



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

DEC 23 2009

HEALTH AFFAIRS

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report is provided in response to the Senate Appropriations Committee Report 111-074, which requests the Assistant Secretary of Defense for Health Affairs (ASD(HA)) to provide a report by November 6, 2009, regarding the conduct of Military Medical Research. The report provides a complete list of capability gaps, a timeline and process for distributing and/or competing the resources, and a detailed description of how the Office of the ASD(HA) has integrated the Services into the development and execution process. We will continue to move forward to provide the most expeditious and highest quality medical research and development in support of our Service members.

Because the attached report contains capability gaps, we respectfully request that the report be protected as "For Official Use Only" and not be released to the public.

Thank you for your continued support of the Military Health System.

A handwritten signature in black ink that reads "Ellen P. Embrey".

Ellen P. Embrey
Deputy Assistant Secretary of Defense
(Force Health Protection and Readiness)
Performing the Duties of the
Assistant Secretary of Defense
(Health Affairs)

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member



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WASHINGTON, DC 20301-1200

DEC 23 2009

HEALTH AFFAIRS

The Honorable James H. Webb
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

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The Honorable Lindsey O. Graham
Ranking Member



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HEALTH AFFAIRS

The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
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Ranking Member



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HEALTH AFFAIRS

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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The Honorable Howard P. "Buck" McKeon
Ranking Member



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WASHINGTON, DC 20301-1200

DEC 23 2009

HEALTH AFFAIRS

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

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Ranking Member



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DEC 23 2009

HEALTH AFFAIRS

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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The Honorable Jerry Lewis
Ranking Member



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DEC 23 2009

HEALTH AFFAIRS

The Honorable John P. Murtha
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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The Honorable C. W. Bill Young
Ranking Member

**Department of Defense
Report to the Congressional Defense Committees on
Military Medical Research**

Background

Secretary of Defense (SECDEF) Planning Guidance for 2010-2025, initiated a comprehensive medical research and development (R&D) program analysis that was led by the Under Secretary of Defense for Acquisition, Technology, and Logistics and the Armed Services Biomedical Research Evaluation and Management (ASBREM) Committee. The program and budget assessment of the Department's medical research, development, test, and evaluation (RDT&E) investments used the Joint Force Health Protection (JFHP) Concept of Operations (CONOPS) as the “capabilities needed” baseline. SECDEF directed Wounded Warrior focus areas of Traumatic Brain Injury (TBI), Post Traumatic Stress Disorder (PTSD), prosthetics, eye injury, and other deployment and battlefield injuries also provided a key context for the assessment. Of the 229 JFHP capability gaps, 69 were assessed as having medical RDT&E solutions. The assessment resulted in a medical RDT&E budget increase to the Defense Health Program (DHP) in the amount \$372.2 million for Fiscal Year (FY) 2010, with continued out-year funding in the DHP dedicated to advance military medical R&D relevance to battlefield operations today and in the future. Increases in DHP RDT&E are balanced across science and technology and medical capability development efforts, with a mandate to focus on JFHP CONOPS gaps, Wounded Warrior capabilities (e.g., improved TBI and PTSD diagnosis and treatment), as well as operationally driven, urgent, execution-year combatant commander joint needs.

The Senate Appropriations Committee Report 111-074 requested the Assistant Secretary of Defense for Health Affairs (ASD(HA)) to report by November 6, 2009, with a complete list of the capability gaps, a timeline and process for distributing and/or competing the resources, and a detailed description of how the Office of the ASD(HA) has integrated the Services into the development and execution process. The following information is provided as the Department of Defense (DoD) response.

Capability Gaps

The additional DHP RDT&E funding is intended to address shortfalls in the ability to resolve capability gaps identified in JFHP Joint Capability Documents (listed in Appendix A, reference: Under Secretary of Defense for Acquisition, Technology, and Logistics, *Guidance for Development of the Force FY2010–2015 Program and Budget Assessment A4.16, Medical Research and Development Investments*, June 2008), as well as the medical research priorities of the SECDEF (reference: June 26, 2008, SECDEF Memorandum, Subject: “Caring for Our Wounded Personnel and Their Families”, see Appendix B). The DoD has identified specific needs for medical R&D associated with

these capability gaps and priorities. These needs will be addressed through forthcoming announcements.

