Report to Congress on the Comprehensive Policy Improvements to the Care, Management and Transition of Recovering Service Members (NDAA Section 1611 and 1615)

September 16, 2008

IMPROVING CARE, MANAGEMENT, AND TRANSITION OF RECOVERING SERVICE MEMBERS

INTRODUCTION

This report summarizes the development of a comprehensive policy by the Department of Defense and the Department of Veterans Affairs that addresses the care, management, and transition of recovering service members, as directed by the National Defense Authorization Act of 2008.

The joint DoD/VA Senior Oversight Committee, chaired by the Deputy Secretary of Defense and the Deputy Secretary of Veterans Affairs, has provided direction and oversight in the development of this policy. The Committee (Exhibit 1) was established in May 2007 to ensure that the recommendations of the Independent Review Group, the President's Commission on Care for Returning Wounded Warriors and the Interagency Task Force on Returning Global War on Terror Heroes were implemented. Working groups, or Line of Actions, for each issue addressed in these reports were established and included Line of Action 3, whose job was to address care and case management issues.

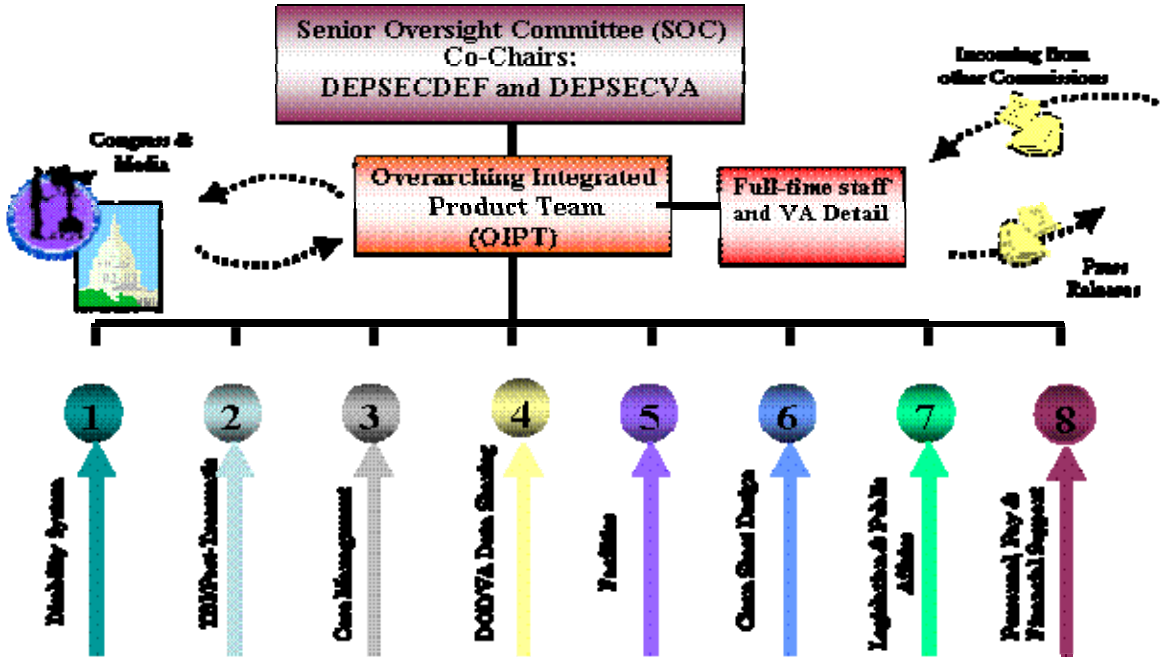

Exhibit 1. Senior Oversight Committee

COMPREHENSIVE POLICY

The National Defense Authorization Act of 2008 requires that the Secretary of Defense and the Secretary of Veterans Affairs jointly develop and implement a comprehensive policy on improving care, management, and transition of recovering service members. In developing this policy, Congress requires that both Departments consult with other federal departments and agencies as appropriate, as well as non-governmental organizations with expertise in the subject matter. The comprehensive policy is to cover the:

- *Care and management of recovering service members;*
- *Medical evaluation and disability evaluation of recovering service members.*
- *Return of service members who have recovered to active duty when appropriate; and*
- *Transition of recovering service members from receipt of care and services through the Department of Defense to receipt of care and services through the Department of Veterans Affairs.*

Line of Action 3 has coordinated the efforts to develop this policy as defined by Congress. In doing so, they have worked with other Lines of Action, the Military Services, the Military Health System, TRICARE, Veterans Health Administration and Veterans Benefits Administration. In addition, they have consulted with other federal, state and local governmental agencies; non-profit philanthropic and faith-based organizations; academic institutions; and professional associations.

EXISTING POLICY REVIEW AND RECOMMENDATION CONSIDERATION

The comprehensive policy was to be developed following a review of all current relevant policies and procedures in both Departments. Congress also requested that the comprehensive policy be developed in light of recent findings and recommendations from the following reports:

- *The Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center (2007);*
- *The Secretary of Veterans Affairs Task Force on Returning Global War on Terror Heroes (2007);*
- *The President's Commission on Care for America's Returning Wounded Warriors (2007);*
- *The Veterans' Disability Benefits Commission (2007);*
- *The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (2003);*
- *The Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance (1999); and*
- *The President's Commission on Veterans' Pensions (1956).*

The Departments were also instructed to use the experiences and best practices of each Department on matters relating to the policy, as well as other related matters that the Secretaries of the Departments deemed appropriate.

A review of current policies and procedures was conducted by each Department to inform the development of the comprehensive policy. The policies which were reviewed are listed in Appendix A.

In addition, the review of report findings and recommendations was completed by DoD and VA. The SOC Lines of Action are implementing the key report recommendations.

SERVICES FOR RECOVERING SERVICE MEMBERS

Congress requires that the military departments provide uniform standards to address the training and skills needed by health care professionals, recovery care coordinators, medical care case manages, and non-medical care managers to detect psychological disorders, including suicide risk, in recovering service members, and notify appropriate health care professionals following detection. The policy is also to include a specific system of tracking appropriate referrals for any individual thus identified.

DoD Uniform Standards for Training and Skills

Psychological Disorders: Detection, Referral, and Tracking

The military departments have developed and implemented a variety of programs to train military personnel to recognize symptoms that might indicate a psychological disorder or identify individuals at increased risk. The military departments are conducting a Department of Defense-wide effort to reduce the perceived stigma of mental health disorders and to teach resiliency techniques before deployment. All service members are trained to identify their own "early warning" signs of stress. Once self identified, service members are encouraged to seek help from Deployment Health Clinics, Vet Centers, installation behavioral health facilities and Military OneSource, or from a health care provider.

All service members are screened using common tools (Pre-Deployment Health Assessment, the Post-Deployment Health Assessment and the Post-Deployment Health Reassessment). The information from these assessments are compared (pre-deployment to post-deployment) and used to monitor the service members at regularly established intervals for stress-related disorders and other behavioral health concerns. Any medical or non-medical personnel who detect signs or symptoms of post-traumatic stress disorder, suicidal, homicidal or behavioral health concerns in a recovering service member will immediately report their observations to a Primary Care Manager or Medical Care Case Manager or the Commander. The Primary Care Manager, Medical Care Case Manager or the Commander will then assume responsibility for assuring that the identified service members get the appropriate care. All referral evaluations resulting from

such notifications are recorded in the medical record and can be tracked using the existing medical data systems.

