



Rebuilding the Trust

Independent Review Group
Report on Rehabilitative Care and
Administrative Processes at
Walter Reed Army Medical Center and
National Naval Medical Center



April 2007

Independent Review Group
on Rehabilitative Care and Administrative Processes at Walter
Reed Army Medical Center and
National Naval Medical Center

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To: U.S. Secretary of Defense Robert Gates

We, the appointed members of the Independent Review Group to report on rehabilitative care and administrative processes at Walter Reed Army Medical Center and National Naval Medical Center, pursuant to our charter do hereby submit the results of our findings and offer our best recommendations.

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Sincerely,

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I. EXECUTIVE SUMMARY

Rebuilding the Trust

President Abraham Lincoln, in his Second Inaugural Address, challenged a healing nation, "...to care for him who shall have borne the battle, and for his widow, and his orphan, to do all which may achieve and cherish a just and lasting peace, among ourselves, and with all nations."¹ The Nation must demonstrate the same determination today by renewing our commitment to our servicemembers and their families. They deserve the highest quality of healthcare services available.

A grandmother of an injured Marine passionately stated, "Seems like I am living in a time warp. The military is fighting a war while the country is shopping at the malls. I want to see the whole country mobilized, take whatever we need from the civilian population to help our young men and women."²

Charter and Methodology

Following the disclosure of deficiencies in outpatient services at Walter Reed Army Medical Center, reported by the *Washington Post* in February 2007, Secretary of Defense Robert M. Gates commissioned an independent panel to review current rehabilitative care and administrative processes at both Walter Reed Army Medical Center in Washington, D.C. and National Naval Medical Center in Bethesda, Maryland.³

Secretary Gates selected nine panelists with backgrounds in politics, industry, military, and medicine, to serve on the Independent Review Group. The co-chairs for the Independent Review Group are: Togo D. West, Jr., former Secretary of Veterans Affairs and Secretary of the Army under President Clinton, and John O. Marsh, Jr., former member of Congress and Secretary of the Army under President Reagan. The other Independent Review Group members include: John J. H. Schwarz, M.D., former member of Congress from Michigan; Jim Bacchus, former member of Congress from Florida; Arnold Fisher, senior partner of Fisher Brothers and Honorary Chairman of the Intrepid Fallen Heroes Fund; retired General John Jumper, former Air Force Chief of Staff; retired Lieutenant General Charles "Chip" Roadman, former Air Force Surgeon General; retired Rear Admiral Kathleen Martin, former Navy Deputy Surgeon General; and retired

¹ Inaugural Addresses of the Presidents of the United States (1989). Abraham Lincoln Second Inaugural Address on Saturday, March 4, 1865. *Bartleby.com*. Retrieved April 5, 2007, from <http://bartleby.com/124/pres32.html>

² Testimony received by the Independent Review Group (March 2007).

³ Terms of Reference and Secretary of Defense's announcement (Appendix A and B).

Command Sergeant Major Lawrence Holland, former Senior Enlisted Advisor to the Assistant Secretary of Defense for Reserve Affairs.⁴

The Independent Review Group was granted unrestricted access to facilities and personnel at Walter Reed and National Naval Medical Center. While these two facilities were the focus of its review, the Group also visited other locations to determine if systemic problems exist. Special advisors were made available to the Group in subject matter areas relevant to patient treatment and administration. The Group was permitted 45 days to review the current situations and report their findings and recommendations which will be provided to the Secretary of the Army, the Secretary of the Navy, the Secretary of the Air Force, and the Assistant Secretary of Defense (Health Affairs).

Scope and Findings

This is the final report of the Independent Review Group. It is intended to communicate the impartial and unbiased review of the continuum of care, leadership, policy, and oversight issues. Additionally, this report offers detailed discussion of the Independent Review Group's findings and offers alternatives and recommendations, as appropriate, to correct deficiencies and prevent them from occurring in the future. Many of the Group's findings are not new. Numerous reports by agencies within both the executive and legislative branches of government have previously identified the problem areas.⁵ Regrettably, many of these problems still exist. The Group's goal in this report is to set forth "actionable" recommendations to the appropriate authorities to improve health care services for servicemembers and veterans.

Every agency of the government, including the Congress and the Executive branch, should bring to bear all the resources necessary to correct the conditions found.

During their efforts, the Group established numerous opportunities to capture comments from servicemembers, their families, personnel at both military treatment facilities, and from the general public. The information used to support this report was obtained through:

- Two public meetings⁶
- One-on-one interviews⁷
- Site visits⁸
- Website postings
- Toll-free telephone hotline comments⁹

⁴ Independent Review Group Member Biographies (Appendix C).

⁵ Reports Reviewed and Considered by the Independent Review Group (Appendix D).

⁶ Transcripts from the public meetings held at Walter Reed Army Medical Center on March 13, 2007 and National Naval Medical Center on March 14, 2007 are available through the Defense Health Board at <http://www.ha.osd.mil/dhb/>.

⁷ Individuals Interviewed by the Independent Review Group (Appendix E).

⁸ Sites Visited by the Independent Review Group (Appendix F).

- Service and command responses
- Commissioned reports of similar interest
- Media sources

After significant review and consideration, the Group identified shortcomings in two main areas at Walter Reed Army Medical Center:

1. Continuum of Care
2. Leadership, Policy, and Oversight.

Several sub-areas of interest were identified and include: Transition to Outpatient Care, Signature Injuries of the War, Physical Disability Evaluation System (PDES), Reserve Component Perception, Command and Control, Family Support, and Facilities.

The Independent Review Group found two principle themes throughout the continuum of care:

1. First class trauma care is provided from the time of injury, through the evacuation from the battlefield, to transport to a tertiary medical facility,¹⁰ and during inpatient hospitalization, and sets a recognized standard of excellence in trauma care.
2. Generally, the breakdown in health services and care management occurs once the servicemember transitions from inpatient to outpatient status.¹¹

During its review of the continuum of care, the Group discovered problems in the transition to outpatient status; sequential diagnosis and treatment of injuries; and navigating the physical disability evaluation system, to include:

- Comprehensive care, treatment, and administrative services are not provided in an interdisciplinary, collaborative manner.
- A clear standard is lacking for the qualifications and training of outpatient case managers.
- Early identification techniques, comprehensive clinical practice guidelines, research, and training are lacking for traumatic brain injury and post-traumatic stress disorder.
- Numbers of mental/behavioral health staff in military medical facilities are declining.

⁹ Independent Review Group Website and Toll- Free Telephone Hotline (Appendix: G).

¹⁰ Tertiary medical facility is a major hospital that usually has a full complement of services including pediatrics, general medicine, various branches of surgery and psychiatry. (Retrieved from *Wikipedia* 5 April 2007 at http://en.wikipedia.org/wiki/Tertiary_referral_hospital).

¹¹ An Inpatient is 'admitted' to the hospital and stays overnight or for an indeterminate time. An Outpatient comes to a hospital or doctor for diagnosis and/or therapy and then leaves again. (Retrieved from *Wikipedia* 8 April 2007 at http://en.wikipedia.org/wiki/Inpatient#Outpatient_vs_Inpatient).

- Adequate compensation is not provided to burn patients for loss of limb function.
- Technologically advanced follow-on care for amputees is not as accessible outside of the Department of Defense.
- The Physical Disability Evaluation System policy and guidance has significant variance and is extremely cumbersome within the military health system.
- An automated interface does not exist in the clinical and administrative systems within the Department of Defense and the Department of Veterans Affairs.
- Reserve Component servicemembers face unique challenges in the military healthcare system.

The Group also found administrative problems in the areas of leadership, policy, and oversight, to include:

- Base Realignment and Closure (BRAC), A-76, and funding constraints contributed to the issues at Walter Reed Army Medical Center.
- Leadership at Walter Reed should have been aware of poor living conditions and administrative hurdles and failed to place proper priority on solutions.
- A smooth integration is lacking for transition into a joint Walter Reed National Military Medical Center.
- Staffing shortages and inadequate training are impacting the delivery of care at Walter Reed and National Naval Medical Center, resulting in compassion fatigue among staff.

Finally, the Group found administrative problems in the areas of family support and facilities, to include:

- Benefit notification and assistance to family members is inconsistent across the Department of Defense.
- Housing for outpatients and family members is insufficient at Walter Reed Army Medical Center.
- The facilities and infrastructure have not been maintained to an acceptable standard at Walter Reed Army Medical Center.

Recommendations

Based on the aforementioned findings, the Independent Review Group offers the following recommendations to improve healthcare services for servicemembers and their families.

- Resources should be provided to staff and train case managers, as well as develop Tri-Service policy and regulatory guidelines for case management services.
- Every returning casualty should be assigned a single primary physician care manager and case manager as their basic unit of support.
- Clear standards, qualifications, and training requirements, to include proper initial and recurring training, should be defined and conducted for case management personnel.
- Functional/cognitive measurements and screening should be developed and implemented upon entry and post-deployment health assessment to include the implementation of training for interpreters of screening and cognitive remediation for servicemembers.
- Comprehensive and universal clinical practice and coding guidelines for blast injuries and traumatic brain injuries with post-traumatic stress disorder overlay, should be developed to include a policy requirement for recording ‘exposures to blasts’ in patient records.

- A center of excellence should be established for traumatic brain injury and post traumatic stress disorder treatment, research, and training.

- Creative recruiting and compensation plans, including a review of the Military Service Obligation, should be pursued to address healthcare professional staffing shortages.

- The Physical Disability Evaluation System should be updated to reflect the loss of function due to burn, similar to that of an amputee.
- The Physical Disability Evaluation System must be completely overhauled to include changes in the US Code, Department of Defense policies and Service regulations, resulting in one integrated solution.
- The availability of health care services to the Reserve Component should continue to improve.

- The Base Realignment and Closure construction projects should be accelerated in the National Capital Region and the transition into the Walter Reed National Military Medical Center (WRNMMC) and new Fort Belvoir medical complex while fully funding existing operations.

- The command and control structure for Walter Reed National Military Medical Center should be established now and immediately begin functional integration.
- Existing regulatory relief to A-76 should be applied to military medical treatment facilities during time of war.

- Leadership should survey patients and family members to assess services and conditions of facilities.
- Medical Hold and Medical Holdover Cadre personnel should be appropriately staffed and trained.
- The efficiency wedge should be reevaluated.
- Appropriate education should be provided to family members on their entitlements and a family advocate assigned.
- Where and when possible, patients should be relocated to receive continuing treatment closer to their homes.
- A senior facilities engineer should be assigned at Walter Reed Army Medical Center to assume responsibility of maintenance of non-medical facilities.
- Facilities assessment tools should be modernized, and facility and infrastructure maintenance, repair, and restoration prioritized and appropriately addressed.

II. INTRODUCTION

Media Reports

On February 18, 2007, the *Washington Post* reported, “Soldiers Face Neglect, Frustration at Army’s Top Medical Facility,” rendering an account of inadequacies and failures at the Army’s premier medical facility, the Walter Reed Army Medical Center.¹² The next day a second article reported, “The Hotel Aftermath: Inside Mologne House, the Survivors of War Wrestle with Military Bureaucracy and Personal Demons,” revealing the red tape and administrative confusion experienced by military members and their families trying to navigate the Department of Defense Physical Disability Evaluation System.¹³

What Now?

We, the members of the Independent Review Group, find ourselves at the nexus of a story replete with evidence of remarkable success, but laced with episodes of disappointing failures. By all accounts the evolution of rapid joint battlefield medical response, rapid evacuation with intensive care, quality air transportation, and unsurpassed trauma care have yielded unprecedented survival rates for our combat forces. Current battlefield survival rates of 87.6% compare with 75% during the Vietnam War.¹⁴

Less well understood by the medical community, and of major concern to the Independent Review Group, are Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). These examples of trauma are not always associated with visible wounds, but with equally debilitating impacts on mental processes and functions. While medical understanding of these conditions is evolving rapidly, the cutting-edge protocols for diagnosis, treatment, and rehabilitation of today’s returning warriors are not readily available, nor are the administrative tools to assign appropriate disability ratings for these conditions.

The failures observed by the Independent Review Group are, in most cases, the product of bureaucratic behavior, inability to reconcile institutional disparities and leaving the wounded warrior and family to untangle that which government agencies cannot.

¹² Priest, D., & Hull, A. (2007, February 18). Soldiers face neglect, frustration at army’s top medical facility. *Washington Post*, p. A01

¹³ Priest, D., & Hull, A. (2007, February 19). Inside the Mologne House, survivors of war wrestle with military bureaucracy and personal demons. *Washington Post*, p. A01

¹⁴ Battlefield Survivability Trends. Power Point Presentation Slide. Directorate for Information Operations and Reports (DIOR), 2007.

Significant effort has been expended to implement corrections following exposure in the media. Many of these actions use money and manpower from functional areas outside medical budgets and resources—certainly subject to be called back to their functional home eventually—and still require funding and training to be institutionalized. Our report will recommend solutions that require permanent institutional change.

The Changing Environment

Soldiers, Sailors, Airmen, Marines and Coast Guardsmen continue to adapt to a changing operational environment in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Rapid movement of the wounded and increased survival is the result of more efficient joint medical response on the battlefield and medical tactics, techniques and procedures that quickly deliver the most critical patients to our premier military medical facilities in Washington DC. In past conflicts, patients spent weeks or months in intermediate care facilities. Today, it is not unusual for a wounded patient to be in care at Walter Reed Army Medical Center or National Naval Medical Center within 36 hours of being wounded. This change has swollen the population of our major hospitals, especially Walter Reed, and significantly increased the demand in the areas of critical care, outpatient care, and rehabilitation.

The numbers are significant. As the Nation's major military medical center for the wounded, Walter Reed has provided care for over 6,000 casualties since September 11, 2001. On a typical day, the hospital cares for 184 inpatients, 62 with war-related illness and injuries, and conducts over 2,700 outpatient visits. There are over 640 servicemembers (Active, National Guard, and Reserve) who are assigned to the medical center as outpatients with 491 whose illnesses, injuries, and wounds are related to the war. Over 300 of these outpatient servicemembers have been in rehabilitative care for greater than 90 days, but less than a year. One hundred seventy three have been under care for greater than a year. Additionally, there are at least 242 family members supporting their loved ones at Walter Reed.¹⁵

At the National Naval Medical Center, over 1,600 casualties have been treated since September 11, 2001. On a typical day, there are 151 inpatients, 23 with war-related illness or injuries, over 2,100 outpatients, of which 95 are casualties, and two patients are considered to be in rehabilitation. Additionally, there are at least 32 family members supporting their loved ones National Naval Medical Center.¹⁶

¹⁵ Source: Army Medical Command response to an Independent Review Group inquiry (March 2007).

¹⁶ Source: Bureau of Medicine and Surgery response to an Independent Review Group inquiry (March 2007).

From the Battlefield through Recovery

From the time a service member is wounded on the battlefield there begins a complex process of actions, reactions, and transitions, starting and continuing through: the immediate medical response and evacuation; the transportation and gathering of the family; inpatient care; outpatient care; rehabilitation; Medical Evaluation Board; Physical Evaluation Board; return to duty or transition to additional evaluations; and into the care of the Department of Veterans Affairs. The entire process can take months or years and must accommodate recurring or delayed manifestations of symptoms, extended rehabilitation and all the life complications that emerge over time from such trauma. During the transition from inpatient to outpatient and into the evaluation board system, the processes reverse their approach to the patient from one of advocacy and caring concern, to that of bureaucratic adversary.

Many cases presented to the Group involved emotional testimony from families. Many of these families relocated to hotels in the vicinity of Walter Reed for extended periods of time to coordinate outpatient medical appointments and muster the resources to challenge board decisions. Some decisions had determined findings of ‘no disability,’ that loss of function was due to a “pre-existing condition,” or a disability rating below the percentage necessary to retain minimal benefits. Frustrations were compounded by outdated policy guidelines for many debilitating conditions such as traumatic brain injury.¹⁷ Once a servicemember transitioned to the care of the Department of Veterans Affairs, they were confronted with yet another set of evaluations, disability standards, and treatment protocols.

The Responsibility of Leadership

Many of the leadership failures have been addressed by the Secretary of Defense. Yet to be addressed, is the role of policy and oversight that control the budget and direct resources for military medicine. The Group discussed these issues with civilian and military leadership of the Services and in the Office of the Secretary of Defense.

Of greater concern, is the frustration expressed to the Group about policies to evaluate physical disabilities. A gap exists between the policies directed by the Department of Defense and implemented by the Services. This allows for wide interpretation and results in inconsistent application across the system, impacting directly on servicemembers, their families, and their entitlements.

Individual Service Secretaries of the Military Departments may, consistent with this Instruction, modify these guidelines to fit their particular needs.¹⁸

¹⁷ Department of Defense Instruction 1332.38, *Physical Disability Evaluation*, E4.1.2. November 14, 1996.

¹⁸ Department of Defense Instruction 1332.38, *Physical Disability Evaluation*, E4.1.2. November 14, 1996.

Written guidance to code and classify emerging disabilities, such as traumatic brain injury, is out of date. There is no mechanism to provide timely information on rapidly emerging findings about traumatic brain and blast related injury. Evaluation boards are left to deal with codes and classifications that do not reflect current medical knowledge. Established timelines for completion of board evaluation processes are not enforced or are unrealistic in light of the volume of patients and lack of board resources.

All of this adds to the perception that the individual servicemember is further traumatized by endless administrative loopholes and adversarial processes.

One traumatic brain injury victim reported, “Soldiers need a bureaucracy with a servant heart.”¹⁹

The Perfect Storm

The situation that overwhelmed Walter Reed Army Medical Center involved the simultaneous occurrence of several elements and is best described as the “Perfect Storm.”²⁰ These elements include: the decision of the Base Realignment and Closure (BRAC) Commission;²¹ pressure to outsource traditional military service functions through A-76;²² and military to civilian personnel conversions. The confluence of these separate factors, coupled with an increase in operational tempo due to the war, created the opportunity for a perfect storm and increased the probability for the failures and shortcomings at Walter Reed. Additionally, inadequate facilities; leadership inattention; failure to meet processing guidelines; conflicting interpretations of laws, rules and regulations (long conditioned by lack of bureaucratic energy to clarify and simplify); and conflicting budget pressures, created their own impact and collectively brewed to feed the storm. While some of these factors also impacted the National Naval Medical Center, the much larger population of patients and families at Walter Reed overwhelmed the leadership and physical capacity, and exacerbated bureaucratic congestion.

The Group’s mandate focused our energies on identifying problem areas and making recommendations to be delivered to the military services and the Department of Defense. Our findings revealed that responsibility did not always accompany accountability. Authority to correct the most difficult issues was beyond the local Commander and the Service Secretaries. These corrections require the attention of the Secretary of Defense and the United States Congress to establish the necessary policies and statutes to institutionalize solutions.

¹⁹ Testimony received by the Independent Review Group (March 2007).

²⁰ Testimony received by the Independent Review Group (March 2007).

²¹ Base Realignment and Closure is the congressionally authorized process Department of Defense has previously used to reorganize its base structure to more efficiently and effectively support forces.

²² The Office of Management and Budget A-76 circular provides for public/private competition for tasks that are not considered inherently governmental.

III. CONTINUUM OF CARE

Transition to Outpatient Care

On the battlefield, the Department of Defense is saving more lives than ever before. Through advances in battlefield medicine, evacuation care, the Department has achieved the lowest mortality rates of wounded in history.²³

The advances in Personal Protective Equipment (PPE),²⁴ in part, account for the initial survivability of our servicemembers. As a consequence of the speed, efficiency and effectiveness in the medical response, our sick and injured servicemembers survive this war at a higher rate than in previous conflicts.²⁵ Nevertheless, these advancements have resulted in increasing numbers of survivors with multiple trauma, visible, and non-visible injuries such as traumatic brain injury (TBI) and post traumatic stress disorder (PTSD). The numbers of servicemembers surviving with these complex injuries have challenged our modern military medical system and exposed weakness and breakdowns in access to care, as well as continuity of care management and follow-on administrative processes.

The *New York Times* recently recounted, an Army Staff Sergeant was released into outpatient care within a week of sustaining a traumatic brain injury and loss of an eye during a firefight in Iraq. Despite being extremely disoriented, he said he was given a map and told to find his own way to his new residence on the hospital's sprawling grounds. He wandered into a building and received directions. He then waited several weeks wondering whether anyone would contact him about additional treatment, eventually making phone calls himself, until he reached his case manager.²⁶

Finding:

Comprehensive care, treatment, and administrative services are not provided to the outpatient in an interdisciplinary collaborative manner at Walter Reed Army Medical Center.

Discussion:

A case manager is assigned to assist sick and injured servicemembers with management of their care through recovery.

²³ Testimony received by the Independent Review Group (March 2007).

²⁴ Personal Protective Equipment could include: helmet, body armor, boots, flack vests, etc.

²⁵ Battlefield Survivability Trends. Power Point Presentation Slide. Directorate for Information Operations and Reports (DIOR), 2007.

²⁶ Luo, M. (2007, March 6). Soldiers testify over poor care at Walter Reed. *New York Times*.

“The purpose of Case Management is to ensure appropriate access to quality care and to promote care that is safe, timely, and cost-effective by maximizing the use of available resources” and the case manager will “...work collaboratively with the patient, family or significant other and the interdisciplinary team in order to develop and implement a plan of care that meets the patient’s individual needs.”²⁷

The transfer of a patient’s care from one clinician, agency, organizational program, or clinical service to another requires a defined process. The accountability and responsibility for ensuring patient safety during transfer rests with the interdisciplinary team who both release and receive patients.²⁸ In addition to the care provider, the case manager plays a significant role in the patient’s continuum of care.

An Army Specialist stated that he did not have any one physician coordinating his care. During a six month period he stated that he had at least two case workers who were very supportive, but extremely overworked. Following his six month stay at Walter Reed, a physician decided that ‘optimum care’ had been achieved and that the Army could not offer any other treatment regimens. He stated that physicians offered conflicting advice on his treatment and did not coordinate with each other on his treatment plan.²⁹

Similar to this Soldier, other patients reported visiting numerous therapists, providers, and specialists, resulting in differing treatment plans as well as receiving prescriptions for multiple medications. The complexity of illness and injuries in some of these patients require a single physician care manager or trauma care manager who can work in conjunction with the case manager to keep the care of the Soldier focused and goal directed. This coordinated method of care management was not evident at Walter Reed Army Medical Center.

Case managers coordinate and work closely with patients and families directly affecting the quality of care provided. American Health Consultants provide the following guideline to assist healthcare leadership in determining appropriate ratios for case manager to patient:

²⁷ Department of Defense. (January 2006). *TRICARE management activity: The medical management guide*. Washington, D.C.: Defense Printing Service.

²⁸ An Interdisciplinary Team may consist of physicians, nurses, social workers, therapists, Department of Veterans Affairs health care liaisons, chaplains, and family members.

²⁹ Testimony received by the Independent Review Group (March 2007).

