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

HEALTH AFFAIRS

AUG - 1 2008

The Honorable Ben Nelson
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510–6050

Dear Mr. Chairman:

The House Report 109-452 (page 344), to accompany H.R. 5122, the National Defense Authorization Act for Fiscal Year 2007, requests the Secretary of Defense to develop a comprehensive and systematic approach for the identification, treatment, disposition, and documentation of traumatic brain injury (TBI) in combat and peace time. On June 1, 2007, I submitted an interim report of the initial efforts of the Department of Defense (DoD).

Combining the talents of subject matter experts from the Services and representatives from the Department of Veterans Affairs, DoD established a high-level work group to design a comprehensive TBI program. TBI and psychological health are linked, as many who sustain TBI suffer psychological effects as a result of their injury. Additionally, family members of those who have sustained TBI may suffer stresses that negatively affect their mental health. Accordingly, in developing a comprehensive program to care for those who have TBI, DoD is simultaneously addressing psychological health. I am enclosing a final report responding to House Report 109-452 that describes our approach.

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

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Lindsey O. Graham
Ranking Member

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

HEALTH AFFAIRS

AUG - 1 2008

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510–6050

Dear Mr. Chairman:

The House Report 109-452 (page 344), to accompany H.R. 5122, the National Defense Authorization Act for Fiscal Year 2007, requests the Secretary of Defense to develop a comprehensive and systematic approach for the identification, treatment, disposition, and documentation of traumatic brain injury (TBI) in combat and peace time. On June 1, 2007, I submitted an interim report of the initial efforts of the Department of Defense (DoD).

Combining the talents of subject matter experts from the Services and representatives from the Department of Veterans Affairs, DoD established a high-level work group to design a comprehensive TBI program. TBI and psychological health are linked, as many who sustain TBI suffer psychological effects as a result of their injury. Additionally, family members of those who have sustained TBI may suffer stresses that negatively affect their mental health. Accordingly, in developing a comprehensive program to care for those who have TBI, DoD is simultaneously addressing psychological health. I am enclosing a final report responding to House Report 109-452 that describes our approach.

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

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

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

HEALTH AFFAIRS

AUG - 1 2008

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515–6035

Dear Mr. Chairman:

The House Report 109-452 (page 344), to accompany H.R. 5122, the National Defense Authorization Act for Fiscal Year 2007, requests the Secretary of Defense to develop a comprehensive and systematic approach for the identification, treatment, disposition, and documentation of traumatic brain injury (TBI) in combat and peace time. On June 1, 2007, I submitted an interim report of the initial efforts of the Department of Defense (DoD).

Combining the talents of subject matter experts from the Services and representatives from the Department of Veterans Affairs, DoD established a high-level work group to design a comprehensive TBI program. TBI and psychological health are linked, as many who sustain TBI suffer psychological effects as a result of their injury. Additionally, family members of those who have sustained TBI may suffer stresses that negatively affect their mental health. Accordingly, in developing a comprehensive program to care for those who have TBI, DoD is simultaneously addressing psychological health. I am enclosing a final report responding to House Report 109-452 that describes our approach.

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

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Duncan Hunter
Ranking Member

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

HEALTH AFFAIRS

AUG - 1 2008

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515–6035

Dear Madam Chairwoman:

The House Report 109-452 (page 344), to accompany H.R. 5122, the National Defense Authorization Act for Fiscal Year 2007, requests the Secretary of Defense to develop a comprehensive and systematic approach for the identification, treatment, disposition, and documentation of traumatic brain injury (TBI) in combat and peace time. On June 1, 2007, I submitted an interim report of the initial efforts of the Department of Defense (DoD).

Combining the talents of subject matter experts from the Services and representatives from the Department of Veterans Affairs, DoD established a high-level work group to design a comprehensive TBI program. TBI and psychological health are linked, as many who sustain TBI suffer psychological effects as a result of their injury. Additionally, family members of those who have sustained TBI may suffer stresses that negatively affect their mental health. Accordingly, in developing a comprehensive program to care for those who have TBI, DoD is simultaneously addressing psychological health. I am enclosing a final report responding to House Report 109-452 that describes our approach.