The DoD Office of Defense Force Health Protection, the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, and the Defense and Veterans Brain Injury Center are also working to identify additional tracking mechanisms to record the number of referrals made by Medical Care Case Managers, Non-Medical Care Managers and recovery coordinators to medical and behavioral health professionals.

Recovering service members evaluated and referred for treatment for post-traumatic stress disorder, suicidal ideation, homicidal ideation or behavioral health problems will be managed based on mental health standards of care in coordination with their appropriate multidisciplinary team members. The TRICARE standards for clinical care govern the transmission of information relevant to the recovering service members' continued care and safety upon their transfer to a non-DoD care provider (e.g., VA Medical Center professional or TRICARE network provider).

VA Uniform Standards for Training and Skills

Psychological Disorders: Detection, Referral, and Tracking

The Department of Veterans Affairs supports a robust basic training and skill set acquisition for any VA employees who have patient contact. Some VA employees receive additional training due to the specific skills required by their job. Some relevant details of such training follow.

VA has implemented screening for PTSD, depression, military sexual trauma, and problem drinking for individuals when they are first seen in VA, and periodically thereafter. For PTSD, the requirement is for screening at least annually for five years, and beyond that, for screening at least once every five years. Health care providers and care managers outside of mental health specialty services usually conduct this screening, and they receive training on appropriate use of the screening tools that are contained with the electronic medical record system. Positive screens must be evaluated for diagnosable mental health conditions and for suicidality by a licensed independent provider, a physician, psychologist, social worker, or advanced practice nurse.

To ensure adequate follow-up for patients who are referred to mental health providers for evaluation or treatment, VHA has instituted a requirement that all new referrals or requests for mental health services receive an initial evaluation within 24 hours, and a full diagnostic and treatment-planning evaluation within two weeks. The 14-day requirement is tracked through the electronic health record. It is being met in approximately 94% of cases and all VISNs are meeting the criterion of at least 90% adherence to this standard. Guidance was sent out in writing to provide training and extensive telephone training, was also offered by the Office of Mental Health Services when this requirement was established, so that field leaders in mental health had extensive explanation of the process expected and all of their questions were answered.

In VHA, health providers and care managers are all licensed clinical providers with training and skills related to their professions. These are supplemented by ongoing training within specific programs. For example, there is required training about suicide prevention for all VA health care providers, and for all non-provider staff with patient contact, as noted in more detail below. In addition, extensive training in evidence-based psychotherapy for PTSD, depression, anxiety concurrent with depression, and serious mental illness has been offered and will continue at least through FY 2009.

Most significantly, VA has designed its health care system to compensate for the variability in knowledge, awareness, and comfort in dealing with mental health issues among non-mental health staff. Although VA provides training on mental health issues for providers and care managers at program-focused meetings, it has also designed screening programs to facilitate the identification of mental health problems in general medical settings, and has developed a number of programs that have integrated mental health providers into primary care, hospital based home care, and nursing homes. In addition, VA has Clinical Practice Guidelines, developed in conjunction with the Department of Defense, to guide care for PTSD, depression, substance use disorder, and other mental health disorders.

Suicide Training and Skills in VA

All VA clinical and non-clinical staff must complete a suicide specific training program. This is also a mandatory requirement for all new VA hires during orientation. Suicide Prevention Coordinators receive ongoing training through monthly conference calls and direct face-to-face training from the National Coordinator. Completion of these mandatory training programs is tracked for compliance by the National Suicide Prevention Coordinator.

The skills taught in the basic programs for non-clinical staff is awareness and how to obtain help for any recovering service member or veteran considered to be at risk. Clinical staff obtains additional skills in the assessment of risk and basic intervention strategies.

Suicide Notification in VA

The Veterans Suicide Prevention Hotline, developed in collaboration with Substance Abuse & Mental Health Services Administration (SAMHSA) and its Lifeline program, is available 24/7 and staffed by mental health professionals, nurses, social workers, and psychologists specifically trained as Lifeline responders. Responders are able to access the VA's electronic medical records for any veteran willing to identify themselves. Responders are also in constant contact with Suicide Prevention Coordinators, located at each of VA's medical centers, who follow-up on each call and initiate referral to the appropriate providers or programs within the VA medical center or clinic. Suicide Prevention Coordinators may also refer veterans to one of several community-based centers where staff have received special training in veteran-specific issues on those rare occasions when local VA resources are at capacity. Anyone, including VA personnel, can call the Hotline to report a concern about a veteran.

The Veterans Suicide Prevention Hotline is not the only access for care for veterans who have attempted suicide or those identified at risk. VA staff can refer individuals at risk to the Suicide Prevention Coordinator or to mental health care professions by direct referral.

Tracking Suicide Referrals in VA

Within each of VA's medical centers, Suicide Prevention Coordinators follow up on each Hotline call, review the mental health care plan for each veteran identified at risk, make sure that specific treatments that reduce the risk for suicide have been considered, and track compliance with the specific plan. Suicide Prevention Coordinators also develop relationships with community agencies and providers, and act as a resource for facilitating referral to the VA of veterans found to be at risk in the community.

They are also responsible for maintaining a list of veterans identified at high risk, as well as those who have attempted suicide, who receive care within the medical center. The Suicide Prevention Coordinators also maintain a chart "flagging" system that identifies individuals at high risk and for reporting this information to the National Suicide Prevention Coordinator. This flagging system ensures that those identified receive enhanced monitoring and care.

Recovery Care Coordinators

All Recovery Care Coordinators will receive uniform standardized training. Training of the initial cadre of Recovery Care Coordinators will parallel training received by the Federal Recovery Coordinators.

The uniform basic training curriculum for Recovery Care Coordinators is being developed consistent with DoD/VA learning objectives and instructional content created for the Recovery Care Coordinators and personnel in other programs such as:

- Army Medical Action Plan and Wounded Warrior Program
- Navy Safe Harbor Program
- Marine Corps Wounded Warrior Regiment
- Air Force Wounded Warrior Program and Air Force Family Liaison Officer
- Military Health System Learn Program

The uniform basic training curriculum will comply with Department of Defense Instruction (DODI) 1322.26, "Development, Management and Delivery of Distributed Learning," and will apply train-the-trainer models and distance learning approaches to ensure all recovery care coordinators, Medical Care Case Managers, and Non-Medical Care Mangers receive common content and instruction according to their roles and responsibilities. Additional modules will be developed for each group, as appropriate. The Military Departments will be responsible for ensuring their respective personnel participate in the required training hours and receive a certificate of completion prior to assuming their duties and responsibilities. They will assign appropriate continuing medical education credits for training.

Recovery Care Coordinators will receive training in the detection, notification and tracking of PTSD, suicide, homicide and other behavioral health concerns as part of their standardized curriculum. DoD Health Affairs and the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury are reviewing current processes and identifying procedures to ensure Medical Care Case Managers, Non-Medical Care Managers and Recovery Care Coordinators can detect behavioral health warning signs, notify appropriate personnel, and refer and track the recovering service member.

