self-worth
- AW2 Advocate not clear on roles of Military Liaisons. However, Marine Corps RCC, and OEF/OIF Liaison work together.

MENLO PARK VA CENTER
Brief provided by (b)(6) MD, PhD, Outpatient Mental Health Services

Overview

- Program stood up over two years ago; 60,000 patients.
- Integrated Primary Care/Mental Health (MH) Care:
  - Psychology/Health Technician located in primary care clinics
  - Provides co-located/collaborative MH care
  - Post deployment clinics
  - Same day access, reduces stigma
- Range of Services:
  - General mental health care, community care program

    - Compensated work therapy/supportive employment
    - Psychosocial recovery and rehab center (began in January 2010 for seriously mentally ill and chronic PTSD patients)
    - Addiction treatment services
    - Women's outreach, prevention, and education center
    - Family services/family therapy
    - Specialized evidence-based therapists
    - Suicide prevention coordinators (3)
        - Track patients who are identified as high-risk for suicide
    - Telemental health
- PTSD clinical team provides specialty care based on outcome measures. Team relies on structured assessments and data gathering.
- OEF/OIF family services provide education, prevention and counseling via outreach and treatment.

Women's Prevention, Outreach & Education Center

- Began in 2007; 15% of Active Duty females, 20% of Reservists females and 12% of OEF/OIF Veteran females are receiving services.
- Grant funded.
- Prevalent conditions are: depression, anxiety, trauma (20% suffer from Military Sexual Trauma)
- Service model is based on public health model:
    - Outreach and education
    - Early detection and risk reduction
    - Intensive mental health
- Center has a Web site and toll free hotline but not yet mining data.
- Intensive outpatient mental health offers a tailored treatment plan which includes:
    - Social work, psychology, psychiatry and recreational therapy staff members
    - Comprehensive assessment
    - Case management and medication management
    - Evidence-based individual and group therapy
- Outpatient therapy groups are same sex whenever possible.
- Center is expanding the training program to include more social workers in Fall, 2010.
- Center is including obesity risk reduction initiatives.

GREATER LOS ANGELES VA HEALTHCARE CENTER (GLA)
Executive Leadership Overview

- 83,000 Veterans across larger geographic area with 14,000 OEF/OIF.
- Large integrated healthcare system with full range of patient care services.
- 945 beds, over 5,000 employees, $600 M budget.
- Need to standardize benefits and programs across all VISNs. **

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- Strong relationships and communications with DoD partners in the area.
- Recent focus groups with Veterans show a growing interest in social media and technology.
- Other use of telehealth is "Telehealth Care Coordination":

  - GLA places computer in the home of a patient to provide oversight and care for weight management, blood sugar levels etc.
  - Currently 500 patients in program.
  - Target audience: frail/elderly Veterans.
  - Cost: approximately $300 per patient.
  - Challenges include employing providers in rural areas and security issues.
- Vocational Rehabilitation Services include:
  - Setting up plan of action for career development.
  - Short/long term goal setting.
  - Acquiring new skills for reintegration/employment.
  - Recreational therapists also handle VSO relationships. VSO staff does not engage Veterans directly.

OEF/OIF Transition Care Management Office

- Office provides support to OEF/OIF veterans who were medically discharged prior to the stand up of the Services' Wounded Warrior Programs or the DOD/VA Recovery Coordinators.
- While these Veterans clearly could have benefitted from enrollment in a Service WWP and services provided by Recovery Coordinators, this VA program provides care and resources to assist them to reintegrate into the community.
- Demobilization: post deployment briefings include Post Deployment Health Reassessment Program (PDHRA) and Yellow Ribbon program.
- Full-time position dedicated to coordinating OEF/OIF Wounded Warriors' transition with VBA, Vet Center and community/DoD partners.
- All the Veterans and families we talked to expressed satisfaction with the care and programs provided by the VA center. As current programs and services were described to these Veterans they all expressed regret that these programs were not available to them as they transitioned from active duty to medically retired Veterans.
- Army assigned one AW2 Advocate to this VA Center. Assists transitioning Soldiers by working closely with the VA OEF/OIF Liaison. Army is adding an additional AW2 Advocate to the LA area to meet increasing number of Soldiers separating and staying in LA and the catchment area.