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

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable John M. McHugh
Ranking Member

Report to Congress in Response to the National Defense Authorization Act for Fiscal Year 2007, House Report 109-452

Comprehensive Approach to Psychological Health and Traumatic Brain Injury

TABLE OF CONTENTS

Introduction 1
Traumatic Brain Injury (TBI) 2
Psychological Health (PH) 3
Access to Care 4
Quality of Care 6
Resilience, Leadership, and Advocacy 8
Surveillance and Screening Systems 10
Transition of Care 12
Funding Strategy 13
Accomplishments to Date 17
Appendix A, Post-Deployment Health Assessment, DD Form 2796 20
Appendix B, Post-Deployment Health Reassessment, DD Form 2900 27

Introduction

The Department of Defense (DoD) is committed to supporting and providing quality care to individuals who experience traumatic brain injury (TBI) and to transforming the provision of services across the continuum of psychological health care. Psychological health (PH) and TBI are often linked, as many who sustain TBI suffer psychologic effects as a result of their injury. Additionally, family members of those who have sustained TBI may suffer stresses that negatively affect their mental health. Accordingly, in developing a comprehensive program to care for those who have suffered TBI, DoD is conjointly and simultaneously addressing PH. Although the committee only asked for a description of DoD's TBI efforts, due to this linkage, initiatives involving TBI necessarily overlap with PH programs. As such, DoD's report describes its comprehensive plan to address both subject areas.

Many of the changes under way in DoD have their genesis in the recommendations of review groups, such as:

- The Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical and National Naval Medical Center;
- The President's Commission on Care for America's Returning Wounded Warriors;
- The DoD Task Force on Mental Health; and
- The Department of Veterans Affairs' (VA) Task Force on Returning Global War on Terror Heroes.

DoD's priorities for comprehensive action were guided by the recommendations from these multiple reviews. DoD leadership's objectives include:

1. Furnish strong, visible leadership and the resources necessary to provide for Service members who have suffered TBI.
2. Create, disseminate, and maintain excellent standards of care across the Department.
3. When best practices or evidence-based recommendations are not readily available, conduct pilot or demonstration projects to better inform quality standards.
4. Monitor and revise the access, quality, and fidelity of program implementation to ensure standards are executed and quality is consistent.
5. With constant attention to the needs of our soldiers and their families, 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.

Traumatic Brain Injury (TBI)

The nature of the current conflict has brought TBI to the attention of all Americans and has compelled civilian and military leaders to take action. DoD has established a vision of a cohesive and integrated approach to TBI for the Military Health System (MHS), closely tied to the VA, and focused on individual Service members and their families. From this vision flows an overarching plan to identify TBI, provide world-class care for the injured, and implement process improvements as we advance our understanding of TBI. Implementation and execution of the plan includes:

- A Department of Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) formed to advance a core body of knowledge related to TBI and PH. The DCoE will also centralize expertise devoted to developing a comprehensive and integrated approach to TBI within the MHS while also collaborating with the VA, civilian, and academic institutions;
- Baseline and/or periodic neuro-cognitive screening which can be repeated, as appropriate, following deployments or exposure to head trauma;
- Clear definitions and terminology related to TBI to help advance our understanding of the natural history of the injury and improve identification, treatment, and rehabilitation;
- Education for all Service members, their families, and leaders at all levels regarding the risks and manifestations of TBI. Education is the cornerstone of treatment for TBI. Increased awareness will lead to earlier identification and management of problems and improved outcomes;
- Identification of the injured through screening that uses appropriate tools to ensure every injured Service member receives the care he/she needs;
- Innovative demonstration projects to advance the treatment of injured Service members. Increases in staff and improvements in equipment will be essential in providing the best quality of care;
- Ensuring outstanding standardized training of all providers and staff based on the best available clinical guidance;
- Creating an integrated system to monitor TBI and collect data across the MHS to ensure quality, identify potential research areas, and continue process improvement;
- Ensuring individual Service members with TBI receive coordinated care management across MHS and VA; and
- Strengthening the rehabilitative resources and providing comprehensive transition programs to maximize the recovery of injured Service members.