Recovery Care Coordinators will discuss the various aspects of behavioral health care with recovering service members and their families as part of the recovery plan development. If individuals begin to develop symptoms or appear to be at risk for the development of psychological or behavioral health problems, the Recovery Care Coordinator will refer the individual to a mental health professional or to their primary health care provider. Any such referral will be recorded in the Recovery Plan.

Recovery Care Coordinators are required to have a bachelor's degree in social science or a minimum of five years experience in military or community service.

Federal Recovery Coordinators

Upon hiring, all Federal Recovery Coordinators spend two weeks in intensive training at VA's Central Office followed by a two week orientation to their assigned facility. During training at Central Office, the Federal Recovery Coordinator is introduced to a variety of subjects from the many Federal agencies and Departments providing services and benefits to service members and veterans. Included in the topics are PTSD and suicide risk identification and the process for referral.

Most of the Federal Recovery Care Coordinators come into the Federal Recovery Care Coordination Program from clinical positions in the military services or the VA. As such, they bring a solid foundation of knowledge about these issues, as well as direct interaction with service members, veterans and their families in crisis. Federal Recovery Care Coordinators have annual training requirements for suicide risk and PTSD assessment, identification, and appropriate referral. These training materials are on the VA's online learning management system for ready access and completion. Compliance with all training requirements is recorded and tracked by the Federal Recovery Care Coordination supervisor.

The suicide training programs provide the Federal Recovery Care Coordinators with the skills necessary to understand suicide as a social and medical issue, assess suicide risk, and take the appropriate steps to intervene with referral to mental health care professionals. For PTSD, the Federal Recovery Care Coordinators must be able to identify and understand combat stress reactions, have an understanding of medications used to treat these conditions, and direct appropriate referrals to mental health care professions. When Federal Recovery Care Coordinators make any referral for care, the referral is tracked, along with any follow up, in their case logs. Case logs are monitored by the Federal Recovery Care Coordination supervisor.

A Comprehensive Recovery Plan

The comprehensive policy must include uniform standards and procedures for developing comprehensive recovery plans for each recovering service member. Furthermore, the plan must cover the full spectrum of care, management, transition and rehabilitation that the service member needs for recovery.

The creation of a recovery plan for each seriously wounded service member was a recommendation of the President's Commission on Care for America's Returning Wounded Warriors. The goal was to efficiently and effectively move a service member through the continuum of care, accessing the services and benefits appropriate to the needs. As recommended by the Commission, components of the recovery plan included identifying the patient's goals, evaluating the family's needs, and specifying the necessary resources.

DoD Comprehensive Recovery Plan

The DoD Recovery Care Coordinator will develop the Comprehensive Recovery Plan for enrolled seriously injured or ill recovering service members. An electronic prototype of the Comprehensive Recovery Plan is under development for use by Recovery Care Coordinators with seriously injured or ill recovering service members.

DoD/VA Federal Individual Recovery Plan

Currently, each severely wounded, ill or injured service member or veteran enrolled in the DoD/VA Federal Recovery Coordination Program has a Federal Individual Recovery Plan created by the assigned Federal Recovery Coordinator. The Plan is created with input from the service member or veteran's multidisciplinary health care team, the service member or veteran, and their family or caregiver. The Plan tracks care, management and transition through recovery, rehabilitation, and reintegration. For each of these care phases, goals are identified, responsibilities are assigned and timelines are created. The Federal Recovery Coordinator works with existing resources, Department of Defense, Veterans Affairs, other government, and non-governmental agencies to implement the Plan. The Federal Recovery Coordinator documents progression toward reaching each goal in a case log until the goal is reached or revised.

The Plan resides within an electronic record begun by Federal Recovery Coordinators when an individual is referred to the Program. The goal creation date, the care phase (recovery, rehabilitation or reintegration), goal, and timeline are captured in the electronic record for tracking and updating. A list of available benefits and services is also part of the electronic record. Goal reports can be generated and shared with the recovering service member or designee. The electronic record has undergone several iterations and currently resides with the Veterans' Tracking Application.

Recovery Plan Goal Categories

Both recovery plans classify goals into the following categories:

- Accommodations and Daily Living
- Behavioral Health
- Career Planning
- Clinical and Non-Clinical Case Management
- Disability Evaluation Process
- Legal
- Education
- Family Caregiver Needs
- Family/community assistance
- Financial
- Housing
- Military considerations
- Orders
- Appointments
- Redeployment
- Resources
- Therapy
- Transportation
- Travel
- TRICARE
- VA

Exhibit 2. Recovery Plan Goal Categories

Recovery Care Coordinators

Recovery care coordinators are specifically defined as those individuals who oversee and assist the service member throughout the care, management, transition and rehabilitation services provided by the Federal Government (including those provided by the Departments' of Defense, Veterans Affairs, Labor, and the Social Security Administration). Congress requires several specific requirements for recovery care coordinators to be included within the policy as follows:

- *Have a uniform method that assigns recovering service members to recovery care coordinators.*
- *Have a caseload limitation for each recovery care coordinator (except that the Secretary of the military department concerned may permit a waiver for no more than 120 days in the event of unforeseen circumstances as specified in the policy).*
- *Specify the appropriate standard training requirements and curricula for the recovery care coordinators.*
- *Provide adequate resources for the recovery care coordinators.*
- *Specify the appropriate supervision of the recovery care coordinators.*

Referral

Recovering service members and veterans are referred to a recovery coordination program in a variety of ways, including from commanders, members of the multidisciplinary team, and case managers. A recovering service member or veteran may also self refer. Generally, these individuals are those whose recovery is likely to require a complex array of specialists, facilities, and rehabilitation. When a referral is made, an evaluation is conducted by a Recovery Care

Coordinator. This evaluation serves as the basis for problem identification and the creation of a Comprehensive Recovery Plan.

Assignment

Assignment procedures are currently being developed that will assign each ill or injured service member to a category of care (Exhibit 3). This assignment will take place at the earliest possible point in the service member's medical care. Assignment to a category of care will be made by a member of the military medical staff. Most injured or ill service members will not require a comprehensive recovery plan. For example, of the 32,135 active duty service members wounded in action while serving in Operation Iraqi Freedom and Operation Enduring Freedom, 17,501 returned to duty within 72 hours.

For those service members with serious or severe injuries or illness who require multiple medical and non-medical providers a comprehensive assessment will be completed and they will be referred to a recovery coordination program for assignment to a recovery coordinator. Information collected from the needs assessment will be used to develop a recovery plan. The plan will identify personal and professional goals of the recovering service member. Members of the recovery team and community-based partners will also be identified in the plan and coordinated through a recovery coordinator.

Recovering Service Member Care Categories

CAT 1 recovering service member:
- Has a mild injury or illness
- Is expected to return to duty in less than 180 days
- Receives primarily local outpatient and short-term inpatient medical treatment and rehabilitation

CAT 2 recovering service member:
- Has a serious injury or illness
- Is unlikely to return to duty in less than 180 days
- May be medically separated from the military

CAT 3 recovering service member:
- Has a severe/catastrophic injury or illness
- Is highly unlikely to return to duty
- Will most likely be medically separated from the military

Exhibit 3. Recovering Service Member Care Categories

DoD Recovery Care Coordinator

Case Load

The initial maximum benchmark number of recovering service members in CAT 2 that the DoD Recovery Care Coordinators and Non-Medical Care Managers will be assigned to serve will be 40. The actual number will depend on the acuity of the service member's medical condition and complexity of his or her non-medical needs. This benchmark maximum is based on a review of current cases assigned to Non-Medical Case Managers in the Wounded Warrior Programs and various acuity-based models such as that used for Medical Care Case Managers in the Military Health System. The actual number of cases assigned to each Recovery Care Coordinator will be closely monitored. The number of recovering service members assigned to the Recovery Care Coordinators and Non-medical Care Managers will be reviewed as part of the overall evaluation of the program and modifications will be made and published. The number of recovering service members assigned to the Medical Care Case Managers will be consistent with the established number of cases under TRICARE guidance of 2006. Any departure from the maximum benchmark number established in the policy will require a waiver by the Military Department Secretary.