Execution Process and Timeline

DoD intends to competitively award proposals to execute the funding. Competition is open to DoD medical R&D laboratories and Military Treatment Facilities (MTFs), to extramural academic institutions, and to commercial or other organizations. Proposals for science and technology funding (Program Elements 0601117HP, 0602115HP, and 0603115HP) are or will be solicited through separate program announcements, one for basic research, and the other for applied research and advanced technology development. For those funds appropriated for advanced component development and system development and demonstration (Program Elements 0604110HP and 0605145HP), Requests for Information (RFIs) are in preparation that will solicit white papers describing technologies addressing the identified materiel needs of DoD, and human studies, and clinical trials that address critical knowledge gaps in the ability to prevent, and effectively treat injury and disease. Requests for Proposals (RFPs) will be generated based on selected white papers that are of greatest interest. Full and open competitions will be conducted for efforts to develop systems, or conduct studies and trials, as applicable. For those funds appropriated for medical products and capabilities enhancement activities (Program Element 0607100HP), pre-planned and emergent improvement opportunities for currently fielded medical products will be collected, validated, and prioritized. In all cases, proposals for funding that are submitted in response to program announcements or RFPs, will be subjected to both an external peer review for scientific merit and quality and to programmatic and military relevance review. The current planned timeline for the execution process is described in Table 1. The timing of awards after project selection will be based on the length of award negotiations.

Table 1. Planned Execution Timetable for DHP Medical R&D Funding

Event	DHP Program Elements		
	Basic Operational Medical Research Sciences	Applied Biomedical Technology Medical Technology Development	Medical Products Support and Advanced Component Development Medical Products and Support Systems Development Medical Products and Capabilities Enhancement Activities
RFI Release	<i>Not Applicable</i>	<i>Not Applicable</i>	November 2009
Program Announcement or Requests for Information Release	November 2009	August 2009	November 2009
Application Deadline	February 2010	December 2009	March 2010
Award	Subject to award negotiation	Subject to award negotiation	Subject to award negotiation

Integration of the Services into the Development and Execution Process

Program development and execution are conducted jointly under the auspices and oversight of the Office of the ASD(HA). Primary responsibility for program development and execution has been assigned to six Joint Technology Coordinating Groups (JTCGs) under the ASBREM Committee, which include as members research program managers from each of the three Military Departments, who serve as formally designated representatives of their respective Departments. For the purposes of DHP medical R&D program planning and execution, the membership of each JTCG has been expanded to include representatives of relevant program management offices from each Service; the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury; the Uniformed Services University of the Health Sciences; the Defense Advanced Research Projects Agency; Service combat developers; the Combatant Command Surgeons and other end users; the Joint Staff; the U.S. Department of Veterans' Affairs; and the National Institutes of Health. These expanded JTCGs have developed and prioritized medical R&D needs using consensus development processes. The needs identified by each JTCG (included in Appendix C) have been incorporated into the program announcements and RFIs described above. However, this list of needs is considered dynamic and will be updated as new needs are identified and vetted through the appropriate processes. The expanded JTCGs will serve as programmatic review committees for the proposals and white papers submitted in response to the program announcements and the RFIs. In this capacity, the expanded JTCGs will evaluate pre-proposals, and white papers, and provide recommendations for solicitation of full proposals. They also will review proposals and make recommendations for funding to ASD(HA), taking into account both external peer review findings and programmatic and military relevance.

Appendix A

Under Secretary of Defense for Acquisition, Technology, and Logistics, *Guidance for Development of the Force FY2010–2015 Program and Budget Assessment A4.16, Medical Research and Development Investments, June 2008*

Joint Force Health Protection Gaps Requiring Medical Research and Development

The following lists capability gaps requiring medical research and development (R&D) that were identified during the conduct of Guidance for Development of the Force FY2010–2015 Program and Budget Assessment A4.16, Medical Research and Development Investments (Under Secretary of Defense for Acquisition, Technology and Logistics, June 2008). Joint Force Health Protection (JFHP) draft Joint Capability Documents (JCDs) or their associated Functional Needs Analysis (FNAs) were reviewed to identify these capability gaps. JCDs and/or FNAs have been developed for each of the six functional areas of JFHP:

