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

HEALTH AFFAIRS

AUG - 4 2009

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

Dear Mr. Chairman:

The enclosed report responds to the request in Senate Report 110-037, accompanying the Emergency Supplemental Appropriations Act for Fiscal Year 2007, that the Assistant Secretary of Defense (Health Affairs) submit a report regarding the extent of treatment and outreach toward patients with traumatic brain injury (TBI).

Since June 2007, the Department of Defense through the efforts of a multi-Service working group, the Department of Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, and the Department of Veterans Affairs, developed a comprehensive approach for the prevention and treatment of TBI and psychological health problems.

The report that accompanies this letter answers specific questions posed in the Senate report. In addition, it provides data concerning TBI through 2008, as well as projections for initiatives in 2009.

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

Sincerely,

Ellen P. Embrey

Ellen P. Embrey
Performing the Duties of the
Assistant Secretary of Defense
(Health Affairs)

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

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

HEALTH AFFAIRS

AUG - 4 2009

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

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cc:
The Honorable Howard P. "Buck" McKeon
Ranking Member

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

HEALTH AFFAIRS

AUG - 4 2009

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

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The Honorable C. W. Bill Young
Ranking Member

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

AUG - 4 2009

HEALTH AFFAIRS

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

Dear Mr. Chairman:

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cc:
The Honorable Lindsey O. Graham
Ranking Member

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

HEALTH AFFAIRS

AUG - 4 2009

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

Dear Madam Chairwoman:

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cc:
The Honorable Joe Wilson
Ranking Member

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HEALTH AFFAIRS

AUG – 4 2009

The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

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The Honorable Thad Cochran
Ranking Member

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WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

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HEALTH AFFAIRS

AUG - 4 2009

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

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Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

RESPONDING TO SENATE REPORT 110-037

REPORT TO CONGRESS

August 2009

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Traumatic Brain Injury Report to Congress
Responding to Senate Report 110-037

Introduction

The Department of Defense (DoD) is committed to supporting and providing quality care to individuals who experience traumatic brain injury (TBI). Psychological health (PH) and TBI are linked because many who sustain TBI suffer psychological effects because of their injury. Additionally, family members of those who have sustained TBI may suffer stresses that negatively affect the quality of life of the entire family. Accordingly, in developing a comprehensive program to care for those who have been diagnosed with TBI, the DoD simultaneously addresses some PH concerns as well. DoD submitted a detailed description of its comprehensive plan for PH and TBI in a separate report to Congress, "Response to the National Defense Authorization Act for Fiscal Year 2007, House Report 109-452."

The answers to specific queries raised in Senate Report 110-037 related to TBI follow.

Extent of treatment of and outreach toward patients with TBI through military and Department of Veterans Affairs hospitals, outpatient clinics, and their families

The treatment of patients with severe TBI is quite robust, as is the outreach to their families. Compared to mild TBI, severe TBI is more readily diagnosed, and the treatment protocols are well established. Severe TBI patients evacuated from Iraq and Afghanistan are hospitalized at Walter Reed Army Medical Center or National Naval Medical Center. Military patients with severe TBI from injuries outside the U.S. Central Command (USCENTCOM) area of responsibility (AOR) also are cared for at other military tertiary care centers where experienced medical specialists with the appropriate diagnostic tools and equipment are available. These medical centers have fostered a close working relationship with the Department of Veterans Affairs (VA) Level 1 Polytrauma Centers in Richmond, Tampa, Minneapolis, and Palo Alto. The military processes for working with families are similar to those of any inpatient, except that a Service member with severe TBI may be transferred to a VA Level I Polytrauma Rehabilitation Center during the course of treatment in accordance with a VA/DoD Memorandum of Agreement that was updated on January 1, 2007. The Defense and Veterans Brain Injury Center (DVBIC), using video-teleconferencing technology to connect military treatment teams and family members with receiving VA treatment teams, has improved coordination of the transition between the military and VA health care systems.