Domiciliary Residential Rehabilitation & Treatment Program

- Provides in-house, evidence-based treatment to 321 residents
- Approximately 32 OEF/OIF Veterans
- Treatment has a higher success rate when patients are inpatients vs outpatients
- Program began as "supportive care" and has moved into "mental health"
- Services include:
  - Trauma Program: for patients who suffer from trauma-related illnesses
  - Community Re-Entry Program: for Veterans who complete other treatment and need assistance with reintegration (this includes Back-to-Work program)

- Women's Program: provides treatment designed to meet needs of women Veterans including substance abuse, mental illness, vocational training, housing and finances.

Sensing Session: 6 OEF/OIF Veterans
Observations

- A female Veteran who is being treated in the Women's Program requested a private sensing session with Mr. Koch to discuss challenges of being co-located in facility with male Veterans. She is being treated for Military Sexual Trauma and has been diagnosed with PTS and TBI. She is experiencing anxiety over the close interaction with the male veterans due to the physical layout of the Domiciliary. While the females have segregated dorms, the laundry and dining facilities are co-ed. After expressing these concerns in the Sensing Session, the VA staff agreed to address this Soldier's concerns and adjust the access to the laundry room and dining facility. An update is to be provided to Mr Koch. **

NOTE: The description of the Women's Program found in the Domiciliary Residential Rehabilitation and Treatment Program states that treatment is provided for substance, abuse, mental illness, vocational retraining and finances. (b)(5)
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"Strawberry Flag" Tour

- Strawberry farm located on grounds of GLA are used to promote compensated work therapy.
- Abandoned strawberry plants are resurrected and nurtured by Veterans and brought back to life at Strawberry Flag.
- Veterans bring in water from the LA River to irrigate the strawberries. Veterans tend the strawberries which are growing in rows of raised polyvinyl white pipes–part of an aquaponic system forming the stripes of the flag. This strawberry initiative forms an American flag visible from the air.
- The project began with a few Veterans and has expanded to more than a dozen, plus volunteers and growing media and national attention.
- The "Strawberry Flag" Project is sustained through solar energy and batteries which are charged by Veterans and volunteers pedaling stationary bicycles.
- As part of the continuation of the life cycle, fish are grown in the water receptacles.
- This effort was developed by L.A. Artist Lauren Bon, GLA-VA associate Chief of Mental Health, Dr. Jonathan Sherrin, and CWT Chief Joe Ciccone.

MADIGAN ARMY MEDICAL CENTER (MAMC)
Briefing provided by (b)(6) **Commander**

- Approximately 450 WTs at MAMC.
- 230-240 are medically non-deployable; 1/3 of WT population never deployed.
- Sub-set of this WT population has complex case management and behavioral health concerns.
- There are challenges with WTs who are perceived as not being able to "pull their weight."
- Combat units encourage WTU to enroll WTs who exhibit high risk behavior; however their diagnoses may not meet WTU enrollment criteria. As a result, there is a challenge for leadership who do not want high risk soldiers who are not ready to deploy and may display high risk tendencies.

- Goal is to allow WTs to leave the WTU, return to Unit but still have access to resources of hospital and outpatient care.
- For every soldier that cannot deploy – another soldier has to deploy again to fill slot.
- MAMC has developed a hybrid triad of care where they assign trained case managers to combat brigades and also loop them into the SFAC. The goal of this hybrid is to manage potential risks prior to deployment. Soldiers may not meet the requirements or need the full-scale care provided at the WTU, but do need some support so that issues do not escalate.
- Madigan Healthcare System enrollment is 112,506:
  - Madigan: 57,133
  - Nisqually Clinic: 22,739
  - Okubo Clinic: 12,394
  - McChord Clinic: 7,598
  - Presidio (Monterey, CA): 6,321
- Specialty services provided at MAMC include: Warfighter Refractive Eye Surgery Program, Chiropractic and Acupuncture Services as alternatives for pain management, Developmental Pediatric Program, Armed Services Blood Donor Center, Bi-Directional Health Information Exchange, Dental and Oral Surgery, and DoD Telehealth and Technology Center (T2).
- Specifically, the DoD Telehealth and Technology Center (T2) provides virtual therapy for Soldiers with Post Traumatic Stress Disorder (PTSD) by exposing them to war-like simulations of what occurs in theater to confront and overcome anxieties. This treatment is also provided at Tripler Army Medical Center.
- U.S. Army Medical Department (AMEDD) is studying pain management alternatives.
- Participating in Phase I of the MiCare Personal Health Records Pilot program held in conjunction with Microsoft and Google. This system allows Service members across DOD to request access to their health records electronically and utilize secure messaging with their healthcare providers.
- The Soldier Evaluation for Life Fitness (SELF) program is similar to the Tripler Wellness Clinic Program.
- The DES Pilot was launched on 4 February 2010. Eighty WTs are enrolled in the DES Pilot
  - Fort Lewis is collocated with one of three Army PEBs and one of two VA DES Rating Activity Sites (D-RAS).
  - Military Service Coordinators (MSCs), Physical Evaluation Board Liaison Officers. (PEBLOs), and VA examiners will be located together, in a new space by the end of FY11
  - Impartial Medical Reviews (IMRs) are averaging between 14-21 days.
  - Universal DES Pilot policy is not yet in place, so Marines and Sailors are processed at Bremerton Naval Medical Center (NMC) and Airmen are processed at McChord.
  - Universal or "purple" MEB is currently in coordination in Office of Wounded Warrior Care and Transition Policy.