Suggested Caseload Template

Level	Amount	Type
Acute	8-10 Cases	Early injury /illness stages (case manager performs all coordination)
Mixed	25-35 Cases	Acute and chronic cases (some requiring semi-annual or annual follow-ups, some needing full-time CM coordination.)
Chronic	35-50 Cases	Cases requiring mostly 1-2 hours follow-up/month.

Source: American Health Consultants (2000).³⁰

Until recently, Walter Reed Army Medical Center could not provide adequate case management staff to provide service to the increasing number of servicemembers. During one of the Group's visits to Walter Reed, several patients commented that case loads overwhelmed their case managers. Walter Reed's ratio of case manager to patient in an outpatient, Medical Hold status was averaging 1:50.³¹ The ratio of case manager to patient in Medical Holdover status was averaging 1:20.^{32 33} The Medical Holdover ratio was notably within the recommended guidelines. The Medical Hold ratio, however, far exceeded the guidelines for the actual case mix. This lack of case managers contributed to the breakdown in care management.

The February 2007 *Washington Post* articles highlighted the need for an appropriate level of case management staff to provide services for Medical Hold patients at Walter Reed Army Medical Center. Army leadership responded to the observations by thoroughly reviewing the care management process and obtaining additional military nurses to support case management at Walter Reed. As a result of this response, the new case manager to Medical Hold patient ratio is now 1:17.³⁴

According to the Department of Defense TRICARE Management Activity Medical Management Guide, there is no single correct way to implement a case management program. This guide acknowledges programs will be different based on size of facility,

³⁰ Department of Defense. (January 2006). *TRICARE management activity: The medical management guide*. Washington, D.C.: Defense Printing Service.

³¹ Source: Army Medical Command response to an Independent Review Group inquiry (March 2007).

³² Source: Army Medical Command response to an Independent Review Group inquiry (March 2007).

³³ Medical Hold refers to Active Army or Reserve Component Soldiers assigned or attached to military hospitals who are unable to perform even in a limited duty capacity. Medical Holdover refers to a Reserve Component Soldier, pre-deployment or post-deployment, separated from his/her unit, in need of definitive health care based on medical conditions identified while in an active duty status. Source: Department of Army. (13 October 2006). Patient administration (Army Regulation 40-400). Washington, D.C.: Department of Army, 130.

³⁴ Source: Army Medical Command response to an Independent Review Group inquiry (March 2007).

number of personnel, existing case management staff, and types of targeted beneficiaries. Regardless of the program in place, the case manager role of collaborator is paramount. Walter Reed Army Medical Center recognized that one of the breakdowns in the care management of their patients may have been attributed to lack of central management of the case management staff. Consequently, the medical center has recently reorganized the case management staff and has implemented standardized performance objectives.³⁵ At National Naval Medical Center, patient comments did not convey the sense of overburdened case managers. The ratio of case manager to patient at National Naval Medical Center is 1:32. Recently, National Naval Medical Center authorized the hiring of six additional case managers to meet case management requirements for all patients, including those other than from Operations Iraqi Freedom and Enduring Freedom.³⁶

Recommendations:

1. The Assistant Secretary of Defense (Health Affairs), in conjunction with the Service Surgeons General, should provide the resources to staff and train case managers at all Military Treatment Facilities in accordance with the Department of Defense guidelines.
2. The Assistant Secretary of Defense (Health Affairs), in conjunction with the Service Surgeons General, should immediately develop or modify existing Tri-Service policy and regulatory guidelines for case management services in line with currently accepted medical practice, to ensure the efficient and effective transfer of the patient throughout the continuum of care. These guidelines should include the identification of outcome criteria and establish measurements to assess compliance.
3. The Commander of Walter Reed Army Medical Center must urgently ensure every returning casualty is assigned a single physician to holistically manage the healthcare and a case manager (to help navigate the system) as their basic unit of support.

Finding:

There is a lack of a clear standard for the qualifications and training of the outpatient case managers that is consistent across the Army, Navy, and Air Force.

Discussion:

According to the Department of Defense TRICARE Management Activity Medical Management Guide, case managers in the Military Health System will possess the requisite job qualifications, which include at least one of the following:

- A bachelors (or higher) degree in a health-related field and licensure as a health professional (where such license is available); or

³⁵ Testimony received by the Independent Review Group (March 2007).

³⁶ Source: Bureau Of Medicine And Surgery response to an Independent Review Group inquiry (March 2007).

- Utilization Review Accreditation Commission (URAC)-approved certification as a case manager; or
- RN licensure and three years clinical practice experience and practice case management within the scope of their licensure (based on the standards of the discipline).

Some of the contracted case managers at Walter Reed did not have the requisite qualifications.

“...case managers are overworked and poorly trained.”³⁷

Not only does a case manager have a requisite minimum qualification to perform assigned duties, the case manager must also receive training, specific to their assignment. As of March 13, 2007, only those case managers assigned to the Medical Holdover patients at Walter Reed were required, and have received, 40 hours of formal training. Following this training, the Medical Holdover case manager is assigned a preceptor and is required to complete a competency check list within the first 12 weeks upon receiving a case load.³⁸ Although not required, Walter Reed also uses the competency checklist procedure for most other non-Medical Holdover case managers. The non-Medical Holdover case managers, however, do not go through the formal training program. As a result of the deficiencies exposed in this area, Walter Reed is actively addressing the shortfalls in case management training.³⁹

The Department of Defense TRICARE Management Activity Medical Management Guide also suggests that case managers, newly employed in the military health system, should receive orientation and training. This guide, however, lacks specificity on the type of training that should be provided.⁴⁰

Recommendations:

1. The Assistant Secretary of Defense (Health Affairs) should modify the Department of Defense TRICARE Management Activity Medical Management Guide to define clear standards, qualifications, and training requirements for case managers.
2. The Service Surgeons General, in conjunction with the Commanders of military treatment facilities, should ensure proper initial and recurring training is conducted for case management personnel in line with the guidance set forth in the revised Department of Defense TRICARE Management Activity Medical Management Guide.

³⁷ Testimony received by the Independent Review Group (March 2007).

³⁸ Source: Army Medical Command response to an Independent Review Group inquiry (March 2007).

³⁹ Army Action Plan: Walter Reed Army Medical Center Outpatient Care. Power Point Presentation. Washington, D.C.: Department of Army, 20 March 2007.

⁴⁰ Department of Defense. (January 2006). *TRICARE management activity: The medical management guide*. Washington, D.C.: Defense Printing Service.

Signature Injuries of the War

Four signature injuries have been associated with the current conflict:

- Traumatic Brain Injury (TBI)
- Post Traumatic Stress Disorder (PTSD)
- Increased survival of severe burns
- Traumatic amputations

Both non-penetrating traumatic brain injuries and post traumatic stress disorder are attributable diseases.^{41 42} These diseases are not physically evident and are diagnosed primarily according to the symptoms reported by the patient. In contrast, burns and traumatic amputations are physically recognizable injuries which allows for easier and more consistent diagnosis.

Traumatic brain injury is an acquired, external force upon the brain most often resulting in an alteration in consciousness at the time of injury, loss of memory around the event, and some level of cognitive dysfunction. It is possible to have a traumatic brain injury in the absence of any observable physical damage to the brain.⁴³ Difficulties after a traumatic brain injury include headaches, sleep difficulties, decreased memory and attention, irritability, depression, and slowed mental processing.⁴⁴

Post traumatic stress disorder is one of a range of deployment related psychological effects of war. The diagnostic criteria include: (1) the person should have been exposed to a traumatic event; (2) the trauma is re-experienced in one of a number of ways, including dreams and flashbacks; (3) there is a persistent avoidance of traumatic stimuli; (4) there is increased arousal; and (5) the duration is longer than a month.⁴⁵

The lessons learned during this war have caused the definition of traumatic brain injury to undergo significant change. Many clinicians now realize that blunt force or sudden acceleration/deceleration reflect only some causes of traumatic brain injury. Traumatic brain injuries in our servicemembers, caused by blasts or explosions, appear to present issues different from sports injuries or automobile accidents. These differences necessitate more urgent research to determine appropriate diagnosis methods and treatment.⁴⁶

⁴¹ A non-penetrating head injury, also known as closed brain injury, occurs when there is no break in the skull. A closed brain injury is caused by a forward or backward movement and shaking of the brain inside the boney skull that result in bruising and tearing of brain tissue and blood vessels. (Retrieved from *Ohio State University Medical Center* 10 April 2007 at <http://medicalcenter.osu.edu/healthinformation/diseaseandconditions/rehabilitation/brain/>).

⁴² Attributable diseases are diagnosed based on the symptoms expressed by the patient or person who is familiar with the patient.

⁴³ Mouratidis, Maria, dir. Traumatic Stress and Brain Injury. Power Point Presentation. Bethesda, MD: Traumatic Stress and Brain Injury Program, National Naval Medical Center, March 2007.

⁴⁴ Testimony received by the Independent Review Group (March 2007).

⁴⁵ Source: Army Medical Command response to an Independent Review Group inquiry (March 2007).

⁴⁶ Mouratidis, Maria, dir. Traumatic Stress and Brain Injury. Power Point Presentation. Bethesda, MD:

More research has been done on post-traumatic stress disorder. According to the American Psychological Association report, “Researchers have found that “95% of respondents reported seeing dead bodies and remains, 95% had been shot at, 89% had been ambushed or attacked, 86% knew a fellow service member who was shot or wounded, and 69% injured a woman or child and felt that he or she could not provide assistance. These difficult events are quite likely to produce the intense feelings of fear, horror, and helplessness required for a diagnosis of PTSD.”⁴⁷

Reportedly, as many as one-fourth of all returning service members, from Operations Iraqi and Enduring Freedom, are struggling with the less visible psychological injuries. These servicemembers report exposure to multiple life-changing stressors, and their wartime experiences often challenge their ability to easily reintegrate to family and peacetime life following deployment. “Survival strategies, which are highly adaptive in a combat environment, are often disruptive to civilian life; interpersonal and family functioning is inevitably affected by combat exposure.”⁴⁸

The *San Francisco Chronicle* recently reported, ...An Army Sergeant is challenging his medical discharge after he says he was rushed through his medical review and the Army failed to diagnose his traumatic brain injury. He believes he should be eligible for a military retirement with full lifetime benefits for his family. He was wounded by an anti-tank mine in May 2004, but returned to active duty a few days later. He finished his tour and returned to Germany, where his unit was based. He felt "off," and doctors ended up diagnosing him with a spinal cord injury related to the explosion, but they ignored his other complaints. "When I told them I was having trouble remembering stuff and my hearing would disappear, they just told me it was my age. I was 32 at the time,"⁴⁹ ...

Many good people are doing a lot of good work regarding traumatic brain injury at many levels and many locations, but it is neither coordinated nor consistent. Although, the Department of Defense and Department of Veterans Affairs established one central body, the Defense and Veterans Brain Injury Center (DVBIC), there is lack of penetration, system-wide, to affect an effective definition, clinical guidelines, and treatment to the scale required for returning servicemembers and veterans.

The DVBIC was formed ‘to serve active duty military, their dependents, and veterans with traumatic brain injury (TBI) through state-of-the-art medical care, innovative clinical research initiatives and educational programs.’⁵⁰ The DVBIC has multiple sites, across the U.S. and is headquartered at Walter Reed Army Medical Center.

Traumatic Stress and Brain Injury Program, National Naval Medical Center, March 2007.

⁴⁷ American Psychological Association. (07 February 2007). The psychological needs of U.S. military service members and their families: A preliminary report.

⁴⁸ American Psychological Association. (07 February 2007). The psychological needs of U.S. military service members and their families: A preliminary report.

⁴⁹ Allday, E. (2007, March 17). Returning troops face a battle for medical care. *San Francisco Chronicle*, p. 1.

⁵⁰ Defense Veterans Brain Injury Center. (2007). Retrieved 10 April 2007 at <http://www.dvbic.org>

The Defense and Veterans Brain Injury Center has three major missions:

- Develop and provide advanced traumatic brain injury-specific evaluation, treatment and follow-up care for all military personnel, their dependents and veterans with brain injury
- Conduct clinical research that defines optimal care and treatment for individuals with traumatic brain injury
- Develop and deliver effective educational materials for the prevention, treatment of traumatic brain injury and management of its long-term effects

Finding:

The lack of early identification techniques and comprehensive clinical practice guidelines for traumatic brain injury and its overlap with post-traumatic stress disorder, within the military health system, results in inconsistent early diagnoses and treatment.

Discussion:

Numerous servicemembers, and their families, expressed considerable angst regarding the lack of diagnosis and/or treatment for traumatic brain injuries and post traumatic stress disorders.⁵¹ Some claim that the military may have unfairly punished servicemembers due to changes in behavior (for example: forgetfulness, discipline and personal hygiene) that may be attributed to a traumatic brain injury.⁵²

In discussions with various professionals, in the medical community, it has become clear that there is a lack of understanding and knowledge for diagnosis and treatment of non-visible injuries at the provider-on-the-ground level.⁵³ Some pockets of expertise exist for sports injuries, but these injuries do not replicate the injuries suffered by servicemembers in Operations Iraqi Freedom and Enduring Freedom. While formation of the Defense Veterans Brain Injury Center, with its broad mission requirements, would seem to have these injuries covered, they do not. In particular, the early screening tools and education for all military providers, in clinical practice, need further attention.

A letter from the Armed Forces Epidemiological Board illustrates the current state of behavioral/mental health services in the military health system:

It is clear we have not had a “system-wide approach for proper identification, management and surveillance for individuals who sustain Traumatic Brain Injury...”⁵⁴

⁵¹ Testimony received by the Independent Review Group (March 2007).

⁵² Testimony received by the Independent Review Group (March 2007).

⁵³ Testimony received by the Independent Review Group (March 2007).

⁵⁴ Armed Forces Epidemiological Board. (11 Aug 2006). *Traumatic brain injury in military service members - 2006-02*. Memorandum for the Honorable William Winkenwerder, Jr., MD, Assistant Secretary of Defense for Health Affairs.

Not only is the diagnoses of the less visible injuries of war difficult, physical injuries may hinder the successful diagnosis and treatment of traumatic brain injury and post traumatic stress disorder. At the point of injury, visible damage receives immediate and continued attention. Blast impacts, as often as not, do not get documented and consequently the patient may have potential brain injuries go unrecognized until later, when evidenced in behavioral changes. An additional compounding factor rests with the length of recovery time for some servicemembers having serious injuries, as depression may set in. Indeed, it has been said that many injuries are treated in series rather than parallel.

“An additional challenge faced by large numbers of military personnel, returning from combat, involves the serious physical injuries they sustained while deployed. Physical injuries are typically associated with traumatic events and the interaction between combat exposure, pain, and concern over long-term disability often leads to a complex recovery process. Grieger et al. (2006), found that the rates of depression and PTSD among severely wounded service members increased significantly between the initial 1-month post-injury assessment (where 4.2% had PTSD symptoms and 4.4% had depression) to seven months post-injury (where 12.0% had PTSD and 9.3% met criteria for depression)” (p. 1777-1783).⁵⁵

“One of the more prevalent injuries associated with the current military operations is traumatic brain injury. Okie (2005), reported that on average, 22% of all Operation Enduring Freedom/Operation Iraqi Freedom wounded have a traumatic brain injury. Okie also reported that the rate of traumatic brain injury is higher than in previous wars, indicating that the recovery process will have no clear end for many of the men and women injured in combat (p. 2043-2047). Warden (2006a; 2006b), described polytrauma found in closed head injuries and diffuse or tertiary neurological symptoms observed in blast injuries. Operations Iraqi and Enduring Freedom veterans experiencing blast injuries have reported cyclical depression, psychomotor coordination problems, hearing loss, affective instability, memory problems, and a decreased ability to concentrate.”⁵⁶

Operations Iraqi and Enduring Freedom have heightened awareness of the implications of fear, visual horror, and ravages of war on the minds of our servicemembers. In the openness of exploratory discussions, clinicians and researchers have found family members of deployed persons also suffer mental stressors, with a consequent need for guidance, counseling, and on occasion, courses of treatment. Servicemembers, in this war, come from locations across the nation. Without standard clinical approaches and access to care for servicemembers and their families, civilian and military providers have inconsistent capability to meet the needs of their patients.

Currently, the military services do not measure individual servicemembers’ cognitive ability upon accession or pre-deployment. This makes it difficult to measure any

⁵⁵ American Psychological Association. (07 February 2007). The psychological needs of U.S. military service members and their families: A preliminary report.

⁵⁶ American Psychological Association. (07 February 2007). The psychological needs of U.S. military service members and their families: A preliminary report.

decreases in cognitive ability that are due to combat or military service, which complicates treatment and disability determinations.⁵⁷

Non-penetrating Traumatic Brain Injury (TBI)

Some efforts have been made to identify traumatic brain injury in the combat theaters. Lt Col (Dr.) Michael Jaffee, United States Air Force, instituted a traumatic brain injury study while deployed to Balad Air Base, Iraq in 2006 and started training providers at 3rd Army Medical Command facilities in Iraq.⁵⁸ National Naval Medical Center has undertaken noteworthy work on traumatic brain injury.⁵⁹ In November 2006, the 332nd Expeditionary Medical Group started offering training (1 to 2 week courses) to general surgeons, on emergent craniotomies, to treat some cases of traumatic brain injury, expanding services available at locations without an assigned neurosurgeon.⁶⁰

Currently, no standard administrative codes exist for documenting mild traumatic brain injuries in the medical record. The lack of documentation in medical records severely limits research and therefore, education efforts. Some military treatment facilities have developed local codes for tracking these patients and the Navy Bureau of Medicine and Surgery is working on codes for use Navy-wide but no standard military health system-wide code-identification effort exists.

Post Traumatic Stress Disorder (PTSD)

The military has attempted to identify post traumatic stress disorder in servicemembers who have returned from the theater. There are two assessments conducted:

1. The Department of Defense uses the Post-Deployment Health Assessment to screen servicemembers at the end of a deployment outside the United States.⁶¹ The questionnaire includes a specific four-item screen for post traumatic stress disorder. The four questions cover key domains of post traumatic stress disorder, including re-experiencing trauma, numbing, avoidance and hyperarousal.
2. The Department of Defense uses a Post-Deployment Health Reassessment questionnaire to assess service members' physical and mental health three to six months following the member's return from a deployment outside the United States.⁶² This reassessment offers servicemembers time to be with their families and

⁵⁷ Mouratidis, Maria, dir. Traumatic Stress and Brain Injury. Power Point Presentation. Bethesda, MD: Traumatic Stress and Brain Injury Program, National Naval Medical Center, March 2007.

⁵⁸ Testimony received by the Independent Review Group (March 2007).

⁵⁹ Mouratidis, Maria, dir. Traumatic Stress and Brain Injury. Power Point Presentation. Bethesda, MD: Traumatic Stress and Brain Injury Program, National Naval Medical Center, March 2007.

⁶⁰ Testimony received by the Independent Review Group (March 2007).

⁶¹ Department of Defense. (April 2003). Post-Deployment health assessment (DD FORM 2796). Washington, D.C.: Defense Printing Service.

⁶² Department of Defense. (June 2005). Post-Deployment health reassessment (DD FORM 2900). Washington, DC: Defense Printing Service.

to begin readjustment. The timing of this reassessment allows servicemembers to identify issues that, if identified earlier, may have kept them from joining their families right away. This reassessment involves all health issues; since the focus does not specify mental health issues, it minimizes stigma as a concern.

Recommendations:

1. The Assistant Secretary of Defense (Health Affairs), in conjunction with the Services, should develop and implement functional and cognitive measurements upon entry to military service for all recruits.
2. The Assistant Secretary of Defense (Health Affairs) should include functional and cognitive screening on the post-deployment health assessment and reassessment.
3. The Assistant Secretary of Defense (Health Affairs) should develop and issue a policy requiring ‘exposures to blasts’ be noted in a patient’s medical record.
4. The Assistant Secretary of Defense (Health Affairs) should develop comprehensive and universal clinical practice guidelines for blast injuries and traumatic brain injury with post traumatic stress disorder overlay, and disseminate Military Health System-wide. This is an urgent requirement.
5. The Services should implement training for interpreters of the screening tools to recognize potential cases of traumatic brain injuries and post traumatic stress disorder.
6. The Assistant Secretary of Defense (Health Affairs) should develop coding guidelines for traumatic brain injury and disseminate Military Health System-wide. This represents an interim measure until updates in the International Classification of Diseases and Diagnostic and Statistical Manual of Mental Disorders occur.
7. The Services should commence cognitive remediation for servicemembers experiencing any decreases in cognitive ability, from their baseline, occurring during their service.
8. The Secretary of Defense must urgently review Traumatic Servicemembers’ Group Life Insurance (TSGLI) to ensure that coverage is expanded to include the full spectrum of traumatic brain injury and post traumatic stress disorder. A thorough review of the program should assure that the criteria for eligibility truly cover the traumatically wounded warriors.⁶³

⁶³ Traumatic Servicemembers’ Group Life Insurance (TSGLI) provides payments to servicemembers severely injured as a direct result of Operations Iraqi and Enduring Freedom. (Source: Office of the Under Secretary of Defense. (2005, November 23). *Traumatic Injury Protection under the servicemembers’ Group Life Insurance (TSGLI) program*. Memorandum for Assistant Secretary of the Army (M&RA); Assistant Secretary of the Navy (M&RA); Assistant Secretary of the Air Force (MR); Director, Joint Staff; and Director, Defense Finance and Accounting Service.

Finding:

More urgent research and training, among the medical community, is needed in the areas of traumatic brain injury and post traumatic stress disorder.

Discussion:

Mary Helen Davis, M.D., American Psychiatric Association Board of Trustees member and work group chairperson stated, “Our work group has found the consequences of the Iraq and Afghanistan wars to be a national public health crisis and it is essential that efforts be made by the federal government and the medical/mental health and patient advocacy communities to work together to expand our knowledge of war-related trauma and to ensure that military families have timely access to quality services.”⁶⁴

The Defense and Veterans Brain Injury Center provides information on traumatic brain injury care and offers educational material for providers and family members. Their findings, however, are not reaching the entire system and are not universally applied.

There is a very urgent operational requirement for rapid answers and approaches to treatment of the attributable diseases, at a rate much faster than most research progresses. Therefore, attention and resources must be urgently focused to get state-of-the-art care throughout the system from medical centers to local clinics.

The American Psychiatric Association’s Board of Trustees, plus military psychiatrists, advocate for research on evidence-based treatment of post traumatic stress disorder and other war-related health consequences and traumatic brain injuries and their long-term effects on health; this requires additional funding.

- The National Center for Post-Traumatic Stress Disorder, part of the Department of Veterans Affairs, states it, “aims to advance the clinical care and social welfare of U.S. Veterans through research, education and training on post traumatic stress disorder and other stress-related disorders.”⁶⁵ It offers education for mental/behavioral health providers, servicemembers and their family members.
- The Center for the Study of Traumatic Stress, at the Uniformed Services University of the Health Sciences, states it, “addresses Department of Defense concerns regarding psychological and health care consequences resulting from threat or exposure to weapons of mass destruction.” Many research outcomes for treating the consequences of weapons of mass destruction also apply to the consequences of war.

