DoD/VA WOUNDED, ILL, AND INJURED
SENIOR OVERSIGHT COMMITTEE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301

OCT 31 2008

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

Dear Mr. Chairman:

Enclosed is the report detailing a comprehensive plan for the DoD to prevent, diagnose, mitigate, treat, research, and otherwise respond to traumatic brain injury, post-traumatic stress disorder, and other mental health conditions in members of the Armed Forces as directed by the National Defense Authorization Act (NDAA) for 2008 Section 1618.

A copy of this report and similar letter are being sent to the Ranking Member of the House Committee on Appropriations, as well as the Chairman and Ranking Member of the Senate Committee on Appropriations.

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Wounded, Ill and Injured
Overarching Integrated Product Team

Michael L. Dominguez
Co-Chair, DoD
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Enclosure:
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The Honorable Robert C. Byrd
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

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The Honorable Jerry Lewis
Ranking Member
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Lewis:

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OCT 31 2008

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

Dear Mr. Chairman:

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

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The Honorable Duncan Hunter
Ranking Member
Committee on Armed Services
U. S. House of Representatives
Washington, DC 20515

Dear Congressman Hunter:

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OCT 31 2008

The Honorable Daniel K. Akaka
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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OCT 31 2008

The Honorable Thad Cochran
Ranking Member
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Senator Cochran:

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OCT 31 2008

The Honorable Richard M. Burr
Ranking Member
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Senator Burr:

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OCT 31 2008

The Honorable Bob Filner
Chairman
Committee on Veterans' Affairs
U. S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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OCT 31 2008

The Honorable Steve Buyer
Ranking Republican Member
Committee on Veterans' Affairs
U. S. House of Representatives
Washington, DC 20515

Dear Congressman Buyer:

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OCT 31 2008

The Honorable John McCain
Ranking Member
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Senator McCain:

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Report to Congress

in Response to the National Defense Authorization

Act for Fiscal Year 2008, Section 1618

Comprehensive Plan on Prevention, Diagnosis, Mitigation, Treatment, and Rehabilitation of, and Research on, Traumatic Brain Injury, Post-Traumatic Stress Disorder, and other Mental Health Conditions in Members of the Armed Forces

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1. Introduction

The Department of Defense (DoD) is committed to transforming and expanding the provision of services across the continuum of psychological health (PH) care, including post-traumatic stress disorder (PTSD), and to providing excellence in protection, prevention, diagnosis, treatment, recovery and care transition for our military members who sustain traumatic brain injury (TBI).

To accomplish and maintain this strategy, the Military Health System (MHS) has developed a program that simultaneously addresses prevention, diagnosis, mitigation, and treatment of psychological disorders and TBI, while identifying gaps and sponsoring research on advanced treatments for TBI and PTSD. In accomplishing these objectives, the DoD is working hand-in-hand with its federal partners in the Department of Veterans Affairs (VA).

To initiate such a change required a strategic vision for the future, as well as a clearly defined mission to ensure that the system would meet the acute and chronic needs of the military community during a time of prolonged conflict, as well as during peacetime.

1.1. Vision

To provide a comprehensive, effective, and Service member-focused program for protecting, preventing, identifying, diagnosing, treating and rehabilitating members of our Armed Forces and veterans with PH and TBI conditions, supported with current and ongoing research efforts aimed at innovative, quality, safe, and evidence-based solutions.

1.2. Mission

To create and sustain a PH/TBI continuum of care of the highest quality.

1.3. Psychological Health and Traumatic Brain Injury Program Summary

To fulfill the comprehensive vision and mission, and with the generous infusion of $900 million in supplemental funding, DoD has funded a broad, comprehensive PH/TBI program for the prevention, diagnosis, mitigation, treatment, and rehabilitation of, and research on, TBI, PTSD, and other psychological disorders. Five guiding principles and seven strategic goals form the framework of the program.

1.4. Guiding Principles

1.4.1. Furnish strong, visible leadership and the resources necessary to provide for Service members who are diagnosed with psychological disorders or who have suffered TBI;

1.4.2. Establish, disseminate, and maintain excellent standards of care across DoD;

1.4.3. Conduct or support pilot or demonstration projects to better inform quality standards, especially when best practices or evidence-based recommendations are not readily available;

1.4.4. Monitor and revise the access, quality, and fidelity of program implementation to ensure standards and quality are executed; and

1.4.5. Construct a system in which each individual can expect and receive the same level and quality of service regardless of Service, Component, status, or geographic location.

1.5. Strategic Goals

1.5.1. Foster Leadership and Advocacy: Build a strong culture of leadership and advocacy.

1.5.2. Expand Access to Care: Ensure Service members, veterans, and family members have timely access to comprehensive healthcare by providing staffing in healthcare areas to include outreach, education, and prevention services, traditional psychological healthcare treatment, behavioral health in primary care, and inpatient care.

1.5.3. Improve Quality of Care: To provide Service members and their families with world-class treatment for TBI and mental health conditions, including PTSD, depression, and substance abuse through recommended and standardized evidence-based practices, comprehensive training of clinicians on the recommended clinical practice guidelines, and provision of the clinical tools, resources, and guidance necessary for state-of-the-art care.

1.5.4. Build Resilience: Build strong minds for Service members, and fortify the awareness and mental strength of the Service member by optimizing and amplifying the ability of the individual, family, community, leader, and unit/organization to mature, thrive, and be productive despite adversity, injury, trauma, and stress.

1.5.5. Improve Surveillance and Screening: Promote the use of consistent and effective assessment practices along with accelerated development of electronic tracking, monitoring, and management of psychological disorders and TBI conditions and concerns.