Sensing Session with 10 WTU Nurse Case Managers and 3 VA Liaison Administrators

- Continued high turnover and lack of consistency amongst medical providers.
- Significant number of WTs with pre-existing behavioral health or chronic health issues that was not reported during recruitment process. Additionally, some potential recruits stopped taking medication to meet recruiting standards. **

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- Nurse Case Manager workload varies by Company; however, average caseload seems to be between 20-25 Soldiers per Case Manager. The majority of their time is devoted to completing Line of Duty paperwork, obtaining TSGLI benefits, scheduling appointments and working with WTs to develop their Comprehensive Transition Plans. VA Liaison Administrator caseload is 150 Soldiers per administrator.
- Conflicting objectives exist between the Line Command and Medical Command WTs assigned to the WTU are still required to meet physical training, and height/weight standards, as well as perform Control & Quarters (CQ) duty. CQ duty requires WTs to be awake for 24 hours, which can trigger symptoms for Soldiers that have PTSD and cause Soldiers to miss appointments.

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- MEB processing is slow for various reasons that include computer system errors, communication, missed appointments, need for specialty examinations, and no case manager access to the MEB Individual Tracking Tool (MEBITTs).
- Risk for National Guardsmen and Reservists "falling through the cracks" as they demobilize
- Processing Line of Duty (LOD) paperwork significantly impacts the workload of Nurse Case Managers. Much of their time is spent completing paperwork. Incomplete LODs cause delays in medical care for WTs.
- WTU Nurse Case Managers and VA Liaisons demonstrate a good working relationship which benefits the WTs in the DES Pilot
- The stigma associated with enrollment into the WTU is a concern. Combat-wounded WTs express concern that they may be associated with those WTs who stay for long periods of time and "milk the system." Currently, 150 WTs are in the WTU and 500 wounded, ill and injured Soldiers are outside of the WTU and do not have case managers. National Guardsmen and Reservists are required to enter the WTU, whereas Active Component Soldiers are recommended to the WTU by their unit command.

Lunch with MAMC MEB and Fort Lewis PEB Staff

- Enthusiasm and support expressed for the DES Pilot. The Fort Lewis PEB is familiar with the DES Pilot and has been adjudicating cases since Spring 2009.
- The PEB notes higher percentages of psychiatric/psychological cases within the WTU.
- Substance abuse among WTs in the WTU is of concern. Use of pain management specialists and research alternatives are being considered. Additionally, Nurse Case Managers would like access

to medication lists because numerous injuries results in multiple physicians prescribing medication and it is essential for physicians to be on the same page.