DoD is addressing TBI outreach through several mechanisms; the most significant of which is the establishment of the Department of Defense Centers of Excellence for

Psychological Health and Traumatic Brain Injury (DCoE), which has patient and family outreach and education on TBI and PH as its core mission. In addition, the Army and Marines have established outreach and case management programs. The Army has a Wounded Warrior Program, Wounded Soldier and Family Hotline, and Community Based Health Care Organizations, as well as Warrior Transition Units. The Marine Corps has established the Wounded Warrior Regiment to incorporate outreach to Marines with TBI and their families. The Office of the Assistant Secretary of Defense (Health Affairs) (ASD (HA)) monitors these programs to assess their applicability to other Services. The Army and Marine Corps have a much higher incidence of war-related TBI than do the Navy or Air Force and, therefore, more urgent needs to implement such programs.

DoD's outreach includes extensive training initiatives for providers of TBI care. In 2008, DVBIC sponsored and served as a primary contributor to an evidence-based clinical practice guideline that the American Association of Neuroscience Nursing developed for the care of the severe TBI patients. Additionally, DVBIC held annual TBI training conferences in 2007 and 2008 in which each year more than 800 military and VA providers attended 2-day educational forums, devoted solely to the issues of TBI management.

The consistent identification of mild TBI is challenging but has been increasing since a case definition of TBI was published by the DoD and VA in 2007, provider training conducted, and assessment tools fielded. Detecting and reporting episodes of mild TBI has increased significantly, such that 90 percent of all TBI diagnosed and reported to DVBIC in 2007 were characterized as mild TBI. To assist deployed health care providers, management guidance for the care of mild TBI in operational settings was published in December 2006 and then revised with new field data in October 2008. The DoD mild TBI guidance for non-deployed settings was finalized in May 2008. In addition, DoD and VA are collaborating to publish evidenced-based clinical practice guidelines for the identification and treatment of mild TBI. The evidence and practices regarding mild TBI continue to evolve.

Diagnosis and screening processes for TBI

On October 1, 2007, ASD (HA) signed the memorandum, "Traumatic Brain Injury: Definition and Reporting," directing the Services to report all cases of TBI; including mild, moderate, and severe; on a monthly basis, to DVBIC. Included in the memorandum is a standardized definition for the Services to use in determining what constitutes TBI, as well as the severity of the TBI. DVBIC has subsequently become a component center of the DCoE and serves as its operational arm for TBI issues. The required monthly reporting includes demographic data, so that DVBIC may track and follow-up on those individuals with TBI. The reporting requirement provides ASD (HA) a mechanism to track and assess aggregate data on all forms of TBI, which will enable

meaningful epidemiologic assessments. By synthesizing data from each of Services, we can more accurately stratify TBI by severity and attempt to quantify the scope of the injuries on force health.

DoD added TBI assessment questions to the Post-Deployment Health Assessment (PDHA) and the Post-Deployment Health Reassessment (PDHRA) processes. The changes to the forms used in these assessments were implemented in May 2008, and VA uses the same questions. These questions are validated, with results published in the peer-reviewed medical literature (*Journal for Head Trauma Rehabilitation*, Volume 22, Number 6, page 377–389), 2007.

Furthermore, the evaluation of a potential mild TBI (also known as concussion) patient may be assisted by the use of automated, computer-based neurocognitive testing. While professional discussion regarding the validity and specificity of neurocognitive testing is dynamic, the consensus recommendation of multiple panels, review groups, and task forces is that DoD should implement neurocognitive testing. This is primarily because our deployed forces are at increased risk of sustaining a TBI and, although we must treat a TBI rapidly, the residual effects of a mild TBI or concussion are difficult to identify. Individual baseline data and post-traumatic event data should aid the health care system in evaluating those Service members who sustain injury that may result in a TBI, and will enable us to assess the efforts of multiple mild TBI events over time.

- Pre-Deployment Assessments: On May 28, 2008, ASD (HA) published interim guidance to the Services to administer automated baseline neurocognitive assessments for all Service members before deployment. As of March 31, 2009, almost 232,000 Service members underwent a baseline neurocognitive assessment.

- Post-Deployment Assessments: There are currently two protocols under review for pilot studies. One pertains to administering the automated neurocognitive assessment after deployment to determine the validity of the tool in the post-deployment period. The other pilot will administer the automated assessment in theater to assess its validity immediately following a concussion. If approved by an institutional review board, the final results of these studies can be expected in 18-24 months. DoD does not anticipate implementing population-based post-deployment assessments until these pilots are concluded.