Psychological Health (PH)

PH is an overarching concept that covers the multidimensional continuum of psychological and social well-being, prevention, treatment, and health maintenance. It refers to a state of subjective well-being as well as mental, emotional, and behavioral functioning that is associated with productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Implicit in this definition is the notion that health is more than the mere absence of illness. It covers a full continuum of experience ranging from positive health and prevention through recovery measures, to include:

- Positive PH, which includes building resilience and psychological fitness, organizational and community-based prevention, protection and operational risk management from environmental, psychological, and psychosocial risk factors, primary prevention, community support networks, health promotion, education and training;
- Early intervention and care, to include screening, effective problem-solving, and early identification and resolution of concerns;
- Special problem identification and treatment, such as substance abuse education and assessment, and other concerns that may fall outside traditional outpatient or inpatient mental health care or general community support services;
- Increased focus on behavioral health concerns in primary care settings, which entails providing support for psychological and behavioral aspects of traditional physical health conditions, such as pain management, sleep management, medication compliance, diet and exercise, smoking, and psychosocial recovery from physical health conditions;
- Traditional mental health clinic care, which includes diagnosis and treatment of mental health disorders;
- Intensive outpatient treatment, which provides specialty care, often using a multi-disciplinary team for patients whose conditions do not respond to traditional outpatient care;
- Inpatient and rehabilitative care, which includes care in more intensive settings such as inpatient, partial hospitalization, day hospital, and milieu therapy; and
- Care coordination and transition, which involves coordinating care from multiple sources as well as facilitating the transfer of patients from one care provider to another and from one care system to another.

DoD places the priorities for TBI and PH initiatives into five major categories or essential components of care:

1. Access to Care.

2. Quality of Care.
3. Resilience Promotion.
4. Surveillance and Screening.
5. Transition and Coordination of Care.

Access to Care

Strategic objective: To ensure Service members, Veterans, and family members have timely access to comprehensive health care.

The primary goal of the access-to-care initiative is to provide staffing in health care areas, to include outreach and prevention services, traditional mental health care, behavioral health in primary care, and inpatient care. The staffing model includes embedded providers and directors of PH, although their functions relate to the resilience initiatives.

A joint team of subject matter experts created a staffing model based on available literature, applicable models, and specific DoD Task Force on Mental Health recommendations. DoD used that staffing model as an instrument to measure the Services' requests for additional staff members. The Services submitted their requests based on their perceived needs. The staffing model generated upper limits for funding those requests. The most important aspect of the increased staffing was that the Services met all the requirements of the different venues of service. The staffing model information promotes consistently available staff to meet our access standards across the MHS. The model is currently being validated through a contract with the Center for Naval Analyses. The Services applied the staffing model concepts and conducted a gap analysis of their staffing needs based on existing resources. They submitted their requirements for additional civil service, U.S. Public Health Service (PHS) officers, and contract staff; and the necessary funds to support the additional personnel have been included in the TBI/PH funding profile.

The staffing requirements for TBI have been determined based on best practices and involve standard capabilities packages of multidisciplinary teams because risk-based modeling is not available. This represents a transformational approach to staff requirements across the entire continuum of care from identification to recovery. DoD developed a generalized model and used it to inform and resource all the Services on recommended staffing levels. Feedback from users of the model will lead to refinements of the model. The model accounts for inpatient teams, outpatient teams, surge teams, and evaluation and initial treatment teams. Teams of trained personnel are necessary to meet a surge capacity for Service members deploying in units from locations without a continuous requirement. There are demonstration projects to fill gaps in transition from inpatient to outpatient care. A description of our goals; treatment and intervention

approach; prevention aspects; measures in screening, detection, and diagnosis; acquisition strategy, and performance measures, as they relate to access to care, follow.