⁶⁴ American Psychiatric Association (14 March 2007). APA urges Congress to increase funds for veterans’ mental health. [news release]. Arlington, VA.

⁶⁵ Department of Veterans Affairs National Center for Post-Traumatic Stress Disorder. (2007). Retrieved 10 April 2007 at <http://www.ncptsd.va.gov/ncmain/index.jsp>

Despite the efforts that currently exist, there is not a coordinated effort to provide the training required to identify and treat these non-visible injuries, nor adequate research in order to develop the required training and refine the treatment plans.

Recommendations:

1. The Secretary of Defense, in conjunction with the Secretary of Veterans Affairs, should establish a center of excellence for traumatic brain injury and post traumatic stress disorder, seeking support from the private sector where appropriate.
 - a. The center should combine existing research platforms within the Department of Defense and the Department of Veterans Affairs.
 - b. The center should include the breadth of research, training, and clinical services.
 - c. The center should define the military uniqueness of traumatic brain injury.

Research:

- The center should perform research on the physical and psychological impact of deployment on military personnel and their families during the various phases of deployment (pre-deployment, during deployment and post-deployment).
- The center should explore differences (if any) between active component and reserve component personnel and families.
- The center should evaluate the effectiveness of current and future military mental health care prevention and intervention programs (for example: medication versus psychotherapy versus a combined approach).
- The center should work with developers to further develop and rapidly deploy use of an accelerometer/over pressure monitor to measure blast impacts to servicemembers.

Training:

- The center should establish a training curriculum and the mechanisms to reach throughout the military to offer this training (for example: distance learning).
 - The center should assist military services in meeting their responsibility to train primary care and specialty providers, case managers, Medical Hold and Holdover staffs, unit commanders, patients and family members on signs, effects, effective management and proper documentation of traumatic brain injury and post-traumatic stress disorder.
 - Curriculum should include how to determine when a patient may return to duty, whether the patient requires a profile or light duty, and when the patient must return for follow-up.
2. The Assistant Secretary of Defense (Health Affairs) should expand the *Millennium Cohort* study to include traumatic brain injury and post-traumatic stress disorder.⁶⁶

Finding:

There is a declining number of mental/behavioral health staff in the military medical system. This directly affects the care and treatment of traumatic brain injury and post-traumatic stress disorder.

Discussion:

“The task of ensuring an adequate supply of well-trained psychologists and other mental health specialists, to provide services, is a primary issue. There is a shortage of professionals specifically trained in the nuances of military life, and those who are highly qualified often experience burn out due to the demands placed on them.”⁶⁷ The Military Services find it increasingly difficult to recruit and retain mental/behavioral health professionals. The Services have critical shortages of both psychiatrists and psychologists.⁶⁸ “In years past, there have been approximately 450 active duty licensed clinical psychologists serving their country in uniform. Today, that number has shrunk to less than 350 (a 22% decrease), and the rate of attrition continues at an alarming pace.”⁶⁹ The Army, Navy and Air Force all experience some difficulty in recruiting and retaining psychiatrists, psychologists and mental health technicians, although the Navy has achieved the most success so far. The numbers for psychology internships below provide an example.

⁶⁶ The *Millennium Cohort* study is designed to evaluate the long-term health effects of military service, including deployments and was launched in 2001.

⁶⁷ American Psychological Association. (07 February 2007). The psychological needs of U.S. military service members and their families: A preliminary report.

⁶⁸ Testimony received by the Independent Review Group (March 2007).

⁶⁹ American Psychological Association. (07 February 2007). The psychological needs of U.S. military service members and their families: A preliminary report.

2007 Academic Year	Navy	Army	Air Force
Available Psychology Training Slots	10	30	23
Number of fills	10	18	13

Chart: Consolidated Testimony⁷⁰

The Services have experienced difficulty in recruiting fully trained clinical psychologists to the active component for several years. The increased operational tempo has resulted in a moderate reduction in retention. Navy Psychiatry (active component) is also experiencing declining retention rates due to high operational tempo. The Navy trains most psychiatrists through its institutional Graduate Medical Education program (GME). It is seemingly becoming more difficult to direct Graduate Medical Education program bound physicians towards Psychiatric residency programs. Army attrition increased by 55%, between 2004-2006, compared to pre-Operation Iraqi Freedom levels.⁷¹ While the Air Force has increased its number of psychiatrists, it is still at less than 90% manned.

Recommendations:

1. The Service Secretaries should investigate and implement compensation plans to retain current staff. As needed, seek Congressional authority to provide financial incentives for critically short and militarily required specialties.
2. The Service Secretaries should ensure that active duty behavioral health staff augment recruiting commands to attract qualified students to the military, e.g., visiting alma maters.
3. The Services should investigate increasing use of the Health Professions Scholarship Program (HPSP) and Financial Assistance Program (FAP) to attract qualified candidates.
4. The Secretary of Defense should seek Congressional authority to change the laws pertaining to service obligation for recruitment of new physicians.

Burn Injuries and Traumatic Amputations

The other two signature injuries of this war, present as visible injuries: burns and traumatic amputations. The Military Health System provides state-of-the-art, successful care to servicemembers with burns and traumatic amputations. Walter Reed is the leader in developing prostheses for amputees and Brooke Army Medical Center has long enjoyed recognition as a center of excellence for treatment of patients with serious burns. There is still room for improvement, however, in the administration and compensation management of our servicemembers with these types of injuries.

⁷⁰ Testimony received by the Independent Review Group (March 2007).

⁷¹ Testimony received by the Independent Review Group (March 2007).

Finding:

There are inconsistencies within the Department of Defense and the Department of Veterans Affairs regulatory systems which deal with the functional loss of limb due to traumatic injury and burn. Currently, the disability system does not adequately compensate for the functional and physiological loss of limb in burn patients.

Discussion:

The Code of Federal Regulations, Title 38, Part IV (Veterans Affairs Schedule for Ratings and Disabilities) does not address specific disability ratings for burn injuries. It does thoroughly cover amputations.⁷² It also addresses many skin injuries such as scarring, disfigurement and dermatitis. There exists a gap for addressing issues specific to burn injuries. Burned skin needs extra protection from the sun and elements; it does not sweat normally and needs extra precautions (for example: ultraviolet protective clothing and salves) for warm/hot environments. Because there are not specific disability ratings for burn patients, they do not qualify for home or vehicle modification as an amputee patient would.

Recommendations:

1. The Secretary of Defense should request the Secretary of Veterans Affairs to update the Code of Federal Regulations, Title 38, Part IV to account for the unique disabilities and needs of traumatic amputees and burn victims, focused on a loss of function and post-service needs. This would require an expedited process for publishing the change.
2. The Secretary of Defense should review the Physical Evaluation Board determinations of all burn cases, dating back to 2001, within one year after the update to United States Code 38.

Finding:

When an amputee leaves the Department of Defense medical system, the follow-on care, the amputee receives, may not be as technologically advanced outside the military medical system.

Discussion:

The Department of Defense, from clinical necessity, has been on the cutting edge of prosthetic replacement for traumatic amputation. The Department of Veterans Affairs has largely been focused on patients who lost a limb (or limbs) through disease or accident instead of combat. In addition, many amputees in the Veterans Affairs system are much older than those who have suffered an amputation due to combat.

⁷² *Code of Federal Regulations, Title 38 (Part IV) Veterans Administration Schedule for Ratings and Disabilities.* Washington, DC: U.S. Government Printing Office.

The *Sun-Times News Group* recently reported, MAJ (RET) Tammy Duckworth, currently the Director of the Illinois Department of Veterans Affairs, testified before the US Senate Committee for Veterans Affairs on March 27, 2007 and stated, “The US Department of Veterans Affairs is absolutely not ready to treat amputee patients at the high tech levels set at Walter Reed. Much of the technology is expensive and most of the Veterans Affairs personnel are not trained on equipment that has been on the market for several years, let alone the state-of-the-art innovations that occur almost monthly in this field. I recommend that the VA expand its existing SHARE program that allows patients to access private prosthetic practitioners. There is simply not enough time for US Department of Veterans Affairs to catch up in the field in time to adequately serve the new amputees from Operations Iraqi and Enduring Freedom during these critical first two years following amputation. Perhaps after the end of current wars in Iraq and Afghanistan, the VA will have time to advance its prosthetics program.”⁷³

Travel for prosthetic care also includes Department of Defense beneficiaries follow up post amputation patients often requires travel to medical centers with competent prosthetics departments. Often a patient does not live in a geographic area where TRICARE Prime is offered. The TRICARE Prime travel benefit covers per diem and travel if a patient is referred to care more than 100 miles away from their home. TRICARE Standard does not offer a travel benefit.⁷⁴

Recommendations:

1. The Secretary of Defense should pursue partnerships with the Secretary of Veterans Affairs to provide treatment; promote education and research in prosthesis care, production, and amputee therapy.
2. The Secretary of Defense should pursue a partnership with the Secretary of Veterans Affairs to expand the Department of Veterans Affairs’ existing program to allow patients to access the military health system and private prosthetic practitioners.
3. Review TRICARE regulations (CFR 199.17) and update specifically to change them so that the geographic home of the patient does not limit access to benefits for prosthetic care and treatment.⁷⁵

⁷³ Sweet, L. (2007, March 27). Tammy Duckworth, chief of Illinois Vet Affairs: Tells Senate panel wounded vets deserve care from private sector. [blog] *Sun-Times News Group*. (Retrieved 10 April 2007 at <http://blog.suntimes.com/sweet>).

⁷⁴ TRICARE Standard is a health care option where military health care system beneficiaries may choose to receive care uniformed service facilities or from any TRICARE authorized providers. TRICARE Prime requires beneficiaries to enroll and use a primary care manager, and it offers TRICARE Standard benefits plus enhanced preventive benefits.

⁷⁵ *Code of Federal Regulations, Title 32 (Part 199) Civilian health and medical program of the uniformed services*. Washington, DC: U.S. Government Printing Office.

Physical Disability Evaluation System (PDES)

In the Department of Defense, the Physical Disability Evaluation System includes the Medical Evaluation Board (MEB), Physical Evaluation Board (PEB), and the applicable Service appeals board review process followed by the entrance into the Department of Veterans Affairs system.

The Physical Disability Evaluation System is the process for determining if active and reserve component members can reasonably perform the duties of their office, grade, rank, or rating; AND if they are unable to perform the military duties because of a disease or injury that is service incurred or aggravated; AND if a disability rating for a lost military career should be assigned.⁷⁶

Recently, the volume of servicemembers receiving treatment and entering the Physical Evaluation Board has exacerbated the complexity and inconsistencies of this process. In 2006, 767 servicemembers were involved in the Medical Evaluation Board process at Walter Reed and 1,251 were involved at National Naval.^{77 78} The overall number of Army Physical Evaluation Board cases has increased from an average of 10,000 during 2001-2003 to 14,500 during 2004-2006.⁷⁹ The overall number of Navy Physical Evaluation Board cases has an average of 4,538 during 2001-2003 to 5,327 during 2004-2006.

There is widespread variance in the application of regulatory guidelines within each Service and between the Services. Variation continues at all levels of the disability process and into the Department of Veterans Affairs. This needlessly cumbersome and perceived adversarial process is the center of gravity in the disability evaluation system and must be totally overhauled.

Finding:

There are serious difficulties in administering the Physical Disability Evaluation System due to a significant variance in policy and guidelines within the military health system.

Discussion:

There is much disparity among the Services in the application of the Physical Disability Evaluation System that stems from ambiguous interpretation and implementation of a Byzantine and complex disability process. It is almost as if a peacetime, draft-era program is being applied to an all-volunteer force engaged in war.

⁷⁶ Department of Defense Directive 1332.18, *Separation or Retirement for Physical Disability*, November 4, 1996.

⁷⁷ Source: Army Medical Command response to an Independent Review Group inquiry (March 2007)

⁷⁸ Source: Bureau Of Medicine And Surgery response to an Independent Review Group inquiry (March 2007)

⁷⁹ Department of the Army. Physical Evaluation Board Process. Power Point Presentation. Washington DC: Walter Reed Army Medical Center Installation, March 8, 2007

The Governing Statute, implementing publications and regulatory guidelines: Code of Federal Regulation: Title 10, USC chapter 61, provides the Secretaries of the Military Departments with the authority to retire or separate members for physical disability. Code of Fed reg Title 38, provides the authority for the VA. DoD Directive 1332.18, Separation or Retirement for Physical Disability; DoD Instruction 1332.38, Physical Disability Evaluation; DoD Instruction 1332.39, Application of Veterans Affairs Schedule for Rating Disabilities, and applicable service specific regulations or instructions set forth the polices and procedures implementing the statute.⁸⁰

For each respective service, the governing service specific guidelines include: Department of the Air Force, AFI 36-3212, Physical Evaluation for Retention, Retirement, and Separation; Department of the Army, AR 635-40, Physical Evaluation for Retention, Retirement, or Separation; Department of the Navy, SECNAV Instruction 1850.4E and Department of the Navy Disability Evaluation Manual.

A Government Accounting Office (GAO) Report (2006), acknowledged the differences among the services and recommended improved oversight of the physical disability evaluation system, to which the Department of Defense agreed and indicated an intent to implement.⁸¹

“The Government Accountability Office noted that eligibility criteria for disability programs need to be brought into line with the current state of science, medicine, technology and labor market conditions.”⁸²

During the course of its review, the Independent Review Group identified no less than five Government Accountability Office reports and one Presidential Task Force report that noted deficiencies and made recommendations to improve the physical disability evaluation system. These reports include:

- November 2004 Government Accountability Office Report: VA and DoD Health Care: Efforts to coordinate a single physical exam process for servicemembers leaving the military.⁸³

⁸⁰ Department of Defense. (2007). *Code of Federal Regulations, Title 10 (Chapter 61) Retirement or Separation for Physical Disability*. Washington, DC: U.S. Government Printing Office.

⁸¹ U.S. Government Accountability Office. (2006, March) *GAO report to congressional committees on the Military Disability System: Improved oversight needed to ensure consistent and timely outcomes for reserve and active duty service members* (Publication No. GAO-06-362). Washington, DC: U.S. Government Accountability Office.

⁸² U.S. Government Accountability Office. (2006, March) *GAO report to congressional committees on the Military Disability System: Improved oversight needed to ensure consistent and timely outcomes for reserve and active duty service members* (Publication No. GAO-06-362). Washington, DC: U.S. Government Accountability Office.

⁸³ U.S. Government Accountability Office. (2004, November) *GAO report to congressional requesters on VA and DOD Health Care: Efforts to Coordinate a Single Physical Exam process for Servicemembers leaving the military* (Publication No. GAO-05-64). Washington, DC: U.S. Government Accountability Office.

- September 2005 Veterans Affairs and Department of Defense Health Care: VA has policies and outreach efforts to smooth transition from DOD Health Care, but sharing of Health Information remains limited.⁸⁴
- June 2006 Government Accountability Office Report: VA and DOD Health Care: Efforts to provide seamless transition of care for OEF and OIF servicemembers and veteran's.⁸⁵
- March 2006 Military Disability System: Improved oversight needed to ensure consistent and timely outcomes for reserve and active duty service members.⁸⁶
- March 2007 Government Accountability Office Report: DOD and VA Health Care: Challenges encountered by injured servicemembers during their recovery process.⁸⁷
- 2003 President's Task Force to Improve Health Care Delivery for Our Nation's Veterans.⁸⁸

Despite the comprehensive findings and recommendations in these reports, the Group found little evidence of action on the recommendations.

Recommendations:

1. The Secretary of Defense should provide recommendations to Congress to amend Title 10 United States Code, Chapter 61, and Title 38 United States Code, to allow the 'fitness for duty' determination to be adjudicated by the Department of Defense and the disability rating be adjudicated by the Department of Veterans Affairs.
2. Following the changes to the United States Code, the Secretary of Defense, should quickly promulgate regulatory guidelines and policy to the Service Secretaries.

⁸⁴ U.S. Government Accountability Office. (2005, September 28) *GAO testimony before the Committee on Veterans' Affairs, House of Representatives: VA and DOD health care* (Publication No. GAO-051052T). Washington, DC: U.S. Government Accountability Office.

⁸⁵ U.S. Government Accountability Office. (2006, June 30) *GAO testimony before the Committee on Veterans' Affairs, House of Representatives: VA and DOD health care: Efforts to provide seamless transition of care for OEF and OIF Servicemembers and Veterans* (Publication No. GAO-06-794R). Washington, DC: U.S. Government Accountability Office.

⁸⁶ U.S. Government Accountability Office. (2006, March) *GAO report to congressional committees on the Military Disability System: Improved oversight needed to ensure consistent and timely outcomes for reserve and active duty service members* (Publication No. GAO-06-362). Washington, DC: U.S. Government Accountability Office.

⁸⁷ U.S. Government Accountability Office. (2007, March 8) *GAO testimony before the subcommittee on oversight and investigations, Committee on Veteran's Affairs, House of Representatives: DoD and VA health care* (Publication No. GAO-07-606T). Washington, DC: U.S. Government Accountability Office.

⁸⁸ President's Task Force. (2003) *Final report to improve health care delivery for our nation's veterans*. Washington, DC

Finding:

The current Medical Evaluation Board/Physical Evaluation Board process is extremely cumbersome, inconsistent, and confusing to providers, patients, and families.

Discussion:

The physical disability evaluation system is the means by which servicemembers are retired or separated due to physical disability in accordance with the aforementioned references. The Department of Defense Directive (DoDD) 1332.18, Section 3.2 outlines four elements of the physical evaluation disability system: the physical evaluation; appellate review; counseling; and final disposition. According to the Department of Defense regulations, the physical evaluation process consists of the Medical Evaluation Board and the Physical Evaluation Board.⁸⁹ The Department of Defense and the Department of Veterans Affairs use the *Veterans Administration Schedule for Rating Disabilities*.⁹⁰

The Veterans Administration Schedule for Rating Disabilities (VASRD) is primarily used as a guide for evaluating disabilities resulting from all types of diseases and injuries encountered as a result of, or incident to, military service.⁹¹

Not all the general policy provisions set forth in the rating schedule apply to the military.⁹² Consequently, disability ratings consistently vary between the Department of Defense and Department of Veterans Affairs. The Services rate only conditions determined to be physically “unfitting,” compensating for loss of a military career.⁹³ The Department of Veterans Affairs may rate any service-connected impairment, thus compensating for loss of civilian employability. Additionally, the term of rating is different among the Department of Defense and the Department of Veterans Affairs. The Services’ ratings are permanent upon final disposition. The Department of Veterans Affairs ratings may fluctuate with time, depending upon the progression of the condition. Further, the Services’ disability compensation is determined by years of service and basic pay; while Veterans Affairs compensation is a flat amount based upon the percentage rating received.

Recommendations:

1. The Under Secretary of Defense (Personnel & Readiness) should completely overhaul the physical disability evaluation system to implement one Department of Defense

⁸⁹ Department of Defense Instruction 1332.39, *Application of the Veterans Administration schedule for rating disabilities*, November 14, 1996.

⁹⁰ Department of Veterans Affairs Schedule for Rating Disabilities

⁹¹ Department of Defense Instruction 1332.39, *Application of the Veterans Administration schedule for rating disabilities*, November 14, 1996.

⁹² DoDI 1332.39 instructs the Department of Defense to use the VASRD. Not all the general policy provisions of the VASRD are applicable to the military departments.

⁹³ Fit rating versus Unfit rating: Whether an active or reserve component servicemember can/cannot reasonably perform the duties of their office, grade, rank, or rating.

level Physical Evaluation Board/Appeals Review Commission with equitable Service representation and expand what is currently the Disability Advisory Council.⁹⁴

- According to a Government Accountability Office report, a problem with the current organization is that the Council only “aims” to meet quarterly, but did not meet for a full year, to discuss issues raised by the Services.⁹⁵ This recommended concept would have consolidated operational oversight and responsibility of the Physical Evaluation Board process, including the current the Service level Physical Evaluation Board and Appeals Review levels of jurisdiction. This action allows for streamlining of personnel and resources, and eliminates the intra and inter-Service disparities of the disability ratings and provides a forum for implementing immediate corrective action. This recommended concept incorporates Veterans Affairs representation and ensures a seamless transition from the Department of Defense into the Department of Veterans Affairs health system.
2. The Under Secretary of Defense (Personnel & Readiness) should conduct a quality assurance review all (Army, Navy/Marine Corps, and Air Force) Disability Evaluation System decisions of 0, 10, or 20 percent disability and Existed Prior to Service (EPTS) cases since 2001 to ensure consistency, fairness, and compliance with applicable regulations.
 3. The Secretary of Defense and the Secretary of Veterans Affairs should establish one solution. Develop and utilize one disability rating guideline that remains flexible to evolve and be updated as the trends in injuries and supporting medical documentation/treatment necessitate. Revise the current process of updating the disability ratings system to include an operation update that pushes changes to the field on a weekly, or as needed basis.⁹⁶

Finding:

A common automated interface does not exist between the clinical and administrative systems within the Department of Defense and among the Services, causing a systemic breakdown of a seamless and smooth transition from Department of Defense to the Department of Veterans Affairs.

Discussion:

Servicemembers should not be burdened with the arduous navigation requirements of our current system. The complexity of the physical disability evaluation system is further

⁹⁴ Carr, W., Office of the Under Secretary of Defense. (2006, December 20). *Department of Defense Disability Advisory Council: Disability Evaluation System*. Charter.

⁹⁵ U.S. Government Accountability Office. (2006, March) *GAO report to congressional committees on the Military Disability System: Improved oversight needed to ensure consistent and timely outcomes for reserve and active duty service members* (Publication No. GAO-06-362). Washington, DC: U.S. Government Accountability Office.

⁹⁶ Similar to the process used in Federal Aviation Administration Bulletin updates

perpetuated as the servicemembers transition into the Veterans Affairs system. Currently there is not a seamless transition.

A “seamless transition” from military service to veteran status is especially critical in the context of healthcare, where readily available, accurate, and current medical information must be accessible to health care providers.⁹⁷

For the administrative aspects of this process, no one system currently exists. The Department of Defense does not have an integrated automated system that supports the standardization of the clinical and administrative requirements of the physical disability evaluation system. Absent a corporate solution, the Services have created individual systems to track the service members within the physical disability evaluation system. This exacerbates the process variation.

The Air Force currently does not have an automated system. The Army currently uses the Medical Evaluation Board Internal Tracking Tool (MEBITT).⁹⁸ The Navy uses the Medical Board On Line Tri-Service Tracking System (MedBOLTT).⁹⁹ Each system serves its Service independently for Medical Evaluation Board processing; yet do not interface with the next step of the Physical Evaluation Disability System, or Physical Evaluation Board.