- MAMC answers 4-5 Congressional inquiries per week from patients expressing discontent with their care or length of time for MEB/PEB processing. They currently have two full time staff members dedicated to answering these inquiries.
- High quality of Pilot case files allows for fast processing. QTC (VA contractor) physicians are providing the PEB excellent, well-assembled case files. Other advantages to the PEB, is its proximity to the VA D-RAS and Regional Office in Seattle. Currently, D-RAS turns cases around in 4-5 days.
- Army and VA work together at the MTF to resolve or document the disagreements in adjudication before the package is sent to the PEB.
- Under the DES Pilot Soldiers are brought in one time to be briefed on the PEB decision and preliminary VA rating.
- Very few Service members request a Formal PEB (FPEB) after receiving initial fitness decision. A FPEB is a request made by the Service member if they disagree with the initial/informal fitness decision. Only 18% of Legacy cases request a FPEB, and only 2-3% of Pilot cases request a FPEB.
- Soldier satisfaction greater in the DES Pilot because they know the rating for their unfitting conditions and their preliminary VA rating
- MEB staff expressed hesitation and confusion about when to refer Soldiers into the DES Pilot, because different standards are used for DES Pilot referral and fitness determinations at the PEB.

Courtesy call with BG Jeff Mathis, Acting CG, I Corps and Joint Base Lewis-McChord

- BG Mathis noted that there are currently several common themes across WTUs:
  - Understaffing of Cadre
  - Co-location of combat and non-combat WTs
- There is a great deal of pressure on the Cadre and there is not a sufficient replacement plan in place
- Emphasized need for standardization of training and recruiting of Cadre
- Working to eliminate the stigma associated with PTSD
- As part of the upcoming surge, there are currently 7brigades with 17,000 returning this summer
- Serve 5,000 – 6,000 mobilized/demobilized (Reserve)
- Family Readiness Groups are supporting family members of WTs
  - 7 new cases within past several weeks
  - No Plan of Action to support the training of families and caregivers of WTs
  - Gen Chiarelli will be briefed about this issue during next visit
- Challenges with Solders who are not "medically ready" to deploy but are also not meeting requirements for intake into WTU
- Attends all Town Hall meetings

WTU Command Brief

- The WTU is organized into 3 companies each containing approximately 50 WTs. Space for 600 WTs
- 48% of the Soldiers are Active Duty, 15% are WTs with combat related injuries or illnesses. This compares to 12-13% of battle-related injuries in WTUs nationwide.
    - 67 Soldiers in the WTU have PTSD, 32 Soldiers in the WTU have TBI
    - 393 Soldiers in the WTU have non-battle related injuries or illnesses
    - 73 Soldiers in the WTU have battle related injuries of illnesses
- Comprehensive Transition Plan (CTP) is developed for every Soldier within their first 30 days assigned to the WTU.
- Soldiers work with the SFAC to learn about their Individualized Transition Plan, TAP and other pre-separation benefits. The SFAC also helps with partnership programs such as Heroes to Hometowns, and provide employment counseling to Soldiers and their families.

Observation:

WTUs were not set up to handle everybody; however, it is difficult to determine a reasonable line of demarcation when it comes to providing care, and what level of care, to Soldiers. **

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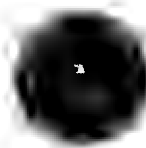
Sensing Session with 20 WTs

- One of the 20 Soldiers was enrolled in the DES Pilot; all other Soldiers were enrolled in the Legacy DES.
- Approximately 8 Soldiers have PTSD, and were encouraged to ask for medical help.
- All of the Soldiers were happy and satisfied with the care they are getting at MAMC. They are interested in alternative pain management.
- Concern with the lack of mental health physicians.
- Miscommunication to WTs and delays in processing MEB cases cause discontent

Sensing Session with WTU Cadre

- Great appreciation that so many services are imbedded in the footprint of Fort Lewis/MAMC.
- While there is a good relationship between the WTU and MAMC, there is frustration that the WTU has no control or influence over the hospital. WTs face long wait lists for appointments and there is a lack of coordination of care because of the disconnect between the Military Treatment Facility (MTF) and WTU.
- Lack of staff a concern. The command is selective in accepting staff due to the high demand of their jobs. However, processing Soldiers off their books is a slow process that prevents the WTU



from bringing on more staff. Squad ratios are 1:14 staff to WT versus the required 1:10 ratio. High risk WTs are not factored into caseload. If a high-risk WT requires more attention on a given day or week this means the Cadre will be required to devote excessive time to him/her while missing potential "lower risk" patients. This underscores the need for more Cadre and more behavioral [illegible] **

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- WTU comprises 50% Active Duty, 25% Reservists on 2 year orders, and 25% Guardsmen
- One half of Cadre staff will rotate in 2010.
- 400% increase in mental health cases in recent years, and the lack of physicians, physician assistants, or graduate student training programs that provide the psychiatric/psychological expertise and services. This increase in cases leaves Cadre under-prepared, under-trained and under-staffed.
- 17-18,000 Soldiers are expected to return from deployment this summer. Command concerned that with staff rotations and shortage of staff, Cadre will be unable to handle surge. **

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- Cadre are using WTs that are "on track" with treatment and CTPs, as auxiliary staff.
- The staff marks the improvement of a WT by physical improvement, involvement in occupational therapy and tests/assessments conducted by social workers.
- There is an exponential misbalance between combat and non-combat related injuries.