1.5.6. Support Transition and Coordination of Care: Improve the quality and effectiveness of treatment through transition, coordination, and management of care across the DoD, VA, and civilian support networks as patients transition between providers and duty status.

1.5.7. Conduct Research: Establish a strong foundation of medical and cross-functional research, continuously improving program vision and capabilities.

DoD is committed to transforming the provision of services across the continuum of psychological healthcare, as well as to support and provide quality care to individuals who experience PH issues and TBI. As a result, these guiding principles and strategic goals provide a framework for the PH/TBI program to implement and bolster capabilities and support the Service member through each phase in the continuum of care within MHS.

2. Comprehensive Plan and Program

2.1. Evolution of MHS Strategy and Programs in PH and TBI

Before the Global War on Terror (GWOT), MHS was better structured to support a force designed to respond to threats from sovereign states, along with the associated staffing plans and clinical procedures to diagnose and treat casualty patterns from identified and expected tactics, techniques, and procedures. Included in this was, in comparison to today, a more minimalist approach to mental health conditions and TBI. The pre-GWOT mental health focus was on diagnosis, treatment, and rehabilitation of individual Service members in the clinical setting. When expanded to a broader behavioral health focus, program initiatives incorporated the treatment for the individual in a clinical setting to address the individual's interaction with family and the individual's immediate environment. In the current GWOT environment, programs have expanded to address the entire spectrum of psychological health across the full continuum of care including mental and behavioral health initiatives and a broad holistic approach to treat the individual, address issues and influences in the individual's immediate environment, and build in mechanisms to change the community or systemic framework.

Likewise, the pre-GWOT MHS had robust mechanisms to diagnose and treat moderate and severe TBI. Unfortunately, our involvement in the current conflict has revealed significant gaps in our ability to identify, track, and treat Service members with mild TBI.

In the pre-GWOT setting, the MHS strategy was to execute policies and procedures supporting PH and TBI in a decentralized fashion across the Services. Additionally, MHS and VA maintained clearly delineated management of transition from Active Duty to veteran status for medical treatment benefits, and the patient was typically responsible for his or her transition of care across institutional lines. Given the smaller number of individuals with PH and TBI conditions in comparison to present figures, this was an adequate method for structuring these programs. By contrast, current conditions have caused the line between MHS-provided care to blur with VA-provided care and created a need to make the transitions as transparent to the patient as possible.

2.2. Catalyst for Change in MHS Strategy and Programs in PH and TBI

Survival rates for battlefield injuries in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are higher than in any armed conflict in which the United States has fought. As the campaigns have transitioned, especially in Iraq, the shifting tactics of insurgents have introduced a change in casualty patterns, revealing imperative need for focus on PH, including PTSD, and TBI conditions in Service members returning from deployment. Explosions of improvised explosive devices (IEDs) can cause severe injuries, yet Service member survival has increased over previous wars for various reasons, to include improved personal protective equipment and evacuation methods; more efficient and theater-wide trauma systems; more immediate neurosurgical capability; and advances in medical technology. With increased survival rates of these quick-onset violent attacks, known associated conditions such as PTSD, depression, and TBI are seen in greater numbers. Because of this catalyst for change, MHS is implementing a comprehensive plan and program to address the full continuum of care for PH and TBI.

2.3. Program Start and Current State: Building the Foundation

In 2007, various bodies including Presidential committees and interagency boards of knowledgeable professionals examined MHS programs and initiatives in PH and TBI. In addition to the resulting recommendations, Congress appropriated $900 million (M) for the PH/TBI program, including $600M for program initiatives and management, and $300M for innovative and progressive research, with which DoD is enhancing capabilities along the full continuum of care. This includes addressing the needs of the Service member and includes: increasing resiliency, informing and supporting unit and community structure, screening and detecting conditions, enrolling into treatment programs, and rehabilitating and reintegrating to the fullest extent possible. Figure 1 illustrates the PH/TBI program continuum of care and the strategic goal framework that promotes growth and reinforcement of those capabilities.

Figure 1. Continuum of Care

	Prevention	Diagnosis	Mitigation	Treatment	Rehabilitation	Reintegration / DES
Strategic Goal	Resilience Surveillance	Access Quality	Resilience Surveillance	Access Quality	Access Quality	Transition
	Transition and Coordination of Care					
	Leadership & Advocacy					
	Research					

Using its established foundation of mental health and behavioral health programs, MHS is expanding and strengthening its capabilities along the continuum of care. Funding from the Fiscal Year (FY) 2007 supplemental appropriation has facilitated and accelerated support of over 100 initiatives identified by the Services to enhance and build program capabilities aligned to each strategic goal. These initiatives include pilot programs under consideration for future expansion. Section 3, "Comprehensive Plan and Program Capabilities by Strategic Goal," provides detailed information on the objectives of strategic goals, current and planned capabilities, and resource requirements.

Many of the program initiatives focus on a single section of the continuum of care, while others address the broader continuum. Underlying and crossing the entire continuum of care are three lanes: Research; Leadership and Advocacy; and Transition and Coordination of Care. DoD is funding a research strategy aligned with program implementation to develop long-term research supporting continual evidence-based practices, innovative protections, and emergent treatment protocols. Leadership and advocacy creates a culture of awareness and education, for both the individual Service member and the immediate familial and broader community environments. Additionally, sufficient staffing and processes provide smooth transition for Service members as they progress through the continuum of care. To specifically address access to care, DoD developed an integrated population-based, risk-adjusted staffing model across the Services to support expanded services. This staffing model is informally implemented while an independent verification and evaluation is performed. Once the staffing model is validated and approved, DoD will adjust staffing accordingly through formal implementation.