- If supported by ongoing studies, automated neurocognitive assessments can fit into DoD's life-cycle assessment cycle model instead of being conducted during the pre- and post-deployment periods.

- Before the test validity is known, providers can use automated, computerized neurocognitive testing for individuals either at the time of injury or any point thereafter, as their clinical judgment indicates.

- The interim tool for the referenced studies is the Automated Neuropsychological Assessment Metrics (ANAM). However, DVBIC is comparing several automated assessment tools, so that the best one is selected if DoD decides to do population-based assessments.

Additionally, USCENTCOM has mandated the use of clinical guidelines, which include the Military Acute Concussion Evaluation (MACE) screening tool, at all levels of care in theater after a Service member has a possible TBI-inducing event. Landstuhl Regional Medical Center uses MACE to screen all patients evacuated from combat zones with a possibility of TBI.

Communication procedures and policies for family members of TBI patients

The communication procedures and policies for family members of TBI patients are similar to those procedures and policies used for families of Service members sustaining other diseases and injuries. These family member communication procedures include daily contacts with nursing, physician, and allied health specialists during Service member hospitalizations and include conversations with case managers and other health care professionals in outpatient settings. However, recognizing the burden of TBI on family members, the Army and Marine Corps have established the additional outreach and communication procedures in the case management programs previously described in this report.

In a similar effort, the VA hired Federal Recovery Coordinators to work in military treatment facilities (MTFs) and selected sites in the United States. The goal is to assist in the recovery, rehabilitation and reintegration into the community of severely injured Service members who are unlikely to return to Active Duty. These DoD recovery care coordinators are part of the Services' wounded warrior programs and assist the Service members and their families as they navigate the continuum of care. The recovery coordinators in both programs work with the multi-disciplinary teams in the MTFs to establish a recovery plan for the Service member and family and monitor that plan, updating it when the Service member transitions between phases.

In addition, DVBIC initiated a program of Regional Care Coordination, specifically dedicated to TBI patients and their families for at least 2 years after a TBI, with 16 people positioned around the world to link Service members sustaining TBI to local and State resources. Another function of DCoE and DVBIC will be to use telehealth capabilities to improve access to expert consultation and family member outreach. Finally, with support and expert advice of VA and the Defense Health Board,

DVBIC will develop TBI family-caregiver curricula that will teach and inform family members on TBI treatments, outcomes, expectations, support services, and advocacy.

The number of Service members suffering from TBI currently in the DoD health care system

DoD's most reliable data on the incidence of TBI resides at DVBIC; however, the DVBIC database has not provided a comprehensive picture of TBI incidence in the entire Military Health System (MHS). The DVBIC database has had comprehensive information for moderate, severe, and penetrating TBIs coming from the war zones in Iraq and Afghanistan, but mild TBI case collection has been primarily from the 10 MTFs within the DVBIC network. The new TBI surveillance policy which begun October 1, 2007 (summarized below), is facilitating accurate collection of mild TBI from across the entire DoD.

In Fiscal Year 2007, 2,352 injured in Iraq or Afghanistan were identified in the DVBIC TBI surveillance database. Of these Service members, 80 percent were from the Army, 14 percent from the Marines, 3 percent from the Navy, and 2 percent from the Air Force. The remaining 1 percent were civilians who were rendered care. Sixteen percent were members of the National Guard or Reserve. Of those in the TBI database, 90 percent were classified as mild TBI, 6 percent moderate TBI, 2 percent severe TBI, and 2 percent as penetrating TBI; 90 percent of the TBIs occurred in Iraq and 10 percent in Afghanistan. According to the DVBIC database, 10,251 Service members have incurred TBI while serving in Iraq or Afghanistan (through March 31, 2009). However, event location data is not available for all occurrences in the database, so this number may be understated.

The table on the following page displays the international classification of diseases clinical modification-based TBI encounters within the MHS among Service members, broken down by calendar year and deployment status at the time of the first TBI-related medical encounter. This table provides an estimate of the baseline prevalence of TBI among Service members (pre-deployment statistics), as well as provides insight to the incidence of deployment related TBI. The sub-analysis of the deployment related TBI further clarifies this data point as traumatic events related to distant deployments are less likely to be the cause of present TBI cases.