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- Utilizing interns, as available, to assist
- Decompression and maintaining Cadre staffs' primary skill set are areas of focus for Cadre who will be rotating and returning to their regular jobs.

TRIP TAKE AWAYS/GOOD IDEAS:

- TAMC Wellness Clinic
    - 1/3 of WTs participating in program return to duty
- PTSD Residential Recovery Program
    - Mentoring by Vietnam Vets beneficial to both WT and Veteran
    - Strong Command support sends positive message
    - DOD/VA co-located with successful program
- Schofield WTU WTs volunteering to assist Cadre
    - Positive outcomes for both staff and WT
- Makalapa Naval Health Clinic's Recreational Therapy Program serves Marine Corps Wounded Warrior Battalion West (Det Hawaii)
- Use of Viet Nam Veterans and retired military to mentor OEF/OIF Wounded Warriors
- WW Battalion West (Det Hawaii) command support for Family Support staff involvement with Wounded Warriors
- Assignment of AW2 Advocate to VA Centers (LA VA Center)
- Use of WTs enrolled in WTU as volunteers to assist Cadre

- Viet Nam Veterans (largest population using system) are mentoring OEF/OIF Active Duty and Veterans
- Army and Marine Corps liaisons on site to assist Wounded Warriors-"speak the same language"

OVERALL OBSERVATIONS/RECURRING THEMES

- Noticeable split between combat-injured WTs and those with non-combat related injuries/illnesses.
- Concern over lack of staff to support surge.
- Cadre staff ratios to WTs.
- Members of the Cadre are required to perform collateral duties (e.g. Staff Duty Officer). This means the Cadre will work long hours at the WTU as well as long hours for collateral duty. Members of the Cadre are being pulled into many directions and with many challenging duties.
- WTs required to participate in physical training and meet height and weight standards despite portfolio showing medical conditions.
- WTs pre-existing health conditions.
- WTs "gaming the system." WTs and Cadre state that some Soldiers are on a "five year plan" to stay in the WTU with no aspirations to reintegrate into their community and improve their well-being.
- According to Command leadership, WTs are memorizing the MACE test while in theatre. WWCTP staff first heard of this at Fort Drum and then again at the Schofield WTU.
- Knowledge of current DOD, VA and private sector programs, services and resources to assist Wounded Warriors, Veterans, Families and providers is sparse and non-existent in places. These programs include the DOD/VA Federal Recovery Coordination and DOD Recovery Coordination Programs, the National Resource Directory Web site (www.nationalresourcedirectory.gov) and TurboTap (www.turbotap.org).
- There is limited/no knowledge of the Heroes 2 Hometown Program. This initiative is in place through a MOU between DoD and the American Legion.
- Need for standardization of VISN programs.
- MAMC has developed a hybrid triad of care where they assign trained case managers to combat brigades and also loop them into the SFAC. The goal of this hybrid is to manage potential risks prior to deployment. Soldiers may not meet the requirements or need the full-scale care provided at the WTU, but do need some support so that issues do not escalate.

RECOMMENDATIONS

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WWCTP Staff on Visit:
Mr. Noel Koch, Deputy Under Secretary of Defense for Wounded Warrior Care and Transition Policy
(b)(6) Special Assistant to ADM Mullen, Chairman of the Joint Chiefs of Staff
Ms. Susan Roberts, Principal Deputy for Care Coordination in Office of Wounded Warrior Care and Transition Policy
Mr. David Dubois, Director of Operations in Office of Wounded Warrior Care and Transition Policy, Transition Assistance Program
(b)(6) Military Assistant for Mr. Noel Koch
(b)(6), Communications Consultant
(b)(6) DES Pilot Consultant