2.4. Way Forward: Growth and Expansion on New Foundation

Midterm plans for the PH/TBI program involve building upon the foundation and expanding services, capabilities, and initiatives across the enterprise. This growth will continue with the same centralized management and strategy set in the initial phase. As the expanded services are implemented and evaluated, the growth phase will include increased inter-Service coordination on the provision of services and sharing of lessons learned. The Department of Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) will have a key role in facilitating this coordination in order to promulgate best practices and promote evidence based practices and effective services across the continuum. DoD will evaluate the pilot programs for efficacy and expansion across the Services and Purchased Care System. Additionally, during this phase a center for excellence will be constructed and equipped to provide a specialized care center for psychological disorders and TBI.

2.5. End-State Vision

As this new expansion of services, capabilities, and initiatives in the PH/TBI program progresses, the healthcare lifecycle of research, pilot programs, and implementation of the successful programs using the evidence-based practices will continue to stabilize and mature. DoD's end-state vision encompasses evidence based expanded services, capabilities, and initiatives across the continuum of care for PH/TBI. With a centralized management and strategy capability driving the healthcare lifecycle for PH/TBI, DoD will have long-term program implementation directly aligned with the most recent research outcomes. Supporting this, DoD will establish a method for continual evaluation and adjustment of the staffing model to maintain access to care and necessary surge capacity.

3. Comprehensive Plan and Program Capabilities by Strategic Goal

Further elaborating on the current state of the program and planned future activities, the following sections provide detailed information on the program capabilities. A section is devoted to each strategic goal section with associated objective, assessment of current capabilities and plans in support of the overall program, gaps in capabilities, and resources required for FY2009-FY2013.

3.1. Leadership and Advocacy

3.1.1. Objective

To forge the way ahead, a priority of the PH/TBI program is to strengthen and maintain a culture of leadership and advocacy, creating a welcome environment for Service members and veterans in need of clinical care for TBI, PTSD, or other psychological concerns. Taking care of people is a leadership responsibility, and the PH/TBI program encompasses this responsibility at every level of leadership—from senior levels to the unit level in military organizations and to the family units in our military community.

3.1.2. Assessment of current capabilities and plans in support of overall program

The Senior Oversight Committee (SOC) drives this priority. The committee, co-chaired by the Deputy Secretary of Defense and the Deputy Secretary of VA, includes senior leadership from each of the Military Departments. This committee plans and monitors the work of improving care and support for our wounded, ill, and injured Service members and families. The SOC established a line of action specifically to develop and monitor the plan for TBI/PH.

The line of action is co-led by the Deputy Assistant Secretary of Defense for Health Affairs, Force Health Protection and Readiness, and a senior

representative from the Department of Veterans Affairs. The DoD lead was tasked todevelop the DoD portion of the plan to include establishing common standards and desired outcomes; overseeing execution of programs; seeking achievement of predetermined outcomes; and identifying and managing gaps and redundancies within and among the Services.

Primary initiatives currently underway include the training of leaders in prevention and recognition of distress, training of self-aid and "buddy" care in the areas of psychological disorders and TBI, increasing social support systems for families, robust education and outreach efforts, and compassion fatigue training for healthcare providers.

In an effort to ensure transparency and coordination among Services, many initiatives under the leadership and advocacy umbrella are associated with demonstration projects with one Service taking the lead on a project to fulfill gaps in capabilities and sharing lessons learned across the system.

As part of the comprehensive PH/TBI program, DoD is coordinating with VA and taking care to focus on the broad military population, including the Reserve Component and including gender- and ethnic-specific considerations in protocols, policies, and rehabilitation. For example, DoD and VA convened a Women's Psychological Health meeting in October 2007, and are planning a scientific conference in October 2008 concentrating on gender issues. This second conference, in collaboration with the VA, the National Institutes of Health (NIH), and other Federal partners, will address a broader audience of civilian, public, and private entities to present and discuss gender-specific issues related to psychological disorders, including PTSD and TBI.

In response to the Mental Health Task Force recommendations, DoD is in the final stages of staffing a Directive Type Memorandum policy to establish a Director of Psychological Health program. This policy memorandum will establish an infrastructure of PH advisors aligned with senior leader and command structures throughout the Office of the Secretary of Defense and the Services (including the Reserve Components). The purpose of this structure will be to promote good psychological health in multiple dimensions by:

- promoting and empowering leadership, culture, and advocacy for psychological health;
- building psychological fitness and resilience, while dispelling negative views towards education in and seeking treatment for psychological disorders and TBI;
- ensuring appropriate timely access to mental healthcare as clinically indicated;

- providing consistently high quality mental healthcare;
- engaging in PH screening, surveillance, research and program evaluations of PH program initiatives; and
- ensuring coordinated continuous healthcare during transitions of patients with mental health disorders from DoD to civilian care, and from civilian care back to DoD.

Leadership and advocacy requires effective financial planning and execution. In FY 2007, Congress appropriated $900M to make improvements to the PH and TBI systems of care and research. DoD leveraged these funds to support, expand, improve, and transform our system. DoD distributed the funds based on an overall strategic plan created by representatives from DoD and the VA. Services and other DoD organizations submitted proposals that outlined specific projects in support of the PH/TBI strategic plan. DoD funded the projects based on their relevance, organizational impact, and alignment with strategic guiding principles.