Most experts agree that until recently, mild TBI and its consequences have been underreported in all health systems of the United States. Within DoD, the reporting is improving and will continue to improve because of the October 1, 2007, ASD (HA) memorandum. This memorandum provided uniform DoD definitions of mild, moderate, and severe TBI. In addition, the memorandum added a DoD-wide surveillance function to DVBIC to expand their current surveillance efforts beyond the DVBIC network (16 sites) to include all of the MHS. We now have a very robust automated methodology for

identifying Service members who have a clinician confirmed TBI. Our number reporting has greatly been enhanced. A separate October 29, 2007, memorandum includes clinical management guidance for mild TBI for use in non-deployed medical activities. This guidance was updated and improved on May 30, 2008. DoD also placed appropriate screening questions concerning possible TBI on the PDHA and the PDHRA questionnaires. Finally, as noted earlier, USCENTCOM has mandated the use of clinical guidelines, including use of the MACE developed by DVBIC, at all levels of care after a Service member encounters an event that might cause TBI, and Landstuhl Regional Medical Center is using the MACE for all patients evacuated from the USCENTCOM AOR. The combination of these initiatives should contribute to identifying cases of TBI, and provide the basis for increasing scientific knowledge of, and improved prevention and treatments for TBI.

Incident* Traumatic Brain Injury Encounters Among Service members (all Components), by Calendar Year and Deployment Status^ at Time of First TBI-related Medical Encounter

Timing	2001	2002	2003	2004	2005	2006	2007	2008	Total
During/post-deployment	45	302	998	1,739	2,095	3,697	6,670	6,998	22,544
Pre-deployment	3,656	3,304	2,690	2,390	2,055	2,302	2,426	2,065	20,888
Total	3,701	3,606	3,688	4,129	4,150	5,999	9,096	9,063	43,432

Subanalysis of During and Post Deployment Cases

Incident* Traumatic Brain Injury Encounters Among Service members (all Components), by Calendar Year
Post-Deployment encounters stratified by whether first encounter was within the 365 days after deployment

Timing	2001	2002	2003	2004	2005	2006	2007	2008	Total
Not within 365 days post-deployment	0	17	134	302	597	786	1379	1962	5177
Within 365 days post-deployment	45	285	864	1437	1498	2911	5291	5036	17367
Total Post-deployment cases	45	302	998	1,739	2,095	3,697	6,670	6,998	22,544
Per-deployment/ Post-deployment %	**100%**	**94%**	**87%**	**83%**	**72%**	**79%**	**79%**	**72%**	**77%**

Methods

**Each Service member could only be labeled as a case once during the period; case was assigned to the year of first encounter*

TBI case definition: One or more hospitalizations - or - two or more ambulatory encounters (on different days) with an ICD-9 code of interest regardless of diagnostic position.

ICD9 codes of interest: 800-801, 803-804, 850-854, 310.2, 950.1-950.3, 959.01, V15.5

^ All deployments regardless of length were used to determine deployment status

Data source: Theater Medical Data Store (TMDS), Defense Medical Surveillance System (DMSS)

(TMDS data were available only since January 2005)

Prepared by Armed Forces Health Surveillance Center

The number of TBI patients discharged, separated, or retired

The following table displays the numbers of discharges, separations, and retirements of DoD Service members for whom the 'unfitting' condition was TBI.

Discharges, Separations, Retirements in DoD due to TBI*									
Department of the Navy (Navy & Marine Corps)									
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**Total**
CR**	13	19	13	30	22	52	49	205	403
NCR***	33	57	36	62	53	103	93	44	481
Total Department of the Navy									884
Department of the Air Force									
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**Total**
CR**	0	0	0	0	1	2	0	7	10
NCR***	16	40	35	11	29	18	14	31	194
Total Department of the Air Force									204
Department of the Army									
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**Total**
CR**	7	12	35	75	115	151	170	323	888
NCR***	28	38	66	88	120	96	87	76	599
Total Department of the Army									1487
Total Military Services									2575

**Denotes those Services members in which the 'unfitting' condition was TBI (VASRD codes 8045 & 9304)*
***CR - Combat Related*
****NCR – Non-Combat Related*

Funds budgeted and expended for these efforts

In the past, expenditures for TBI have covered nonspecific symptoms, many diverse clinical conditions, and multiple health-related disciplines in many patient care venues. As such, the ability to appropriately integrate and attribute such diverse expenditures as due to TBI is beyond the current capabilities of our information systems. Accordingly, with the exception of funding for DVBIC, DoD finds it difficult to provide an accurate accounting of past expenditures related specifically to TBI. The table below displays the funding profile for DVBIC over the past 7 years.