The Army Physical Evaluation Board uses the Physical Disability Case Processing System (PDCAPS) to track Army cases once they enter the Physical Evaluation Board stage of the process.¹⁰⁰ Using the Army as an example of the lack of interface between systems, during the Medical Evaluation Board phase of the process, the Medical Evaluation Board Internal Tracking Tool is used. During the Physical Evaluation Board phase, the Physical Disability Case Processing System is used. These two systems, unique to one Service, result in numerous disparities within the Army since the systems do not interface. From a clinical perspective, all medical documentation should be available to the servicemembers’ providers throughout the entire process. This includes the transition into the Veterans Affairs system where there is no continuity other than what records the servicemember carries to the Veterans Affairs. This issue has been continually addressed without resolution.

“The Department of Veterans Affairs and the Department of Defense should develop and deploy, by fiscal year 2005, electronic medical records that are interoperable, bi-directional and standards-based”.¹⁰¹

⁹⁷ President’s Task Force. (2003) *Final report to improve health care delivery for our nation’s veterans*. Washington, DC

⁹⁸ Medical Evaluation Board Internal Tracking Tool is Army Medical Command’s automated solution for tracking the Medical Evaluation Board process.

⁹⁹ Medical Board On Line Tri-Service Tracking System is the Bureau of Medicine and Surgery’s web-based Medical Evaluation Board tracking system.

¹⁰⁰ Physical Disability Case Processing System is the Army Physical Disability Agency’s automated solution for tracking the Physical Evaluation Board process.

¹⁰¹ Refer to Recommendation 3:1 of President’s Task Force. (2003) *Final report to improve health care delivery for our nation’s veterans*. Washington, DC

The same report recommends a single separation physical and electronic transmittal of the Department of Defense Form 214 (DD214) to the Department of Veterans Affairs.¹⁰² These recommendations have yet to come to fruition and as a result, there is a significant amount of redundancy is still required at this point starting at the physical examination.

Recommendation:

The Secretary of Defense, in conjunction with the Secretary of Veterans Affairs, should direct the transition process be streamlined for the servicemember separating from the Department of Defense and entering the Department of Veterans Affairs.

- As already identified in the Government Accountability Office report (2004),¹⁰³ implement the single physical exam. Review the 1998 Department of Defense memorandum of understanding (MOU) between the Department of Defense and Department of Veterans Affairs, implement a common physical for use by the Services and the Department of Veterans Affairs for those servicemembers in the physical disability evaluation system, and allow flexibility in the timelines test or procedures that would eliminate redundant efforts.¹⁰⁴

Rapidly develop a standard automated systems interface for both clinical and administrative systems that allows bilateral electronic exchange of information. Review and implement the recommendations of the 2003 President's Task Force.¹⁰⁵

¹⁰² President's Task Force. (2003) *Final report to improve health care delivery for our nation's veterans*. Washington, DC

¹⁰³ U.S. Government Accountability Office. (2004, November) *GAO report to congressional requesters on VA and DOD Health Care: Efforts to Coordinate a Single Physical Exam process for Servicemembers leaving the military* (Publication No. GAO-05-64). Washington, DC: U.S. Government Accountability Office.

¹⁰⁴ Department of Defense and Department of Veterans Affairs. (1998, May 19). *Guidelines for completion of a single separation physical examination that meets the requirements for a Department of Veterans Affairs compensation and pension disability evaluation examination*. Memorandum of understanding between Office of Assistant Secretary of Defense (Health Affairs) and Under Secretary for Health, Department of Veterans Affairs.

¹⁰⁵ President's Task Force. (2003) *Final report to improve health care delivery for our nation's veterans*. Washington, DC: Government Printing Office.

Reserve Component

The Independent Review Group acknowledges that progress has recently been made in the availability of health care benefits to Reserve Component servicemembers.

Reserve Component consists of Army and Air National Guard and Reserve Forces.¹⁰⁶

The Army and Air Force National Guard and Reserves from all Services play a key role as an “operational” component of the nation’s total force. Currently, the reserve components comprise 16.2% of deployed forces. During previous rotations in this war, the percentage has been substantially higher.¹⁰⁷ In light of this role, the Group believes more should be done to facilitate the transition in duty status and access to healthcare for the Reserve Component.

Finding:

The Reserve Component servicemembers of our Armed Forces face unique challenges with respect to the military health care system.

Discussion:

When an illness or injury presents itself, after the Reserve Component servicemember has been demobilized from active duty, (for example: traumatic brain injury or post traumatic stress disorder) these servicemembers may have a difficult time returning to the military health care system to receive the appropriate treatment. They may reside a considerable distance from a military or Veterans Affairs medical treatment facility, limiting their access to care.

Senior leaders within the Reserve Component told the Group that servicemembers are encountering growing difficulties in finding health care providers in their local communities willing to accept TRICARE payment.¹⁰⁸ The volume of documentation and time delay in payment were the leading cause for the provider’s reluctance to accept TRICARE. Overall, there were positive comments on the success of the Army’s use of the Community Based Health Care Organization (CBHCO) program which allows the Guard or Reservist to return home, continue medical care while in an active status and work in the local Reserve Center.

Reserve Component leadership informed the Group that Veterans Affairs’ medical facilities are commonly not postured to provide the required care for their servicemembers. They expressed concern that the Veterans’ system was not prepared for

¹⁰⁶ Reserve Forces includes: Army Reserve, Navy Reserve, Air Force Reserve, and Coast Guard Reserve.

¹⁰⁷ Testimony received by the Independent Review Group (April 2007).

¹⁰⁸ TRICARE is the Department of Defense’s managed health care program for active duty service members, service families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. (Source: *Assistant Secretary of Defense (Health Affairs) website*. Retrieved 11 April 2007 at <http://ha.osd.mil/manuals>).

the volume nor the age or type of veteran returning. The Reserve Component leadership also expressed concern that upon release from active duty, the servicemember often experiences gaps in time waiting for Veterans Affairs benefits.

Recommendations:

1. The Secretary of Defense, in conjunction with Service Secretaries, should establish a program that returns previously deployed Reserve Component servicemembers back to an active status for a Post Deployment Health Reassessment and an evaluation by a medical professional, six months post demobilization.
2. The Secretary of the Army should continue to build the success of the Community Based Health Care Organization program and expand where possible. Other Services should be encouraged to use this program.
3. The Secretary of Defense should initiate a thorough review of post-service Reserve Component health care and develop systems and policies that assure quality care is delivered for service connected illness and injuries.
4. The Secretary of Defense should seek regulatory change to offer incentives to individual health care providers to accept TRICARE.

IV. LEADERSHIP, POLICY, AND OVERSIGHT

Command and Control

The leadership at Walter Reed Army Medical Center did not maintain an acceptable standard of managing outpatient services for injured and sick servicemembers. Walter Reed's inclusion on the Base Realignment and Closure list and pressure to outsource traditional military service functions through A-76 implementation, complicated leadership's ability to appropriately manage outpatient services. Additional factors include military to civilian conversions; retention and recruitment of quality staff members; facilities maintenance; and staff attitude, also impacted the efficacy of leadership's role at Walter Reed.

"Commanders set overall policies and standards, but all leaders must provide the guidance, resources, assistance, and supervision necessary for subordinates to perform their duties."¹⁰⁹

At Walter Reed, the leadership is expected to properly resource the personnel supporting the Medical Hold and Medical Holdover Companies.¹¹⁰ Failure to provide guidance and assistance to Medical Hold and Medical Holdover personnel resulted in a lack of discipline, numerous missed medical appointments, and a waste of hospital resources. The staff's failure to effectively monitor the progress of patients in Medical Hold and Medical Holdover complicated the cumbersome and overtaxed Medical Evaluation Board and Physical Evaluation Board processes.

Reserve Component Perceptions

The Reserve Component's perception that its treatment is different than their Active Component counterparts is widespread.

A senior military leader stated, "This perception likely stems from the historical use of the Reserve Components as a strategic reserve."¹¹¹

The segregation of Reserve Component and Active Component into separate holding companies; labeling the Reserve Component outpatients as "Medical Holdovers" and the Active Component outpatients as "Medical Holds," has further complicated the

¹⁰⁹ Department of the Army. (1999, August 31). *Army Leadership: Be, Know, Do* (Field Manual 22-100). Washington, DC: Defense Printing Service.

¹¹⁰ Medical Hold refers to Active Army or Reserve Component Soldiers assigned or attached to military hospitals who are unable to perform even in a limited duty capacity. Medical Holdover refers to a Reserve Component Soldier, pre-deployment or post-deployment, separated from his/her unit, in need of definitive health care based on medical conditions identified while in an active duty status. [Source: Department of Army. (2006, October 13). *Patient administration* (Army Regulation 40-400). Washington, D.C.: Defense Printing Service, 130.]

¹¹¹ Testimony received by the Independent Review Group (April 2007).

perception of inequality at Walter Reed. Every form a patient is required to complete, asks the patient to identify their component (for example: Active Duty, National Guard, United States Army Reserve). While this information may solely be for statistical purposes, it may leave the servicemember with the impression that their care is being unfairly managed and that a caste system exists.

The Group is not aware of any policy that supports this perception. The perception, however, does exist and the Group suggests that the Under Secretary of Defense (Personnel & Readiness) conduct a thorough review of all policies and statutes that govern the management of the Reserve Component to see if a policy change could alleviate this perception.

Base Realignment and Closure (BRAC)

In August 2005, the Base Realignment and Closure Committee recommended Walter Reed Army Medical Center installation, including the Armed Forces Institute of Pathology, be closed. The Committee also recommended that the Walter Reed Army Medical Center be realigned with the National Naval Medical Center to create the Walter Reed National Military Medical Center (WRNMMC). The recommendation was approved by Congress in November 2005, and plans call for the full integration to take place by September 2011. This timeline effectively places Walter Reed Army Medical Center in a state of “limbo” regarding its ability to make capital improvements and recruit and retain qualified staff. The complexity surrounding the creation of Walter Reed National Military Medical Center requires significant attention from the current leadership, resulting in time and resources being taken away from the effective management of the hospital.

There is no doubt that the facilities at Walter Reed require replacement and the present campus is too small to accommodate the large patient load and influx of family members resulting from Operations Iraqi Freedom and Enduring Freedom. There are economies to be gained through the creation of Walter Reed National Military Medical Center. The timing of the Base Realignment and Closure decision and implementation of its timeline could not have been worse; a time when the mission to treat war wounded, sick, and injured servicemembers, while maintaining normal patient load, was at its highest demand at Walter Reed.

The establishment of the Walter Reed National Military Medical Center, on the campus of Bethesda, along with the co-location with the Uniformed Services University of the Health Sciences and close proximity to the National Institutes of Health, makes an ideal setting for the continued cooperation between the civilian sector and the Armed Forces Institute of Pathology. The Armed Forces Institute of Pathology is integral to the military and civilian medical research communities of today as well as to the future of our healthcare system.

Finding:

The Base Realignment and Closure decision to create the new Walter Reed National Military Medical Center contributed to staffing problems, inattention of leadership to day-to-day operations, and a lack of resources for capital improvements.

Discussion:

The inclusion of Walter Reed Army Medical Center on the Base Realignment and Closure list forced leadership to devote a substantial amount of time to the planning for integration of clinical services with the National Naval Medical Center.

At least one senior staff member indicates he spends over 30% of his time devoted to Base Realignment and Closure issues; time that could be spent seeing to the needs of patients and their families.¹¹²

The leadership complexities of Walter Reed Army Medical Center Command are challenging and very broad in scope and span of control. From the operation of a major military academic medical center, providing a full range of casualty care to managing the healthcare market for beneficiaries in the National Capital Region, the commander is also responsible for health care oversight for the northeastern United States. The addition of the responsibilities associated with Base Realignment and Closure demanded long term strategic focus and planning and competed with other operational requirements of day-to-day leadership.

Recruitment and retention of critical specialists have also been affected by the Base Realignment and Closure decision.

According to the Deputy Commander of Clinical Services, “since the announcement of the Base Realignment and Closure decision, Walter Reed Army Medical Center has lost six long-term highly trained anesthesiologists, a key clinical information programmer, a senior claims attorney, patient safety officer and a candidate to run the credentials office to name a few.”¹¹³

Due to the perceived instability surrounding the continued operation of Walter Reed Army Medical Center, the Accreditation Council for Graduate Medical Education recently reduced the accreditation of many Walter Reed Army Medical Center’s programs from five years to two years of accreditation, making these residency programs less desirable.¹¹⁴ The long-term effects of the accreditation change have yet to be realized.

¹¹² Testimony received by the Independent Review Group (March 2007).

¹¹³ Testimony received by the Independent Review Group (March 2007).

¹¹⁴ Testimony received by the Independent Review Group (March 2007).

The Assistant Secretary of the Army (Installations & Environment) made a decision to discourage capital expenditures for facility improvement projects on Army installations scheduled for closure as a result of the Base Realignment and Closure recommendations.¹¹⁵

Noted in a Department of Army memo, “At installations recommended for closure, all facility projects, regardless of fund source, not under contract or, if in-house, not started, shall be deferred pending the final Base Realignment and Closure decision. Any exception based on legal, health, or environmental requirements shall be addressed on a case-by-case basis to Assistant Secretary of the Army (Installations & Environment) for decision.”¹¹⁶

This created a decline in facility improvements, and impeded leadership’s efforts to convince legislators of its need for critical facility improvements, such as the Warrior Rehabilitation Training Center (Amputee Center), currently under construction.

The replacement of the aging hospital facility at Walter Reed as well as others within the National Capital Region was the target for Base Realignment and Closure and acceleration of the processes for both the new Walter Reed and Fort Belvoir will move all patients in the region to include the combat injured into modern facilities faster. Current proposals for the acceleration of the new Walter Reed National Military Medical Center move the construction completion date ahead eight months to October 2010. Creation of the new Warrior Care Center at the Bethesda campus could be completed by October 2009, allowing use of this resource as early as possible. Similar acceleration strategies should also be considered with the new hospital construction at Fort Belvoir with completion by August 2010. During a time of war, focusing on serving the needs of soldiers and families by providing them the best possible facilities for care and recovery is imperative.

Recommendation:

1. The Secretary of Defense should seek legislative approval to accelerate the implementation of the Base Realignment and Closure Commission’s recommendations. Specifically, accelerate or waive the Environmental Impact Study (EIS) and release monies required to start construction of the “new” Walter Reed National Military Medical Center.
2. The existing facilities should not be allowed to “die on the vine.” Expedient integration of these two facilities will lessen the time Walter Reed Army Medical

¹¹⁵ Prosch, G., Department of Army (2005, May 25). *Policy for facility operations and construction at installations contained in the Department of Defense Base Closure and Realignment Report, May 13, 2005*. Memorandum for Assistant Chief of Staff for Installation Management; Director, Army National Guard; Chief, Army Reserve.

¹¹⁶ Prosch, G., Department of Army (2005, May 25). *Policy for facility operations and construction at installations contained in the Department of Defense Base Closure and Realignment Report, May 13, 2005*. Memorandum for Assistant Chief of Staff for Installation Management; Director, Army National Guard; Chief, Army Reserve.

Center is in a state of “limbo,” and can take advantage of economies at a quicker pace while ultimately improving the treatment of eligible servicemembers and their families. The servicemembers and their families should not experience any delays in service during this transition. Funding must be provided to maintain full operation until the day of closure.

A-76

The Office of Management and Budget A-76 circular provides for public/private competition for tasks that are not considered inherently governmental.¹¹⁷

The A-76 program was designed for the government to select the “most efficient organization” to perform those tasks that are not considered inherently governmental tasks. The announcement to implement the provisions of the A-76 at Walter Reed Army Medical Center took place in 2000, almost seven years prior to the last contract award to a private firm. During that time, the government bid on the contract to provide base operations support, including facilities maintenance, clerical functions, and other tasks. The government bid was originally calculated to be \$7 million less than a private contractor. The bids were later recalculated and it was determined the private contractor’s bid was more favorable by the same \$7 million amount. The A-76 process had a huge destabilizing impact on the civilian workforce at Walter Reed Army Medical Center.¹¹⁸

During times of declared war or military mobilization, the Department of Defense can opt-out of the A-76 process.

The revised A-76 Circular, states “The Department of Defense Competitive Sourcing Official (without delegation) shall determine if this circular applies to the Department of Defense during times of declared war or military mobilization.”¹¹⁹

The Department of Defense Competitive Sourcing Official is the Deputy Undersecretary of Defense, Installations and Environment. Had the option to exclude the Department of Defense from A-76 been exercised, significant personnel shortages could have been avoided at a crucial time when Walter Reed Army Medical Center and National Naval Medical Center were focused on the treatment of wounded, sick or injured servicemembers.

With the local civilian personnel office focused on A-76 business, non-A-76 business, such as recruitment of healthcare personnel, was not a priority.

¹¹⁷ OMB Circular A-76 rests on a policy of subjecting commercial activities to public-private competition.

¹¹⁸ Testimony received by the Independent Review Group (March 2007).

¹¹⁹ Executive Office of the President, Office of Management and Budget. (2003, May 29). Circular to the heads of executive departments and establishments: Performance of commercial activities (Circular No. A-76). Washington, DC: Government Printing Office.

Finding:

The A-76 process created a destabilizing effect on the ability to hire and retain qualified staff members to operate garrison functions. The cost savings proved to be counterproductive.

Discussion:

The implications of the A-76 program created yet another pressure for Walter Reed Army Medical Center staff and leadership to overcome. The award of a contract to a private vendor for facility maintenance resulted in a hiring freeze in June 2006 followed by a reduction in force (RIF) action of civilian employees in August 2006.¹²⁰ The contractor, International American Products (IAP), however, did not begin work until February 2007, which resulted in a serious shortage of staff for an eight month period (June 2006 until Feb 2007).¹²¹ This action restricted leadership's ability to hire front desk clerks and administrative staff, resulting in critical staff shortages. The most devastating effect of the hiring freeze was the impact on garrison and brigade functions designed to support outpatient servicemembers and their families.

The long lag time from the announcement of the A-76 competition to contractor selection and implementation led to staff shortages of more than 100 personnel during a time the patient load was at peak levels.¹²²

Recommendation:

The Secretary of Defense should provide the Service Secretaries the opportunity to apply for regulatory relief from A-76 during a time of war; specifically for Walter Reed and other military treatment facilities.

¹²⁰ Testimony received by the Independent Review Group (March 2007).

¹²¹ IAP Worldwide Services, headquartered in Cape Canaveral, FL, is a provider of support services and expertise to the U.S. Department of Defense, other federal customers, and state and foreign governments. (Retrieved from *IAP Worldwide Services'* website 10 April 2007 at <http://www.iapws.com/who/about.aspx>).

¹²² Mandel, J. (2007, March 5). Officials say outsourcing partly to blame for Walter Reed failures. *GOVEXEC.com* (Retrieved 11 April 2007 at <http://www.govexec.com/dailyfed/0307/030507ml.htm>).

Medical Hold and Holdover Companies

The Medical Hold and Medical Holdover Companies are responsible for the oversight of treatment for outpatients among the Medical Center Brigade. The Medical Hold and Medical Holdover Companies, however, did not provide guidance, assistance, discipline or leadership to staff to ensure a smooth transition between inpatient to outpatient status at Walter Reed, nor was continued guidance and oversight provided to the servicemembers or their families in the Medical Hold and Holdover Companies. The requisite assistance to help guide wounded servicemembers and their families through the complicated bureaucracy was ineffective and sometimes non-existent.

Medical Hold refers to Active Army or Reserve Component Soldiers, assigned or attached to military hospitals, who are unable to perform even in a limited duty capacity.

Medical Holdover refers to a Reserve Component Soldier, pre-deployment or post-deployment, separated from his/her unit, in need of definitive health care based on medical conditions identified while in an active duty status.¹²³

A noteworthy observation includes patients experiencing extended stays in the Medical Hold and Holdover Companies without meaningful duties and left with too much idle time. It is a disservice to the patient to limit activity and restrict involvement in significant duties; and contributes to altered behaviors such as substance abuse. Leadership is responsible for meeting the physical, psychological, and sociological needs of Medical Hold and Medical Holdover servicemembers.¹²⁴

Accountability

During a visit to Walter Reed Army Medical Center on March 30, 2007, President George W. Bush affirmed, “The problems at Walter Reed were caused by bureaucratic and administrative failures.”¹²⁵

Assessments from the Department of Army indicated that leadership was aware of complaints about administrative processes and poor facility conditions at Walter Reed Army Medical Center and either delayed in acting or failed to act altogether.

¹²³ Medical Hold refers to Active Army or Reserve Component Soldiers assigned or attached to military hospitals who are unable to perform even in a limited duty capacity. Medical Holdover refers to a Reserve Component Soldier, pre-deployment or post-deployment, separated from his/her unit, in need of definitive health care based on medical conditions identified while in an active duty status. Source: Department of Army. (2006, October 13). *Patient administration* (Army Regulation 40-400). Washington, D.C.: Defense Printing Service, 130.

¹²⁴ Testimony received by the Independent Review Group (March 2007).

¹²⁵ Bush, George W. (Speech). Walter Reed Army Medical Center, Washington DC. 30 March 2007.

The U.S. Army Vice Chief of Staff (VCSA), General Richard Cody conducted an exhaustive assessment of conditions at Walter Reed Army Medical Center, leading to several overarching conclusions. The Army's internal findings, reported March 19, 2007, include: ¹²⁶

1. Outdated and cumbersome regulations.
2. Information overload for soldiers struggling through the disability evaluation system.
3. Overworked case managers with poor training.
4. Understaffed Medical Hold Unit employees.
5. Poorly maintained facilities with minimal to no inspection for mice, mold, or loose drywall.
6. No follow-up on process with the soldiers' home units.
7. Too few liaison officers between the medical evaluation and physical evaluation boards, some of which are only privates first class without the experience or rank to properly handle cases.
8. No top-level oversight.

Finding:

Leaders should have been aware of the poor living conditions and administrative hurdles faced by some outpatients at Walter Reed Army Medical Center.

Discussion:

During a *Military.com* interview on March 6, 2007, a senior leader from Walter Reed Army Medical Center accepted responsibility for the bureaucratic roadblocks and frustrations suffered by patients and their families along with poor living conditions of outpatient housing; particularly highlighting Building 18. ¹²⁷

A former Commander of Walter Reed Army Medical Center publicly indicated he was not aware of many of the facility problems that surfaced in *Washington Post* articles. ¹²⁸ Interviews with patients revealed that there was no known formal process for voicing concerns and recommendations or for receiving a response or notification that action would be taken. One patient indicated he had lodged a complaint through the Inspector General system but never received a response. It appears that the lack of an adequate program hindered patients from voicing their concerns and recommendations and restricted an accurate level of awareness among command personnel.

¹²⁶ Kennedy, K. (2007, March 19). We're going to fix it. *Army Times*. p. 8

¹²⁷ Philpott, T. (14 March 2007). Exclusive interview: Maj. Gen. George W. Weightman. *Military.com*. Retrieved 9 April 2007 at <http://www.military.com/features/0,15240,128647,00.html>

¹²⁸ Milbank, D. (2007, March 6). Two generals provide a contrast in accountability. *Washington Post*. p.A01

Recommendation:

The Surgeon General of the Army should ensure the tools available to measure patient and family satisfaction and provide feedback on facility conditions are being used to the maximum extent. Use of the patient feedback system must ensure recurring and unresolved problems are acted upon and substantiated complaints are resolved and resolution is documented and reviewed by senior hospital leadership.