Spend plans generally call for a measured distribution of expenditures in accordance with specific program requirements. DoD did not expect that all funds will be expended at the beginning of each year, but rather that the execution of funds would flow throughout the year, in accordance with projected expenditures based on program objectives and activities. To track the planned expenditure rate, the PH/TBI program implemented a spend plan monitoring program that seeks to examine the planned rate of expenditure against the actual rate to determine how efficiently the funds are executed.

To foster a culture of leadership and advocacy, DoD created DCoE, appointed the DCoE Director in September 2007, and initiated operations in November 2007. DCoE leads efforts to develop excellence in practice standards, training, outreach initiatives, research, and direct care for our military community. DCoE also provides a nexus for organizational, clinical, and research innovation in this important area of force health protection.

The DCoE staff incorporates a balanced mix of uniformed and civilian professionals charged with building, orchestrating, and administering a national network of research, training and clinical expertise. In addition, DCoE coordinates existing expertise from the Center for Deployment Psychology; the Deployment Health Clinical Center; the Center for the Study of Traumatic Stress, and the Defense and Veterans Brain Injury Center (DVBIC).

The DCoE's expertise provides a foundation for a culture of leadership and advocacy through establishing and instilling high-level, quality military healthcare for PH/TBI patients.

Functionally, DCoE focuses on the following areas:

- Mounting a resilience campaign projected through a national collaborative network that includes partnering with the Uniformed Services University of the Health Sciences, National Institutes of Health, VA, the Department of Labor, the Department of Agriculture, the Department of Justice, the Social Security Administration, the Substance Abuse and Mental Health Services Agency, our coalition partners, as well as others in the public and private sectors.
- Establishing effective outreach and educational initiatives to include creating an information clearinghouse, a public website, a wide-reaching newsletter, and a 24/7 outreach center that will allow any Service member or family member who needs assistance in navigating the system of care to get information with a single phone call (to include what health care options are available to them). The outreach center also will serve clinicians across DoD with questions concerning clinical practices, training, or standards of care in the area of PH and TBI.
- Promulgating a telehealth network and technology operations for clinical care, consultation, monitoring, support and follow-up, particularly those in remote locations.
- Coordinating an overarching program of research that is relevant to the needs of the field, in coordination with other DoD organizations, VA, NIH, and other partners.
- Providing expertise for the development of clinical guidelines in coordination with the VA and providing consultation, guidance, and resources to standardize the provision and management of care for TBI and mental health conditions
- Developing training programs and educational tools aimed at providers, line leaders, families, and community leaders.
- Designing, planning, and overseeing the National Intrepid Center of Excellence (NICoE), a building funded by the Intrepid Fallen Heroes Fund and built on the Bethesda campus adjacent to the new Walter Reed National Military Medical Center (anticipated completion in fall 2009). The NICoE will be a state-of-the-art facility that provides intensive outpatient evaluation, advanced diagnostics, initial treatment plans, treatment modalities, and long-term follow-up for patients suffering from TBI and PH issues. Using innovative evidence-based practice, technology, and research tools, the Center will facilitate maximum recovery for Service members and families and their return to function in their home communities.

3.1.3. Gaps in current capabilities

- DCoE will not be fully operational as a coordinating headquarters until December 2008;
- The original 2007 Supplemental Appropriation language ("treatment of PTSD") constrained DoD in its ability to execute funding in support of the broader psychological health initiatives;
- Funding stream in the Supplemental appropriation versus the annual appropriation makes it difficult to stabilize newly established initiatives;
- Education and outreach programs have begun, yet effectiveness of those programs has not yet been evaluated (ensure those who receive the information find it informative and actionable).

3.1.4. Estimated Resources required for 2009 - 2013: The budget for FY 2010 and the Program for FY 2011 - 2013 are still under development and are not ready for release at this time.

Condition	FY 2009
PH	$51,301
TBI	$51,441

As of 9/8/2008

Figures in thousands

3.2. Access to Care

3.2.1. Objective

The primary objective of the access to care initiative is to ensure Service members, and family members have timely access to comprehensive PH/TBI-related healthcare. This involves improved staffing and innovative delivery strategies including outreach and prevention services, specialty mental healthcare, specialized TBI care, primary care based mental health services, improved primary care capability for TBI, and improved inpatient care.

3.2.2. Assessment of current capabilities and plans in support of overall program

Our ability to deliver the highest quality care depends, in part, on easy and timely access. Access, in turn, depends on the adequacy of staff, both military and civilian, to meet the demand in accordance with acceptable standards for appointment wait times. Access also depends on services in a location or manner in which the Service member or family member can interface with the provider or system without undue hardship or long travel times and distances.

To ensure ready access to mental health and TBI care in our medical treatment facilities (MTFs), DoD is increasing the number of staff, both military and civilian, using a number of different approaches. In October 2007, a new DoD policy reiterated that patients should be scheduled for initial mental health appointments within seven days of request. In addition to increasing access for initial mental health appointments, behavioral health functions are being incorporated into primary care settings with each Service funded to augment primary care clinics with behavioral health personnel. In this primary care setting, behavioral health providers can easily consult with primary care providers to help identify mental health conditions and make the appropriate referrals for treatment or manage the care at the earliest time possible. Enhancing the primary care setting with behavioral health capability also enables the provision of care for behavioral aspects of more traditionally physical health problems, such as pain and sleep problems that cause patients to seek care.

For TBI, DoD is assessing a standard capabilities model of multi-disciplinary staffing for TBI care and management for full use across all the military Services. This model provides the basis for a site certification pilot the Army is leading to ensure that Service members with TBI receive care only at those MTFs with an established capability to care for them.