DVBIC Expenditures FY01-08 (in Millions)									
Fiscal Year (FY)	**FY01**	**FY02**	**FY03**	**FY04**	**FY05**	**FY06**	**FY07**	**FY08**	
Program Objective Memorandum (POM) Funds	$7.0	$7.0	$7.0	$7.0	$6.5	$7.0	$7.0	$5.0	
Added Congressional Funds	$0.0	$3.0	$3.0	$4.2	$6.0	$7.0	$14.8	$18.2	
Total	$7.0	$10.0	$10.0	$11.2	$13.0	$14.0	$21.8	$23.2	$110.2

In 1991, Congress established DVBIC by including the following language in the Defense appropriation, "This funding will be for [DoD to take the lead] in tracking and evaluating head injury survivors, ensuring that the survivor is getting appropriate treatment, studying the outcome of the treatment, and for counseling family members of the survivor." Partnering with VA and the Brain Injury Association, and working through the Army Medical Department and the Uniformed Services University of the Health Sciences, DVBIC developed a network of participating MTFs and pursued a tri-fold mission of managing clinical research, providing clinical care, and developing educational programs to assist health care providers, patients, and families. With the advent of the Overseas Contingency Operations and the increased incidence of TBI, DVBIC added surveillance and informing force management to its portfolio of responsibilities. More recently, DVBIC has become the primary operational TBI component of DCoE. Spanning the spectrum of PH and TBI, DCoE builds upon the foundational efforts of DVBIC and will coordinate an expanded range of outreach, research, surveillance, and education.

Public Law 110-28 contained $600 million in funding to support DoD programs directed at treatment of TBI and post-traumatic stress disorder (PTSD), and an additional $300 million in funding to support research to improve capabilities to prevent, diagnose, and treat TBI and PSTD. As previously noted, PH and TBI are often linked, because many who sustain TBI have psychological stresses pertaining to the event that caused it and the physical injuries resulting in the TBI. Due to this linkage, initiatives involving TBI often overlap with PH.

In allocating these funds for TBI and PH initiatives, DoD adopted a funding strategy for resources to support new or expanded programs, policies, and initiatives that will improve the Department's system of care and support to Service members and their families. The allocation plan was developed with subject matter expertise from the DoD and the Services, including the VA. In keeping with the comprehensive plan, the initiatives were grouped into six major categories or essential components of care:

1. Access to Care: To ensure Service members, veterans, and family members have timely access to comprehensive health care.

2. Quality of Care: Evidence-based, evidence-informed clinical practice guidelines, clinical guidance, or best practices are developed, trained and used to provide consistently excellent quality care across MHS.

3. Resilience Promotion: To strengthen psychological health 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.

4. Surveillance and Screening: 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.

5. Transition and Coordination of Care: To improve quality through transition and coordination of care across the DoD, VA, civilian network, and between Active and Reserve status, including rapid and effective information sharing to support continuity of care and support.

6. Joint/Cross Cutting: Programs managed centrally when determined to be more resource-efficient or more readily support requirements imposed on all Services.

Funds have been distributed to the Services for execution of the comprehensive plan for PH and TBI. Of the $600 million Operations and Management funds, $566 million or 94 percent has been distributed, including $316 million for PH and $250 million for TBI. The small amount remaining ($34 million) is reserved for expansion of promising or emerging demonstration programs and for additional costs that may become apparent as the plans are being executed. A breakout of the funding allocation is provided in the table below.