Finding:

Leadership failed to provide clear direction or place proper priority on the management and treatment of outpatients at Walter Reed Army Medical Center.

Discussion:

Staffing and other resources needed to monitor and care for the non-medical needs of outpatients were not obtained or allocated as needed. Hospital leadership admitted during Congressional testimony and interviews that they had failed to provide the necessary support staff to accommodate the needs of the large outpatient population.

The Medical Hold and Medical Holdover Companies are significantly understaffed and poorly trained. Patients were charged with taking care of other patients and the case worker to patient ratio was as high as 50:1. Current plans call for the establishment of a Medical Hold Brigade with a staffing level of 166 versus the current 57 positions. Additionally, the case manager level the new brigade will be reduced to a case worker to patient ratio of 17:1.¹²⁹ This is evidence a severe shortage of staff and leadership existed in the Medical Hold and Medical Holdover Companies. Had leadership been fully engaged in the oversight of outpatient care, the changes outlined in the recently produced Army Action Plan for Walter Reed Army Medical Center Outpatient Care might have been previously developed.¹³⁰

Recommendation:

The Secretary of the Army should ensure implementation of recommendations made in the Army Inspector General report on the Army physical disability evaluation system and the resulting Army Action Plan on Walter Reed Army Medical Center Army Outpatient Care. Both of these documents contain information that can be used as a part of a sound roadmap in improving the leadership and management of the newly formed Medical Hold Brigade. The Army Action plan has a May 31, 2007 due date to have all positions filled in the Medical Hold Brigade. Follow-up action by the Deputy Chief of Staff G1 must be

¹²⁹ Source: Walter Reed Army Medical Center response to an Independent Review Group inquiry (March 2007).

¹³⁰ Internal review of soldier accountability, infrastructure, medical administrative process, and information dissemination. (Source: Department of the Army. Physical Evaluation Board Process. Power Point Presentation. Washington DC: Walter Reed Army Medical Center Installation, March 8, 2007).

undertaken to ensure this timeline is met and effectiveness of the changes adopted should be measured by September 30, 2007 and adjustments made accordingly.

Management and Executive Direction

Since the decision to close the Walter Reed installation and relocate services to Bethesda, the Services have been working a variety of plans to prepare for the transition of mission and personnel. The task is formidable. The fact that the Nation is at war adds to the urgency of ensuring a smooth transition plan that will facilitate an uninterrupted quality of service to all servicemembers. The commanders already have the daunting task of managing major hospitals that are deeply involved in the war effort, let alone planning for the transition to consolidated medical facilities. Strong management and leadership is required to make this transition one that will, in the final analysis, improve the quality of care our Nation provides to its servicemembers and their families.

Finding:

Although there is a plan being initiated for the physical merger of Walter Reed Army Medical Center and National Naval Medical Center; the current Army, Navy, and Air Force Service cultures have tremendous strength within each Service, but present a significant barrier to the smooth integration into a joint Walter Reed National Military Medical Center.

Discussion:

Senior leaders in both medical centers have the mammoth task of ensuring the smooth operation of their hospitals and outlying clinical facilities. The commanders for both Walter Reed and National Naval Medical Center are dually tasked; serving as both medical center commander and the regional commander. Time devoted to the construction of new hospital facilities and the transition of patients and services from Walter Reed to the new facilities detracts from time required to manage each medical facility.

Additionally, each Service has its own standards; overarching philosophy regarding the return of wounded troops to duty; personnel and classification systems; and a host of other differences that hamper efforts to plan and execute a smooth transition to a combined facility. Unless addressed immediately, these philosophical and operational differences will continue to slow progress and will likely stifle efforts of a smooth transition from Walter Reed Army Medical Center and National Naval Medical Center to the Walter Reed Army Medical Center National Military Medical Center.

A continued parochial approach by each service involved will be at the detriment of our wounded troops and their families. ¹³¹

¹³¹ Testimony received by the Independent Review Group (March 2007).

Recommendations:

1. The Secretary of Defense should appoint a senior flag officer to oversee the transition of Walter Reed Army Medical Center to the Walter Reed National Military Medical Center. Recommend an officer with the rank of O-8 or above be placed in charge of the transition team and report progress on a regular basis to the Secretary of Defense.
2. The Secretary of Defense, in conjunction with the Service Secretaries, must immediately initiate the functional integration of Walter Reed National Military Medical Center for the formation of cohesive joint team to ensure success.

Staffing and Personnel

Both Walter Reed and National Naval Medical Center suffer from staffing shortages caused by the impact of the Base Realignment and Closure decision, local economic and employment factors, as well as continual operational deployment of medical personnel. The National Capital Region is an extremely competitive market for employees, especially in the medical professional fields. As this competition for staff tightens, rates of pay escalate and the government is tied to the Federal Civil Service salary structure. The announcement of the closing of Walter Reed due to the Base Realignment and Closure decision caused some staff members to seek employment elsewhere and made recruiting new staff members more difficult. Additionally, the six year long A-76 process exacerbated by the shortage of Medical Hold and Holdover staff created an environment in which it was difficult to provide the treatment and care our servicemembers deserve. While the consolidation of military hospitals in the National Capitol Region promises to reduce staff shortages and produce other savings, there is an urgent need to staff hospitals now so the Nation can care for its military members and their families.

Finding:

Staff training of the Medical Hold and Medical Holdover Cadre is inadequate.

Discussion:

According to the U.S. Army Inspector General Report,¹³² staff training of the Medical Hold and Medical Holdover Cadre is lacking or insufficient. Training of the Medical Hold and Holdover staff, at Walter Reed Army Medical Center either did not take place or was not formally documented. Additionally, no formal training criteria were developed by the Office of the Surgeon General for the Medical Holding Cadre. Lack of training impacts the ability to provide the necessary command and control over the Medical Holding Cadre and ultimately has a negative impact on patient care due to wasted system resources.

¹³² Department of Army. (2007). *Inspector General report: Army physical disability evaluation system inspection*. Washington, DC: Defense Printing Service.

Recommendation:

The Army Surgeon General should develop and institute a training program for the Medical Holdover Cadre that contains a specific focus on the care of wounded, ill, and injured servicemembers, assistance to families, and the administrative care of patients in a hospital setting. Follow-up action and inspection of training effectiveness should be accomplished within 60 days of training implementation.

Finding:

Shortages of staff in key positions, inability to recruit new staff members, and the staff's uncertainty of future employment has serious implications on the ability to continue to provide quality care and services to patients at Walter Reed Army Medical Center.

Discussion:

The decision by the Base Realignment and Closure Commission to close Walter Reed has had a negative impact on the ability to recruit and retain staff at all levels. This is particularly true in the nursing arena where a combination of non-competitive starting salaries, scheduled closure, and a very competitive job market have seriously hampered attempts to properly staff the hospital.

There is no transition hiring panel or authority in place to provide any assurance to current employees that they will be placed in positions at the resulting Walter Reed National Military Medical Center. Lack of job security has caused significant numbers of personnel to seek employment elsewhere, further hindering staffing efforts and setting the stage for long-term degradation of services.

There are currently 94 registered nurse vacancies at Walter Reed and the average fill request to vacancy time is 131 days. Hiring contract services to provide nursing care has met some of the demand for services. The fill rate for critical care nurses in the past year by the contractor has been 21.1%. The medical-surgical registered nurse fill rate has been only 54.7%.¹³³

The Office of Personnel Management guidelines for the recruitment of new registered nurse graduates were written in 1977 and are a hindrance to the current hiring process. The regulation requires one year of registered nurse clinical experience before a registered nurse can be employed at the GS-9 level, with new graduates being employed at the GS-5 level. While the Office of Personnel Management granted a waiver to allow Walter Reed Army the direct hiring authority for nurses and to hire them in an accelerated GS-5-7-9 program, wages still lag the civilian sector. The starting rate of pay for civil service registered nurse graduates is \$14.56-\$18.93 per hour, while the local civilian market rate of pay is \$22.00-\$26.00 per hour. Lower pay coupled with the

¹³³ Testimony received by the Independent Review Group (March 2007).

impending closure of the hospital does not make attractive recruiting incentives for prospective staff members.¹³⁴

Staffing to provide oversight, supervision, and assistance in the Medical Hold and Holdover Companies was woefully inadequate. In addition to a shortage of case managers serving Medical Hold and Holdover patients, there was a lack of officers and non-commissioned officers to provide assistance, oversight, and discipline. The Army Action Plan is intended to address this issue by reclassifying the Medical Hold and Holdover Companies into a single Medical Hold Brigade, commanded by an Army Colonel.¹³⁵ This proposed structure appears to have sufficient officer and enlisted leadership to provide the necessary oversight and assistance to the wounded, ill, and injured soldiers and their families who continue to receive outpatient care. This new structure should guide Soldiers, and their families, through the myriad of medical appointments and through the Medical Evaluation Board and Physical Evaluation Board processes. It is unfortunate that it took negative publicity in the press to bring about action on this front.

Recruitment of health care professionals is a challenge for staffing of our medical facilities, with both civilians and uniformed personnel. Of particular note, there is a market of older health care professionals, doctors and nurses who are willing to serve their country and have a wealth of experience. The statutory Military Service Obligation (MSO) requires eight years of service for all. This requirement is a significant disincentive for Americans, fifty years of age or older. An exception to policy for this eight year requirement for healthcare professionals would enable the Armed Services to capitalize on an untapped resource and fill a critical need.

Recommendations:

1. The Commanders of Walter Reed Army Medical Center and National Naval Medical Center should establish a combined transition hiring panel to provide employment assurances to staff members who will be needed to staff the new Walter Reed National Military Medical Center. This panel must have authority to provide employment opportunities and guarantee employment at the new hospital(s) for qualified staff members who meet performance standards.
2. The Service Secretaries should ensure standardized job classifications and grades for like positions at each facility are in place.
3. The Secretary of Defense should seek legislative relief from the archaic classification system that prevents paying competitive wages for nursing school graduates and other key hard-to-fill staff positions.

¹³⁴ Testimony received by the Independent Review Group (March 2007).

¹³⁵ Department of Army. Army Action Plan: Walter Reed Army Medical Center Outpatient Care. Power Point Presentation. Washington, D.C.: Department of Army, 20 March 2007.

4. The Secretary of the Army should ensure actions outlined in the Army Action Plan are implemented and measured for success within sixty days after implementation with a report back to the Secretary of Defense.
5. The Secretary of Defense, in conjunction with the Service Secretaries, should review all statutory and regulatory guidance regarding military service obligations and grant an exception to policy for health care professionals.

Finding:

The Medical Hold and Holdover Companies are not properly staffed to provide guidance to patients, especially those with traumatic brain injury and post traumatic stress disorder.

Discussion:

The Medical Hold and Holdover Companies are sparsely staffed with platoon sergeants and squad leaders. Also, there are no medical personnel on staff to provide care and counseling to patients. The ratio of platoon sergeants to patients is too low to provide effective supervision and assistance. The situation is exacerbated by the fact that many patients have other issues, such as support to visiting family members, keeping track of personnel and finance records, and in some cases their own social/psychological conditions.¹³⁶

There are instances of patients suffering from traumatic brain injury being assigned to the regular Medical Hold/Holdover Companies with no on-site medical assistance in the housing area. One parent indicated the lack of available on site medical care for traumatic brain injury patients in the Mologne House on Walter Reed served as a detriment to recovery and was a dangerous situation.¹³⁷

With staffing levels low, the Army has reverted to assigning patients to assist or even act as platoon sergeants in the Medical Hold and Holdover Companies. These patients have their own, sometimes complicated, schedules to maintain, much less having the time to supervise and assist other patients with their schedules. Additionally, the amount of time required to train and supervise patients who are serving as squad leaders and other positions detracts from the permanently assigned leadership staff of the Company. The Army Action Plan calls for the assignment of additional platoon sergeants, which will bring the ratio up to 1:35 platoon sergeants to patient. The Army Inspector General report states that ratios of 1:25 can sometimes be overwhelming for platoon sergeants, given the complexity of patient's schedules and the amount of time that must be spent on their individual cases.¹³⁸

¹³⁶ Department of Army. (2007). *Inspector General report: Army physical disability evaluation system inspection*. Washington, DC: Defense Printing Service.

¹³⁷ Testimony received by the Independent Review Group (March 2007).

¹³⁸ Department of Army. (2007). *Inspector General report: Army physical disability evaluation system inspection*. Washington, DC: Defense Printing Service.

Recommendations:

1. The U.S. Army Deputy Chief of Staff, G1 should establish a platoon sergeant to patient ratio sufficient to provide required supervision, tracking of appointments, and leadership to the Medical Hold and Holdover Cadre. The majority of Medical Holdover platoon sergeants recommend a 1:15 ratio as the necessary standard. Whatever standard of staffing is finally agreed upon, the G1 must review the effectiveness of the Medical Hold and Holdover Companies within 60 days of completing the recommendation and must then take action to adjust staffing levels as the situation dictates.
2. The Army Surgeon General should ensure behavioral specialists are assigned to the Medical Hold and Holdover Companies to meet the needs of patients with traumatic brain injury and post traumatic stress disorder symptoms. Additional staff is needed to help identify patients who exhibit mental health problems such as depression, substance abuse, and suicidal behavior.
3. The U.S. Army Deputy Chief of Staff, G1, in conjunction with the Surgeon General of the Army, should ensure a manpower standard is developed for the safe and effective operation of the Medical Hold and Holdover companies and brigades.
4. The Service Secretaries should review and update applicable directives to ensure there is no distinction in the care management and disability processing of Active Component and activated Reserve Component servicemembers.

Finding:

The Medical Hold and Holdover Cadres were significantly understaffed to handle their missions.

Discussion:

The Medical Holding Company was significantly understaffed with one platoon sergeant sometimes being in control of as many as 130 patients.¹³⁹ This fact has been acknowledged by the Army and efforts are underway to increase the assigned cadre members from 59 to 166 by May 31, 2007.¹⁴⁰ This staff shortage led to poor service for wounded and ill servicemembers and their families and the lack of any advocate to assist patients through the bureaucratic maze.

¹³⁹ Priest, D., & Hull, A. (2007, February 18). Soldiers face neglect, frustration at army's top medical facility. *Washington Post*, p. A01

¹⁴⁰ Department of Army. Army Action Plan: Walter Reed Army Medical Center Outpatient Care. Power Point Presentation. Washington, D.C.: Department of Army, 20 March 2007.

Recommendation:

The U.S. Army Deputy Chief of Staff, G1 should establish staffing guidelines for Medical Holding Cadres as recommended in the Army Inspector General report. In the interim, the Commander of Walter Reed Army Medical Center must fully staff the newly established Medical Holding Brigade by May 31, 2007 as outlined in the Army Action Plan. The Deputy Chief of Staff, G1 should follow-up within 60 days of full staffing of the brigade to measure effectiveness in terms of meeting the needs of servicemembers.

Finding:

Walter Reed Army Medical Center and National Naval Medical Center staff members, especially those in the nursing field, are showing signs of compassion fatigue.

Discussion:

The ramifications of staff shortages, along with the complexity and seriousness of war injuries and the impact these injuries have on family members, sets the stage for compassion fatigue on the part of the medical staff and potentially leads to negative impacts on morale. Surveys of nursing personnel in 2003 and 2006 indicated a high degree of stress resulting from caring for a constant stream of severely wounded soldiers from Operations Iraqi Freedom and Enduring Freedom. A December 2006 survey of clinical nursing personnel and nurse case managers at Walter Reed indicated over 80% reported moderate to high stress levels with 66% reporting the major source of stress to be their jobs. Of these, 60% reported coming to work despite feeling ill between 5-10 days during the preceding three month period. It is clear that stress levels such as this can have a negative impact on care and compassion for the wounded soldiers and their families. The Deputy Commander for Nursing has identified stress as a major job factor and has taken steps to implement stress reduction programs for the staff. Without addressing continued staff shortages and the consequent workload on individual nurses, along with the expected steady influx of wounded patients, stress reduction efforts will not likely produce desired results.¹⁴¹

Recommendation:

The Commanders of Walter Reed Army Medical Center and National Naval Medical Center should ensure programs are initiated and are in place to help the staff combat compassion fatigue and other stresses caused by the nature and intensity of work at these two medical centers. The Deputy Commander for Nursing at Walter Reed has taken positive steps in this regard by initiating a no-cost contract request to develop a tailored stress reduction program for the nursing staff. A formal study of stress and immediate action to provide stress reduction programs for all personnel as needed should be undertaken.

¹⁴¹ Testimony received by the Independent Review Group (March 2007).

Resource Management

Military medical treatment facilities receive their financial resources from the Assistant Secretary of Defense (Health Affairs) via their Service Military Medical Headquarters. This funding is received in the form of an annual appropriation at the beginning of the fiscal year. At times, sufficient funding to operate a command may be delayed as a result of a Congressional Continuing Resolution¹⁴² when the Department of Defense Authorization Bill has not yet been signed prior to the beginning of the Fiscal Year. Command leadership is charged with being fiscally responsible in executing these funds while faced with prioritizing requirements (contracts, equipment, supplies, maintenance, etc) to be resourced. When funding is insufficient to adequately operate their facility, the proactive leader should communicate their shortfalls through their chain of command and articulate the impact on the facility operations and care to the patient.

Finding:

Resource constraints at Walter Reed Army Medical Center contributed to the failings addressed in this report.

Discussion:

National health expenditures have had an average annual growth of 7.1% each year from 2003 through 2006 (for a total of 28.4% total growth during this period).¹⁴³ Conversely, the Walter Reed Army Medical Center budget only grew 12.3% during the period of 2003 through 2006, and the National Naval Medical Center budget only grew 21.6% this same period.^{144 145} This lag in budget growth at these military medical facilities that have been receiving and treating casualties, in comparison to the national health expenditures during this same time period, is questionable. The Independent Review Group members were not specifically told during interviews and site visits that inadequate funding was an issue. Although briefed by Assistant Secretary of Defense (Health Affairs) Resource Management staff at length, the Independent Review Group staff still had difficulty understanding the mechanisms of the convoluted budget process within the military health system. Other resource management issues stood out, such as personnel vacancies due to the A-76 action at Walter Reed, as well as Army leadership's conscious decision to not funnel money to address non-medical facilities maintenance.¹⁴⁶

¹⁴² A continuing resolution is a type of appropriations legislation used by the United States Congress to fund government agencies if a formal appropriations bill has not been signed into law by the end of the Congressional fiscal year. The legislation takes the form of a joint resolution, and provides funding for existing federal programs at current or reduced levels. (Retrieved from *Wikipedia* 9 April 2007 at http://en.wikipedia.org/wiki/Continuing_resolution).

¹⁴³ Health Affairs. (2007). *Exhibit 2 National health expenditures, average annual growth, selected calendar years 1988-2011*, Retrieved April 11, 2007 from <http://content.healthaffairs.org/cgi/content/full/21/2/207/T2>

¹⁴⁴ Source: Army Medical Command response to an Independent Review Group inquiry (March 2007)

¹⁴⁵ Source: Bureau Of Medicine And Surgery response to an Independent Review Group inquiry (March 2007)

¹⁴⁶ Prosch, G. G., Department of Army (25 May 2005). *Policy for facility operations and construction at*

The Independent Review Group is concerned the imposition of an “Efficiency Wedge” that was passed onto the Service Military Medical Departments by the Department of Defense starting in fiscal year 2006 will be a strain on the military health system in the future.

The “Efficiency Wedge” refers to assumed savings based upon the implementation of the prospective payment system in the military treatment facilities. The assumed savings are phased in over a multi-year period.¹⁴⁷

The purpose of the wedge is to decrement the Defense Health Program budget funding over a multi-year period to account for “efficiencies gained” in the military medical departments. The Army Medical Command did not pass on a portion of the \$30 million Army Medical wedge to Walter Reed Army Medical Center, or any other Army medical treatment facility, in fiscal year 2006 or of the \$82 million wedge in fiscal year 2007. The Acting Army Surgeon General, however, testified to the House Armed Services Subcommittee on Personnel, on March 27, 2007, that Army Medicine cannot execute the fiscal year 2008 wedge of \$142 million without cutting services.¹⁴⁸ Unlike the Army Medical Department, the Navy Medical Department has passed on a portion of the Navy’s wedge to National Naval Medical Center in fiscal year 2006 (\$2 million) and fiscal year 2007 (\$5 million). Echoing the concerns of the Acting Army Surgeon General, the Navy Surgeon General has also testified that Navy Medicine “...will have to have a serious conversation about what services we can provide at 16 percent less funding than a year before.”¹⁴⁹ Navy Medicine’s portion of the fiscal year 2008 efficiency wedge is \$146.5 million.

Recommendation:

The Secretary of Defense should evaluate the imposition of the “Efficiency Wedge” on the Service Medical Departments during this time of war.

installations contained in the Department of Defense Base Closure and Realignment Report, May 13, 2005. Memorandum for Assistant Chief of Staff for Installation Management; Director, Army National Guard; Chief, Army Reserve.

¹⁴⁷ Testimony received by the Independent Review Group (March 2007).

¹⁴⁸ Philpott, T. (2007, March 30). Top docs blast phony health budget ‘efficiencies.’ *Military.com*. Retrieved 2 April 2007 at http://www.military.com/Content/Printer_Friendly_Version/1,11491,,00.html?

¹⁴⁹ Philpott, T. (2007, March 30). Top docs blast phony health budget ‘efficiencies.’ *Military.com*. Retrieved 2 April 2007 at http://www.military.com/Content/Printer_Friendly_Version/1,11491,,00.html?

Family Support

The Department of Defense views family support as an integral element in the recovery process of wounded, injured, and ill servicemembers. The Department has specific provisions in regulatory guidance and public law to provide for the transportation, housing, and other care of family members who arrive at bedside by physician's request.¹⁵⁰ The obligations that the Armed Forces have to the military member are recognized as being extended to immediate family members, in terms of support, during time of injury and illness.

When a servicemember is wounded or injured, family members sometimes travel from all over the world to be at their bedside. Family members may be entitled to transportation, lodging, and per diem reimbursement. Their chief concern is for the welfare and recovery of their loved one and the support they receive from the military is crucial in allowing the family to concentrate on the recovery of the servicemember. Family members' concerns include transportation, housing, financial needs, meals, and traveling to an unfamiliar environment. Their main mission of helping their servicemember recover is made more complicated and frustrating dealing with these other issues.

In many instances, family members are with the injured servicemember throughout rehabilitative care and play an integral part during the recovery process. It is common for family members to assist with appointment schedules, provide transportation, serve as attendants, and perform a host of other tasks in caring for their loved one in addition to providing the level of support that can only be provided by a family member.

Support systems found on active military installations are often not available or have a reduced presence at Walter Reed for supporting family members on invitational orders. This, coupled with the extremely high cost of living and excessive commuting stress, in the National Capital Region, can make for a daunting experience for family members who visit Walter Reed. The Department of Defense must take all measures necessary to ensure that the best support is provided to the family members of wounded, injured, and ill servicemembers.