A. Goals for access to care:

- Increase access to state-of-the-art care through increased staffing for TBI and PH. The increases in staffing will be based on the Services gap analysis and are validated by the jointly developed population-based, risk-adjusted staffing model for PH.
- Enhance availability to the full continuum of interventions for PH problems and TBI.
  - Create infrastructure for a world-wide tele-health system, which can provide consultation to military providers in remote locations and offer outreach to isolated Reserve and Guard members.
  - Enhance the ability of the TRICARE Management Activity (TMA) to support the Services in providing timely care to all eligible beneficiaries.
- Increase availability of behavioral health care in primary care settings, including women's health clinics.
- Fund the Directors of PH system, which will oversee and coordinate the PH of military communities and the delivery of prevention and outreach services.
- Increase prevention and delivery of PH services through the Directors of PH system and through embedding PH officers and enlisted personnel into deployable units.
- Improve coordination and control of new and existing programs through the Military Departments, National Guard Bureau, and Office of the Secretary of Defense headquarters-based program leadership teams.

B. Treatment and intervention approach:

- Increase staffing to help manage the increasing number of TBI patients.
  - Inpatient care, intensive outpatient, rehabilitative staff, surge teams, special populations.
  - Management offices to aid in the tracking of patients and the standardization of treatment of TBI patients.
- Determine the need for additional PH staff through a Service-based gap analysis, which will be compared to estimates from the jointly developed staffing model and matched to the increased requirements.
- Increase PH staff to cover specific, Service-identified needs, such as better addressing substance misuse.
- Invest in cutting-edge technology to increase access to subject matter experts using tele-health's expanding capabilities.

C. Prevention aspects:

- Directors of PH and Unit PH teams will offer prevention services and psychological resilience training to nonmedical deployable units.

D. Measures in screening, detection, and diagnosis:

- Enhance and promote early identification, referral, and education by placing behavioral health providers in nonmedical, deployable units and primary care settings; and.
- Enhance and promote early TBI identification, evaluation, treatment, documentation, and education by placing the right teams with the right provider mix at the right time and place.

E. Acquisition strategy:

- Provide funding for civilian and contract providers'; staffing model used to validate the Services' requests for increased staffing;.
- Encourage Services to program starting in 2010 for increased providers in the base program; and.
- Fund 200 PHS officers to work in DoD medical treatment facilities (MTFs).

F. Performance measures:

- Percent success in acquiring PH and TBI health care personnel based on Service target acquisition plan;.
- Percent met access-to-care standards of seven days or less to first appointment, including network providers for PH;.
- Percent of installations with primary care clinic settings that include behavioral health support personnel; and
- Percent of installations with suicides.

Quality of Care

Strategic Objective: Evidence-based, evidence-informed clinical practice guidelines, clinical guidance, or best practices are developed and used by trained providers to assure consistently excellent quality care across the MHS.

Quality initiatives include training of behavioral health and primary care staff, including providers involved with TBI identification and treatment. They also include developing and disseminating clinical practice guidelines, updating clinical practices and management practices, and providing clinical tools needed for state-of-the-art care. A

description of our goals; treatment and intervention approach; prevention aspects; measures in screening, detection, and diagnosis; and performance measures, as they relate to quality of care, follows in paragraphs A through E.

A. Goals for quality of care:

- Ensure that Service members and their families receive world-class care for their mental health conditions and TBIs.
  - Compassionate, evidence-based treatments should be comparably available wherever the Service member enters the medical system.
  - Identify, disseminate, and use existing best practices or help develop such practices if they do not exist.
  - Identify and test promising new treatment approaches.
- Provide training in latest treatment approaches for mental health, primary care, and network providers.
- Develop and train neuro-cognitive rehabilitation teams for the management of TBI.
- Offer comprehensive recovery-oriented treatment for TBI.

B. Treatment and intervention approach:

- Train mental health and primary care providers in the identification and management of mental health conditions and concerns and TBI in accordance with established clinical practice guidelines.
- Provide training in evidence-based treatment of post-traumatic stress disorder (PTSD) for mental health and network providers.
- Train mental health and primary care providers in the management of combat and operational stress-related health concerns (shared goal with Resilience initiative).
- Fund demonstration projects using virtual reality as a treatment modality for PTSD.
- Develop and disseminate clinical guidance for TBI.
- Obtain equipment for the identification, management, and rehabilitation of TBI.