Standard Training

Standard training requirements and curricula are currently being developed and refined "real time" to meet the needs of the recovery coordinators. Included in the basic training is information regarding goal setting, communication, transition assistance, family support, traumatic brain injury, psychological and behavioral health, gender-specific needs, National Guard and Reserve specific information, employment, education and training, housing, adaptive equipment, transportation, MEB/PEB, and benefits and compensation. Also included in the training is the use of technology (databases and tracking tools) to enhance productivity and to assure that no enrolled recovery service member "falls through the cracks."

Resources

The Senior Oversight Committee provided input for the Fiscal Year 2010 President's Budget Request with the goal of achieving the care, management and transition mission, including the support of a Recovery Care Coordinator, Medical Care Case Manager and Non-Medical Care Manager, through the best use of resources. The Fiscal Year 2010-2015 Program Objective Memorandum includes additional resources for programs that were established or endorsed by the Senior Oversight Committee, including the NDAA requirements. All requirements will be included in the baseline beginning in Fiscal Year 2010. An annual review and analysis of resources will be conducted and used to make adjustments as needed.

Supervision

DoD Recovery Care Coordinators are attached to a Military department Wounded Warrior Program.

The supervisor for the Recovery Care Coordinators will be a military officer in the grade of 0-5 or 0-6, or a civilian employee of equivalent grade, in the Wounded Warrior Program leadership structure.

DoD/VA Federal Recovery Coordinators

Case Load

The appropriate workload or case ratio for Federal Recovery Coordinators is not known. These are new positions for which there are no comparable data or ratios. Currently, all Federal Recovery Coordinators are tracking time utilization and new cases are distributed based on existing cases. In the near future, the Program will implement acuity based measures to more precisely balance caseloads.

Standard Training

Standard basic training requirements and curricula were initially developed for newly hired Federal Recovery Coordinators. Included in the basic training is information regarding goal setting, communication, transition assistance, family support, traumatic brain injury, psychological and behavioral health, gender specific needs, National Guard and Reserve specific information, employment, education and training, housing, adaptive equipment, transportation, MEB/PEB, and benefits and compensation. Also included in the training is the use of technology (databases and tracking tools) to enhance productivity and to assure that no enrolled recovery service member or veteran "falls through the cracks". Newly hired Federal Recovery Coordinators also spend time in orientation at their assigned workplace (military or VA medical center).

In addition to the basic initial training, the Federal Recovery Coordinators are provided with bi-monthly seminars consisting of information they have identified as necessary and helpful to their job performance. Because each Federal Recovery Coordinator is a licensed medical professional, they must also meet any state requirements for ongoing medical education, as well as specific course work, such as PTSD and suicide risk identification, assigned by the Federal Recovery Coordination Program.

Resources

The Federal Recovery Coordination Program is supported by a variety of sources. Within its administrative home, the Department of Veterans Affairs, support includes office space at Central Office, technical and information technology support, access to human resources and budget specialists, and "open door policy" for access to both VBA and VHA for programmatic support. The Program also has access to the expertise and guidance from the VA's Office of Public and Intergovernmental Affairs, as well as the Office of Congressional and Legislative Affairs.

The Department of Defense provides assistance to the Program through the Line of Action Co-Lead and the Strategic Oversight Committee and staff. This support includes assistance with reporting requirements, development of appropriate tools, and coordination of activities. Two senior level military health personnel are detailed to the Program for additional assistance, coordination, and as a resource for the Federal Recovery Coordinators. Liaisons from the military services wounded warrior programs are available for immediate consultation.

The Federal Recovery Coordinators are individually supported by their host facilities as determined by Memoranda of Agreement with each facility. This support includes information technology, office space, office supplies, and other support as necessary. This is in addition to the financial requirements for both Department of Defense and Department of Veterans Affairs as noted in the MOU of October 30, 2007. The Program's best resources are, however, the individuals who serve as Federal Care Recovery Coordinators.

Supervision

Supervision of the Federal Recovery Coordinators is provided by a supervisor, who is based at the Department of Veterans Affairs Central Office in Washington, DC. The supervisor reviews each Federal Individual Recovery Plan and monitors progress in achieving goals. This individual also monitors time utilization statistics. Weekly teleconferences are held with the supervisor and the Federal Recovery Coordinators to discuss problems and identify solutions. The supervisor establishes clear performance goals for the Federal Recovery Coordinators and conducts yearly performance evaluations.

Medical Care Case Managers

Medical care case managers are defined as those individuals who assist a recovering service member (or the service member's immediate family or other designee if the service member is incapable of making a decision about personal medical care) in understanding their medical status, in obtaining the prescribed medical care, and in periodically reviewing the medical status, with the review conducted in person to the extent practicable. Congress specifically requests that the military departments provide a uniform program to assign recovering service members to medical care case managers. Congress furthermore requires that the military departments include the following in their policy for medical care case managers:

- *Caseload limitations;*
- *Standard training requirements and curricula;*
- *Adequate resources; and*
- *Appropriate supervision requirements.*

The Medical Care Case Manager, typically a nurse, will ensure that the recovering service member and family understand and have timely access to the recommended treatment including behavioral health services. The NDAA for 2008 (section 1611(e)(3)) defines their role as:

- Assisting in understanding the service member's medical status during the care, recovery, and transition of the service member
- Assisting in the receipt by the service member of prescribed medical care during the care, recovery, and transition of the service member
- Conducting a periodic review of the medical status of the service member, which shall be conducted, to the extent practicable, in person with the service member, or whenever the conduct of the review in person is not practicable, with the Medical Care Case Manager submitting to the manager's supervisor a written explanation why the review in person was not practicable (if the Secretary of the military department concerned elects to require such written explanations for purposes of the program)

The Medical Care Case Manager ensures that the recovering service member receives quality medical and behavioral health care which may include lengthy inpatient treatment and movements between facilities, or outpatient medical or behavioral health services.

The Medical Care Case Managers will follow their respective established workload ratios.[1]

Medical Care Case Managers will be supervised by a military medical officer in the grade of 0-5 or 0-6 or a civilian employee of equivalent grade or higher within his or her medical chain of command.

Non-Medical Care Managers

Congress also defines and sets criteria for non-medical care managers. These individuals are to communicate with recovering service members and their families regarding non-medical issues; assist in providing oversight for the service members' welfare and quality of life; and assist in resolving financial, administrative, personnel, transitional, and other issues that may arise during care, recovery, or transition.