Deployment-related healthcare has proven most effective when integrated with total healthcare. The Institute of Medicine advocated for this position, and it was codified in the DoD/VA Post-Deployment Health Evaluation and Management Clinical Practice Guideline mandated for implementation and practice across the DoD.

New telehealth technology is being exploited to bridge gaps in access. While DCoE will coordinate and integrate telehealth activities and capabilities across DoD, the Services have begun demonstration projects to assess how best to leverage telehealth technology to increase care for TBI patients in remote or underserved locations. DCoE/DVBIC stood up a virtual TBI clinic, and provides teleconsultations to in-theater providers for management of TBI.

Service members who return from deployments often get their information on the Internet. Afterdeployment.org has been launched for Service members and their families to access information about the possible mental and physical health effects of deploying to a warfighting theater. It can be accessed anonymously or provide additional information if you create a personalized account. The intent of the "dot org" address is that anyone can access the website regardless of where they are.

To address the mental health provider shortage, a population-based, risk-adjusted staffing model clearly identifies the correct number of mental health providers needed, and the Services are currently filling positions in alignment with this model. Upon validation of the model by the Center for Naval Analyses, DoD will approve and formally implement the staffing model across the Services, adjusting the number of providers according to final results of the validated model. Mental health providers are in short supply across the country, especially in some hard-to-serve areas, such as remote rural locations. To increase providers in these areas, the Department of Health and Human Services has partnered with DoD to provide uniformed Public Health Service mental health officers in MTFs. The Public Health Service has committed to provide 200 mental health providers of all disciplines in positions and locations of highest need as judged by the Services.

In terms of civilian and contract providers, the Services are planning to hire more than 750 mental health providers and 95 support personnel across DoD. The MTF commanders have direct hire authority to increase their staffs through local means to meet any unique demands in their communities. Within the past few months, the managed care support contractors have added more than 3,000 new mental health providers to the TRICARE network across the three regions. In addition, they have reached out to thousands of non-network providers to identify clinicians who would take on new patients if a network provider were unavailable within the established access-standard time.

3.2.3. Gaps in current capabilities

Fiscal law constrains DoD's ability to use appropriations seamlessly across the full continuum of care. Defense Health Program dollars cannot be used to support many pre-clinical activities (e.g., prevention of substance abuse), nor can they be used to support the Reserve Component (e.g., Directors of Psychological Health);

- Nationwide shortage of qualified individuals and low interest in many geographic duty locations hampers recruiting and retention of mental health providers;
- Limited access to mental health services in underserved areas (particularly rural areas);
- Inadequate access to child and adolescent health services;
- Lack of evidence and understanding of how mental health conditions develop co-morbidly with TBI. (DCoE/DVBIC is hosting with the Congressional Brain Injury Task Force an international conference to identify specific strategies to address this gap).

3.2.4. Estimated Resources required for 2009 - 2013: The budget for FY 2010 and the Program for FY 2011 - 2013 are still under development and are not ready for release at this time.

Condition	FY 2009
PH	$161,718
TBI	$85,625

As of 9/8/2008
Figures in thousands

3.3. Quality of Care

3.3.1. Objective

The primary objectives of the Quality of Care initiative are to ensure that Service members and their families receive the best possible care by ensuring training in and use of evidence-based clinical practice guidelines (CPGs) based on established standards, as well as ensuring availability of clinical tools, equipment, and guidance needed for state-of-the-art care.

3.3.2. Assessment of current capabilities and plans in support of overall program

DoD funded each Service to initiate quality of care functions including critical clinician training (both primary and specialty care) in recommended CPGs and evidence-based treatment, and formed a strong partnership with VA to develop and deliver this training. Additionally, each Service received funding to train primary care providers in recommended mental health CPGs. Over the coming months, DCoE will consolidate and standardize these training efforts into a comprehensive, long-range training plan.

DCoE/DVBIC also organized and facilitated a TBI training course attended by more than 800 providers, including VA providers. This training course will repeat in 2008 to expand the number of clinicians with a basic understanding of signs and symptoms of TBI, as well as evidence-based treatment for mild TBI. Teams composed of TBI specialists have traveled to more than 15 different bases providing training to providers at those MTFs.

Severe and moderate TBI are observed and diagnosed more easily and CPGs exist for them. On the other hand, mild TBI is a more common condition but is more difficult to identify and diagnose on the battlefield, just as it is in civilian scenarios. The index of suspicion must be high to ensure appropriate detection, evaluation, treatment, and protection for those who have sustained a concussion/mild TBI. DoD established a strategy to improve the

entire continuum of care for TBI, concentrating our efforts on mild TBI. A multi-Service panel developed and the United States Central Command adopted a CPG for management of mild TBI in theater. DoD published policy on the definition and reporting of TBI, which serves as a foundation for shaping a more mature TBI program across the continuum of care. Additionally, DoD funded the Army Quality Management Office (the DoD executive agent for CPGs) to create a formal evidence-based CPG for mild TBI. Guidelines generally require two years to develop; however, DoD expects these TBI CPGs this fiscal year.

Deployment-related healthcare has proven most effective when integrated with total healthcare. The Institute of Medicine advocated for this approach, and it has been codified in the DoD/VA Post-Deployment Health Evaluation and Management Clinical Practice Guideline mandated for implementation and practice across the DoD.

As part of the reporting process and the self-reporting assessments, DoD amended the post-deployment health assessment (PDHA), and the post-deployment health reassessment (PDHRA) processes to include questions related to blast injuries and TBI. Additionally, the VA screening and assessments of veterans provide another avenue for clinicians to record information on blast injuries and potential mild cases of TBI.