C. Prevention aspects:

- Develop and use screening tools for the early identification of cognitive deficits and combat-related mental health conditions (shared goal with Surveillance Programs).

D. Measures in screening, detection, and diagnosis:

- Develop and disseminate tools for the early identification of cognitive deficits and combat-related mental health conditions.

E. Performance measures:

- Percent mental health and primary care providers trained in setting specific procedures for identification and management of behavioral health and TBI conditions and concerns.
- Percent mental health and primary care providers trained in PTSD and TBI clinical practice guidelines and available evidence-based treatment protocols.
- Percent implementation of TMA network provider training for combat-related mental health and TBI clinical guidance.

Resilience, Leadership, and Advocacy

Strategic Objective: To strengthen PH of our total force and reduce stigma associated with care through systems-based, community-based, and organizationally based prevention and proactive outreach, education, and training approaches.

Primary initiatives include training of leaders in prevention and recognition of distress, training of self-aid and buddy care in the area of PH and TBI, increasing social support systems for families, robust education and outreach efforts, compassion fatigue training for health care and community support personnel, and system-based or organization-based intervention to reduce the risk factors associated with distress. This objective includes enhancement of the Directors of PH system of advocacy and intervention.

Many initiatives in this objective area are associated with demonstration projects with one Service taking the lead in each project, and sharing lessons learned for dissemination across the system. Continued funding will be contingent on success during the test period. A description of our goals; treatment and intervention approach; prevention aspects; measures in screening, detection, and diagnosis, and performance measures, as they relate to resilience, leadership, and advocacy, follows in paragraphs A through E.

A. Goals for resiliency, leadership, and advocacy:

- Optimize and amplify the ability of the individual, family, community, and unit/organization to mature, thrive, and be productive despite adversity, trauma, and stress.
- Create and foster the use of protective factors such as leadership, self-care, self-awareness, social support, training to promote competence.

- Using individually targeted approaches, which are consistent with the Military Departments' and Services' culture and organization to strengthen the PH of individual Service members and their families while simultaneously, strengthening bonds within their units and communities; creating a health engendering organizational culture and climate.
- Support the soldier by direct interventions and by supporting their leadership, family, and community.

B. Treatment and intervention approach:

- Develop and assess brief interventions to combat misuse of alcohol among military members.
- Create and disseminate intervention to combat "compassion fatigue" among medical providers.
- Evaluate and enhance the functioning of couples following deployments via family reintegration workshops.
- Develop and disseminate programs designed to train all PH professionals in principles of combat and operational stress control and psychological first aid in an effort to promote resilience among deployers.

C. Prevention aspects:

- Develop and assess programs to increase family and community resilience through individual and community-wide programs.
- Create programs to support children of deployed Service members.
- Work with interested parties to develop media friendly education tools for the families of deployed members (e.g., Sesame Street: Talk, Listen and Connect).
- Develop and use standardized training materials for resilience promotion.
- Embed Directors of PH in organizations and PH officers and enlisted personnel in deployable units to consult with leaders in promoting organizational health and in taking care of their people.
- Train leaders at all levels in tools needed for both organizational health and individual resilience along with abilities to recognize and manage personnel in distress.
- Disseminate prevention education for TBI such as importance of cycle helmets, seatbelts, and tips for fall prevention.
- Explore further design innovations in combat helmets to improve prevention of combat TBI and concussion

D. Measures in screening, detection, and diagnosis.

- Conduct and report to commanders accurate, timely assessments of the PH of their command.
- Directors of PH conduct unit needs assessments.

E. Performance measures:

- Percent of leadership training courses that include resilience promotion, combat and operational stress awareness, or related training; completion of core curriculum for PH in leadership training courses.
- Percent of installation-level Directors of PH hired, trained, and in place.
- Percent completion of development and DoD-wide use of standardized PH Needs Assessment (initial metric is completion of measurement developed; once developed measure metrics rolled up from base to Service to DoD).