- Joint Human Performance Enhancement (JHPE)
- Joint Health Surveillance, Intelligence, and Preventive Medicine (JHSIPM)
- Joint Casualty Management (JCM)
- Joint Patient Movement (JPM)
- Joint Medical Logistics and Infrastructure Support (JMLIS)
- Joint Theater Medical Command and Control (JTMC2)

A total of 229 JFHP gaps were identified in these documents. These gaps were then evaluated by user representatives on the Guidance for Development of the Force Assessment 4.16 Working Group to determine which gaps required medical R&D, either to provide new medical materiel and system capabilities, or to provide medical or biomedical information needed to guide policy, new clinical procedures, or safe design and health risk assessment for nonmedical systems. Of the original 229 JFHP gaps, 69 gaps were deemed likely to require medical R&D to enable their resolution. These 69 gaps are listed in the following tables, listed by JFHP Functional Area, and in high (1), medium (2), and low (3) priority bands as assessed by each FNA.

Area	Priority	Gap
JCM	1	JCM-1-1: Inadequate ability to diagnose, resuscitate, and stabilize casualties with survivable wounds
JCM	1	JCM-1-2: Inadequate initial emergent resuscitative surgery coupled with life- and limb-saving actions
JCM	1	JCM-1-2.1: Inadequate definitive, restorative, and rehabilitative medical care and surgery for life- and limb- and eyesight-saving actions
JCM	1	JCM-1-3: Inadequate ability to locate and evaluate casualties

Area	Priority	Gap
JCM	1	JCM-1-4: Inability to stop internal bleeding and external bleeding
JCM	1	JCM-1-5: Poor ability to stop life-threatening extremity bleeding
JCM	1	JCM-1-6: Poor ability to ensure casualty airway
JCM	1	JCM-1-7: Inability to adequately monitor, evaluate, and triage casualties by combat medical personnel for early identification of life saving interventions
JCM	1	JCM-1-8: Inadequate therapy for shock and head injury
JCM	1	JCM-1-8.1: Inadequate definitive, restorative, and rehabilitative therapy for head injury and shock
JCM	1	JCM-1-9: Inadequate battlefield analgesia with minimal side effects
JCM	1	JCM-1-10: Inadequate integrated medical information systems across the taxonomy of casualty care
JCM	1	JCM-1-11: Inadequate ability to immediately recognize and correct coagulopathy
JCM	2	JCM-2-1: Inadequate stabilization of injuries and ability to monitor response to treatment
JCM	2	JCM-2-2: Poor ability to provide tissue oxygenation and compatible shelf-stable blood products
JCM	2	JCM-2-3: Poor ability to restore blood volume
JCM	2	JCM-2-4: Inability to prevent traumatic disconnect/removal of IVs
JCM	2	JCM-2-5: Inability to prevent bleeding problems associated with hypothermia
JCM	2	JCM-2-6: Inability to prevent vomiting due to pain or medications
JCM	2	JCM-2-8: Inadequate casualty evacuation (CASEVAC) by non-standard platforms, attended by combat lifesaver en route (refer to JPM JCD)
JCM	2	JCM-2-9: Inadequate ability to operate in a chemical, biological, radiological, and nuclear (CBRN) environment
JCM	2	JCM-2-10: Inadequate ability to diagnose, treat, and prevent dental injury and disease
JCM	3	JCM-3-1: Lack of therapeutics to combat infection
JCM	3	JCM-3-2: Inadequate medical intelligence
JHPE	1	JHPE-FRE-CE1: {Provide/maintain the ability to operate in a CBRN environment} Inability to perform to optimum levels in a CBRN environment
JHPE	1	JHPE-FRE-KE1: {Provide/maintain the ability to operate in a kinetic and high-explosive threat environment} Lack of ability to adequately protect warfighters against a kinetic and high-explosive threat
JHPE	1	JHPE-FRE-KE2: {Provide/maintain the ability to operate in a kinetic and high-explosive threat environment} Lack military equipment that adequately prevents injury/death from non-combat accidents