The Department of Defense supports the activities of many family support organizations such as *America Supports You*, which provide ongoing assistance to the families of servicemembers.¹⁵¹

¹⁵⁰ *Code of Federal Regulations, Title 37 (Chapter 7) Travel and transportation allowances: transportation of family members incident to the serious illness or injury of members.* Washington, DC: U.S. Government Printing Office.

¹⁵¹ **America Supports You** is a nationwide program launched by the Department of Defense, recognizes citizens' support for our military men and women and communicates that support to members of our Armed Forces at home and abroad (Retrieved 12 April 2007 at <http://www.americasupportsyoudmil>).

Finding:

Inconsistent education processes exist across the Department of Defense, in advising families of available benefits to assist them upon the hospitalization of the servicemember and with travel and lodging.

Discussion:

The notification of family members that their servicemember is wounded or seriously injured or ill can be made by a variety of people or offices. The notification can be made by the servicemember's Commander, the servicemember, the attending physician, and in some cases the Service's casualty affairs office. In general, only the casualty affairs office is equipped to discuss travel entitlements and other benefits that may be available for family members who travel to be at the bedside of an injured servicemember. For this reason, family members are sometimes left to make their own travel arrangements. Consequently, they arrive at hospital locations with no lodging, local transportation, or other arrangements. Travel orders are not generally approved for family travel until the attending physician requests that the family be at the bedside to aid in the recovery of the patient. This request may be made days or weeks after the injury occurs; too long of a period for family members who are concerned for the well-being of their loved one to wait. For example, the physicians will not normally request family members to be at bedside at Landstuhl Regional Medical Center in Germany due to the likelihood that the patient will be transferred to a stateside facility for further medical care in a few days.

Recommendations:

1. The Department of Defense should ensure swift education on entitlement of benefits for family members of all wounded, injured, and ill servicemembers in a Very Seriously Ill (VSI) and Seriously Ill (SI) category. Briefings should include information on the invitational travel benefits, the process, and the assignment of a liaison to assist the family with transportation arrangements, lodging, and other plans.
2. The U.S. Army Deputy Chief of Staff, G1, and other Service equivalents, should ensure a liaison officer is appointed to the family of the wounded, ill, or injured servicemember to facilitate local transportation, lodging arrangements, and assist with any other benefits needed to support the family so that they can focus on the recovery and well being of their loved one.

Finding:

Insufficient housing exists, on the grounds of Walter Reed Army Medical Center, to accommodate family members who are at the hospital to aid in the recovery of their servicemember.

Discussion:

Housing for outpatients and family members is not sufficient on the grounds of Walter Reed Army Medical Center. The Mologne House was built as a temporary motel-type accommodation and not designed for long stays and large numbers of patients who are currently outpatients in rehabilitative care at Walter Reed. There are large numbers of patients who are at Walter Reed for periods in excess of one year staying in housing that is not conducive to family life. In addition to the Mologne and Fisher Houses, the large influx of patients and family members results in a large number staying off post, sometimes at their own expense, in contract hotels and rental properties.

Recommendations:

1. The Army Surgeon General should review patient populations and nature of injury and illness and determine if patients can be moved from the Walter Reed Army Medical Center campus to medical treatment facilities close to the servicemembers' homes or home units. This will provide a better environment for patients and their families and may prove more economical for the government.
2. The Secretary of the Army should empower uniformed Army leadership to make a determination on the feasibility of using permanent change of station (PCS) entitlements for families of wounded, ill, and seriously injured servicemembers who are destined for long term outpatient rehabilitative care. Permanent change of station entitlements must be used on a case by case basis with consideration given to the needs of the family and laws governing permanent change of station entitlements.

Finding:

Family members are sometimes left on their own to deal with the bureaucracy in their quest for assistance in completing administrative paperwork and for reimbursement of expenses incurred when visiting their wounded, ill, or injured servicemember.

Discussion:

Support provided to family members of injured servicemembers at Walter Reed and other facilities is inconsistent. In some cases, family members report they do not know from whom to seek assistance, nor do they have a clear picture of available benefits and entitlements. One family member indicated that she had paid transportation and lodging costs to visit her injured husband at Walter Reed and had not been reimbursed almost a full year after her first trip. When they attempted to seek assistance, they were sent from office to office with no advocate to assist. Though the family insisted that they had filed a travel voucher, no record of this voucher exists in the Army finance system.¹⁵² When families are sent to various offices for assistance, having to negotiate a maze of acronyms

¹⁵² Testimony received by the Independent Review Group (March 2007).

and bureaucratic processes, anxiety results at a time when their chief focus should be on assisting their wounded or injured servicemember in their struggle towards recovery.

Recommendation:

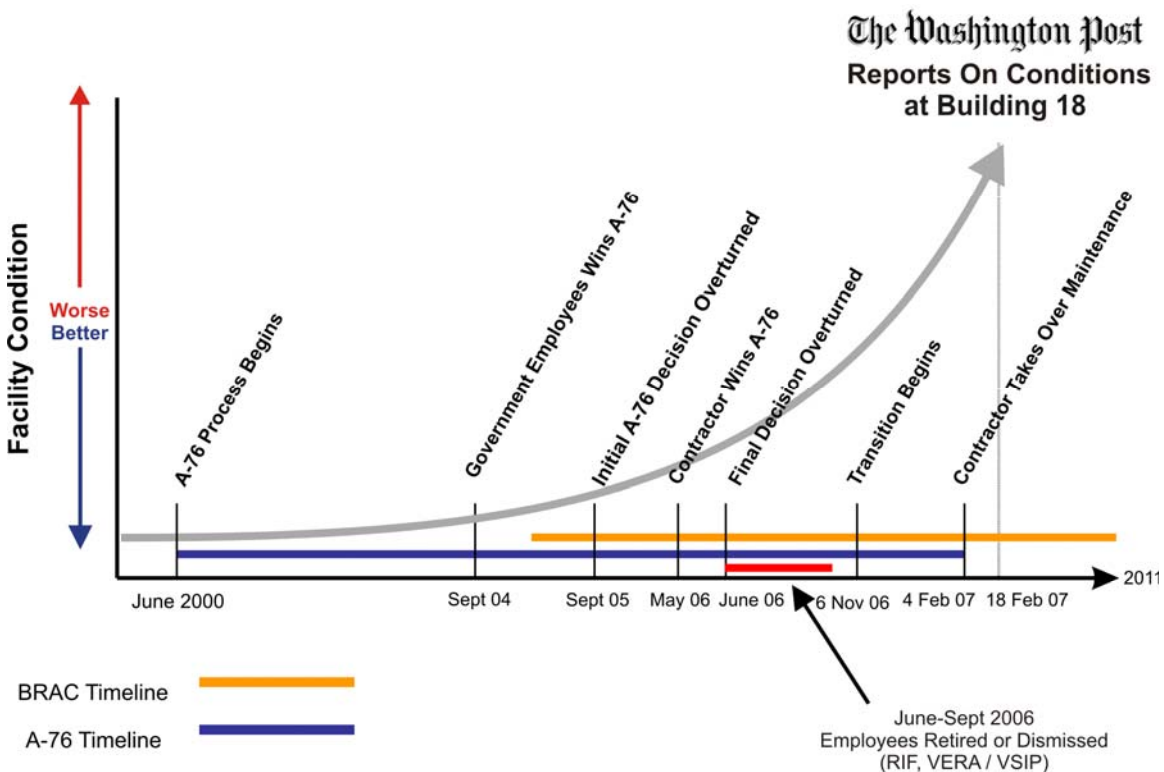
The Army Deputy Chief of Staff, G1 should assure that each family who travels on invitational travel orders to a medical treatment facility is assigned an advocate to assist with all administrative functions pertaining to the trip, including personal assistance to complete travel vouchers and necessary paperwork for reimbursement. The family advocate must take steps to follow-up and ensure family members are reimbursed in accordance with the provisions outlined in the Joint Federal Travel Regulations (JFTR).¹⁵³ The assistance should be patterned after that provided by the Marine Corps Liaison Office at National Naval Medical Center.

¹⁵³ Department of Defense. (2005, February 1). *Joint Federal Travel Regulations (Vol 2)*. Washington, DC: Defense Printing Service.

Facilities

In a recent *Washington Post* article, the US Army Chief of Staff stated he was, “Extraordinarily angry and embarrassed by the living conditions at the hospital.”¹⁵⁴

Leadership at Walter Reed Army Medical Center knew at some levels, and should have known at all levels, about the conditions at Building 18 and could have offered alternative housing solutions for Soldiers. The Group’s research revealed documentation of the conditions, over a period of time, prior to the disclosures in the press. The ineffective facility maintenance process coupled with the Base Realignment and Closure (BRAC) decision and the implementation of A-76, directly contributed to the state of disrepair of non-medical facilities at Walter Reed. Implementation of A-76 inherently caused a decline in morale amongst the workforce. In the case of Walter Reed, this was exacerbated due to the six year period it took to complete the A-76 process. Additionally, the Base Realignment and Closure decision resulted in reductions to facility maintenance funding by an average of 37%.¹⁵⁵



¹⁵⁴ Abramowitz, M., & Vogel, S. (2007, March 6). Apologies, anger at Walter Reed hearing. *Washington Post*, p. A01

¹⁵⁵ Testimony received by the Independent Review Group (March 2007).

Finding:

The facilities and infrastructure at Walter Reed Army Medical Center have not been maintained to an acceptable standard and have not received the required funding to sustain operations.

Discussion:

The current Director of Public Works stated that because the rooms in Building 18 were occupied, the maintenance staff did not routinely inspect the rooms and therefore Standard Preventive Maintenance checks were not completed.¹⁵⁶ The Department of Public Works, however, does provide maintenance personnel on a 24-hour, 7-day a week schedule to “respond to problems.”

It is inconceivable that the command would not have conducted regular inspections at some level and identified unacceptable living conditions and taken the appropriate action to rectify the conditions. During the Group’s site visits to Walter Reed, problems were prevalent and noted throughout many of the facilities on the campus.¹⁵⁷ Furthermore, there appears to be no prioritization of maintenance and repair of facilities. The prioritization of repair and maintenance of facilities would allow leadership to make appropriate decisions regarding funding, repairs, restoration, and allocation of labor.

Presently, the primary tool used by the Department of Army to assess physical conditions of non-medical facilities is the 2006 Installation Status Report (ISR).

Installation Status Report (ISR) is used by installation commanders to categorize installation facilities that are deficient, develop funding requests for Congress, and to allow the installations to better articulate their needs to the Department of the Army. ISR results are used to provide a non-technical evaluation of current installation readiness. This is significant in that it was developed to help policymakers to understand the status of the installations.¹⁵⁸

The Installation Status Report ratings are based on standardized checklists which are very subjective. Those used at Walter Reed did not offer an actual, clear reflection of facility conditions.

¹⁵⁶ Testimony received by the Independent Review Group (March 2007).

¹⁵⁷ Problems include: Steam leaks, mold, mildew, roof leaks, missing ceiling tiles, peeling paint, non-handicap accessible doorways, fire code violations, etc.

¹⁵⁸ Department of Army. (2001, January 1). *The Army installation status report* (Army Regulation 210-14). Washington, DC: Defense Printing Service.

According to a 1998 National Research Council Report, “Stewardship of Federal Facilities, A Proactive Strategy for Managing the Nation's Public Assets.” ... “standardized checklists cannot, in and of themselves, provide for consistency in condition assessments across physical inventories” (such as the installation status report).¹⁵⁹

A Facilities Assistance and Assessment Support Team from the US Army Medical Command conducted inspections of medical facilities at Walter Reed in 2002, 2003, and 2005 and exposed multiple problems. During this period, the problems decreased rapidly based on the detail of the inspection and appropriate action taken on the findings of the assessment team. This process, however, was not used in the non-medical facilities.¹⁶⁰ Had it been used, there is a likelihood the problems would have been identified and acted upon.

US Army Medical Command metrics, as listed below, do not identify facilities problems in advance:

- Percentage of demand to total maintenance
- Dollars for preventative maintenance service order
- Average manhours for scheduled maintenance
- Average manhours for demand maintenance

Utilizing leading or predictive metrics is a more proactive approach to identifying maintenance deficiencies.¹⁶¹

Maintenance and construction requirements are present year round, but the typical dearth of funding in the first quarter of a fiscal year puts maintenance behind and excess funding in the fourth quarter puts a strain on development and execution of large numbers of contracts with limited staff.

Recommendations:

1. The Secretary of the Army should identify a senior facilities engineer from US Army Medical Command or Installation Management Command to assume full responsibility for non-medical facility maintenance at Walter Reed Army Medical Center, to stabilize the maintenance process, conduct maintenance process assessment, and to improve the condition of critical facilities and infrastructure.

¹⁵⁹ The National Academy of Sciences. (1998). *Stewardship of federal facilities: A proactive strategy for managing the Nation's public assets*. Washington DC: National Research Council.

¹⁶⁰ Non-Medical Facilities at Walter Reed Army Medical Center Installation include: administration, training, housing, maintenance, etc.

¹⁶¹ Society for Maintenance and Reliability Professionals. (2007). *Best Practices Committee*. (Retrieved April 11, 2007 from <http://www.smrp.org/page.asp?newpageid=39>).

2. The US Army Medical Command Assistant Chief of Staff for Installations, Environmental & Facilities Management should prioritize assets and infrastructure based on risk and condition of all non-medical facilities.
3. The United States Army Corps of Engineers should conduct a facility condition assessment at all Walter Reed Army Medical Center facilities (medical and non-medical), focusing on high priority facilities and infrastructure first.
4. The Walter Reed Army Medical Center Garrison Commander should eliminate the use of the Installation Status Report for non-medical facilities and utilize a more efficient tool such as the Facilities Assistance and Assessment Support Team model which is currently being used in all US Army Medical Facilities.¹⁶²
5. The U.S. Army Medical Command Assistant Chief of Staff for Installations, Environmental & Facilities Management should identify proactive maintenance metrics to manage the facility maintenance process.
6. The Assistant Secretary of Defense (Health Affairs) should provide the Services adequate funding levels for facility sustainment, restoration, and modernization.
7. The U.S. Army Medical Command Assistant Chief of Staff for Installations, Environmental and Facilities Management should hire a maintenance consulting company with experience in assessing private sector facility “best practices” and conduct a facility maintenance process assessment to identify the gap between current and desired performance of the maintenance process at Walter Reed Army Medical Center and develop an action plan for change to present to Army Medical Command’s Chief of Staff for approval to implement.
8. The Secretary of Defense should assure that the Army, Navy, and Air Force assign one senior facility leader to the assessment team as an observer.

¹⁶² Department of Army. (2004, November 20). *Department of the Army supply bulletin, Army medical department supply information* (Publication No. SB8-75-11). Washington, DC: U.S. Army Medical Materiel Agency. p. 8-33.

V. SUMMARY

The following are the Independent Review Group's comprehensive findings and recommendations.

Continuum of Care

I. Transition to Outpatient Care

Finding:

Comprehensive care, treatment, and administrative services are not provided to the outpatient in an interdisciplinary collaborative manner at Walter Reed Army Medical Center.

Recommendations:

1. The Assistant Secretary of Defense (Health Affairs), in conjunction with the Service Surgeons General, should provide the resources to staff and train case managers at all Military Treatment Facilities in accordance with the Department of Defense guidelines.
2. The Assistant Secretary of Defense (Health Affairs), in conjunction with the Service Surgeons General, should immediately develop or modify existing Tri-Service policy and regulatory guidelines for case management services in line with currently accepted medical practice, to ensure the efficient and effective transfer of the patient throughout the continuum of care. These guidelines should include the identification of outcome criteria and establish measurements to assess compliance.
3. The Commander of Walter Reed Army Medical Center must urgently ensure every returning casualty is assigned a single physician to holistically manage the healthcare and a case manager (to help navigate the system) as their basic unit of support.

Finding:

There is a lack of a clear standard for the qualifications and training of the outpatient case managers that is consistent across the Army, Navy, and Air Force.

Recommendations:

1. The Assistant Secretary of Defense (Health Affairs) should modify the Department of Defense TRICARE Management Activity Medical Management Guide to define clear standards, qualifications, and training requirements for case managers.
 2. The Service Surgeons General, in conjunction with the Commanders of military treatment facilities, should ensure proper initial and recurring training is conducted for case management personnel in line with the guidance set forth in the revised Department of Defense TRICARE Management Activity Medical Management Guide.
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II. Signature Injuries of the War

Finding:

The lack of early identification techniques and comprehensive clinical practice guidelines for traumatic brain injury and its overlap with post-traumatic stress disorder, within the military health system, results in inconsistent early diagnoses and treatment.

Recommendations:

1. The Assistant Secretary of Defense (Health Affairs), in conjunction with the Services, should develop and implement functional and cognitive measurements upon entry to military service for all recruits.
2. The Assistant Secretary of Defense (Health Affairs) should include functional and cognitive screening on the post-deployment health assessment and reassessment.
3. The Assistant Secretary of Defense (Health Affairs) should develop and issue a policy requiring 'exposures to blasts' be noted in a patient's medical record.
4. The Assistant Secretary of Defense (Health Affairs) should develop comprehensive and universal clinical practice guidelines for blast injuries and traumatic brain injury with post traumatic stress disorder overlay, and disseminate Military Health System-wide. This is an urgent requirement.
5. The Services should implement training for interpreters of the screening tools to recognize potential cases of traumatic brain injuries and post traumatic stress disorder.
6. The Assistant Secretary of Defense (Health Affairs) should develop coding guidelines for traumatic brain injury and disseminate Military Health System-wide. This represents an interim measure until updates in the International Classification of Diseases and Diagnostic and Statistical Manual of Mental Disorders occur.

7. The Services should commence cognitive remediation for servicemembers experiencing any decreases in cognitive ability, from their baseline, occurring during their service.
8. The Secretary of Defense must urgently review Traumatic Servicemembers' Group Life Insurance (TSGLI) to ensure that coverage is expanded to include the full spectrum of traumatic brain injury and post traumatic stress disorder. A thorough review of the program should assure that the criteria for eligibility truly cover the traumatically wounded warriors.¹⁶³

Finding:

More urgent research and training, among the medical community, is needed in the areas of traumatic brain injury and post traumatic stress disorder.

Recommendations:

1. The Secretary of Defense, in conjunction with the Secretary of Veterans Affairs, should establish a center of excellence for traumatic brain injury and post traumatic stress disorder, seeking support from the private sector where appropriate.
 - a. The center should combine existing research platforms within the Department of Defense and the Department of Veterans Affairs.
 - b. The center should include the breadth of research, training, and clinical services.
 - c. The center should define the military uniqueness of traumatic brain injury.

Research:

- The center should perform research on the physical and psychological impact of deployment on military personnel and their families during the various phases of deployment (pre-deployment, during deployment and post-deployment).
- The center should explore differences (if any) between active component and reserve component personnel and families.
- The center should evaluate the effectiveness of current and future military mental health care prevention and intervention programs (for example: medication versus psychotherapy versus a combined approach).

¹⁶³ Traumatic Servicemembers' Group Life Insurance (TSGLI) provides payments to servicemembers severely injured as a direct result of Operations Iraqi and Enduring Freedom. [Source: Office of the Under Secretary of Defense.(2005, November 23). *Traumatic Injury Protection under the servicemembers' Group Life Insurance (TSGLI) program*. Memorandum for Assistant Secretary of the Army (M&RA); Assistant Secretary of the Navy (M&RA); Assistant Secretary of the Air Force (MR); Director, Joint Staff; and Director, Defense Finance and Accounting Service.]

- The center should work with developers to further develop and rapidly deploy use of an accelerometer/over pressure monitor to measure blast impacts to servicemembers.

Training:

- The center should establish a training curriculum and the mechanisms to reach throughout the military to offer this training (for example: distance learning).
 - The center should assist military services in meeting their responsibility to train primary care and specialty providers, case managers, Medical Hold and Holdover staffs, unit commanders, patients and family members on signs, effects, effective management and proper documentation of traumatic brain injury and post-traumatic stress disorder.
 - Curriculum should include how to know when a patient may return to duty, whether the patient requires a profile or light duty, and when the patient must return for follow-up.
2. The Assistant Secretary of Defense (Health Affairs) should expand the *Millennium Cohort* study to include traumatic brain injury and post-traumatic stress disorder.
-

Finding:

There is a declining number of mental/behavioral health staff in the military medical system. This directly affects the care and treatment of traumatic brain injury and post-traumatic stress disorder.

Recommendations:

1. The Service Secretaries should investigate and implement compensation plans to retain current staff. As needed, seek Congressional authority to provide financial incentives for critically short and militarily required specialties.
 2. The Service Secretaries should ensure that active duty behavioral health staff augment recruiting commands to attract qualified students to the military, e.g., visiting alma maters.
 3. The Services should investigate increasing use of the Health Professions Scholarship Program (HPSP) and Financial Assistance Program (FAP) to attract qualified candidates.
 4. The Secretary of Defense should seek Congressional authority to change the laws pertaining to service obligation for recruitment of new physicians.
-

Finding:

There are inconsistencies within the Department of Defense and the Department of Veterans Affairs regulatory systems which deal with the functional loss of limb due to traumatic injury and burn. Currently, the disability system does not adequately compensate for the functional and physiological loss of limb in burn patients.

Recommendations:

1. The Secretary of Defense should request the Secretary of Veterans Affairs to update the Code of Federal Regulations, Title 38, Part IV to account for the unique disabilities and needs of traumatic amputees and burn victims, focused on a loss of function and post-service needs. This would require an expedited process for publishing the change.
 2. The Secretary of Defense should review the Physical Evaluation Board determinations of all burn cases, dating back to 2001, within one year after the update to Title 38.
-

Finding:

When an amputee leaves the Department of Defense medical system, the follow-on care, the amputee receives, may not be as technologically advanced outside the military medical system.

Recommendations:

1. The Secretary of Defense should pursue partnerships with the Secretary of Veterans Affairs to provide treatment; promote education and research in prosthesis care, production, and amputee therapy.
 2. The Secretary of Defense should pursue a partnership with the Secretary of Veterans Affairs to expand the Department of Veterans Affairs' existing program to allow patients to access the military health system and private prosthetic practitioners.
-

III. Physical Disability Evaluation System

Finding:

There are serious difficulties in administering the Physical Disability Evaluation System due to a significant variance in policy and guidelines within the military health system.

Recommendations:

1. The Secretary of Defense should provide recommendations to Congress to amend Title 10 United States Code, Chapter 61, and Title 38 United States Code, to allow the ‘fitness for duty’ determination to be adjudicated by the Department of Defense and the disability rating be adjudicated by the Department of Veterans Affairs.
 2. Following the changes to the United States Code, the Secretary of Defense, should quickly promulgate regulatory guidelines and policy to the Service Secretaries.
-

Finding:

The current Medical Evaluation Board/Physical Evaluation Board process is extremely cumbersome, inconsistent, and confusing to providers, patients, and families.