Surveillance and Screening Systems

Strategic objective: To promote use of consistent and effective assessment practices along with accelerated development of electronic tracking, monitoring, and management of TBI and PH conditions and concerns.

Screening and surveillance are ongoing initiatives that are being rolled out in an iterative fashion and need to be incorporated into the life cycle of the Service member, as well as the deployment cycle. Funding will be required over time to shape and further develop a robust system that allows tracking and monitoring of both TBI and mental health conditions and treatment outcomes; as well as to provide all levels of leadership physical and psychological near real-time information to enable key decisions regarding the health status of individuals and units under their cognizance. A description of our goals; treatment and intervention approach; prevention aspects; measures in screening, detection, and diagnosis, and performance measures, as they relate to surveillance and screening systems, follows in paragraphs A through E.

A. Goals for surveillance and screening systems:

- Develop valid, efficient, and easy-to-use surveillance systems to monitor the PH of our military members.
- Expand rugged, Joint Service tools to assess and more comprehensively track the prevalence and management of TBI and mental health conditions and concerns.
- DoD and VA have developed a joint proposal to standardize the ICD coding for TBI and concussion that will enhance the accuracy and consistency of TBI surveillance
- Create the capability to disseminate this data widely within DoD and VA treatment facilities to promote continuity of care.

- Analyze the data and look for interventions, which will minimize PH issues among at-risk populations.
- Test the validity and usefulness of the collection of baseline neuro-cognitive functioning for comparison after a potential TBI-related event.

B. Treatment and Intervention Approach:

- Test available and developing tools and develop military norms for the assessment of neuro-cognitive function in theater and in garrison.

C. Prevention Aspects:

- Conduct a demonstration program to perform baseline neuro-cognitive screening with new recruits to determine utility in future prevention efforts.

D. Measures in Screening, Detection, and Diagnosis:

- A Soldier Wellness Assessment Pilot Program, which expands psychological assessment with the Periodic Health Assessment (PHA).
- Develop and test joint systems to assess neuro-cognitive functioning of military members post-injury.
- Create a standardized DoD suicide event reporting mechanism.
- Increase use of a standardized substance use assessment tool.
- Expand and upgrade the standardized registry for TBI, which will monitor the care and progress of affected patients.

E. Performance Measures:

- Screening
  - Percent implementation of PHA across all Services to promote annual assessment of mental health conditions and concerns.
  - Percent of Service members screened using neuro-cognitive assessment in accordance with pre-deployment demonstration project proposals.
- Surveillance
  - Standardized DoD suicide event reporting system fully deployed and used across all DoD installations (percentage of installations with suicides feeding into reporting system).
  - TBI registry system expansion (percentage of installations reporting into registry according to established criteria).
  - Inclusion of medical data associated with mental health visits functional in both directions between DoD and VA (Bi-directional Health Information

Exchange).

Transition of Care

Strategic objective: To improve quality through transition and coordination of care for TBI and PH across the DoD, VA, and civilian network and between Active Duty and Reserve status, including rapid and effective information sharing to support continuity of care and support. A description of our goals; treatment and intervention approach; prevention aspects, and performance measures, as they relate to transition of care, follows in paragraphs A through D.

A. Goals for transition of care for TBI and PH:

- Improve quality of comprehensive treatment through seamless transitions of care and medical information among DoD, VA, and TRICARE partners.
- Reach out to offer PH services to those, who because of distance or stigma, are hesitant to come to MTFs.
- Create vigorous program management that monitors groups of patients in addition to assertive care management, which follows them individually.

B. Treatment and intervention approach:

- Leverage the potential of tele-health for outreach and care management for the total force, including the Reserve Component (RC).
- Fund a Wounded Warrior Outreach Center that will provide 24/7 referral services and care management for wounded Service membersmarines.
- Develop systems of regional care coordination. Initiatives have been launched by VA with a federal care coordinator system focusing on polytrauma patients and the DoD regional care coordinator system focusing on needs of TBI patients.

C. Prevention aspects:

- Minimize the potential and severity of relapse by close-care management and outreach services.