Area	Priority	Gap
JHPE	1	JHPE-HFF-EM1: {Ensure mental health of returned warfighters} Limited ability to ensure optimal psychological health in warfighters
JHPE	1	JHPE-HFF-RE1: {Restore/enhance health and fitness of casualties} Inability to restore loss of sight/hearing
JHPE	1	JHPE-HFF-RE2: {Restore/enhance health and fitness of casualties} Limited ability to restore optimal psychological health in warfighters
JHPE	1	JHPE-HSI-PWS1: {Provide human systems integration with weapons systems} Inadequate guidance, requirements, and application of HSI with weapons systems in the pre-systems acquisition (capability/concept development–FAA/FNA/FSA) life cycle phase
JHPE	1	JHPE-MWF-EF1: {Evaluate fatigue} Lack of validated, reliable, non-intrusive means to recognize and evaluate, in real-time, levels of fatigue in self and others
JHPE	1	JHPE-MWF-MWP1: {Monitor Warfighter Performance} Lack of capability to nonintrusively and noninvasively monitor vigilance and performance in stationary and mobile subjects in real time
JHPE	1	JHPE-SCM-ESC1: {Enhance and sustain cognitive performance} Lack of strategies to enhance/maximize cognitive abilities for optimal decision making (i.e., ability to overcome task saturation, information overload, and/or stress)
JHPE	1	JHPE-SCM-ESC2: {Enhance and sustain cognitive performance} Inadequate means to augment cognitive ability to modulate information flow and prioritize inputs in order to maximize warfighters' and units' performance and decision making
JHPE	1	JHPE-SCM-MAU1: {Monitor, assess and utilize physical and mental status of individual warfighters and units to enhance commander's decision making} Inability for decision makers to know when warfighters and units are physically and mentally incapable of performing the mission required of them
JHPE	2	JHPE-EPC-EA1: {Enhance ability to withstand trauma} Inability to provide, in advance or on site, countermeasures to prevent morbidity/mortality directly related to trauma
JHPE	2	JHPE-EPC-ME1: {Maintain and enhance performance despite the physical, social, and psychological stressors of military operations} Lack of physiologic countermeasures to the performance degradation associated with stressors of military operations
JHPE	2	JHPE-EPC-MM1: {Manipulate metabolic processes related to water intake, nutrition, and waste production} Inability to reduce requirement for food and water

Area	Priority	Gap
JHPE	2	JHPE-EPC-MM2: {Manipulate metabolic processes related to water intake, nutrition, and waste production} Inability to manage bodily waste production
JHPE	2	JHPE-EPC-PN1: {Provide neuroprotection to decrease brain injury} Inability to provide, in advance or on site, countermeasures to prevent morbidity/mortality directly related to traumatic brain injury (TBI)
JHPE	2	JHPE-HFF-ME1: {Maintain or enhance health and fitness of deployed forces} Inability to sustain adequate warfighter nutritional and dietary requirements when deployed for lengthy period and existing on field rations
JHPE	2	JHPE-HFF-ME2: {Maintain or enhance health and fitness of deployed forces} Limited capacity for understanding and providing solutions to maintain warfighter health and fitness while conducting continuous operations in extreme environments
JHPE	2	JHPE-HSI-PVS1: {Provide human systems integration (HSI) with vehicles, ships, aircraft, and spacecraft} Inadequate guidance, requirements, and application of HSI with vehicles, ships, aircraft, and spacecraft in the pre-systems acquisition (capability/concept development–FAA/FNA/FSA) life cycle phase
JHPE	2	JHPE-LCD-ED3: {Enhance decision making} Need to develop improved autonomous decision making
JHPE	2	JHPE-MWF-CWF1: {Counter warfighter fatigue} Lack of effective pharmacological or nonpharmacological countermeasures that maintain wakefulness, mental acuity, physical performance, psychomotor performance, and decision-making ability, with minimal residual or adverse effects, during: prolonged periods of continuous wakefulness; multiple consecutive days of partial sleep (≤ 4 hours per day); adverse circadian phases; or irregularly scheduled or nighttime operations.
JHPE	2	JHPE-MWF-PWP1: {Predict warfighter performance} Lack of validated, predictive models of fatigue and performance that account for individual differences, effects of sleep loss, and countermeasure effects
JHPE	2	JHPE-SCM-ESP2: {Enhance and sustain physical performance} Lack capability to enhance warfighters to superphysiologic levels (e.g., exoskeleton or bionic arm)
JHPE	3	JHPE-FRE-DE1: {Provide/maintain the ability to operate in directed energy environments} Inability to perform to optimum levels in a directed energy environment
JHPE	3	JHPE-FRE-EC1: {Provide/maintain the ability to operate in extreme climates (temp and altitude)} Inability to perform to optimum levels in extreme climates