The military departments shall develop a uniform program to assign recovering service members to non-medical care case managers and to require that these non-medical care case managers continue to assist recovering service members until the member returns to duty or separates. Congress requires that the policy establish caseload requirements, standard training

[1] 2006 TRICARE Medical Management Guide, Version II, Page 10, http://www.tricare.mil/ocmo/download/MM_Guide_2006.pdf

requirements and curricula, adequate resources, and appropriate supervision for non-medical care case managers.

The Non-Medical Care Manager will ensure the recovering service member and family receive all the non-medical (e.g., travel orders, housing, child care, benefits information and access) support they need. The NDAA for 2008 (section 1611(e)(4)) defines their role as:

- Communicating with the service member and with the service member's family or other individuals designated by the service member regarding non-medical matters that arise during the care, recovery, and transition of the service member
- Assisting with oversight of the service member's welfare and quality of life
- Assisting the service member in resolving problems involving financial, administrative, personnel, transitional, and other matters that arise during the care, recovery, and transition of the service member

The Medical Care Case Manager and Non-Medical Care Managers will regularly discuss the status of their activities with the recovery coordinator as they support the implementation of the recovering service member's recovery plan. This continuous exchange of information ensures accountability across providers and eliminates gaps or redundancy in care support. Per the National Defense Authorization Act for 2008, the Non-Medical Care Manager performs duties for a recovering service member until the service member is returned to active duty or retired or separated from the Armed Forces.

The Non-Medical Care Managers will follow their respective established workload ratios. The supervisor for the Non-Medical Care Managers will be a military officer in the grade of 0-5 or 0-6, or a civilian employee of equivalent grade, in the Wounded Warrior Program leadership structure.

ACCESS TO NON-URGENT HEALTH CARE

Congress specifically requires the policy to establishment appropriate minimum standards for access to non-urgent health care, as well as other health care services, for recovering service members in DOD medical facilities and through TRICARE programs. The policy must address maximum waiting time standards for follow-up care, specialty care, diagnostic referrals and studies, and medically necessary surgical procedures. The policy shall also specify circumstances and conditions in which a recovering service member may waive a standard of access.

Recovering service members are usually provided non-urgent health care at military treatment facilities. In addition, they may receive non-urgent health care through TRICARE's civilian preferred provider network or in the VA medical system. TRICARE access standards apply to all military treatment facilities, as well as to the civilian preferred network. The current access to care standards, including wait times, that apply to all patients are delineated in 32 CFR 199.17(p)(5)(ii) (Appendix B). The standards for non-urgent care can only be waived at the request of, and for the benefit of, the service member.

ASSIGNMENT TO LOCATIONS OF CARE

The Department of Defense shall define a policy that will create uniform guidelines to assigning recovering service members to specific locations of care, including those closest to their military duty station, home of record, or designated care giver when medically appropriate. The policy shall require that uniform guidelines and procedures be developed to reassign recovering service members to other facilities if the facilities in which they are currently receiving care are found by the Secretary of Defense to violate section 1648 of the NDAA for 2008.

Recovering service members should receive care in the most appropriate facility and location closest to his or her home or duty station or the location of his or her care provider. The assignment to locations of care is primarily a medically-driven process led by the recovering service member's Primary Care Manager in consultation with the recovering service member, family members, Medical Care Case Manager, Non-Medical Care Managers and the Command. With inpatient military treatment facilities, VA Medical Centers and Polytrauma Rehabilitation Centers nationwide, hundreds of outpatient facilities, and the thousands of authorized professionals in the TRICARE Provider Network nationwide the goal of achieving proximity of care becomes realistic.

Proximity to home is an especially important consideration for National Guard and Reserve service members' when deciding on a location of care. For example, recovering service members of the Army National Guard and Army Reserve who require only outpatient care, may request transfer to an Army Community Based Health Care Organization. This program allows the service member to live at home and perform duties at a local military organization such as an armory or recruiting station. Community Based Health Care Organizations are located in Alabama, Arkansas, California, Florida, Massachusetts, Puerto Rico, Utah, Virginia, and Wisconsin. Each one is responsible for ensuring recovering service members in a specific area of the United States receive the medical care he or she needs.

A memorandum of agreement between DoD and VA, dated July 2003, allows recovering service members who have sustained spinal cord injury, traumatic brain injury, or blindness to be transferred to VA medical facilities for treatment and rehabilitative services. DoD, VA, the TRICARE Management Activity and the Military Medical Support Office work closely to determine when a recovering service member can be referred to a VA facility for care. Ideally, the recovering service member will be treated at the VA facility that is as close as possible to family and home. This memorandum of agreement and ongoing efforts to meet the demands of trauma care illustrate how the DoD/VA Joint Executive Council and the Senior Oversight Committee are working to refine existing programs and improve care for recovering service members and veterans.

Reassignment from deficient facilities

Regardless of the location of inpatient or outpatient care, the quality of care and facility standards will be upheld by the multidisciplinary team. Recovering service members in inpatient status will be transferred from facilities that fail to meet the generally accepted standards for accreditation of medical facilities as written by the Joint Commission on Accreditation of Healthcare Organizations. All military medical inpatient treatment facilities are required to meet the Joint Commission's standards.

The "DoD Housing Inspection Standards for Medical Hold and Holdover Personnel" policy defines the housing standards for outpatient recovering service members and prescribes the basis for evaluating the adequacy of housing facilities. These standards require that a housing unit assigned to a particular recovering service member shall be appropriate for the member's medical condition, expected duration of treatment, dependency status, and pay grade.

TRANSPORTATION AND SUBSISTENCE

The military departments shall create policy that will establish uniform standards for the availability of appropriate transportation and subsistence in order for recovering service members to obtain needed medical care and services.

Service members who return to duty after suffering from a serious or severe injury or illness may require follow-up care. Normally this medical care will be provided by the local military treatment facility, but in some cases the service member may need to travel to a different location for care. These service members receive orders that authorize funding for travel, lodging and meals. The funding allowances cover transportation expenses to include the cost of airline, train, vessel, and bus tickets to and from carrier terminals and the cost of special conveyances such as taxis. Service members who use their privately owned vehicle to travel to a medical appointment are entitled to a mileage allowance plus reimbursement of parking fees and tolls. All service members who are on orders to travel to a medical appointment are authorized per diem to offset the cost of lodging, meals and incidental expenses.

Members of the National Guard or Reserve who return to his or her unit in an inactive status, but are entitled to non-urgent medical care for injuries or illnesses that occurred while on active duty, coordinate authorization and schedule appointments through his or her unit and the Military Medical Support Office. Members of the National Guard and Reserve are entitled to the same travel allowances and per diem as active duty service members.

Service members receive information about VA benefits, compensation and services before he or she leaves active duty. The VA also sends every veteran a letter with this information following his or her discharge to ensure he or she is aware of, and takes advantage of, the benefits and services available to him or her.

In general, recent combat-theater veterans have enhanced eligibility for VA hospital care and medical services for any medical condition that may be related to his or her combat service, including screening for signs of post-traumatic stress disorder, for up to five years from the date he or she is discharged or released from active military service. Veterans may seek care from the

VA health care system if he or she has a service-connected disability rated at 50% or higher, is unemployable due to his or her service-connected conditions, or is seeking care for the service-connected disability. These veterans have priority for appointments in the VA health care system.

WORK AND DUTY ASSIGNMENTS

The military departments shall develop uniform criteria for assigning recovering service members to work or duty compatible with their medical condition.