Recommendations:

1. The Under Secretary of Defense (Personnel & Readiness) should completely overhaul the physical disability evaluation system to implement one Department of Defense level Physical Evaluation Board/Appeals Review Commission with equitable Service representation and expand what is currently the Disability Advisory Council.
 - According to a Government Accountability Office report, a problem with the current organization is that the Council only “aims” to meet quarterly, but did not meet for a full year, to discuss issues raised by the Services. This recommended concept would have consolidated operational oversight and responsibility of the Physical Evaluation Board process, including the current the Service level Physical Evaluation Board and Appeals Review levels of jurisdiction. This action allows for streamlining of personnel and resources, and eliminates the intra and inter-Service disparities of the disability ratings and provides a forum for implementing immediate corrective action. This recommended concept incorporates Veterans Affairs representation and ensures a seamless transition from Department of Defense into the Veterans Affairs health system.
2. The Under Secretary of Defense (Personnel & Readiness) should conduct a quality assurance review all (Army, Navy/Marine Corps, and Air Force) Disability Evaluation System decisions of 0, 10, or 20 percent disability and Existed Prior to Service (EPTS) cases since 2001 to ensure consistency, fairness, and compliance with applicable regulations.
3. The Secretary of Defense and the Secretary of Veterans Affairs should establish one solution. Develop and utilize one disability rating guideline that remains flexible to evolve and be updated as the trends in injuries and supporting medical documentation/treatment necessitate. Revise the current process of updating the

disability ratings system to include an operation update that pushes changes to the field on a weekly, or as needed basis.

Finding:

A common automated interface does not exist between the clinical and administrative systems within the Department of Defense and among the Services, causing a systemic breakdown of a seamless and smooth transition from Department of Defense to the Department of Veterans Affairs.

Recommendation:

The Secretary of Defense, in conjunction with the Secretary of Veterans Affairs, should direct the transition process be streamlined for the servicemember separating from the Department of Defense and entering the Department of Veterans Affairs.

- As already identified in the Government Accountability Office report (2004), implement the single physical exam. Review the 1998 Department of Defense memorandum of understanding (MOU) between the Department of Defense and Department of Veterans Affairs, implement a common physical for use by the Services and the Department of Veterans Affairs for those servicemembers in the physical disability evaluation system, and allow flexibility in the timelines test or procedures that would eliminate redundant efforts.
- Rapidly develop a standard automated systems interface for both clinical and administrative systems that allows bilateral electronic exchange of information. Review and implement the recommendations of the 2003 President's Task Force.

IV. Reserve Component

Finding:

The Reserve Component servicemembers of our Armed Forces face unique challenges with respect to the military health care system.

Recommendations:

1. The Secretary of Defense, in conjunction with the Service Secretaries, should establish a program that returns previously deployed Reserve Component servicemembers back to an active status for a Post Deployment Health Reassessment and an evaluation by a medical professional, six months post demobilization.

2. The Secretary of the Army should continue to build the success of the Community Based Health Care Organization program and expand where possible. Other Services should be encouraged to use this program.
3. The Secretary of Defense should initiate a thorough review of post-service Reserve Component health care and develop systems and policies that assure quality care is delivered for service connected illness and injuries.
4. The Secretary of Defense should seek regulatory change to offer incentives to individual health care providers to accept TRICARE.

Leadership, Policy, and Oversight

V. Command and Control

Finding:

The Base Realignment and Closure decision to create the new Walter Reed National Military Medical Center contributed to staffing problems, inattention of leadership to day-to-day operations, and a lack of resources for capital improvements.

Recommendations:

1. The Secretary of Defense should seek legislative approval to accelerate the implementation of the Base Realignment and Closure Commission's recommendations. Specifically, accelerate or waive the Environmental Impact Study (EIS) and release monies required to start construction of the "new" Walter Reed National Military Medical Center.
2. The existing facilities should not be allowed to "die on the vine." Expeditious integration of these two facilities will lessen the time Walter Reed Army Medical Center is in a state of "limbo," and can take advantage of economies at a quicker pace while ultimately improving the treatment of eligible servicemembers and their families. The servicemembers and their families should not experience any delays in service during this transition. Funding must be provided to maintain full operation until the day of closure.

Finding:

The A-76 process created a destabilizing effect on the ability to hire and retain qualified staff members to operate garrison functions. The cost savings proved to be counterproductive.

Recommendation:

The Secretary of Defense should provide the Service Secretaries the opportunity to apply for regulatory relief from A-76 during a time of war; specifically for Walter Reed and other military treatment facilities.

Finding:

Leaders should have been aware of the poor living conditions and administrative hurdles faced by some outpatients at Walter Reed Army Medical Center.

Recommendation:

The Surgeon General of the Army should ensure the tools available to measure patient and family satisfaction and provide feedback on facility conditions are being used to the maximum extent. Use of the patient feedback system must ensure recurring and unresolved problems are acted upon and substantiated complaints are resolved and resolution is documented and reviewed by senior hospital leadership.

Finding:

Leadership failed to provide clear direction or place proper priority on the management and treatment of outpatients at Walter Reed Army Medical Center.

Recommendation:

The Secretary of the Army should ensure implementation of recommendations made in the Army Inspector General report on the Army physical disability evaluation system and the resulting Army Action Plan on Walter Reed Army Medical Center Outpatient Care. Both of these documents contain information that can be used as a part of a sound roadmap in improving the leadership and management of the newly formed Medical Hold Brigade. The Army Action plan has a May 31, 2007 due date to have all positions filled in the Medical Hold Brigade. Follow-up action by the Deputy Chief of Staff, G1 must be undertaken to ensure this timeline is met and effectiveness of the changes adopted should be measured by September 30, 2007 and adjustments made accordingly.

Finding:

Although there is a plan being initiated for the physical merger of Walter Reed Army Medical Center and National Naval Medical Center; the current Army, Navy, and Air Force Service cultures have tremendous strength within each Service, but present a significant barrier to the smooth integration into a joint Walter Reed National Military Medical Center.

Recommendations:

1. The Secretary of Defense should appoint a senior flag officer to oversee the transition of Walter Reed Army Medical Center to the Walter Reed National Military Medical Center. Recommend an officer with the rank of O-8 or above be placed in charge of the transition team and report progress on a regular basis to the Secretary of Defense.
 2. The Secretary of Defense, in conjunction with the Service Secretaries, must immediately initiate the functional integration of Walter Reed National Military Medical Center for the formation of cohesive joint team to ensure success.
-

Finding:

Staff training of the Medical Hold and Medical Holdover Cadre is inadequate.

Recommendation:

The Army Surgeon General should develop and institute a training program for the Medical Holdover Cadre that contains a specific focus on the care of wounded, ill, and injured servicemembers, assistance to families, and the administrative care of patients in a hospital setting. Follow-up action and inspection of training effectiveness should be accomplished within 60 days of training implementation.

Finding:

Shortage of staff in key positions, inability to recruit new staff members, and the staff's uncertainty of future employment has serious implications on the ability to continue quality care and services to patients at Walter Reed Army Medical Center.

Recommendations:

1. The Commanders of Walter Reed Army Medical Center and National Naval Medical Center should establish a combined transition hiring panel to provide employment assurances to staff members who will be needed to staff the new Walter Reed National Military Medical Center. This panel must have authority to provide employment opportunities and guarantee employment at the new hospital(s) for qualified staff members who meet performance standards.
2. The Service Secretaries should ensure standardized job classifications and grades for like positions at each facility are in place.

3. The Secretary of Defense should seek legislative relief from the archaic classification system that prevents paying competitive wages for nursing school graduates and other key hard-to-fill staff positions.
 4. The Secretary of the Army should ensure actions outlined in the Army Action Plan are implemented and measured for success within 60 days after implementation with a report back to the Secretary of Defense.
 5. The Secretary of Defense, in conjunction with the Service Secretaries, should review all statutory and regulatory guidance regarding military service obligations and grant an exception to policy for health care professionals.
-

Finding:

The Medical Hold and Holdover Companies are not properly staffed to provide guidance to patients, especially those with traumatic brain injury and post traumatic stress disorder.

Recommendations:

1. The U.S. Army Deputy Chief of Staff, G1 should establish a platoon sergeant to patient ratio sufficient to provide required supervision, tracking of appointments, and leadership to the Medical Hold and Holdover Cadre. The majority of Medical Holdover platoon sergeants recommend a 1:15 ratio as the necessary standard. Whatever standard of staffing is finally agreed upon, the G1 must review the effectiveness of the Medical Hold and Holdover Companies within 60 days of completing the recommendation and must then take action to adjust staffing levels as the situation dictates.
 2. The Army Surgeon General should ensure behavioral specialists are assigned to the Medical Hold and Holdover Companies to meet the needs of patients with traumatic brain injury and post traumatic stress disorder symptoms. Additional staff is needed to help identify patients who exhibit mental health problems such as depression, substance abuse, and suicidal behavior.
 3. The U.S. Army Deputy Chief of Staff, G1, in conjunction with the Surgeon General of the Army, should ensure a manpower standard is developed for the safe and effective operation of the Medical Hold and Holdover companies and brigades.
 4. The Service Secretaries should review and update applicable directives to ensure there is no distinction in the care management and disability processing of Active Component and activated Reserve Component servicemembers.
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Finding:

The Medical Hold and Holdover Cadres were significantly understaffed to handle their missions.

Recommendation:

The U.S. Army Deputy Chief of Staff, G1 should establish staffing guidelines for Medical Holding Cadres as recommended in the Army Inspector General report. In the interim, the Commander of Walter Reed Army Medical Center must fully staff the newly established Medical Holding Brigade by May 31, 2007 as outlined in the Army Action Plan. The Deputy Chief of Staff, G1 should follow-up within 60 days of full staffing of the brigade to measure effectiveness in terms of meeting the needs of servicemembers.

Finding:

Walter Reed Army Medical Center and National Naval Medical Center staff members, especially those in the nursing field, are showing signs of compassion fatigue.

Recommendation:

The Commanders of Walter Reed Army Medical Center and National Naval Medical Center should ensure programs are initiated and are in place to help the staff combat compassion fatigue and other stresses caused by the nature and intensity of work at these two medical centers. The Deputy Commander for Nursing at Walter Reed has taken positive steps in this regard by initiating a no-cost contract request to develop a tailored stress reduction program for the nursing staff. A formal study of stress and immediate action to provide stress reduction programs for all personnel as needed should be undertaken.

Finding:

Resource constraints at Walter Reed Army Medical Center contributed to the failings addressed in this report.

Recommendation:

The Secretary of Defense should evaluate the imposition of the “Efficiency Wedge” on the Service Medical Departments during this time of war.

VI. Family Support

Finding:

Inconsistent education processes exist across the Department of Defense, in advising families of available benefits to assist them upon the hospitalization of the servicemember and with travel and lodging.

Recommendations:

1. The Department of Defense should ensure swift education on entitlement of benefits for family members of all wounded, injured, and ill servicemembers in a Very Seriously Ill (VSI) and Seriously Ill (SI) category. Briefings should include information on the invitational travel benefits, the process, and the assignment of a liaison to assist the family with transportation arrangements, lodging, and other plans.
 2. The U.S. Army Deputy Chief of Staff, G1, and other Service equivalents, should ensure a liaison officer is appointed to the family of the wounded, ill, or injured servicemember to facilitate local transportation, lodging arrangements, and assist with any other benefits needed to support the family so that they can focus on the recovery and well being of their loved one.
-

Finding:

Insufficient housing exists, on the grounds of Walter Reed Army Medical Center, to accommodate family members who are at the hospital to aid in the recovery of their servicemember.

Recommendations:

1. The Army Surgeon General should review patient populations and nature of injury and illness and determine if patients can be moved from the Walter Reed Army Medical Center campus to medical treatment facilities close to the servicemembers' homes or home units. This will provide a better environment for patients and their families and may prove more economical for the government.
 2. The Secretary of the Army should empower uniformed Army leadership to make a determination on the feasibility of using permanent change of station (PCS) entitlements for families of wounded, ill, and seriously injured servicemembers who are destined for long term outpatient rehabilitative care. Permanent change of station entitlements must be used on a case by case basis with consideration given to the needs of the family and laws governing permanent change of station entitlements.
-

Finding:

Family members are sometimes left on their own to deal with the bureaucracy in their quest for assistance in completing administrative paperwork and for reimbursement of expenses incurred when visiting their wounded, ill, or injured servicemember.

Recommendation:

The U.S. Army Deputy Chief of Staff, G1 should assure that each family who travels on invitational travel orders to a medical treatment facility is assigned an advocate to assist with all administrative functions pertaining to the trip; including personal assistance to complete travel vouchers and necessary paperwork for reimbursement. The family advocate must take steps to follow-up and ensure family members are reimbursed in accordance with the provisions outlined in the Joint Federal Travel Regulations (JFTR). The assistance should be patterned after that provided by the Marine Corps Liaison Office at National Naval Medical Center.

VII. Facilities

Finding:

The facilities and infrastructure at Walter Reed Army Medical Center have not been maintained to an acceptable standard and have not received the required funding to sustain operations.

Recommendations:

1. The Secretary of the Army should identify a senior facilities engineer from US Army Medical Command or Installation Management Command to assume full responsibility for non-medical facility maintenance at Walter Reed Army Medical Center, to stabilize the maintenance process, conduct maintenance process assessment, and to improve the condition of critical facilities and infrastructure.
2. The US Army Medical Command Assistant Chief of Staff for Installations, Environmental & Facilities Management should prioritize assets and infrastructure based on risk and condition of all non-medical facilities.
3. The United States Army Corps of Engineers should conduct a facility condition assessment at all Walter Reed Army Medical Center facilities (medical and non-medical), focusing on high priority facilities and infrastructure first.
4. The Walter Reed Army Medical Center Garrison Commander should eliminate the use of the Installation Status Report for non-medical facilities and utilize a more efficient tool such as the Facilities Assistance and Assessment Support Team model which is currently being used in all U.S. Army Medical Facilities.

5. The United States Army Medical Command Assistant Chief of Staff for Installations, Environmental & Facilities Management should identify proactive maintenance metrics to manage the facility maintenance process.
 6. The Assistant Secretary of Defense (Health Affairs) should provide the Services adequate funding levels for facility sustainment, restoration, and modernization.
 7. The U.S. Army Medical Command Assistant Chief of Staff for Installations, Environmental and Facilities Management should hire a maintenance consulting company with experience in assessing private sector facility “best practices” and conduct a facility maintenance process assessment to identify the gap between current and desired performance of the maintenance process at Walter Reed Army Medical Center and develop an action plan for change to present to Army Medical Command’s Chief of Staff for approval to implement.
 8. The Secretary of Defense should assure that the Army, Navy, and Air Force assign one senior facility leader to the assessment team as an observer.
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VI. CONCLUSION

The Independent Review Group efforts led to the following general conclusions about the medical services administered at military treatment facilities, especially those services which continue at Walter Reed Army Medical Center.

1. Overhauling the Physical Disability Evaluation System (PDES) is the key to correcting the cumbersome, inconsistent, and confusing bureaucracy faced by sick and injured servicemembers and their families. If there is only one action taken, this is the one.
2. An incredible opportunity exists to make Walter Reed National Military Medical Center a premier military healthcare facility. In order to do so, immediate attention must be given to leading the physical, functional and, importantly, the cultural integration.
3. Research and knowledge pertaining to the signature injuries of this war, which are traumatic brain injury, post traumatic stress disorder, amputations, and burns, must be operationalized.
4. The transition from inpatient to outpatient status at Walter Reed Army Medical Center will be seamless and responsive if the appropriate resources, staffing, and training demands are quickly addressed.
5. Family support is an integral part of the servicemember's recovery. Institutionalizing policies and programs that facilitate the families' role in this regard is critical.
6. While Building 18 brought all of the above to the forefront and received the Nation's attention, facilities are merely symptomatic of larger systemic issues.

The systems issues, such as: physical disability evaluating system; Medical Hold and Holdover; and clinical diagnosis and management of blast and stress injuries, are indicative of problems that need to be addressed above the local level. The local issues, such as volume of patients, maintenance of facilities, and "perfect storm" dynamics are specific to Walter Reed Army Medical Center.

The Group believes that the appropriate attention must be given to aid the current culture at Walter Reed. The current culture at Walter Reed must be committed to the success of patient care and support for patient families.

Generally, the Nation must recognize that there is a moral, human, and budgetary cost of war. When we engage in armed conflict we must recognize those costs and be prepared to execute on those obligations.

If a mother feels that their son or daughter has been treated fairly then success will have been achieved and the trust will have been rebuilt.

In order to assure that the necessary changes occur in the system and culture of medical care within the Department of Defense, the Secretary of Defense should appoint an individual to be responsible for the implementation of the recommendations put forth by this Group.

While being careful not to condone future bureaucracy, it would be useful to consider a synchronized multi-agency initiative to continue reviewing and ultimately resolve shortcomings, gaps, and overlaps in disability evaluation for ill and injured servicemembers. This venture would require a great deal of consideration for and further debate from all parties involved, to include: The Department of Defense, The Department of Veterans Affairs, and The Department of Health and Human Services.

Acknowledgements

The Independent Review Group wants to thank all who have contributed to this report through interviews, testimonies, and website and hot-line comments.

Appreciation is further extended to each fellow review group member and staff who have tirelessly compiled this report in a very compressed timeframe.

In presenting our report to the Secretary of the Army, the Secretary of the Navy, the Secretary of the Air Force, and the Assistant Secretary of Defense (Health Affairs), we dedicate it to the servicemembers who have become casualties in support of national defense. We are eternally grateful and forever indebted to them for their patriotism, courage, and sacrifice.

Appendix A

Terms of Reference

Terms of Reference for Independent Review Group to Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center

Introduction:

The Independent Review Group (IRG) is established as a subcommittee of the Defense Health Board to review, report upon, and provide recommendations regarding any critical shortcomings and opportunities to improve rehabilitative care, administrative processes, and quality of life at Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC).

Overarching Goal:

Identify any critical shortcomings and opportunities to improve the rehabilitative care, administrative processes, and quality of life for injured and sick members of the armed forces at WRAMC and NNMC, and make recommendations for corrective actions.

Specific Objectives:

- Determine what services and support are most important to injured and sick members and their families during the process of recovery, rehabilitation and transition, and how the Military Services and DoD should ensure they are properly delivered.
- Identify what improvements are needed in the maintenance and management of housing facilities for injured and sick members.
- Ascertain what improvements are needed in the administration of the Disability Evaluation System.
- Address what improvements are needed in the administration of the Disability Evaluation System.
- Address what improvements are needed in the provision and coordination of rehabilitative care for ambulatory injured and sick members.
- Find what command climate issues are impacting the rehabilitative care, administrative processes, and quality of life for injured and sick members.

Scope of Review:

This review may include, if indicated in the judgment of the IRG, other sites where large volumes of casualty rehabilitative care, disability review, and processing are conducted.

The review should include:

- Policies and procedures for routine evaluation and maintenance of facilities where injured and sick members are housed.
- Accountability and empowerment of personnel responsible for correcting deficiencies in upkeep of facilities.
- Appointing and scheduling processes for rehabilitative care, including performance standards.
- Case management policies and procedures for injured and sick members.
- Process and accountabilities for determining when a Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) are initiated.
- MTF administrative processes and performance standards for creating and processing an MEB report prior to submission for review by the PEB.
- Physical Evaluation Board standards and procedures.
- Provision of support and educational materials for family members of injured and sick members (e.g., financial assistance, social services, counseling, housing).

Review should focus on those Military Department and DoD directed and controlled medical, administrative and personnel processes relevant to these issues.

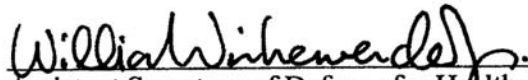
The IRG shall also have access to special advisors not serving as members of the group who can provide advice and expertise in the area of social work, rehabilitation, psychological counseling, family support and legal issues. The IRG shall be able to call upon other relevant advice or expertise in the government regarding medical facilities, disability review processes, housing and other pertinent matters. The IRG shall be given free and unrestricted access to facilities and personnel, and be able to call upon the assistance and administrative support of the Department of Defense to execute its responsibilities.

Report:

The IRG shall conduct its work and report its findings and recommendations through the Defense Health Board, a Federal Advisory Committee, to the Secretary of the Army, the Secretary of the Navy, and the Assistant Secretary of Defense for Health Affairs. The IRG may recommend location and issues meriting further study. The Report is due not later than April 16, 2007. The Report will include:

- An assessment of current processes and procedures involved in the rehabilitative care, administrative processes, and quality of life of injured and ill members, including analysis of what the injured and ill members and their families consider essential for a high quality experience during recovery, rehabilitation and transition.
- Alternatives and recommendations, as appropriate, to correct deficiencies and prevent them from occurring in the future.

Approved:

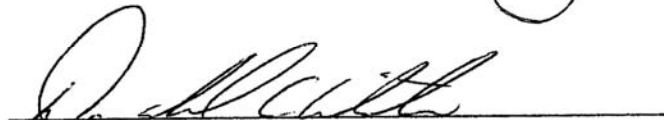

Assistant Secretary of Defense for Health Affairs
(Sponsor, by delegation, of the Defense Health Board)

1 March 2007
Date

Concurred in by:


Secretary of the Army

3/1/07
Date


Secretary of the Navy

3/1/07
Date

Appendix B

Secretary of Defense, Robert M. Gates—
Announcement of the Independent Review Group

Remarks by Secretary of Defense Robert Gates and Adm. Edmund Giambastiani

SEC. GATES: Thank you all for being with us this morning. I want to start by saying that like many Americans, I was dismayed to learn this past week that some of our injured troops were not getting the best possible treatment at all stages of their recovery, in particular the outpatient care. This is unacceptable and it will not continue.

I just met with the President this morning before coming out here, to brief him on the situation and on the actions that are under way. He is, understandably, concerned and emphatic in wanting the best possible care for our wounded soldiers and for their families.

I'm grateful to reporters for bringing this problem to our attention, but very disappointed we did not identify it ourselves. Our nation is truly blessed that so many talented and patriotic young people have stepped forward to serve. The men and women recovering at Walter Reed and at other military hospitals have put their lives on the line and paid a considerable price for defending our country. They should not have to recuperate in substandard housing, nor should they be expected to tackle mountains of paperwork and bureaucratic processes during this difficult period for themselves and for their families. They battled our foreign enemies; they should not have to battle an American bureaucracy.

To the best of my knowledge, there have not been complaints about the world-class level of medical care these troops have received, and that was true of the soldiers we just met with.

The issues raised this past week are about outpatient facilities and administration. These outpatient troops deserve a clean, relaxing place to recuperate from their injuries and ample assistance to navigate the next steps in their lives.

Today I'm announcing the formation of an independent review group. This group, which consists of eight military, medical and political leaders, will take a broad look at all our rehabilitative care and administrative processes here at Walter Reed and at the National Naval Medical Center. The co-chairs of this group are Togo West, former secretary of Veterans Affairs and secretary of the Army under President Clinton, and Jack Marsh, former secretary of the Army under President Reagan. The other members of the group are Dr. Joe Schwarz, former Republican congressman from Michigan; Jim Bacchus, former Democratic congressman from Florida who is now at Vanderbilt University; retired General John Jumper, former Air Force chief of staff; retired Lieutenant General Chip Roadman, former Air Force surgeon general; retired Rear Admiral Kathy Martin, former Navy deputy surgeon general; and retired Command Sergeant Major Larry Holland, formerly with the assistant secretary of Defense for Reserve Affairs.