Area	Priority	Gap
JHPE	3	JHPE-FRE-FE1: {Provide/maintain the ability to perform in a flight environment} Lack of ability to perform at optimum levels in a flight environment (characterized by high-G, high-altitude, high noise, and vibration, etc.)
JHPE	3	JHPE-FRE-UE1: {Provide/maintain the ability to operate in underwater environments} Inability to perform to optimum levels in an underwater environment
JHPE	3	JHPE-HFF-OH2: {Optimize health and fitness of the nondeployed force} Lack ability to ensure sufficient and consistent warfighter fitness levels
JHPE	3	JHPE-MWF-EF2: {Evaluate fatigue} Inadequate application of knowledge and understanding regarding fatigue and its effects on performance
JHPE	3	JHPE-SCM-ESP1: {Enhance and sustain physical performance} Inability to sustain baseline physical capability in other-than-optimal operational environments (e.g., individual warfighter and unit performance degrades from inactivity or operational exposure)
JHPE	3	JHPE-SCM-ESS2: {Enhance and sustain sensory capabilities} Lack the capability to protect while preserving and enhancing hearing capability. Augmented hearing is necessary to surpass our enemies' abilities, especially in extreme conditions such as high noise, fog, smoke, and low light
JHPE	3	JHPE-SCM-MCS1: {Manage and control sensory inputs} Lack ability to manage (increase/decrease, shape) sensory input <ul style="list-style-type: none"> • Desensitize to negative stimuli • Correct inappropriate natural sensory input with appropriate artificial sensory input (e.g., spatial disorientation corrected by artificial horizon in an airplane)
JHSIPM	1	JHSIPM-PRV-AEP1: Current materiel solutions for information systems are inadequate and must include detection, identification, and quantification. An area especially lacking is the forecasting of CBRN threats. Lack of clear doctrinal direction has caused the Preventive Medicine (PM) materiel solutions to be insufficient for joint analysis and synchronization, such as the Joint Medical Work Station (JMeWS), Medical Situational Awareness in Theater (MSAT), and the Theater Medical Information Program-Joint (TMIP-J).
JHSIPM	1	JHSIPM-PRV-AEP2: Current materiel solutions for Occupational and Environmental Health Surveillance sampling and detection are inadequate

Area	Priority	Gap
JHSIPM	1	JHSIPM-PRV-PIC1: Joint Immuno-Chemoprophylaxis Countermeasures (I&C) materiel solutions are inadequate in the timeliness and completeness of R&D, information systems and production capability
JMLIS	1	JMLIS-OS-TAP3: 3) Current C4I systems do not enable medical logisticians to efficiently remedy identified medical materiel deficiencies/excesses across an enterprise (i.e., redistribution)
JMLIS	1	JMLIS-SSA-ALI2: 2) Current medical logistics systems and tools are not sufficiently integrated with clinical systems
JMLIS	1	JMLIS-SSA-COP3: 3) There is insufficient linkage between clinical and medical logistics information systems or between theater medical logistics and institutional medical facilities
JPM	1	JPM-TER-ER2: Interoperability between C4 systems in support of reception/staging operations is lacking. A single joint medical C4 system does not exist. Joint medical C4 systems do not provide operational and clinical situational awareness to nonmedical C4 systems. PM and personnel tracking systems do not interact and are labor intensive.
JPM	1	JPM-TRA-AE2: En route care lacks standardization. Standardized joint medical equipment for transport of critical patients is lacking. Joint critical care transport capability and training platforms do not exist. There is no adequate joint directive/authority to ensure standardized Patient Movement Instructions program compliance.
JPM	1	JPM-TRA-AE3: Interoperability between C4 systems supporting en route care is lacking. A single joint medical C4 system does not exist. Joint medical C4 systems do not provide operational and clinical situational awareness to nonmedical C4 systems. PM and personnel tracking systems do not interact and are labor intensive.
JPM	3	JPM-TER-EC3: JPM training platforms and skill-identification tracking systems are lacking. Models to replicate medical processes in joint exercise are lacking. Programs to establish JPM leadership development and education are inadequate.
JTMC2	1	JTMC2-CMI2: {Integrate Comprehensive Medical Information with JFSA Systems and Processes} Requires dynamic integration (interrelational movement of data) of medical information with the COP
JTMC2	1	JTMC2-CMI3: {Integrate Comprehensive Medical Information with JFSA Systems and Processes} Requires access to a standardized collaborative information environment (CIE)