Funding Summary by Initiative, as of January 2008 (in Millions)						
		Army	AF	Navy	Joint	Total
PH	Access to Care	$64.948	$18.569	$40.881	$28.000	$152.398
	Quality	$3.384	$3.900	$13.355	$4.000	$24.639
	Resilience	$20.136	$10.600	$25.427	$11.500	$67.663
	Surveillance	$6.300	$3.900	$2.500	$22.970	$35.670
	Transition	$1.000	$0.000	$11.020	$0.050	$12.070
	Central Mgt	$0.300	$0.000	$0.000	$23.060	$23.360
	Total PH	$96.068	$36.969	$93.183	$89.580	**$315.800**
		Army	AF	Navy	Joint	Total
TBI	Access to Care	$95.768	$1.000	$8.903	$28.000	$133.671
	Quality	$20.598	$1.715	$3.532	$0.000	$25.845
	Resilience	$1.000	$0.000	$0.000	$0.000	$1.000
	Surveillance	$45.500	$1.000	$5.023	$10.000	$61.523
	Transition	$2.380	$2.000	$0.210	$0.000	$4.590
	Central Mgt	$0.000	$0.000	$0.000	$23.360	$23.360
	Total TBI	$165.246	$5.715	$17.668	$61.360	**$249.988**
	Total TBI/PH	$261.314	$42.684	$110.851	$150.939	**$565.788**

Separate from the $600 million just described, is the previously mentioned $300 million devoted to research on TBI and PH. The Congressionally Directed Medical Research Program (CDMRP) of the U.S. Army Medical Research and Materiel Command (MRMC) awards and manages these funds. MRMC releases broad area announcements to request proposals and forms expert panels to conduct peer review of proposals for funding recommendations. Approximately half of the research funding is devoted to TBI and the other half to PH research. The selection process was completed in the spring of 2008.

DoD's leadership of the comprehensive plan entails not only effective financial preparation but also careful oversight of spending execution. DoD does not expect all funds to be expended at the beginning of the year, but rather that the execution of funds to be in accordance with projected expenditures. Also, spending plans are not typically equally distributed across each month of the FY but are obligated based on the specific program requirements. DoD has established a monitoring program to examine the planned rate of expenditure against the actual rate to assess if funds are being executed according to plan and in a timely manner. The monitoring program includes a monthly report to ensure the rapid ability to intervene should problems arise.

FY09 TBI/PH Program

Dollars in Thousands

Type	Initiative	Army	Navy	Air Force	TMA	USUHS	DHP
	O&M	FY09 Planned	FY09 Planned	FY09 Planned	FY09 Planned	FY09 Planned	FY09 Planned
PH	Access to Care	$ 84,618	$ 37,641	$ 13,018	$ 10,000	$ -	$ 145,277
	Quality of Care	$ 2,536	$ 12,976	$ 2,079	$ -	$ -	$ 17,591
	Resilence Promotion	$ 17,660	$ 22,063	$ 650	$ -	$ -	$ 40,373
	Surveillance	$ 11,981	$ 5,850	$ 1,958	$ -	$ -	$ 19,789
	Transition	$ -	$ 7,844	$ -	$ -	$ -	$ 7,844
	Central Management	$ -	$ -	$ -	$ 171,934	$ 4,000	$ 175,934
	TOTAL PSYCHOLOGICAL HEALTH	$ 116,795	$ 86,374	$ 17,705	$ 181,934	$ 4,000	$ 406,808
TBI	Access to Care	$ 61,130	$ 10,269	$ -	$ -	$ -	$ 71,399
	Quality of Care	$ 12,585	$ 1,375	$ 914	$ -	$ -	$ 14,874
	Resilence Promotion	$ -	$ -	$ -	$ -	$ -	$ -
	Surveillance	$ 32,600	$ 4,199	$ 320	$ -	$ -	$ 37,119
	Transition	$ -	$ -	$ -	$ -	$ -	$ -
	Central Management	$ -	$ -	$ -	$ 44,800	$ -	$ 44,800
	TOTAL TRAUMATIC BRAIN INJURY	$ 106,315	$ 15,843	$ 1,234	$ 44,800	$ -	$ 168,192
PH/TBI	Total All Initiatives	$ 223,110	$ 102,217	$ 18,939	$ 226,734	$ 4,000	$ 575,000
	Unobligated	$ -					
	Total O&M Execution	$ 575,000	$ 575,000	100%			

Dollars in Thousands

1. $10M has been withdrawn from TMA to "undistributed. " Funds are programmed to the Army to conduct a suicide study with the National Institute of Mental Health. New DHP Program value is $575M.

2. $4M allocated to USUHS from TMA