Having standard guidelines and a trained staff is only part of the quality equation. A similarly important factor is having the proper equipment for the provision of care. The Army and Marine Corps are the populations at highest risk for potential brain trauma. Therefore, DoD allocated funds to purchase or lease equipment to enhance screening, diagnosis, and recovery support for soldiers and marines. In addition, DoD is funding demonstration projects using virtual reality, and the required equipment, as a treatment modality for PTSD.

3.3.3. Gaps in current capabilities

Lack of full complement of evidence-based clinical practice guidelines for entire range of TBI care;

Lack of evidence indicating treatments for psychological disorders and TBI (other than for sexual assault) need to differ by gender (recently funded research has been asked to oversample for women [gender] to gather data to ensure informed programmatic decisions).

3.3.4. Estimated Resources required for 2009 - 2013: The budget for FY 2010 and the Program for FY 2011 - 2013 are still under development and are not ready for release at this time.

Condition	FY 2009
PH	$30,142
TBI	$16,332

As of 9/8/2008
Figures in thousands

3.4. Resilience Promotion

3.4.1. Objective

The goal is to build strong minds for Service members, fortify the awareness and mental strength of the daily framework within which the Service member operates, and optimize and amplify the ability of the individual, family, community, and unit/organization to mature, thrive, and be productive despite adversity, trauma, and stress. Resilience Promotion encompasses solid prevention and mitigation and is most pertinent to PH, although leaders can influence TBI resilience through enforcement and oversight of safety programs. As such, this strategic initiative focuses on the full continuum of PH to produce psychologically stronger individuals. This is done by using individually targeted approaches consistent with the Services' cultures and organizations to strengthen the psychological health of individual Service members and their families, while simultaneously strengthening individuals' bonds within their units and communities. Line leader ownership of PH and resilience-based programs is a critical requirement.

3.4.2. Assessment of current capabilities and plans in support of overall program

Pursuing this vision of building psychological resilience is equally important and analogous to building physical fitness. Before health concerns become apparent, the program strives to break down the barriers to seeking care at the earliest possible time and in the least restrictive forum, including non-medical settings, such as through chaplains and Military OneSource counselors.

An important part of reducing stigma is education of the individual, the family, units/organizations, and communities. DCoE is pursuing a standardized curriculum for PH/TBI education for leaders, Service members, and family members. In the interim, DoD funded each Service to implement

training across the leadership spectrum that adheres to our overarching principles yet is adapted to the culture of their particular Service.

Wounded Service members not only fight on the battlefield, but also they fight a battle to recover from injuries, both visible and invisible. For many Service members, the real battle begins when they return home and begin this recovery process. DCoE is planning to launch the "Real Warriors, Real Battles, Real Strength" campaign to highlight this concept. The intent of the campaign is to stress the importance of resilience, recovery, and reintegration for every Service member, and to raise awareness of the battle each wounded Service member fights when he or she returns home and begins the process of recovery and reintegration.

For families, the Services have implemented and expanded several education and outreach initiatives. A prime example is the Mental Health Self-Assessment Program. This program is a web-based tool that provides a low-risk mechanism for Service members and their families to determine if an individual should seek professional assistance and consultation. DoD is expanding this program to serve our school-aged family members. Another program available is "The Signs of Suicide Program," an evidence-based prevention and mental health education program in DoD Educational Activity schools. Expanding this program will add target populations of public middle and high schools in areas with high concentrations of deployed forces.

For younger children, the Sesame Street Workshop has proven to be quite successful in helping them understand and manage the emotions that go along with having a parent deployed. In fact, DoD has distributed this Emmy-nominated program to more than 400,000 families. Due to the high demand for the Sesame Street Workshop materials, DoD is supporting an expansion of this program to include sessions on the impact of having a deployed parent who returns home with an injury or illness.

In pursuing resilience, the healthcare and community support personnel who work tirelessly to support deployed forces and their families must not be forgotten. For this critically important group, compassion fatigue is an issue. Therefore, part of the DCoE mission is to develop a new curriculum of training or to validate existing training that will help to alleviate and mitigate compassion fatigue within the ranks of healthcare and community support members. Compassion fatigue among providers is tied to treating PH and TBI conditions, as the healthcare and community support personnel provide treatment and services to individuals suffering these medical conditions. As the access to care initiative grows and additional providers for PH and TBI become available, the existing personnel should serve a lower number of

distressed Service members and thus reduce the possibility of compassion fatigue. With the combination of compassion fatigue training for providers and an increased number of healthcare and community support personnel, it is expected that the potential for fatigue or burnout will decrease.

3.4.3. Gaps in current capabilities

Lack of a commonly understood definition of resilience;

Many current resilience initiatives are not founded on evidence-based practices. Ongoing research should provide evidence to support resilience program design, but current deficiency of such evidence will require additional research programs as the PH/TBI program progresses.

3.4.4. Estimated Resources required for 2009 - 2013: The budget for FY 2010 and the Program for FY 2011 - 2013 are still under development and are not ready for release at this time.

Condition	FY 2009
PH	$56,506
TBI	$500

As of 9/8/2008

Figures in thousands

Note: Resilience promotion is most pertinent to PH, encompassing solid prevention and mitigation, and augmenting the diagnosis, access, and treatment capabilities addressed by other strategic initiatives.

3.5. Surveillance and Screening Systems

3.5.1. Objective

The primary objective of the screening and surveillance initiative is to promote the use of consistent and effective assessment practices along with accelerated development of electronic tracking, monitoring, and management of PH and TBI conditions. DoD is incorporating screening and surveillance initiatives into the lifecycle health assessment process as screening tools are developed and validated.