D. Performance measures:

- TBI/PH patient satisfaction as they transition between DoD, VA, and TRICARE health systems.
- Percent of TBI/PH patients transferred between MTFs who receive provider-to-provider transfer briefing.
- Percent of TBI/PH patients transferred between MHS and VA or VA to MHS who receive provider-to-provider transfer briefing.

Funding Strategy

The May 2007 Emergency Supplemental Appropriation legislation included $600 million (M) in funding to support DoD programs directed at preventing, diagnosing, treating, and providing support to Service members, and their families, suffering from TBI and deployment-related mental health conditions. In allocating these funds for TBI or PH initiatives, DoD adopted the three-phased funding strategy described below.

The Services requested funds to support DoD's TBI/PH guiding principles within their current and future programs. In accordance with the recommendations of the various high-level advisory groups, the proposals were evaluated and prioritized by a joint planning group of senior subject matter experts to ensure the provision of a consistent, excellent system of care across the MHS. DoD allocated resources to the Services to support programs, policies, and initiatives that improved the system of care and the support of Service members and their families. Some programs are being managed centrally because it is more resource-efficient to do so or more effective in supporting enterprise-wide requirements (Joint/Cross Cutting). The priorities for initiatives were categorized into six major categories or essential components of care. The funds from the Emergency Supplemental Appropriation establish the baseline for Fiscal Year (FY) 2009 and will be used to build the Program Objective Memorandum for FY 2010-2015.

Funding Summary by Initiative, as of 18 Jan 08						
		Army	AF	Navy	Joint	Total
PH	Access to Care	$64,948,000	$18,569,000	$40,881,000	$28,000,000	$152,398,000
	Quality	$2,439,396	$3,900,000	$13,355,000	$4,000,000	$23,694,396
	Resilience	$20,136,000	$10,600,000	$25,427,000	$11,500,132	$67,663,132
	Surveillance	$6,300,000	$3,900,000	$2,500,000	$22,970,000	$35,670,000
	Transition	$1,000,000	$0	$11,020,000	$50,000	$12,070,000
	Central Mgt					
	Total PH	$94,823,396	$36,969,000	$93,183,000	$89,880,132	$314,855,528
		Army	AF	Navy	Joint	Total
TBI	Access to Care	$95,768,000	$1,000,000	$8,903,309	$28,000,000	$133,671,309
	Quality	$20,598,113	$1,715,000	$3,532,000	$0	$25,845,113
	Surveillance	$46,500,000	$0	$0	$10,000,000	$56,500,000
	Transition	$1,000,000	$3,000,000	$5,233,010	$0	$9,233,010
	Central Mgt				$23,360,000	$23,360,000
	Total TBI	$165,246,113	$5,715,000	$17,668,319	$61,360,000	$249,989,432
TBI & PH Summary Totals		$260,069,509	$42,684,000	$110,851,319	$151,240,132	$564,844,960

In addition to the $565M displayed above, $35M is not being allocated at this time to allow flexibility in responding to emerging or urgent developments.

Separate from the $600M detailed in the previous paragraphs is $300M devoted to research on TBI and PH that the Congressionally Directed Medical Research Program of the U.S. Army Medical Research and Materiel Command (MRMC) will award and manage. Although specific projects and awards are unknown at this time, MRMC has worked with joint service, interagency, and expert groups to determine research priorities. MRMC released a broad area announcement to request proposals, and formed expert panels to conduct peer review of proposals for funding recommendations. It is anticipated that $150M of the research funding will be devoted to TBI and the other $150M devoted to PH research. The selection process will be completed in the spring of 2008. Obligation of the $900M should occur before the end of FY 2008.