The military medical departments, parent commands and Wounded Warrior Programs consider all relevant criteria in determining the most appropriate work assignments for recovering service members. The assignments support healing, rehabilitation and transition, including the return to duty, and may include training and education tailored to the limitations of the recovering service member's medical condition. The work and duty assignment will be reflected in the recovering service member's recovery plan.

ACCESS TO EDUCATION, VOCATIONAL TRAINING, AND REHABILITATION

The military departments shall provide uniform standards for recovering service members to access appropriate education, vocational training, and rehabilitation opportunities at the earliest possible time in the course of their recovery.

The Veterans Affairs Department of each state are critical partners in the success of community reintegration. As part of the transition planning the recovery coordinator and recovering service member will discuss the service member's short term and long term personal and professional goals such as employment, education and vocational training and the rehabilitation needed to meet these goals. Options will be identified in the recovery plan with sufficient time for acquiring services such as financial aid, housing adaptation, assistive technology, employer support and college assistance.

A wide variety of federal, state, local agency and private sector programs, identified in the National Resource Directory will support these efforts including:

- Departments of Defense, Labor and VA Transition Assistance and Disabled Transition Assistance Programs
- Department of Labor's Veterans Employment and Training Service, REALifeLines, America's Heroes at Work, eVets Resource Advisor, and Hire Vets First programs
- VA's Vocational Rehabilitation and Employment Program Services and Vocational Educational Counseling

The Veterans Affairs Offices of each state are critical partners in the success of community reintegration. As part of the transition planning, the recovery coordinator and recovering service member will discuss the service member's short term and long term personal and professional goals such as employment, education and vocational training and the rehabilitation needed to

meet those goals. Options will be identified in the recovery plan with sufficient time for acquiring services and resources such as financial aid, housing adaptation, assistive technology, employer support, and college or university assistance.

A wide variety of federal, state, local agency and private sector programs, identified in the National Resource Directory, will support these efforts including:

TRACKING

The military departments shall develop uniform procedures for tracking recovering service members in order to:

Facilitate in locating each recovering service member; and

Ensure that each recovering service member complies with appointments, and other physical and evaluation timelines, and to provide any other information needed to oversee care, management, and transitions.

The Military Department Wounded Warrior Programs have procedures in place to track recovering service members as they move through recovery, rehabilitation and return to duty or separation/retirement and reintegration into the community.

Recovering service members are served by a recovery coordinator and recovery team, including a Non-Medical Care Manager and Medical Care Case Manager. All members of the recovery team and the service member will have access to the online recovery plan. They will use this tool to help locate recovering service members and track appointments to support compliance with the medical care plans. DoD and VA share essential health, personnel, and administrative data to support stability, rehabilitation and transition of recovering service members. Development of a joint solution to electronic health records for DoD/VA is a goal of, and is being addressed by, the new Interagency Program Office.

REFERRALS TO OTHER CARE AND SERVICE PROVIDERS

The military departments are required to develop a uniform policy for referral of recovering service members to the Department of Veterans Affairs and other private and public entities when appropriate for care, taking into account the medical needs of the recovering service member and the geographic location of services.

Title 38, Section 8111 of U. S. Code requires that DoD and VA develop agreements and contracts for the mutually beneficial coordination, use, or exchange of use of health care resources. Under this authority, there have been 148 sharing agreements established between VA and DoD (as per FY 2007) and the VA has been established as part of the TRICARE network.

A memorandum of agreement between DoD and VA, dated July 2003, allows recovering service members who have sustained spinal cord injury, traumatic brain injury, or blindness to be transferred to VA medical facilities for treatment and rehabilitative services. DoD, VA, the TRICARE Management Activity and the Military Medical Support Office work closely to determine when a recovering service member can be referred to a VA facility for care. Ideally, the recovering service member will be treated at the VA facility that is as close as possible to family and home. Transfers to VA facilities are assisted by a cadre of VA liaisons and VA polytrauma nurses stationed at various military treatment facilities. At receiving VA medical and rehabilitation facilities are individuals designated as part of the OEF/OIF team. This team helps with the transition and with any specific issue that may arise.

The Comprehensive Recovery Plan will identify needed services and resources from other governmental and public and private providers, based on the recovering service members' identified medical, rehabilitation, personal and professional goals and needs. These other providers include, but are not limited to, academic and private medical centers, rehabilitation facilities, and philanthropic supported clinics.

The Recovery Care Coordinator will work with the Medical Care Case Manager and Non-Medical Care Manager to ensure that appropriate referrals are identified in the recovery plan and facilitated for the recovering service member and family. The recovery plan provides a mechanism across service sites and providers that the recovery coordinator can use to assist in making and tracking referrals.

SERVICES FOR FAMILIES

The military departments are required to include in the comprehensive policy:

- *Guidelines for providing support to family members who might not be eligible for care (Sec. 1672 of NDAA for 2008);*
- *Uniform requirements and standards for the provision of advice and training to family members caring for a service member with respect to care for the service member during their recovery;*
- *Uniform procedures among the military departments on the measurement of the satisfaction of family members of recovering service members with the quality of health care services provided to service members during their recovery;*
- *Procedures for eligible family members to apply for Department of Defense job placement services during a one-year period.*

Support for Family Members Not Otherwise Eligible for Medical Care

Guideline for access to medical and behavioral health services is important for family members who are not otherwise eligible for care as dependents (e.g., parent, sibling) through the DoD

Military Health System. Currently, medical care and counseling through DoD facilities is provided on a space-available basis under three conditions:

- If the family member is on invitational travel orders to care for the recovering service member
- If he or she is a non-medical attendant caring for a recovering service member
- If he or she is receiving per diem payments from DoD while caring for the recovering service member

The DoD Medical Care Case Manager, Non-Medical Care Manager, and Recovery Care Coordinator will assist non-dependent family members in obtaining access to care and non-federal care providers as needed.

A memorandum of understanding between the DoD and the American Red Cross, signed in July 2008, provides access to financial assistance for the recovering service member or his or her family members through the military aid societies. Counseling services, referral to community resources, and assistance to veterans are also available.

In December 2007, the American Red Cross expanded its financial assistance service through the Casualty Assistance Travel Program. When traveling to the bedside of a recovering service member injured in a combat zone, financial assistance is available for up to two immediate family members or eligible non-dependent family members visiting a recovering service member in the United States or its territories.

Advice and Training for Family Members

In many instances, family members begin their involvement in the care of their recovering service member during an inpatient hospitalization. This involvement may continue – sometimes as the primary care giver – after discharge when the recovering service member returns home and needs rehabilitation or long-term care. The DoD Family Handbook will provide a quick reference guide for the care, management, and transition process. It will clearly identify the recovery coordinator and members of the multidisciplinary team and their distinct roles and contact information, and include Frequently Asked Questions and checklists for easier access to information, services and resources.

Family members are also receiving information on the prevention, signs, symptoms and treatment options for post-traumatic stress disorder and behavioral health concerns before and after their service member deploys. Family members' concerns about their own personal stress or that of a recovering service member can be discussed with a Medical Care Case Manager, Non-Medical Care Manager or recovery coordinator. Referrals will be made to the appropriate military department Family Service Center, installation behavioral health facility, the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, the Traumatic Brain Injury Information Clearinghouse, and/or other partners such as Military OneSource or the American Red Cross.