3.5.2. Assessment of current capabilities and plans in support of overall program

DoD published a policy for surveillance purposes to collect information on all Service members diagnosed with TBI. There has been a robust workgroup with representation from all the Services to upgrade and further develop a comprehensive system for TBI surveillance. One component of this endeavor is establishing consistent International Classification of Diseases

(ICD) codes for TBI. A joint committee of VA and DoD representatives developed a proposal for TBI ICD codes to enhance consistency and provide more precise surveillance efforts.

To effectively and quickly diagnose and treat PH and TBI conditions, efficient and easy-to-use surveillance systems will capture and disseminate data across providers and facilities. In addition to aiding in treatment, these rugged tools will assess and track the prevalence and management of PH and TBI conditions and concerns.

As these data are collected, they will be analyzed for interventions that will help minimize PH and TBI issues among at-risk populations. The capability will be developed to disseminate this data widely within DoD and VA MTFs to promote continuity of care. Additionally, questions on the PDHA and the PDHRA facilitate screening for PH and TBI conditions. DoD resourced initial identification teams at high-density deployment locations to help ensure consistent screening and assist further evaluation and treatment for those who screen positive.

For the assessment and treatment of TBI-related events, comparison tests are underway that measure the validity and usefulness of the collection of baseline neurocognitive function, both pre- and post-event. Using these results, DoD will establish military norms for the assessment of neurocognitive function in the United States and while on deployment. Until the lifecycle health assessment process includes baseline neurocognitive assessments, DoD will collect pre-deployment baseline assessments.

DCoE will play a pivotal role in collecting and analyzing screening data and in making recommendations for future programs and tools. In addition, a critical element for TBI surveillance is a single repository for TBI case information across DoD. Additionally, DoD has established a standardized Suicide Event Reporting mechanism.

Funding will be required over time to implement a robust system that allows tracking and monitoring of both TBI and PH conditions and treatment outcomes. This includes training providers on the processes and tools used for tracking, as well as providing to leadership at all levels nearly real-time information in order to make key decisions regarding individual status and unit operations.

3.5.3. Gaps in Current Capabilities

- Lack of a comprehensive and well-integrated PH and TBI registry
- Lack of ICD9 codes specific to TBI (DoD and VA are collaborating to submit new codes for approval)

3.5.4. Estimated Resources required for 2009 - 2013: The budget for FY 2010 and the Program for FY 2011 - 2013 are still under development and are not ready for release at this time.

Condition	FY 2009
PH	$30,077
TBI	$54,231

As of 9/8/2008

Figures in thousands

3.6. Transition and Coordination of Care

3.6.1. Objective

The objective of this goal is to improve the quality and effectiveness of treatment through transition and coordination of care across DoD, VA, and civilian networks for all duty statuses (Active and Reserve). This includes ensuring rapid and effective information sharing to support continuity of care and support across all levels.

An effective Service member-, patient- and family-centered system should manage care and ensure a seamless transition between healthcare systems and phases of care. Transition and Coordination of Care programs help wounded Service members and their families make the transition among clinical and other support resources in a single location, across different medical systems, across geographic locations, and across functional support systems, which often can include non-medical systems. Such robust program management practices will ensure coordinated monitoring of not only patient groups, but also assertive care management that follows the individual.

3.6.2. Assessment of current capabilities and plans in support of overall program

Improved transition methods will better ensure provider-to-provider referrals when patients move from one location to another or from one healthcare system to another, such as between DoD and VA or to the TRICARE network. This is particularly relevant for our Reserve Component members upon demobilization.

DCoE has collaborated with the lead program office as assigned by the Under Secretary of Defense for Personnel and Readiness on the implementation of the "Yellow Ribbon Reintegration Program" to ensure maximum coordination of Psychological health considerations and support. Additionally, DCoE and VA are co-leading a priority-working group facilitated by the Substance Abuse and Mental Health Services Administration. The workgroup is chartered to link Federal, State and local partners in support of reintegration activities.

Care coordination particularly pertinent to those patients who have multiple health concerns treated by multiple medical disciplines and supported by other service providers. An important part of this coordination function includes accurate and timely information on benefits and resources available. The DCoE outreach and clearinghouse functions are assisting in this effort. In the meantime, DoD funded the Army and Marine Corps, who have the highest number of individuals affected by multiple injuries and illnesses, to establish enhanced care coordination functions.

Several key programs are supporting and improving transition activities by hiring care managers. The Marine Corps created a robust outreach center within its Wounded Warrior Regiment to proactively assist marines diagnosed with PH and TBI conditions to ensure they are successfully maneuvering the healthcare system until their full recovery or transition to the VA. The Navy is hiring PH coordinators to work with their returning reservists, and other Reserve Components are looking closely at these programs to obtain lessons learned as they set up their own programs to better support their members.

DCoE is coordinating with VA as they have recently established the Federal Care Coordinator program focusing on needs of polytrauma patients. To complement this, DCoE/DVBIC recently stood up a TBI care coordination system specializing in TBI needs. There are 14 care coordinators throughout the country working to integrate Federal, State, and local resources for Service members as they transition as well as to provide follow up contact on all identified TBI patients.

Information sharing is a critical part of care coordination. The information management offices of both DoD and VA are working to ensure that information passes smoothly and quickly to facilitate effective transition and coordination of care. DCoE also will implement telehealth and technology systems to assist in documentation and sharing information, as well as tracking and coordinating care for Service members and their families as they transition back to their hometowns.