Appendix B

Secretary of Defense Memorandum

**Subject: Caring for Our Wounded Personnel and Their Families,
June 26, 2008**



SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

JUN 26 2008

MEMORANDUM FOR DEPUTY SECRETARY OF DEFENSE

SUBJECT: Caring for Our Wounded Personnel and Their Families

Over the past year, the Department has achieved significant progress in the level of care available to our wounded men and women. Within the remaining time left in this Administration, I would like to focus on achieving some specific additional objectives.

1. Wounded Warriors Disability Ratings

The pilot program to streamline the disability rating system has made good initial progress. Based on preliminary feedback, it is evident that, for those participating in the pilot, the adjustments made have reduced the time required to navigate the system and, most importantly, reduced the frustration that Wounded Warriors experience during disability processing.

Despite this progress, I remain concerned that our Wounded Warriors are still subjected to a system designed to evaluate the broader population within the Veteran's Affairs Health System and not necessarily those who have experienced wounds in armed conflict. It is and will continue to be inherently difficult to ensure appropriate responsiveness by a system of this size and complexity, particularly given the significant limitations imposed by decades of case law and statutory direction. Accordingly, I believe we must give serious consideration to moving toward a tiered system that better addresses the unique circumstances facing service members with combat related ailments.

I request that you determine options to, within the framework of existing law, design an architecture that evaluates and compensates Wounded Warriors separately. This separate evaluation system should be designed to grant the benefit of the doubt to the wounded warrior when making a disability determination. In the interim, is there a reason why we could not change the disability rating presumption for wounded warriors to a minimum of 30 percent service connected disability? This would provide a foundational base of lifetime support that could then be supplemented based on specific circumstances.

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2. Families of the Fallen and Severely Wounded

I am concerned that, as a Department, we have not done enough to recognize and address the enormous burden placed on the families of our fallen and severely wounded. I am aware and very appreciative of the wonderful programs that do exist to provide support to this special category of families. However, my impression is that the level of support resulting from these efforts is inconsistent and highly dependent on the military service, installation, command or specialty involved. As the President recognized in his State of the Union address this year, we have an obligation to properly care for our military families in all circumstances. We need to look at all these programs and determine how we can apply consistency of the best practices found across services and commands.

3. Medical Related Research

The Department funds billions of dollars of medical research annually for a variety of purposes. Some of this goes for research of tenuous benefit to our military population. However, it is not apparent to me that our medical research program has been adjusted to refocus priority resources on advancing the state of medical science in those areas of most pressing need and relevance to today's battlefield experience, particularly in the area of mental health and traumatic brain injury. Beyond the recent one-time increase by the Congress for this specific purpose, I request the development of a tailored plan to provide R&D investments that advance state of the art solutions for world class medical care with an emphasis on Post Traumatic Stress Disorder, Traumatic Brain Injury, prosthetics, Restoration Sight Eye-Care, and other conditions directly relevant to the injuries our soldiers are currently receiving on the battlefield.

4. Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI)

I believe that PTSD and TBI and associated ailments are, and will continue to be, the signature military medical challenge facing the Department for years to come. I realize that we are addressing this challenge on a number of fronts, but I believe we have yet to muster the proper amount of management energy and priority on the various legal, policy, medical, process, budget and human implications associated with these types of injuries. We should think this through and identify available options to ensure we are properly addressing the full range of challenges that this situation poses for the Department and the millions of men and women entrusted to our care.

I appreciate the diligent efforts to work these problems on a daily basis. The Department of Defense is doing more for our wounded soldiers and their families today than at any point in history. My intent and hope is to institutionalize this progress where possible, and recalibrate the significant efforts being expended in this area to achieve maximum results in the time we have left. I request and welcome your thoughts and perspectives on how best to do this. I look forward to your preliminary thinking and plans in these four areas at our next Wounded Warrior update meeting.



cc:
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Secretary of the Air Force
Chairman of the Joint Chiefs of Staff
Under Secretary of Defense for Acquisition,
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