Consistent with the spirit of the NDAA and the promotion of family stability and resiliency, the comprehensive policy will establish uniform guidelines for advice and training for family members of recovering service members diagnosed with traumatic brain injury, post-traumatic stress disorder, spinal cord injuries, amputations, blindness, and other injuries and illnesses. The focus of this education will be on the medical (e.g., use of medications), psychological (e.g., detection and notification), and non-medical (e.g., adaptive housing) needs of recovering service members. These needs will be identified as goals in the recovery plan and information on services and resources will be available in the plan and through the National Resource Directory.

Measurement of Satisfaction of Family Members

The military medical departments' currently measure family satisfaction with the health care provided to recovering service members through mail-in surveys, face-to-face interviews, and telephone surveys that measure:

- Timeliness of service
- Staff responsiveness
- Understanding of the diagnosis and the care plan
- Access to services and resources
- Awareness of the roles and responsibilities of the care providers and coordinators

The DoD TRICARE Management Activity conducts health care surveys to measure patient satisfaction with inpatient and outpatient care and specific visits to providers. The results of these standard, formal assessments of patient and family satisfaction are used to implement improvements and ensure quality in the delivery of health and supportive services in inpatient and outpatient settings. The evaluation of the Recovery Coordination Program activities is also pursuing formal assessment of family satisfaction with the non-medical care coordination services provided to them and their recovering service members. The majority of this information on family satisfaction with non-medical services is now collected through periodic DoD surveys.

The Secretary of Defense is hosting a DoD Wounded, Ill and Injured Family Support Summit to share and identify best practices and usability of family support services. The participants will be service members, families, and representatives of the Services' Wounded Warrior and Family Support Programs. The Summit will evaluate impact of services and resources on spouses, children non-dependent family members and significant others.

Job Placement Services for Family Members

When family members take time off or leave their jobs in order to care for a recovering service member, their earnings decrease and their career may be negatively affected. The Comprehensive Needs Assessment will evaluate the family's financial challenges; the recovery

plan will identify benefits, compensation, services and resources for which they are eligible. Federal or non-federal resources such as grants from non-profit organizations will be identified and accessed along with other services from service and benefits organizations and state and local agencies.

The Departments of Defense, Labor and Veterans Affairs have developed joint efforts to support these family members with job training and placement services. These collaborative efforts include REALifelines, a program to enhance job protection, access to career opportunities, training information, and education options for family members who are placed on leave or displaced from employment while caring for a recovering service member or veteran.

OUTREACH

The comprehensive policy shall include outreach efforts by both the Departments of Defense and Veterans Affairs to inform recovering service members and their families about the medical care, management, and transition policies as well as the responsibilities of the recovering service member and family.

The joint DoD/VA Senior Oversight Committee has conducted several outreach efforts to consult with associations and organizations that support recovering service members, veterans and families such as Veterans Service Organizations, Military Service Organizations, and family associations.

Web-based outreach sites help recovering service members, veterans and families identify available services and resources and access those which might be helpful. Military OneSource is a 24/7 toll-free information and referral telephone service available worldwide to active duty, Reserve, and National Guard service members and families.

The comprehensive, web-based National Resource Directory will be available to recovering service members, veterans, families, and care coordinators, care providers and care partners nationwide beginning in the fall of 2008. The directory will highlight checklists for common processes and frequently asked questions. It will provide information on services and resources available through national, state and local governmental agencies, veterans' benefit/service/advocacy organizations, professional provider associations, community and faith-based/non-profit organizations, academic institutions, employers and philanthropic activities of business and industry. As a non-subscription tool, it will provide information, and facilitate connections that will help meet the medical or non-medical needs and goals of recovering service members and veterans at any location and at any time in his or her life. The Directory will include the ability to search for information by type of user, geographic location, military affiliation, and specific service or resource required. The Directory is being developed jointly by DoD, VA and the Department of Labor with information contributing partners across the nation. A screen shot of this resource is provided below (Exhibit 4).

Exhibit 4. Home Page of the National Resource Directory Prototype

The National Resource Directory will support the Wounded Warrior Resource Center. The Wounded Warrior Resource Center serves as a single point of contact for wounded, ill and injured service members, their families, caregivers and those who support them. The benefits portal, recommended by the President's Commission on Care for America's Returning Wounded Warriors, is under development.

In-person outreach for National Guard members is conducted through the National Guard Family Assistance Centers established throughout the 54 states, territories and the District of Columbia. The Centers augment the support system for geographically dispersed families by providing information, referrals, and assistance to families during a service member's deployment. They support any military family member from any branch or component of the military departments.

The VA's outreach efforts to veterans include:

- A letter from the Secretary of Veterans Affairs
- "GWOT OIF and OEF review" newsletter
- A summary of VA benefits" and "A Summary of VA Benefits for National Guard and Reservists" brochures
- "Iraqi Freedom Benefits" brochure
- "VA Health Care and Benefits Information for Veterans" wallet card
- "Welcome Home" events
- News Releases (sent out by facilities and the Office of Public and Intergovernmental Affairs)
- Post- Deployment Health Reassessment events
- Polytrauma Call Center outreach to severely injured veterans
- Participation in military conferences, Family Day events, Unit Reunions and Stand-downs
- Increased use of the Internet

Applicability to the Temporary Disability Retired List

Recovering service members eventually placed on the Temporary Disability Retired List will generally be assigned to Category 2 (serious injury or illness and is unlikely to return to duty in less than 180 days or Category 3 (severe or catastrophic injury or illness and highly unlikely to be returned to duty in 180 days. These individuals will be referred to a recovery coordination program. Once enrolled into the program, a recovery plan will be developed and implemented. Individuals on the Temporary Disability Retired List receive the same benefits as other retired members of the military departments. As a veteran, he or she is eligible for care at VA facilities. As a retiree, he or she has access to DoD military treatment facilities and the TRICARE civilian preferred provider network.

Appendix A. Policies, Processes and Procedures Review

Legislative

USC Title 10

USC Title 32
Code of Federal Regulations Title 32
Code of Federal Regulations Title 38
Joint Federal Travel Regulation Volume 1
Joint Federal Travel Regulation Volume 2

DoD

DODD 1342.17 Family Policy (Dec 88)
DODD 5136.12 TRICARE Management Activity (TMA) (May 01)
DODD 5154.06 Armed Services Medical Regulating (Jan 05)
DODD 6010.14 Healthcare for Uniformed Services Members and Beneficiaries (Mar 07)
DODI 1300.18 Military Personnel Casualty Matters, Policies, and Procedures (Dec 00)
DODI 1332.38 Physical Disability Evaluation (Nov 96)
DODI 1332.39Application of the Veterans Administration Standards for Rating Disabilities (Nov 96)
DODI 1342.22 Family Centers (Dec 92)
DODI 6000.11 Patient Movement (Sep 98)
DODI 6000.14 Patient Bill of Rights and Responsibilities in the Military Health System (MHS) (Sep 07)
DODI 6010.23 Department of Defense and Department of Veterans Affairs Health Care Resource Sharing Program (Sep 05)
DODI 6025.20 Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas (Jan 06)
DODI 6490.03 Deployment Health (Aug 06)
DOD Health Affairs Interim Policy for Clinical Case Management for the Wounded, Ill, and Injured Service Member in the Military Health System UPDATE January 22, 2008
DOD Health Affairs Policy 08-001 Implementation of New Medical Expense and Performance Reporting System Codes to Track Case Management Associated with Global War on Terror Heroes (Mar 08)
DOD Health Affairs Policy 07-030 Traumatic Brain Injury Definition and Reporting (Oct 07)
DOD Health Affairs Policy 05-018 Expediting Veterans Benefits to Members with Serious Illnesses and Injuries (Sep 05)
DOD Health Affairs Policy 04-031 Coordination of Policy to Establish a Joint Theater Trauma Registry (Dec 04)
DOD Health Affairs Policy 03-026 Personnel on Medical Hold (Oct 03)
DOD Health Affairs Policy 02-022 Department of Veterans Affairs Participation in TRICARE (Dec 02)
DOD Health Affairs Policy 99-023 Inclusion of Department of Veterans (VA) Affairs Health Facilities TRICARE Network Providers (May 99)
DOD Health Affairs Policy 99-028 Establishment of DOD Centers for Deployment Health (Sep 99)
DOD Financial Management Regulation, Volume 7A, Chapter 35 (Nov 05)
DOD Financial Management Regulation, Volume 7A, Chapter 50 (May 06)