3.6.3. Gaps in Current Capabilities

Fiscal law precludes Defense Health Program funding to support hiring Directors of Public Health at Reserve or Guard headquarters, thus constraining staffing of critical coordination positions.

3.6.4. Estimated Resources required for 2009 - 2013: The budget for FY 2010 and the Program for FY 2011 - 2013 are still under development and are not ready for release at this time.

Condition	FY 2009
PH	$43,418
TBI	$1,256

As of 9/8/2008

Figures in thousands

3.7. Research

3.7.1. Objective

The overall goal of the PH/TBI research program is to prevent, mitigate, and treat the effects of traumatic stress and TBI on function, wellness, and overall quality of life for Service members as well as their caregivers and families. DoD will fund scientifically meritorious research in accordance with directives received from Congress. Key priorities of the PH/TBI research program are to complement ongoing DoD efforts to ensure the health and readiness of our military forces, and to support DCoE in its efforts to advance and spread PH/TBI knowledge, enhance clinical and management approaches, and facilitate other vital services to best serve the needs of Service member families impacted by PH or TBI problems.

3.7.2. Assessment of current capabilities and plans in support of overall program

Public Law 110-28 appropriated $331,700,000 for research, development, testing, and evaluation (RDT&E) in May 2007 to remain available until September 30, 2008, and Conference Committee Report Number 109-676 provided another $1M FY07 PTSD RDT&E funding. DoD assigned the funds to the United States Army Medical Research and Materiel Command (USAMRMC) for management in accordance with Congressional intent. DoD directed that the program follow the well-established two-tiered review process used by the USAMRMC Congressionally Directed Medical Research Programs (CDMRP) Office. In June 2007, the USAMRMC assigned the $301M PTSD and TBI funds to the CDMRP for management. The

remaining $31.7M was assigned to the United States Army Institute of Surgical Research (USAISR), Fort Sam Houston, Texas, for investment in Burn, Orthopedic, and Trauma-focused research.

The PH/TBI research program Joint Program Integration Panel (JPIP), composed of leading experts from the military Services, the Office of the Assistant Secretary of Defense (Health Affairs), VA, and the Department of Health and Human Services, was responsible for developing the program's vision, investment strategy, and funding timeline. In analyzing the expected research and developing the investment strategy at a stakeholders meeting in June 2007, the approximately 200 stakeholders recommended the following research focus areas: six for PH/PTSD and five for TBI:

<u>PH, including PTSD*</u>

Treatment and Intervention	Epidemiology
Prevention	Families / Caregivers
Screening, Detection, and Diagnosis	Neurobiology / Genetics

<u>TBI*</u>

Treatment and Clinical Management	Field Epidemiology
Neuroprotection and Repair Strategies	Physics of Blast as it relates
Rehabilitation / Reintegration Strategies	to Brain Injury

*Includes pharmacological proposals received and awarded

JPIP completed scientific peer review and programmatic review of proposals solicited between July and November 2007, with 158 research projects approved for funding. Additionally, JPIP placed another 94 proposals on an Alternate List eligible for funding in priority order commensurate with cost savings and research outcomes from current research.

In addition to the CDMRP, there have been several efforts to stimulate TBI research by federal agencies, including a 15-year longitudinal TBI study, an evaluation of computer-based cognitive assessment instruments for TBI patients, and a joint laboratory focusing on mitigation strategies through the study of biophysics and materials.

<u>Burn, Orthopedic, and Trauma</u>

The USAMRMC assigned the $31.7M to USAISR in June 2007 for investment oversight, implemented for Burn, Orthopedic, and Trauma (BOT) research programs. Casualty patterns that cause burns, orthopedic, and trauma injuries often result in PH and TBI conditions in the Service member, so the

BOT research also directly supports the PH/TBI research program. The USAISR assigned funds to the following research focus areas:

- Orthopedic Trauma Research Program (OTRP): The purpose of OTRP is to complement, expand, and broaden the research in orthopedic trauma that is currently funded by DoD, NIH, and industry. Emphasis is on clinical and mature technologies and directed towards improvement of clinical outcomes in combat casualties. Currently 12 awards are complete or are in process.
- Burn Research: Awards will focus on burn research.
- Damage Control Resuscitation: The USAISR posted a Request for Information in December 2007 for a Massive Transfusion Prospective, Multicenter Trial Data Coordination Center. Inquiries were submitted and a Request for Proposals is pending and will encompass the following:
  - A data and coordination center will provide the necessary infrastructure to conduct a collaborative trial to identify the optimal blood component resuscitation ratios for patients receiving massive transfusion.
  - Up to 25 centers will participate in this study as part of the multi-center consortium to correlate transfusion practices and blood component ratios.
- Armed Forces Institute of Regenerative Medicine: There are two awards as of March 11, 2008, one to Wake Forest University and the second to Rutgers University. These awards will be augmented with funding from the Navy, NIH, and VA.

3.7.3. Gaps in Current Capabilities

- Research that can improve the evidence base behind clinical information systems and systems-level delivery strategies for care of PH/TBI conditions;
- An additional consortium to provide scientific peer review and joint research capability for the PH/TBI Research Program;
- Current TBI research funding applied to the neuroprotection and repair strategies is applied only to neuroprotection research proposals. Research programs are needed in regenerative medicine for the head/neck area; and
- Lack of data on gender- and ethnic-specific services and treatments.

3.7.4. Estimated Resources required for 2009 - 2013: The budget for FY 2010 and the Program for FY 2011 - 2013 are still under development and are not ready for release at this time.

Condition	FY 2009
PH / TBI	$147,837

As of 9/8/2008

Figures in thousands