	TBI FY07-08 Research Investments
Initiative	Functional Category
TBI	TBI Research
	Concept: Neuroprotection and repair strategy research, rehabilitation/reintegration strategies, field epidemiology with emphasis on mild TBI, physics of blast as it related to brain injury.
	New investigator: Clinical management of TBI, treatment, neuroprotection and repair, rehabilitation/reintegration strategies, field epidemiology with emphasis on mild TBI, and physics of blast as it related to brain injury.
	Investigator Initiated Research: Basic and clinical research that results in substantial improvement over current approach to clinical management of TBI; facilitate development of novel preventive measures, enhance quality of life of persons with TBI.
	Advanced Technology-Therapeutic Development: Access therapeutics and devices for the treatment, prevention, detection, and diagnosis of TBI.
	Multidisciplinary Research Consortium (Extramural): Address a single, critical question relevant to the prevention, detection, diagnosis, and/or treatment of TBI through synergistic multidisciplinary research program.
TBI to be funded at $150M	

	PH FY07-08 Research Investments
Initiative	Functional Category
PH	PH Research
	Concept: Proposals must include preliminary data relevant to PTSD research; multidiscipline teams. Collaboration among academia, HBC, and minority institutions, industry, military, DVA and other federal agencies are encouraged. Research gaps: treatment/intervention.
	New investigator: Research gaps; treatment and intervention; prevention; measures in screening; detection and diagnosis; epidemiological studies; families/caregivers; neurobiology/genetics.
	Investigator Initiated Research: Research that will result in substantial improvements in treatment and clinical management; facilitate the development of novel preventive measures; enhance quality of life of persons with PTSD.
	Advanced Technology-Therapeutic Development: Accelerate the introduction of improved therapies for PTSD into the clinical setting by supporting 1) the generation of preclinical data and/or 2) the generation of safety and/or efficacy data on therapeutic interventions.
	Multidisciplinary Research Consortium (Extramural): Proposal must address a single critical question relevant to the prevention, detection, diagnosis, and/or treatment of PTSD through synergistic, multidisciplinary research programs.
PH to be funded at $150M	

Accomplishments to Date

Access to Care

- Published PH seven-day access policy for DoD and VA.
- Developed a preliminary population-based and risk-adjusted mental health staffing model.
  - Funded a study to validate and expand the model.
- Expanded staffing for both PH and TBI.
- Drafted Memorandum of Agreement with the PHS, pending Service coordination and signing, to put PHS mental health providers in MTFs.
- Conducted a recruiting and retention conference.
- Piloted standard capabilities package for TBI identification, screening, and treatment teams.

Quality of Care

- Conducted a TBI training conference for 800 primary care providers.

- Established PTSD evidence-based care training for mental health providers.
- Published and disseminated TBI definition and clinical management guidance based on multiple cross-functional, interagency, academic, and interdisciplinary summits.
- Conducted a DoD-VA strategic workshop to address ways to improve care for women's PH.

Resilience

- Performed an analysis of resilience models.
- Drafted policy distribution for coordination to establish the Directors of PH system across DoD, including the RC.
- Conducted conference on embedding PH officers in deploying units.
- Expansion of Sesame Street Deployment Education program.

Screening & Surveillance

- Added V codes for TBI to AHLTA. V codes allow for the description of health care encounters associated with routine examinations or administrative processes in the international classification of diseases-9-clinical modification coding system.
- Joint proposal developed by VA and DoD to modify ICD codes to provide improved consistency and accuracy in TBI surveillance
- Included PTSD questions in Millennium Cohort Study.
- Published alternative versions of the Military Acute Concussion Evaluation tool.
- Added questions to the Post-Deployment Health Assessment (see Appendix A), and Post-Deployment Health Reassessment (see Appendix B) questionnaires.
- Initiated 15-year longitudinal study on long-term effects of TBI.

Transition & Coordination

- Established the DCoE for PH and TBI.
- Developed system of regional care coordination for TBI with coordinators positioned in 14 regions throughout the country
- Developed requirements for Behavioral Health module for inclusion in AHLTA.
- Implemented Bi-directional Health Information Exchange information sharing.

Joint and Cross Cutting

- Established the DCoE for PH and TBI.
- Under the Deputy Assistant Secretary of Defense (Force Health Protection and Readiness), established the joint, multidisciplinary work group that developed the comprehensive approach to TBI and PH outlined in this report.

Appendix A -- starts page 20

Appendix B -- starts page 27