TMA - Medical Management Guide (Jan 06)

VA

VHA Directive 2007-012 Eligibility Verification Process for VA Health Care Benefits (Apr 07)
VHA Directive 2005-045 Treatment of Active Duty Service members in VA Health Care Facilities (Oct 05)
VHA Directive 2005-020 Determining Combat Veteran Eligibility (Jun 05)
VHA Directive 2007-013 Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans (Apr 07)
VHA Directive 2006-041 Veterans Health Care Service Standards (Jun 06)
VHA Directive 2006-055 VHA Outpatient Scheduling Processes and Procedures (Oct 06)
VHA Directive 2006-038 Considerations for VA Support for the Department of Defense (DOD) Post Deployment Health Reassessment (PDHRA) Program for Returning Deployed Service Members (Jun 06)
VHA Directive 2006-59 Active Patients in the Primary Care Management Module (PCMM) (Nov 06)
VHA Directive 2007-016 Coordinated Care for Traveling Veterans (May 07)
VHA Directive 2006-028 Process for Ensuring Timely Access to Outpatient Clinical Care (May 06)
VHA Directive 2003-003 Provision of Hospital Outpatient Care to Enrolled Veterans (Jan 03)

Army

Warrior Transition Unit Consolidated Guidance (Mar 2008)
Comprehensive Care Plan (Draft – Feb 2008)
Soldier and Family Assistance Handbook
Army Regulation 40-400 Patient Administration (Feb 08)
Army Regulation 40-501 Standards of Medical Fitness (Dec 07)
Army Regulation 635-40 Physical Evaluation for Retention, Retirement or Separation (Feb 06)
Army Regulation 600-8-4 Line of Duty Policy, Procedures and Investigations (Apr 04)

OTSG/MEDCOM Policy Memo 07-019 Guidance for MEDCOM Reunion and Reintegration of Redeploying Soldiers (Jun 07)
OTSG/MEDCOM Policy Memo 07-029 Physical Evaluation Board Liaison Officer (PEBLO) Training and Certification (Jul 07)
OTSG/MEDCOM Policy Memo 07-031 Access to Veterans Benefits Counseling (Aug 07)
OTSG/MEDCOM Policy Memo 07-036 Escorts for Non-Medical Caregivers and Families Traveling on Official Orders (Aug 07)
OTSG/MEDCOM Policy Memo 07-038 Ombudsman Program in Support of Warriors I Transition (Sep 07)
OTSG/MEDCOM Policy Memo 07-040 Metrics and Continuous Process Improvement for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) (Sep 07)
OTSG/MEDCOM Policy Memo 07-041 Patient Movement from Outside Continental United States (OCONUS) and Reception of Warriors in Transition to Continental United States (CONUS) Military Treatment Facilities (MTFs)

Navy

Navy Policy Memorandum (Unnumbered) Traumatic Brain Injury (TBI) Definition and Reporting (Dec 07)

Navy Policy Memorandum 07-018 Case Management Policy (Jun 07)
Navy Policy Memorandum 05-002 Implementing Traumatic Injury Protection Under the Service Members Group Life Insurance (Dec 05)

SECNAVINST 1850 Severely Injured Marines and Sailors (SIMS) Pilot Program (Sep 06)
SECNAVINST 1850.4E Department of the Navy Disability Evaluation Manual, Part 6 –Policy Governing the Temporary Disability Retired List (Apr 02)
JAGINST 5800.7D Reporting Requirements for Line of Duty (LOD) Determinations (Feb 05)

BUMED Directive 5370.3 Navy Medicine Hotline Program (Apr 06)
BUMED Directive 6300.10A Customer Relations (Aug 01)
BUMED Directive 6320-12 Transfer of Patients of the Naval Service to Veterans Administration Facilities (Jan 87)

Marine Corps
Casualty Care Process (Dec 07)
Wounded Warrior Regiment Marine Reserve MEDHOLD Checklist
Marine Corps Order 1754.8A Marine for Life (May 03)
Marine Corps Order 6320.2E Administration and Processing of Injured/Ill/Hospitalized Marines (Nov 07)
Leaders Guide for Managing Marines in Distress (web based)

Air Force
Air Force Instruction 36-2910 Line of Duty (Misconduct) Determination (Oct 02)
Air Force Instruction 36-3212 Physical Evaluation for Retention, Retirement and Separation (Feb 06)
Air Force Instruction 36-3009 Airman and Family Readiness Centers (Jan 08)
Air Force Instruction 44-102 Medical Care Management (May 06)
Air Force Instruction 44-147_Air Force Order SISUP Medical Evaluation Boards (MEB) and Continued Military Service (Nov 07)
Memorandum: PALACE HART (Helping Airmen Recover Together) (Feb 06)

Appendix B. Access Standards to Care

32 CFR 199.17(p) (5) (ii)[2]

[2] http://law.justia.com/us/cfr/title32/32-2.1.1.1.7.0.1.18.html

(5) *Access standards.* Preferred provider networks will have attributes of size, composition, mix of providers and geographical distribution so that the networks, coupled with the MTF capabilities, can adequately address the health care needs of the enrollees. Before offering enrollment in Prime to a beneficiary group, the MTF Commander (or other authorized person) will assure that the capabilities of the MTF plus preferred provider network will meet the following access standards with respect to the needs of the expected number of enrollees from the beneficiary group being offered enrollment:

(i) Under normal circumstances, enrollee travel time may not exceed 30 minutes from home to primary care delivery site unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area.

(ii) The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four weeks; for a routine visit, the wait time for an appointment shall not exceed one week; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours.

(iii) Emergency services shall be available and accessible to handle emergencies (and urgent care visits if not available from other primary care providers pursuant to paragraph (p) (5) (ii) of this section), within the service area 24 hours a day, seven days a week.

(iv) The network shall include a sufficient number and mix of board certified specialists to meet reasonably the anticipated needs of enrollees. Travel time for specialty care shall not exceed one hour under normal circumstances, unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area. This requirement does not apply under the Specialized Treatment Services Program.

(v) Office waiting times in non-emergency circumstances shall not exceed 30 minutes, except when emergency care is being provided to patients, and the normal schedule is disrupted.