This group will inspect the current situation at Walter Reed here in Washington, the National Naval Medical Center in Bethesda and any other centers they choose to examine.

I have no information to suggest there are problems at Bethesda or elsewhere such as we have learned about here at Walter Reed, but we need to know the scope of this problem.

I appreciate the willingness of each of these men and women to serve on this panel. This group will have special advisors in the areas of social work, rehabilitation, psychological counseling and family support issues. They will be given free and unrestricted access to facilities and personnel. The group will report back their findings and recommendations within 45 days to the secretary of the Army, the secretary of the Navy, and the assistant secretary of Defense for Health Affairs. Their report will be made available to the Congress and to the public.

A final point on the question of accountability. A bedrock principle of our military system is that we empower commanders with the responsibility, authority and resources necessary to carry out their mission. With responsibility comes accountability. It is my strong belief that an organization with the enormous responsibilities of the Department of Defense must live by this principle of accountability at all levels. Accordingly, after the facts are established, those responsible for having allowed this unacceptable situation to develop will indeed be held accountable.

Thank you.

I'd be happy to take some questions.

Q Secretary Gates, do you support Lieutenant General Kiley's comments yesterday that The Post story was one-sided and that there was not a breakdown in leadership and that he did not consider Building 18 substandard?

SEC. GATES: My recollection from reading that story was that he did not quarrel with any of the conclusions or any of the facts as presented in the article. I think his concern was more about tone.

I think that some of those issues remain to be seen, and those are the kinds of things that I want the review group to look at.

Q Mr. Secretary, you talked about accountability. Has anyone in the chain of command offered to resign over these problems?

SEC. GATES: No one. No one has offered to resign at this point.

Q How do you feel about that?

SEC. GATES: Well, first of all, there have been -- we are not going to wait 45 days to begin addressing these problems. And so there have been some people who are most directly involved, who have been relieved. But we will be looking and evaluating the rest of the chain of command as we get more information.

Yes?

Q Can I ask you about the -- another subject, the call-up of National Guard units, the accelerated call-up for duty in Iraq next year? Can you explain why that was felt necessary?

SEC. GATES: That really is -- I'll ask the admiral to comment on this as well, but my understanding is that that really -- if you're talking about the article in the paper earlier this week, that really was about FY -- or into calendar year '08.

And it's the implications of our deployments to Iraq right now, including the reinforcement, and the impact of that on the call-up dates during 2008. Obviously, the situation and requirement will depend on the situation on the ground.

ADM. GIAMBASTIANI: What this is about is the secretary last month talked about unit mobilizations and alertments for our National Guard, for example. And when we do this, we are going to do this mobilization period for a year. The intent of us doing that was to give them sufficient time ahead of time and alert them well in advance, so that we could get lots of the training, all of the types of administrative items done so that when they came in, they would be mobilized for just a short period of time: that one year, as opposed to 18 or 24 months. That is something that all of us military leaders wanted to do -- was limit the mobilization period to short ones. And the National Guard leaders across all of the states are very much in support of that.

Q (Off mike) -- meeting with some of the outpatient soldiers. Did you have a message for those in uniform and their families about where we go from here?

SEC. GATES: Well, I think that the senior leadership at the Department of Defense knows how strongly I feel about this.

I walked into my staff meeting Tuesday morning with the two articles from The Washington Post in my hand.

I think that the senior military leaders -- and I certainly share their view -- feel very strongly about this because this is about our family, and it appears to us that some of our family may not have been treated the way they should have been. And it's not just the facilities. Based on the soldiers we were just talking to and some of the things we've heard, there are some real problems in terms of the size of staffing, in terms of administrative tie-ups, bureaucratic or paperwork issues.

Everybody agrees that the medical care that they have received here at Walter Reed is just unsurpassable, that it is the best they could ever have hoped for. And their treatment while here, and their families', has been superb. It's the outpatient aspect of this. And we are just determined to fix it. These wounded soldiers deserve the best of everything, as far as all of us are concerned. And, you know, there's a lot in the papers about disagreements on Capitol Hill, and so on. I'll tell you, if there's one thing that everybody is unanimous on, it is how these soldiers need to be treated. And so we're determined to fix it and fix it fast.

Q Mr. Secretary, there have been two cases in which rape allegations have been leveled against Iraqi security forces. Are you concerned that this will aggravate sectarian violence there? And what has the U.S. military done? What actions has the military taken either to investigate or otherwise?

SEC. GATES: I don't know the answers to your question -- to the second part of your question. The first part, there certainly has been a lot of publicity attached to these rape allegations. I think anything like that has the potential to aggravate the situation. I hope it won't.

Q (Off mike.)

SEC. GATES: Well, there are some immediate fixes that we can take, just like there are some immediate fixes on the facilities. We really have just a snapshot at this point from talking to five soldiers, but it sounds like they have some very dedicated case officers who work extra hours, who work seven days a week, who are really dedicated. But some of them, maybe many of them, are overwhelmed. There's just too much work for the number of people that are available. So that's one thing that can be addressed pretty quickly.

In terms of whether there are deeper and more difficult problems, those are the kinds of things I think that the review group will take a look at.

Q Mr. Secretary, you told us a few weeks ago we are not planning a war against Iran. In an interview with ABC recently, the vice president said we have not taken any options off the table, which makes it sound as if there is at least some kind of contingency planning for possible future action against Iran. Can you elaborate?

SEC. GATES: I think that there's nothing incompatible between those two statements.

Yeah?

Q (Off mike.) China is due to announce its defense budget -- (off mike). Is there a concern that that state budget may not reflect the full thrust of China's -- (off mike) -- and that the Chinese, in fact -- (off mike)?

SEC. GATES: Well, I think that in the absence of something like congressional oversight, it's pretty easy for other states to disguise exactly how much they're spending on their military forces. This obviously was a huge problem with the Soviet Union. My suspicion is that the Chinese are probably spending more on their military than will be reflected in the state budget.

Q (Off mike.)

SEC. GATES: There are developments under way with respect to the Chinese military capabilities that are a concern, yes.

Q Mr. Secretary, back on Iran, with the U.N.'s determination yesterday that they're not following the rules and they're closer to a bomb than anybody thought, does this move military action up at all on the list of options? Or is the administration perhaps preparing to accept a nuclear-armed Iran, like it has had to accept a nuclear-armed North Korea?

SEC. GATES: I think the administration's focus at this point continues to be on a diplomatic solution to the problem.

Q Following up on a question asked earlier, General Kiley called The Washington Post articles one-sided. Do you agree with that characterization?

SEC. GATES: I don't know how to characterize the articles other than I'm not going to use other people's characterizations. All I can tell you is that I read the articles on Sunday and Monday, and I was upset by them. And I have not seen anything or heard anything in the time since then to lead me to believe that those articles were in any substantial way wrong.

Thank you, all, very much.

Appendix C

Independent Review Group Member Biographies

Independent Review Group Members



The Honorable Togo D. West, Jr., Co-Chair

Mr. West served in President Clinton's administration as Secretary of Veterans Affairs and also as Secretary of the Army. He is currently in the private practice of law in Washington, DC, and serves as the President of the National Learning for Life Program for the Boy Scouts of America.



The Honorable Jack Marsh, Co-Chair

Mr. Marsh served in President Reagan's administration as Secretary of the Army and previously in the U.S. House of Representatives (R, VA). He is an Army veteran and currently a Distinguished Professor of Law at George Mason University.



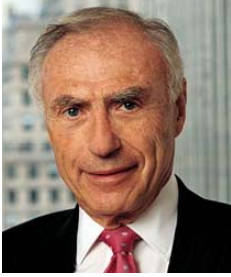
The Honorable Jim Bacchus

Mr. Bacchus served in the U.S. House of Representatives (D, FL) and, also, as chairman of the Appellate Body of the World Trade Organization. He is currently chairman of the Global Trade Practice Group of Greenberg Traunig, P.A. He is also a visiting Professor of Law at the Vanderbilt University Law School.



The Honorable Joe Schwarz, MD

Dr. Schwarz served in the U.S. House of Representatives (R, MI), as mayor of Battle Creek, Michigan, and in Vietnam as a U.S. Navy combat surgeon. He currently practices medicine and surgery in Battle Creek and serves on several college and university boards.



Arnold Fisher

Mr. Fisher served as Chairman & CEO of the Zachary & Elizabeth Fisher House Foundation from 1999 until 2003 and is an Honorary Knight of the British Empire. He is currently a senior partner at Fisher Brothers, a leader in New York City real estate.



John Jumper, General, U.S. Air Force (Retired)

General Jumper served as Chief of Staff, U.S. Air Force from 2001 until his retirement in 2005. A combat veteran of Vietnam and Iraq, he currently serves on several public, private, and charitable boards and as a strategic policy consultant.



Chip Roadman, MD, Lieutenant General, U.S. Air Force (Retired)

General (Dr.) Roadman served as Surgeon General, U.S. Air Force, until his retirement in 1999. He is currently Chairman of the Board of Altarum Institute, a non-profit health systems research group, and is a scientific board advisory member for IBM and LSTAT and a director for Assisted Living Concepts.



Kathy Martin, Rear Admiral, U.S. Navy (Retired)

Admiral Martin served as Deputy Surgeon General, U.S. Navy, from 2002 until her retirement in 2005. Her previous assignment was as Commander, National Naval Medical Center in Bethesda, Maryland. She is currently CEO of Vinson Hall Corporation in McLean, Virginia.



Larry Holland, Command Sergeant Major, U.S. Army (Retired)

CSM Holland served as Senior Enlisted Advisor to the Assistant Secretary of Defense for Reserve Affairs before retiring from the U.S. Army with 37 years of active and reserve service. He is currently the CEO of LWH, Inc., a supply chain management consulting company.

Appendix D

Reports Reviewed and Considered
by the Independent Review Group

Reports Reviewed and Considered by the Independent Review Group

The Independent Review Group reviewed and considered the following previous investigations and reports:

Government Accounting Office (GAO) Report: DOD and VA Health Care:

Challenges encountered by injured servicemembers during their recovery process (testimony) March 8, 2007

Army Inspector General (IG) Report: Army Physical Disability Evaluation Report Inspection, March 6, 2007

Department of Defense Inspector General Report on DOD / VA Interagency Care Transition, February 23, 2007

American Psychological Association (APA) Report: The Psychological Needs of U.S. Military Service Members and their Families: A preliminary report, February 2007

Department of Veterans Affairs (VA) Office of Inspector General (OIG) Report:

Healthcare Inspection, Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after traumatic brain injury rehabilitation, July 12, 2006

Government Accounting Office (GAO) Report: VA and DOD Health Care: Efforts to provide seamless transition of care for OEF and OIF Servicemembers and Veteran's, June 30, 2006

Military Disability System: Improved oversight needed to ensure consistent and timely outcomes for reserve and active duty service members, March 2006

Department of Veterans Affairs (VA) and Department of Defense (DoD) Health Care: VA has policies and outreach efforts to smooth transition from DOD Health Care, but sharing of Health Information remains limited (testimony) September 28, 2005

Government Accounting Office (GAO) Report: VA Disability Benefits and Healthcare: Providing services to the seriously injured poses challenges (testimony) March 17, 2005

Government Accounting Office (GAO) Report: Vocational Rehabilitation: More VA and DOD collaboration needed to expedite services for seriously injured servicemembers, January 2005

An Analysis of Military Disability Compensation, RAND National Defense Research Institute, 2005

Government Accounting Office (GAO) Report: VA and DOD Health Care: Efforts to Coordinate a Single Physical Exam process for Servicemembers leaving the military, November 2004

Government Accounting Office (GAO) Report: VA and Defense Health Care: More Information needed to determine if VA can meet an increase in demand for Post-Traumatic Stress Disorder Services, September 2004

United States Senate National Guard Caucus: Report on National Guard and Army Reservists on Medical Hold at Ft. Stewart, Georgia, October 24, 2003

President's Task Force: Final Report to Improve Health Care Delivery For Our Nation's Veterans, May 2003

1998 National Research Council Report, "Stewardship of Federal Facilities. A Proactive Strategy for Managing the Nation's Public Assets", National Academy Press, LCCN 98-87971

Appendix E

Individuals Interviewed
by the Independent Review Group

Individuals interviewed by the Independent Review Group

March 5, 2007

- Walter Reed Army Medical Center (WRAMC), Washington, DC
 - MG Eric Schoomaker, CG, North Atlantic Regional Medical Command (NARMC) & WRAMC
 - COL Virgil T. Deal, Commander, Walter Reed Health Care System (WRHCS), Washington, DC
 - COL Charles Callahan, Dep Cdr, Clinical Services, WRHCS
 - COL Reginald Miller, Deputy Cdr, Administration, WRHCS
 - COL Patricia Horoho, Dep Cdr, Nursing, WRHCS
 - Mr. Steve Brooks, Dep Garrison Cdr, WRAMC
 - CSM Jeffrey Miller, CSM, NARMC & WRAMC
 - CSM Donna Simmons, CSM, WRHCS
 - Mr. Dave Fortune, HFPO Amputee Center, WRAMC

March 6, 2007:

- Brooke Army Medical Center (BAMC), Fort Sam Houston, TX
 - BG James Gilman, Cdr, BAMC
 - LTC Guy T. Kiyokawa, Asst Chief of Staff (Installations), U.S. Army Medical Command, Fort Sam Houston, TX
 - COL Rick Bond, Cdr, US Army Health Facility Planning Agency
- Andrews Air Force Base, Camp Springs, MD
 - MG Robert Smolen, Cdr, Air Force District of Washington
 - BG Gary S. Graham, Cmd Sur, AFDW and Cdr, 79th Med Wing, Andrews AFB, MD

March 7, 2007:

- Walter Reed Army Medical Center
 - COL Charles Callahan, Dep Cdr, Clinical Services, WRHCS
 - COL Reginald Miller, Deputy Cdr, Administration, WRHCS
 - COL Patricia Horoho, Dep Cdr, Nursing, WRHCS
 - Mr. Steve Brooks, Dep Garrison Cdr, WRAMC

March 8, 2007:

- U.S. Army Physical Disability Evaluation Agency (USAPDA), DC
 - BG Reuben D. Jones, The Adjutant General & Cdr, USAPDA
 - COL Carlton A. Buchanan, Dep Cdr, USAPDA
 - Mr. Dennis Brower, Legal Advisor, USAPDA

March 13, 2007:

- National Naval Medical Center (NNMC), Bethesda, MD
 - RDML Adam Robinson, Cdr, National Naval Medical Center (NNMC), Bethesda, MD
 - CAPT Smith, NNMC Staff
 - CDR Frank R. Dunne, NNMC Staff
 - SGT Neil Duncan, 173rd Airborne Brigade
 - Ms. Marilyn Taylor (ret. Navy), STC Operator
- Walter Reed Army Medical Center
 - Public Meeting – See Transcript
 - One-on-One meetings - Twenty-seven Patients/Family Members

March 14, 2007:

- National Naval Medical Center
 - Public Meeting – See Transcript
 - One-on-One Meetings – Three Staff Members
 - One-on-One Meetings - Three Patients/Family Members
- Crystal Plaza 6
 - Mr. Steve Robinson, Veterans of America

March 15, 2007:

- Crystal Plaza 6
 - LTG (ret) Ronald Blanck, former Army Surgeon General

March 16, 2007:

- Wilford Hall USAF Medical Center, San Antonio, TX
 - Col Gerald W. Talcott, AF Med Spt Agency, Falls Church, VA
 - COL Bruce Crow, Chief Psychologist, Madigan Army Medical Center (MAMC), Fort Lewis, WA Ctr
 - BG David G. Young III, Cdr, 59th Med Wing, Lackland AFB, TX
- Pentagon
 - CSM Kenneth Preston, Sergeant Major of the Army
 - Hon. Thomas F. Hall, Asst Sec Def (Reserve Affairs)

March 19, 2007:

- National Naval Medical Center
 - Commander Master Chief Laura A. Martinez, U.S. Navy, NNMC
 - Mr. Michael D'Amico, NNMC
 - Mr. Henry Mitchell, NNMC
 - Mr. Steve Seyfried, NNMC
 - Mr. David Spurlock, NNMC

March 20, 2007

- Crystal Plaza 6
 - CAPT David Wade, Chief of Staff, Multi Service Market Office, WRAMC
- Pentagon
 - Hon. William Winkenwerder, Asst Sec Def (Health Affairs)
 - GEN Richard Cody, Vice Chief of Staff, U.S. Army

March 21, 2007

- Crystal Plaza 6
 - COL David McLeod, USU
 - COL Greg Argyros, WRAMC
 - COL (Ret) John Pierce, DVA
- Pentagon
 - Hon. David C. Winter, Secretary of the Navy
 - LTG Stanley Green, Army Inspector General

March 22, 2007

- Crystal Plaza 6
 - CAPT Miguel Cubano, Dep Dir, Office of Integration, National Capital Area Military Health System
- Pentagon
 - Hon. David Chu, Under Secretary of Defense (P&R)

March 23, 2007:

- WRAMC
 - Ms. Carol Altstatt, Social Worker, WRAMC

March 26, 2007:

- Crystal Plaza 6
 - Dr. Michael Kussman, Executive in Charge, Veterans Health Administration, VA

March 27, 2007:

- Crystal Plaza 6
 - Dr. Deborah Warden, Defense and Veterans Brain Injury Center
 - Dr. Maria Mouratidis, Staff, NNMC
 - COL Charles Engel, Uniformed Services University of the Health Sciences (USU)
 - LTC David Benedek, USU
 - COL Mary Lopez, USU (SG's Occupational Therapy Consultant)
 - COL Michael Hammond, OTSG (Army)
 - Mr. Ron Grubb, USAPDA
 - LTG (Ret) James Peake, former Surgeon General (Army)
- Walter Reed Army Medical Center
 - Mr. Larry Gies, Physical Evaluation Board Liaison Officer (PEBLO), WRAMC
 - MAJ Stephen Oates, PAD, Eisenhower Army Medical Center, EAMC, Ft. Gordon, GA
 - MAJ Richard Wilson, PAD, MAMCPEBLO trainee
 - Mr. Ron Grubb, PEB President
 - COL Samuel Smith, Center Judge Advocate (CJA), WRAMC
 - Ms. Jane Winand, Chief, Legal Assistance Division, OCJA, WRAMC
- Pentagon
 - Mr. Nelson Ford, Asst Sec Army (FM&C)
 - Mr. Pete Geren, Acting Secretary of the Army

March 30, 2007:

- Crystal Plaza 6
 - Ms. Elizabeth Leier

March 30, 2007:

- Camp Pendleton, CA
 - CAPT Joseph Sarachene, XO, Naval Hospital Camp Pendleton

April 1, 2007:

- Balboa Naval Medical Center, San Diego, CA
 - RDML Christine Hunter, Cdr, Balboa Navy Medical Center

April 3, 2007

- Crystal Plaza 6
 - VADM Donald Arthur, Surgeon General, USN, and Co-chair, DoD Mental Health Task Force
 - Dr. Shelley MacDermid, Co-chair, DoD Mental Health TF
 - LTG Jack C. Stultz, Chief, Army Reserve
 - COL Mike Jones, Chief, Recruiting Branch, Army National Guard
 - COL Craig Urbauer, Surgeon, Army National Guard
 - CSM Leon Caffie, CSM, Army Reserve
 - CSM John Gipe, CSM, Army National Guard
- Pentagon
 - GEN John D. W. Corley, Vice Chief of Staff, USAF, and Co-chair, TF on the Future of Military Health Care

April 4, 2007

- Pentagon
 - MG Gail Pollock, Acting Army Surgeon General

April 5, 2007

- Crystal Plaza 6, Alexandria, VA
 - Mr. Al Middleton, Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA), Falls Church, VA
 - Mr. Mark Yow, OASD(HA)

Appendix: F

Sites Visited by the Independent Review Group

Sites Visited

by the Independent Review Group

- ✓ Walter Reed Army Medical Center,
Washington, DC
- ✓ National Naval Medical Center, Bethesda, MD
- ✓ Brook Army Medical Center, San Antonio, TX
- ✓ Andrews Air Force Base, Camps Spring, MD
- ✓ Wilford Hall Medical Center, San Antonio, TX
- ✓ Balboa Naval Medical Center, San Diego, CA
- ✓ Defense and Veterans Brain Injury Center
- ✓ Naval Hospital, Camp Pendleton, CA
- ✓ Wounded Warrior Center, Camp
Pendleton, CA
- ✓ Army Physical Disability Agency,
Walter Reed Installation, Washington, DC

Appendix G

Independent Review Group
Website and Toll- Free Telephone Hotline

Independent Review Group

Website and Toll-Free Telephone Hotline

March 1-April 16, 2007

Website

IRG Public Comment Website
www.ha.osd.mil/dhb/irg

Hotline

IRG Telephone Hotline
1-866-268-2285

Appendix H

Acronym List

LIST OF ACRONYMS

(S)	Select
BRAC	Base Realignment and Closure Commission
BUMED	U.S. Navy Bureau of Medicine and Surgery
CBHCO	Community Based Health Care Organization
DD214	Department of Defense Form 214
DoD	United States Department of Defense
DoDD	Department of Defense Directive
DVA	Department of Veterans Affairs
DVBIC	Defense and Veterans Brain Injury Center
FAP	Financial Assistance Program
FY	Fiscal Year
GAO	Government Accountability Office
GME	Graduate Medical Education
GS	General Series
HPSP	Health Professions Scholarship Program
IAP	International American Products
IG	Inspector General
IRG	Independent Review Group
ISR	Infrastructure Status Report
ITOs	Invitational Travel Orders
JFTR	Joint Federal Travel Regulations
MEB	Medical Evaluation Board
MEBITT	Medical Evaluation Board Internal Tracking Tool
MedBOLTT	Medical Board On Line Tri-Service Tracking System
MEDCOM	US Army Medical Command
MOU	Memorandum of Understanding
MSO	Military Service Obligation
MTF	Military Treatment Facility
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PCS	Permanent Change of Station
PDCAPS	Physical Disability Case Processing System
PDES	Physical Disability Evaluation System
PPE	Personal Protective Equipment
PTSD	Post Traumatic Stress Disorder
Ret or RET	Retired
RIF	Reduction in Force
RN	Registered Nurse
SECNAV	Secretary of the Navy
SI	Seriously Ill
TBI	Traumatic Brain Injury
URAC	Utilization Review Accreditation Commission
VASRD	Veterans Administration Schedule for Rating Disabilities
VCSA	Vice Chief of Staff for the Army
VSI	Very Seriously Ill
WRAMC	Walter Reed Army Medical Center
WRNMMC	Walter Reed National Military Medical Center



**Independent Review Group
2221 South Clark Street
Arlington, VA 22202**